



Office of  
Mental Health

Department  
of Health

Office of Addiction  
Services and Supports

# **New York State Medicaid Managed Care Behavioral Health Billing and Coding Manual**

**For Individuals enrolled in Mainstream, Health and Recovery Plan  
(HARP), and Human Immunodeficiency Virus-Special Needs Plan  
(HIV-SNP) Product Lines**

Updated April 2024<sup>1</sup>

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<sup>1</sup> This update includes any behavioral health billing guidance/announcements released as of January 1, 2024.

## Table of Contents

I. Introduction.....	3
II. Managed Care Contracting, Billing and Technical Assistance Requirements .....	3
A. Contracting .....	3
B. Government Rates.....	3
C. Claims.....	5
D. Claims Coding Taxonomy .....	5
E. Medicaid Managed Care Network Provider Enrollment .....	5
F. Provider Technical Assistance .....	6
III. OMH Ambulatory Mental Health Services.....	7
A. Service Types .....	7
➤ Assertive Community Treatment (ACT): .....	7
➤ OMH-Licensed Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS, formerly known as Clinic) .....	8
➤ Continuing Day Treatment (CDT): .....	8
➤ Comprehensive Psychiatric Emergency Program (CPEP):.....	9
➤ Personalized Recovery Oriented Services (PROS): .....	12
➤ Transportation: .....	14
B. Telehealth Services .....	14
IV. Office of Addiction Services and Supports (OASAS) –Addiction Services and Billing .....	14
A. Service Types .....	15
➤ OASAS Outpatient Clinics, Opioid, and Rehabilitation Programs:.....	15
➤ OASAS Residential Services Programs.....	17
➤ Withdrawal and Stabilization Services and Inpatient Rehabilitation Programs .....	19
B. Provider Qualifications for all Addiction Services.....	19
C. Reimbursement for Addiction Services .....	20
➤ General Addiction Services Requirements and Limitations.....	20
D. OASAS Program ASAM Crosswalk .....	23
E. Service Reimbursement and Coding for Addiction Services.....	23
F. OASAS Telehealth Service Reimbursement .....	26
V. Crisis Intervention .....	27
A. Mobile Crisis Services.....	27
B. Crisis Residence Services .....	28
VI. Adult Behavioral Health Home and Community Based Services (BH HCBS) .....	28
A. BH HCBS Utilization Thresholds .....	28
B. BH HCBS Billing Guidelines:.....	29
➤ Habilitation: .....	29
➤ Education Support Services: .....	29
➤ Pre-Vocational Services: .....	29
➤ Transitional Employment: .....	29
➤ Intensive Supported Employment (ISE):.....	29
➤ Ongoing Supported Employment:.....	30

- BH HCBS Staff Transportation: ..... 30
- Non-medical Transportation (only for HARP enrollees and individuals in HIV-SNPs meeting the HARP eligibility criteria and qualifying under a BH HCBS needs assessment): ..... 31
- VII. Community Oriented Recovery and Empowerment (CORE) Services ..... 31
- VIII. Service Combinations ..... 32

## I. Introduction

This manual outlines the claiming requirements necessary to ensure proper behavioral health claims submission with respect to Mainstream Medicaid Managed Care Plans (MMCPs), Health and Recovery Plans (HARPs), and Human Immunodeficiency Virus-Special Needs Plans (HIV-SNPs) herein referred to as “MMCPs” unless otherwise noted. Each behavioral health service in Medicaid Managed Care is covered in detail. This manual should be used in conjunction with the [OMH coding taxonomy](#) and [OASAS coding taxonomy](#) which provides a crosswalk of rate code to procedure code/modifier code combinations prepared by the New York State Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) for use by both MMCPs and providers. The coding taxonomies are for existing State Plan services, and 1115 Waiver services including Adult Behavioral Health Home and Community Based Services (BH HCBS), and Community Oriented Recovery and Empowerment (CORE) Services.

This billing manual does not apply to office-based practitioner billing. It applies only to behavioral health services that can be billed under Medicaid fee-for-service rate codes by OMH-licensed or OASAS-certified programs and to the BH HCBS and CORE Services delivered by OMH and OASAS designated providers.

**Note:** This manual addresses billing guidance only. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, initial and on-going treatment planning and reviews, etc. Those standards are in the regulations for each program.

**Note:** The Medicaid Advantage Plus (MAP) product line for individuals dually eligible for Medicaid and Medicare has different behavioral health billing and reimbursement rules. For specific behavioral health billing requirements for OMH and OASAS services in MAP, please refer to the MAP Billing and Coding Manual found here: [Billing Behavioral Health Services Under Managed Care](#).

## II. Managed Care Contracting, Billing and Technical Assistance Requirements

### A. Contracting

To ensure network adequacy and timely access to behavioral health services, including each type of BH HCBS and CORE Service, MMCPs must offer contracts to behavioral health providers licensed, certified, or designated by OMH and OASAS. MMCPs must meet minimum network adequacy standards in each service category as outlined in the current [Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract](#) Section 21.19 (herein referred to as Model Contract).

### B. Government Rates

New York State law requires that MMCPs pay the equivalent of Ambulatory Patient Group (APG) rates for Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) as well as for Outpatient Addiction Treatment Clinics Rehabilitation Service, and Opioid Treatment Programs (OTPs). Since October 1, 2015, in New York City (NYC) and July 1, 2016, in counties outside of NYC, MMCPs have been required to pay 100% of the Medicaid fee-for-service (FFS) rate (aka, “government rates”) for selected behavioral health services (see list below) delivered to individuals enrolled in MMCPs when the service is provided by an OASAS and/or OMH

licensed, certified, or designated program. For Adult BH HCBS and CORE Services, the government rate is the reimbursement listed for each program respectively on the BH HCBS and CORE Fee Schedules located on the [OMH Medicaid Reimbursement](#) page. Per Chapter 57 of the Laws of 2022, MMCPs are required to pay claims based on the effective date of the rate changes. MMCPs are required to reconcile and adjust the payment accordingly, for clean claims, without further action from the provider when there are rate updates. The State will conduct routine monitoring for MMCP reported encounter data and other appropriate claims data to verify compliance with this Law.

Government rates are required for the following five categories of services:

**OASAS Government Rate Services (MMCPs):**

- OASAS Clinic
- Opioid Treatment Programs (outpatient)
- Outpatient Rehabilitation
- Outpatient Services Provided in the Community by Freestanding Providers
- Part 820 Residential Addiction Treatment Services

**OMH State Plan Services (MMCPs):**

- Assertive Community Treatment (ACT)
- Mental Health Outpatient Rehabilitation Treatment Services (MHOTRS)
- Comprehensive Psychiatric Emergency Program (CPEP)<sup>2</sup>
- Continuing Day Treatment (CDT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Crisis Intervention Benefit- Mobile Crisis and Crisis Residence Services

**Adult BH HCBS (HARP and HIV-SNP):**

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Provider Travel Supplement (Staff Transportation)
- Non-Medical Patient Transportation (Note: As is already the case with medical transportation, non-medical transportation is carved out of the MMCP benefit, managed by a transportation manager based on the Plan of Care, and paid by FFS directly to the transportation provider.)

**CORE Services (HARP and HIV-SNP):**

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Family Support and Training
- Empowerment Services – Peer Supports
- Provider Travel Supplement (Staff Transportation)

<sup>2</sup> CPEP- EOB is classified as inpatient and therefore the government rate is not required.

## C. Claims

MMCPs shall support both paper and electronic submission of claims for all claim types. Claims will be submitted using the institutional claims form (837i for electronic or UB-04 for paper). This will allow for use of rate codes which will inform the MMCP as to the type of behavioral health program that is submitting the claim and the service(s) being provided. The Medicaid rate code will be submitted to the Encounter Intake System (EIS) for all inpatient and outpatient mental health (MH) and addiction services. Rate codes are a recognized and mandatory data element in encounter reporting for all services that are licensed, certified, and/or designated by OMH and OASAS. MMCPs must accept rate codes on all behavioral health inpatient and outpatient claims and include those rate codes on encounters submitted to the EIS.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four-digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing. This field is already used by MMCPs to report the weight of a low-birth-weight baby.

MMCPs should refer to the [OMH Medicaid Reimbursement](#) and/or [OASAS Reimbursement](#) page for any rate updates to ensure providers are being reimbursed at the correct rates based on date of service.

Billing requirements depend on the type of service provided; however, every electronic claim submitted requires at least the following:

- Use of the 837i (electronic) or UB-04 (paper) claim format;
- Medicaid rate code;
- Diagnosis code(s);
- Procedure code(s);
- Procedure code modifiers (as needed);
- Units of service; and
- Attending and/or Ordering/Referring Practitioner NPI.

## D. Claims Coding Taxonomy

The coding taxonomy for Adult BH HCBS/CORE and all other ambulatory behavioral health services, including 1115 demonstration services, can be found here: [OMH Mainstream/HARP coding taxonomy](#) or [OASAS Mainstream/HARP Coding Taxonomy](#). These coding taxonomies provide a helpful crosswalk between existing FFS rate code-based billing and the unique rate code/procedure code/modifier code combinations that are required under Medicaid managed care. Providers will use these coding combinations to indicate to the MMCP that the claim is for a behavioral health service provided by a behavioral health program and is to be paid at the government rate. The procedure and modifier code combinations have been created such that even if the rate code did not exist, the MMCP would be able to differentiate between the various services and mirror the correct FFS payment amount.

## E. Medicaid Managed Care Network Provider Enrollment

Section 5005(b)(2) of the 21st Century Cures Act and Section 1932(d) of the Social Security Act requires that effective January 1, 2018, both participating and non-participating Medicaid

Managed Care providers must enroll as a Medicaid provider. The Medicaid provider enrollment process is to ensure appropriate and consistent screening of providers and improve program integrity. If a provider is not actively enrolled with the NYS Medicaid Program and are providing services to Medicaid eligible members, the provider must enroll or are at risk of getting their claims denied per the [April 2022 NYS DOH Medicaid Update](#).

*Required: Medicaid Enrollment as a Provider Agency*

All OMH/OASAS licensed, certified, designated, and/or approved providers must be enrolled as a Medicaid provider agency to bill and be reimbursed for services. Provider agencies who have not yet enrolled with Medicaid should follow the process outlined at the following site: [eMedNY Provider Enrollment & Maintenance Page](#).

*Required: Medicaid Enrollment as an Individual Practitioner Affiliated with OMH/OASAS Agency*

Individual practitioners who are a Medicaid enrollable type and are providing services to Medicaid individuals must be enrolled in Medicaid or enroll as a non-billing Ordering, Prescribing, Referring, and Attending (OPRA) provider. Practitioners who wish to **enroll as an OPRA provider (non-billing)** should alternatively enroll as an OPRA provider on the [eMedNY "Provider Enrollment and Maintenance" web page](#).

Not all practitioners will meet the criteria to qualify for enrollment. Providers can review the provider manuals available on the [eMedNY "Provider Manuals" web page](#) and are advised to continuously monitor the [eMedNY "Provider Enrollment and Maintenance" web page](#) for any new Medicaid enrollable practitioner types. This can be done by reviewing the practitioners listed in the "Practitioner" filter located within the right-hand box titled "Provider List Filter."

Providers can check their enrollment status by utilizing the tools available on the [NYS DOH "Medicaid Enrolled Provider Lookup" web page](#) and can search by entering their NYS Medicaid provider ID or their NPI. Providers who have submitted enrollment applications may check the status of their application in the "Medicaid Pending Provider Listing," which is updated weekly on the [eMedNY "Medicaid Managed Care Network Provider Enrollment" web page](#).

## F. Provider Technical Assistance

Per the [Model Contract](#) Section 21.19 (i), MMCPs are required to develop and implement a comprehensive provider training and a support program for network providers to gain appropriate knowledge, skills, expertise and receive technical assistance to operate and provide quality behavioral health care within a managed care payer system.

Training and technical assistance shall be provided to behavioral health network providers on billing, coding, data interface, and as described in Appendix F of the [Model Contract](#) utilization management documentation requirements.

Per the [Model Contract](#) Section 21.22, MMCPs must have provider services staff who can provide technical assistance and must ensure providers receive prompt resolution to their problems. At a minimum, provider services staff are responsible for the following:

- Assisting providers with prior authorization and referral protocols.
- Assisting providers with claims payment procedures.
- Fielding and responding to provider questions and complaints.

It is expected that MMCPs will reach out to and offer billing / claim submission training to newly contracted behavioral health providers. This should include a claims submission testing environment and issuance of plan contacts and support information to assist programs in claims submission.

### III. OMH Ambulatory Mental Health Services

#### A. Service Types

##### ➤ **Assertive Community Treatment (ACT):**

[ACT Regulations](#) (Part 508)  
[ACT Program Guidelines Adult and Young Adult](#)  
[ACT Billing Memo](#)

ACT services are billed once per month using one rate code for the month's services. ACT treatment services shall be reimbursed at the following rates: full; partial step-down; and inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. ACT must therefore be reimbursed on a monthly basis using the full, partial, or inpatient State rate. These rates include required contacts, as outlined in regulation. The coding taxonomy indicates the procedure code (H0040) and modifier combinations to be used with the ACT rate codes. MMCPs may not authorize "partial months" of ACT, or units of service defined by the number of contacts within the month. ACT may only be authorized in months, as each month is considered 1 unit of ACT service (1 unit = 1 month of ACT service).

##### **ACT Intensive Full Payment (Rate Code 4508)**

Reimbursement shall be made at the full payment rate for services provided to active clients who receive a minimum of six (6) face-to-face contacts in a month, up to three (3) of which may be collateral contacts. If the client is admitted or discharged from an inpatient setting during the month, full payment rate reimbursement is permitted for any month in which four (4) or more community-based contacts combined with inpatient face-to-face contacts equals six (6) or more total contacts in the month.

##### **ACT Intensive Partial Payment (4509)**

Reimbursement shall be made at the partial step-down payment rate for services provided to active clients who receive a minimum of two, but fewer than six, face-to-face contacts in a month. If the client is admitted or discharged from an inpatient setting during the month, stepdown/partial payment rate reimbursement is permitted when a minimum of two community-based contacts are provided in a month, or when a minimum of one community contact, combined with a minimum of one inpatient contact, is provided.

##### **ACT Inpatient Payment (4511)**

For services to ACT clients who are admitted for treatment to an inpatient facility and are anticipated to be discharged within 180 days of admission, inpatient payment rate reimbursement is permitted when a minimum of two inpatient face-to-face contacts are provided in a month, regardless of the number of community contacts. Reimbursement for more than one contact per day during inpatient status is not permitted.



➤ **OMH-Licensed Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS, formerly known as Clinic)**

[OMH MHOTRS Regulations](#) (Part 599)

[OMH MHOTRS Fiscal/Billing Resources](#)

[Integrated Outpatient Services \(IOS\) Clinic Guidance](#)

[Integrated Outpatient Services \(IOS\): Updated Billing for Offsite and Primary Care Services for OMH Host Sites](#)

[Clinic-Based Intensive Outpatient Program \(IOP\) Guidance](#)

[Mandated Rate Update: July 1, 2023 Rate Increase and New APG Rate Codes for School-Based Mental Health Services in MHOTRS Programs](#)

OMH-licensed MHOTRS programs, both hospital-based and free-standing, have been billing FFS under the APG rate-setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010. For non-SSI recipients enrolled in managed care, OMH-licensed MHOTRS programs have been billing MMCPs for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012. Beginning October 1, 2015, for NYC and July 1, 2016 for ROS, MMCPs started covering OMH-licensed MHOTRS services for all enrollees and utilize the same APG rates as used for the non-SSI population.

For recipients enrolled in Mainstream, HARP, or HIV-SNPs with an aligned D-SNP, also referred to as an IB-Dual (Integrated Benefits for Dually Eligible Enrollees)<sup>3</sup>, please adhere to the following guidance: [Duals Reimbursement in MMC \(ny.gov\)](#)

➤ **Continuing Day Treatment (CDT):**

[CDT Operational Regulations](#) (Section 587.10)

[CDT Reimbursement Regulations](#) (Section 588.7)

CDT services are billed on a daily basis. The reimbursement rates are separated into three tiers: 1-40 hours, 41-64 hours, and 65+ hours. These three tiers span two types of visits: full-day (four hours minimum) and half-day (two hours minimum). Tiers are determined by totaling the number of full-day and half-day regular visits, based on their hour equivalents. As the hours accumulate throughout the month, the provider will need to move from one tier to another to bill. Each subsequent tier has a decline in payment. Providers must keep track of the number of hours-of-service provision in order to know what rate code (tier) should be billed. When the program hours of any single visit include more than one tier, the service provider will be reimbursed at the tier that applies to the first hour of that visit. Each CDT service tier has a unique combination of rate code/procedure code/modifier code(s), as indicated in the [coding taxonomy](#).

**Half-Day Visit (4310, 4311, 4312)** – Requires a minimum duration of two hours. To be eligible for reimbursement for a half-day visit, one or more medically necessary services must be provided and documented.

**Full-Day Visit (4316, 4317, 4318)** – Requires a minimum duration of four hours. To be eligible for reimbursement for a full-day visit, three or more medically necessary services

<sup>3</sup> Please refer to the following link for more information on IB-Duals: [Dual Eligible New Yorkers \(ny.gov\)](#)

must be provided and documented.

Claims for collateral, group collateral, preadmission and crisis visits are billed separately (i.e., on different claims) from the CDT regular visits using the rate codes below. The reimbursement is the equivalent to the half-day, tier 1 amount, regardless of the cumulative total of hours for CDT regular visits in that month. Collateral, group collateral, preadmission and crisis visits are excluded from the calculation of the cumulative total hours in the program for a recipient.

**Collateral Visit (4325)** – Clinical support services of at least 30 minutes duration of face-to-face interaction documented by the provider between one or more collaterals and/or family members of the same enrolled recipient and one therapist with or without a recipient.

**Group Collateral Visit (4331)** – Clinical support services of at least 60 minutes duration of face-to-face interaction documented by the provider between collaterals and/or family members of multiple recipients of the continuing day treatment provider and one therapist with or without the recipients.

**Crisis Visit (4337)** – Crisis intervention services are face-to-face interactions documented by the provider between a recipient and a therapist, regardless of the actual duration of the visit.

**Pre-admission Visit (4346)** – Services of at least 60 minutes duration of face-to-face interaction documented by the provider between a recipient and a therapist.

➤ **Comprehensive Psychiatric Emergency Program (CPEP):**

[CPEP Operational Regulations \(Part 590\)](#)

[CPEP Reimbursement Regulations \(Part 591\)](#)

[CPEP Program Guidance \(ny.gov\)](#)

[CPEP MMC Guidance](#)

CPEP is claimed on a daily basis. A patient may receive one triage and referral visit or one full emergency visit service in one calendar day. If a patient receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for either one crisis outreach service or one interim crisis service and either one triage and referral visit or one full emergency visit per recipient, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code). Each CPEP service has a combination of rate code/procedure code/modifier code indicated on the coding taxonomy.

**Triage and Referral Visit (4007)** – Face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, to determine the scope of emergency service required. This interaction should include a mental health diagnostic examination. It may result in further CPEP evaluation or treatment activities on the patient's behalf or discharge from the CPEP.

**Note:** Services provided in a medical/surgical emergency or clinic setting for comorbid

conditions are separately reimbursed. If medical and/or nursing evaluations provided outside the CPEP are utilized by the CPEP, the CPEP may be reimbursed for a triage and referral visit only. For example, a patient is evaluated and/or treated in the emergency room (non-CPEP) for a medical condition and subsequently transferred to the CPEP for evaluation. Both the emergency room (non-CPEP) and the CPEP may submit claims. The CPEP should utilize the evaluation completed by the emergency room and submit a claim for a triage and referral visit.

**Full Emergency Visit (4008)** – A face-to-face interaction between a patient and a psychiatrist and other clinical staff as necessary to determine a recipient's current psychosocial and medical condition. It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when comprehensive psychiatric emergency program or services are completed. It may include other examinations and assessments as clinically indicated by the recipient's presenting problems. Full emergency visits should be provided to recipients whose presenting symptoms are initially determined to be serious and where the clinical staff believes commencement of treatment should begin immediately, and/or where staff is evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. No person may be involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an extended observation bed. (See extended observation beds below.)

**Crisis Outreach Service (4009)** – Emergency services provided outside an emergency room setting which includes clinical assessment and crisis intervention treatment. This is a per diem service and is billed on a daily basis.

**Interim Crisis Service (4010)** – Mental health service provided outside an emergency room setting for persons who are released from the emergency room of the comprehensive psychiatric emergency program, which includes immediate face-to-face contact with a mental health professional for purposes of facilitating a recipient's community tenure while waiting for a first post-CPEP visit with a community based mental health provider.

**Note:** Effective June 29, 2023, CPEP providers are approved to provide and be reimbursed for all Mobile Crisis services for adults and children under the Crisis Intervention SPA. As a result, CPEP rate code 4010 for Interim Crisis retired effective July 1, 2023, and rate code 4009 for Crisis Outreach will be retired effective July 1, 2024.

**Extended Observation Bed (EOB) (4049)** - No person may be involuntarily retained in a comprehensive psychiatric emergency program for more than 24 hours unless the person is admitted to an extended observation bed. The director of the CPEP may involuntarily receive and retain in an extended observation bed any person alleged to have a mental illness which is likely to result in serious harm to the person or others and for whom immediate observation, care, and treatment in the CPEP is appropriate. Retention in an extended observation bed shall not exceed 72 hours (voluntarily, or involuntarily), which shall be calculated from the time such person is initially received into the emergency room of the CPEP.

Claiming for Extended Observation Beds –

- Admission to the extended observation bed is, for billing purposes, the calendar

day after the calendar day in which the full or brief visit is completed.

- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A brief or full visit claim is submitted for the calendar day in which the visit is completed and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient's initial arrival in the CPEP.
- If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed.

**Note:** For managed care and FFS billing, providers are instructed to use rate code 4049. MMCPs can refer to the [OMH Medicaid Reimbursement Rates](#) page for the list of providers and suggested per diem rates for EOB.

### **Partial Hospitalization:**

[Partial Hospitalization Operational Regulations](#) (Section 587.12)

[Partial Hospitalization Reimbursement Regulations](#) (Section 588.9)

[Medicare Claims Processing Manual](#)

Partial Hospitalization provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program. These services are reimbursable through the following four groups of rate codes under Medicaid.

**Regular Rate Codes (4349 – 4352), Crisis Rate Codes (4357 – 4363)** - A partial hospitalization claim is submitted on a daily basis. The applicable rate code / procedure code / modifier code(s) combination is dependent on the number of hours of service a day. The combination is listed in the [coding taxonomy](#). Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day.

**Collateral Service (4353, 4354)** – Clinical support services of at least 30 minutes in duration but not more than two hours of face-to-face interaction between one or more collaterals and one therapist with or without a recipient.

**Group Collateral Service (4355, 4356)** – Clinical support services, of at least 60 minutes in duration but not more than two hours provided to more than one recipient and/or his or her collaterals. The service does not need to include recipients and cannot include more than 12 collaterals and/or recipients in a face-to-face interaction with a therapist.

**Pre-admission/Crisis (4357 - 4359, 4349 - 4352)** – Visits of one to three hours are billed using the pre-admission / crisis visit rate codes (4357, 4358, 4359). Visits of four hours or more are billed using partial hospitalization regular rate codes (4349, 4350, 4351, 4352). Per the coding taxonomy, the UA modifier is required on all partial hospitalization pre-admission claims.

➤ **Personalized Recovery Oriented Services (PROS):**

[PROS Regulations](#) (Part 512)

[PROS Guidance](#)

[Guidelines for Medicaid Managed Care Organizations regarding UM for PROS \(ny.gov\)](#)

[Medicare Claims Processing Manual](#)

A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month.

**Note:** For all PROS elements listed below, it is allowable for providers to bill on the discharge date. Additional information for these services can be found below.

Each unique procedure code / modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the rate code in the header of the claim. For example: if services provided during the month to an individual would have been billed under rate codes 4521, 4525, and 4527 under the old structure, those services must be submitted to the MMCP on three claims showing the rate code in the header and the applicable procedure code / modifier code(s) combination and units of service at the line level. See examples below:

- Claim 1 - Rate code 4521 in the header plus H2019U2 and 13 - 27 units at the line level.
- Claim 2 - Rate code 4525 in the header plus T1015HE and 1 unit at the line level.
- Claim 3 - Rate code 4527 in the header plus H2025HE and 2 units at the line level.

The reimbursement structure for a comprehensive PROS program consists of several elements:

- Monthly base rate;
- Intensive Rehabilitation (IR) component add-on;
- Ongoing Rehabilitation and Support (ORS) component add-on;
- Clinical treatment component add-on.

**Community Rehabilitation and Support Services (CRS) Monthly Base Rate (4520, 4521, 4522, 4523, 4524)**

The basic measure for the PROS monthly base rate is the PROS unit. PROS units are accumulated during the course of each day that the individual participates in the PROS program and are aggregated to a monthly total to determine the PROS monthly base rate for the individual. The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation and service frequency (see table below). Daily program participation is measured in 15-minute increments, rounded down to the nearest quarter hour. In order to accumulate PROS units for a day, a PROS program must deliver a minimum of one medically necessary PROS service to an individual or collateral on that day. The maximum number of PROS units per individual per day is five. Services provided in a group format must be at least 30 minutes

in duration. Services provided individually must be at least 15 minutes in duration. A minimum of two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate.

Table for the Calculation of PROS Units can be found at the following link: [Personalized Recovery Oriented Services \(PROS\) Unit Conversion Chart \(ny.gov\)](#)

### **PROS Component Add-Ons**

In addition to the monthly base payment, PROS providers are also reimbursed for three component add-ons: IR, ORS, and Clinic Treatment services. Up to two component add-ons may be billed per individual, per month. **In no event will an ORS component add-on and an IR component add-on be billed in the same month for the same individual.** Component add-ons are not billed prior to the calendar month in which the individual is registered with the PROS program.

**Intensive Rehabilitation - IR (4526):** In order to bill the IR component add-on, an individual must have received at least six PROS units during the month, including at least one IR service. In addition to receiving at least 6 PROS units and one IR service, the individual must also be seen by the program at least once in that month (either via audio-visual telehealth or in-person). In instances where a comprehensive PROS program provides IR services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an IR-only bill. When an IR-only bill is submitted, the minimum six PROS units required may be limited to the provision of IR services.

**Ongoing Rehabilitation and Support - ORS (4527):** PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of 10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement. A minimum of two face-to-face contacts (telehealth or offsite/in-person) with the individual and/or identified collateral which include ORS services must be provided per month. A minimum contact for ORS is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days. A contact may be split between the individual and the collateral. At least one visit per month must be with the individual only. In instances where a comprehensive PROS program provides ORS services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an ORS-only bill.

**Clinical Treatment (4525):** In order to bill the clinical treatment add-on, a minimum of one clinical treatment service must be provided during the month. Individuals receiving clinical treatment must have, at a minimum, one face-to-face contact with a psychiatrist or nurse practitioner in psychiatry (NPP) every three months, or more frequently as clinically appropriate. Such contact during any of the first three calendar months of the individual's admission will enable billing for the month of contact, any preceding months in which the recipient has been registered with the PROS program, and the two months following the month of contact. Thereafter, each month that contains a

contact with a psychiatrist or nursepractitioner in psychiatry will enable billing for that month and the next two months. The clinical treatment component may only be reimbursed in conjunction with the monthly base rate and/or the IR or ORS.

**Pre-admission Program Participation (4510):** Reimbursement for individuals who are in pre-admission status is limited to two consecutive months, whether or not the individual is ultimately admitted to the program. If pre-admission program participation occurs during the month of admission, the pre-admission program participation may be included in the total number of PROS units accumulated during the calendar month, but the pre-admission rate cannot be billed.

#### ➤ **Transportation:**

##### **Medically Necessary Transportation for Behavioral Health Services:**

Medically necessary transportation is a carved-out service that is billed directly to the State on an FFS claim submitted by the transportation provider. These services must be approved by the regional transportation manager.

**Note:** For New York City based enrollees receiving services at an OASAS Certified Opioid program transportation (MetroCard reimbursement) is accommodated through the New York City Human Resources Administration (HRA)/ PTAR system.

#### **B. Telehealth Services**

##### [Telehealth Regulation \(Part 596\)](#) [Telehealth Services](#)

The Office of Mental Health under Part 596 allows licensed, designated, or authorized providers of service where the recipient is admitted to bill Medicaid for telehealth services. MMCPs must reimburse at the government rate for mental health services delivered by providers that have been authorized by OMH to provide this optional service. Detailed information regarding telehealth may be found on the [OMH Telehealth Guidance](#) page.

Please see the link for specific telemental health codes: [Telehealth Modifier Use for OMH-licensed/Designated Programs](#)

#### **IV. Office of Addiction Services and Supports (OASAS) –Addiction Services and Billing**

The following section of this manual is to provide MMCPs and providers with a brief overview of all the addiction services and, the related coding for the services that are incorporated into the capitated benefit package.

Under the SPA/1115 Waiver New York State addiction services include an array of participant-centered crisis, inpatient, residential and outpatient services consistent with the individual's identified treatment needs, with a rehabilitation and recovery focus designed to promote skills for managing addiction related symptoms, and behaviors.

Addiction services are provided by programs that are OASAS certified pursuant to applicable program specific sections of Title 14 NYCRR (Part 822; Part 818, Part 820, and Part 816).

Additionally, programs are subject to shared Title 14 NYCRR [Part 800](#) regulatory staffing definitions for: clinical staff; medical director; medical staff; and Qualified Health Professionals.

This subsection offers a brief overview on the primary SUD service settings:

- Outpatient (including clinic; opioid; outpatient rehabilitation);
- Addiction Services in a Residential Setting; and,
- Inpatient (including detoxification and inpatient rehabilitation).

## A. Service Types

### ➤ OASAS Outpatient Clinics, Opioid, and Rehabilitation Programs:

[Part 822 Outpatient Services Regulations](#)  
[OASAS Medicaid APG Clinical and Billing Manual](#)

For both free-standing and hospital-based programs, OASAS outpatient service reimbursement employs government rates since being carved into Managed Care (including HARPs). For a complete list of the OASAS outpatient program rates codes, please see the [OASAS Medicaid APG Clinical and Billing Manual](#)

#### Outpatient Services Setting

OASAS Certified [Title 14 NYCRR Part 822 Outpatient Clinic; Opioid Treatment Programs, and Outpatient Rehabilitation Programs](#). The setting will be determined by information gathered at the admission assessment and identified by the [Level of Care for Alcohol and Drug Treatment Referral 3.0](#) (LOCADTR 3.0). Services will be provided to address the person-identified goals for treatment and willingness to participate in services at the level indicated. SPA 16-04 gives OASAS demonstration authority to provide any clinic service outside of the clinic (when provided by a freestanding clinic). For example, peer services may be provided [within the community](#), in the individual's home, or at another OASAS certified program such as a residential detox program.

In addition to the Part 822 Outpatient Clinic, OASAS Certifies [Part 825 Integrated Outpatient Services](#). The [OASAS Integrated Outpatient Services webpage](#) contains further information regarding this licensure as well as specific [IOS guidance](#).

Outpatient clinic settings and services are indicated for individuals whose needs warrant this level of treatment, or when an individual steps-down from a higher level of care based on an individualized assessment, [LOCADTR](#) and treatment plan. Medication assisted therapies should be utilized when a client has an established addiction related disorder that has been shown through sufficient research to respond to the specific medication. This includes but is not limited to methadone, buprenorphine, naltrexone (for opioid use disorder) and acamprosate (Campral - for alcohol use disorder), where clinically indicated and where tolerance and withdrawal criteria are met.

The MMCPs shall include medications for the treatment of addiction in the Contractor's formulary, including drugs for the treatment of addiction and/or opioid dependency, as indicated by Official Compendia. The Contractor shall not cover these drugs solely through a medical exception process. The Contractor's formulary shall include at least one formulation each of buprenorphine and buprenorphine/naloxone. Naloxone is available in



vials and prefilled syringes and auto-injector. Naloxone vials/prefilled syringes or the auto-injector shall be covered by the Contractor as a medical and/or pharmacy benefit. Additionally, extended-release naltrexone injectable (Vivitrol®) shall be covered by the Contractor as a medical and/or pharmacy benefit.

Outpatient services include person centered services consistent with the individual's identified needs, with a rehabilitation and recovery focus, designed to promote skills for coping with and managing symptoms and behaviors associated with addiction related issues. These services are designed to help individuals achieve and maintain recovery from addiction. Services should address an individual's identified needs and desire for treatment. Outpatient services are delivered on an individual, family or group basis in a wide variety of settings including site-based facility, in the community or in the individual's place of residence.

### **1. Outpatient Clinic Service**

Outpatient Clinic programs provide treatment services to individuals presenting with difficulties associated with their use/misuse of substances, and or have problem gambling related concerns. Family members and/or significant others who are affected by another's addiction can also receive services in this setting.

Outpatient services may be delivered at different levels of intensity responsive to the severity of the problems presented by the patient. The length of stay and the intensity (as measured by frequency and duration of visits) will vary during the course of treatment. In general, persons are engaged in more frequent outpatient treatment visits earlier in the treatment process; visits generally become less frequent as treatment progresses.

Treatment may include but is not limited to the following services: group and individual counseling; Medication for Addiction Treatment (MAT), education about, orientation to, and opportunity for participation in, relevant and available self-help groups; addiction awareness and relapse prevention; HIV and other communicable disease education, risk assessment, supportive counseling, and referral; and family treatment. In addition, social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation must be available either directly or through written agreements. Procedures are provided according to an individualized assessment and treatment plan. The [OASAS Medicaid APG Clinical and Billing Document](#) provides a comprehensive listing of services for Outpatient Treatment.

### **2. Opioid Treatment Programs (OTP)**

In addition to the services described for the Outpatient Clinic, OTP's target those with Opioid Use Disorder. OTP's assist to stabilize individuals with either methadone or other MAT to achieve improved functioning. Medication specific to Opioid Use Disorder, when administered/dispensed by OASAS certified programs, is covered under the behavioral health benefit.

### **3. Outpatient Rehabilitation Services**

Outpatient Rehabilitation Services are a configuration of services designed to improve

functioning for individuals with more chronic conditions emphasizing development of basic skills in prevocational and vocational competencies, personal care, nutrition, communication, and community competency. Individuals should be scheduled for between three and five days a week for a minimum of two hours per service date.

#### 4. Physical Health Services

Physical Health services are services provided **outside** of regulatory requirements. Physical Health Services encompass a wide range of assessment and treatment procedures performed by medical staff for identifying and treating physical problems associated with addiction.

Examples of Physical Health services may include but are not limited to immunizations, hepatitis, TB/HIV testing, pregnancy testing, and preventative care. Laboratory services not required by regulation would also fall under the physical health rate code.

Physical Health procedures are reimbursed using the Physical Health Rate Code and appropriate E/M code (most commonly CPT codes in the range 99202-99205, 99211-99215). Each claim should include the diagnosis of the issue being treated as the primary diagnosis code.

#### ➤ OASAS Residential Services Programs

[PART 820 Residential Services Regulations](#)  
[NYS Medicaid Managed Care Plan Resource Guide](#)

##### Setting

Residential services are delivered utilizing a combination of counseling services and milieu to individuals who are having difficulty functioning outside of a structured setting. [Title 14 NYCRR Part 820](#) services range from Stabilization where individuals need a level of intensity and/or MAT to be able to benefit from further care to Rehabilitation where individuals continue to work on establishing long term recovery within a community setting, and Reintegration where individuals are supported as they transition back into independent living.

##### Services

Include person centered residential services consistent with the person's expressed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing addiction related symptoms and behaviors.

These services are designed to help individuals achieve changes in their addiction related behaviors within a safe and supportive setting when the individual lacks a safe and supportive residential option in the community. Services should address the person's major lifestyle, interpersonal, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment.

Residential Addiction services include [medically necessary care](#) according to assessed

needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with addiction; (3) counseling to address a person's major lifestyle, attitudinal, and behavioral problems; and (4) Medication for Addiction Treatment when medically necessary.

### **1. Stabilization**

Residential programs that provide medical and clinical services including: medical evaluation; ongoing medication management and limited medical intervention; ancillary withdrawal and medication for addiction treatment; psychiatric evaluation and ongoing management; and group, individual and family counseling focused on stabilizing the individual and increasing coping skills until the individual is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence. This service has a physician who serves as medical director, psychiatrist, nurse practitioner and/or physician assistants to provide and oversee medical and psychiatric treatment. Medical staff are available in the residence daily, but 24-hour medical/nursing services are not. There is medical staff available on call 24/ 7 and there are admitting hours 7 days per week.

### **2. Rehabilitation**

Residential programs that also provide rehabilitative services for individuals who are stable enough to manage emotional states, urges and cravings, co-occurring psychiatric symptoms and medical conditions within the safety of a residential setting. This service requires a physician who will serve as medical director, nurse practitioner, psychiatrist, and nursing staff on site daily and clinical staff provide monitoring for medical and psychiatric symptoms that are stable. Services include medical monitoring of chronic conditions including routine medication management and individual, group and family counseling focused on rehabilitation. The service requires a treatment plan to address functional needs including personal and interpersonal functioning. The treatment program teaches individuals to manage self and interactions with others with increasing independence.

### **3. Reintegration**

Residential programs that also provide reintegration services to transition from structured treatment environments to more independent living. This setting does not require a physician to serve as medical director and staff coordinate treatment services but do not provide direct clinical care. Most services are provided in the community and include can clinical and social services. Reintegration programs provide 5+ hours per week of Rehabilitative Services aimed at building the individuals independency skills and coping outside of a structured setting. Individuals are provided a safe living environment with a high degree of behavioral accountability. Services include medical and clinical oversight of chronic but stable medical and psychiatric symptoms and conditions in a community treatment program including an outpatient Addiction treatment program. Services also include community meetings; activities of daily living (ADL) support; case management; and vocational support and clinical services to support transition to independent living.

## ➤ **Withdrawal and Stabilization Services and Inpatient Rehabilitation Programs**

[Part 816 Withdrawal and Stabilization Service Regulations](#)

[Part 818 Inpatient Rehabilitation Program Regulations](#)

The Title 14 NYCRR OASAS Certified [Part 816 Withdrawal and Stabilization Services](#); and Title 14 NYCRR OASAS Certified [Part 818 Inpatient Rehabilitation Services](#) are already incorporated into the benefit package. Providers of such services should speak with the enrollee's MMCP regarding the MMCP coding; contract; and reimbursement policies.

### **1. Part 816 Withdrawal and Stabilization Services**

Withdrawal and Stabilization Services also known as Crisis or detoxification services are provided in hospital or community based inpatient setting that is certified by OASAS under [Title 14 NYCRR Part 816](#).

#### **Services**

Crisis or detoxification services are medically directed with 24-hour medical staff monitoring including vital sign monitoring, medication to manage withdrawal and other medical intervention required to stabilize the individual. Crisis addiction services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) Medication for addiction treatment as medically necessary, and linkage to the next level of addiction care.

### **2. Part 818 Inpatient Rehabilitation**

These services are delivered in inpatient settings certified by OASAS under [Title 14 NYCRR Part 818](#).

#### **Services**

Inpatient Rehabilitation Services are person-centered services consistent with the person's expressed treatment needs, with a rehabilitative and recovery focus designed to stabilize acute addiction related symptoms, medical and psychiatric needs within a structured setting with 24-hour medical oversight.

Inpatient addiction services include medically necessary care according to assessed needs including:

- assessment and clinical treatment plan development;
- skill development for coping with and managing symptoms and behaviors associated with addiction;
- counseling to address the person's major lifestyle, attitudinal, and behavioral problems; and
- Medication for addiction treatment when medically necessary.

## **B. Provider Qualifications for all Addiction Services**

When offering a contract to an OASAS licensed or certified programs the MMCP / Contractor must contract for the full range of services offered under the program's license/certification

and **MAY NOT** separately credential individual staff members in their capacity as employees of these programs. Within an OASAS Certified Program services are provided by licensed; certified; and unlicensed professional staff, who are at least 18 years of age with a high school or equivalent diploma, according to their [Scope of Practice](#).

Licensed practitioners are licensed by the New York State Department of Education and include, but are not limited to, licensed master social worker (LMSW), licensed clinical social worker (LCSW), licensed mental health counselor (LMHC), licensed marriage and family therapists (LMFTs), licensed psychoanalysts; registered nurses (RNs); licensed practical nurses; nurse practitioners (NPs); medical doctors (MD and DO) and psychologists.

Any staff who is unlicensed and providing addiction services must be credentialed by OASAS as a credentialed alcoholism and substance abuse counselor (CASAC); a credentialed alcoholism and substance abuse counselor–trainee (CASAC-T); or be under the supervision of a qualified health professional (QHP) as defined in the [OASAS Part 800 regulation](#). State regulations require supervision of CASAC-T and non-credentialed counselors by QHP meeting the supervisory standards established by OASAS [Scope of Practice](#).

## C. Reimbursement for Addiction Services

### ➤ General Addiction Services Requirements and Limitations

#### 1. General Service Requirements

All state plan addiction services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from an identified addiction related diagnosis.

[Based on NYS Insurance Law](#) services are subject to authorization and must be medically necessary. In accordance with [NYS Medicaid OPRA Guidelines](#) services must be recommended by a Medicaid Enrolled licensed practitioner or physician, who is acting within the scope of his/her professional license[s] and applicable State law, to promote the maximum reduction of symptoms and/or restoration of the person to his/her best age-appropriate functional level according to an individualized treatment plan.

#### 2. Services Delivered in Accordance with a Plan of Treatment

The activities included in the service must be intended to achieve person identified goals or objectives. The plan of treatment should be developed in a person-centered manner with the active participation of the person, family, and providers and be based on the person's preferences and the standards of practice for the provision of rehabilitative services.

The plan of treatment should identify the individual's expressed goals for treatment and any medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The plan of treatment must specify the frequency, amount, and duration of services based on the individual's preferences.

### 3. Service Documentation

Providers must maintain medical records that include a copy of the plan of treatment as defined by the level of care operating regulations, the name of the person, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid enrollee, are not eligible for Medicaid reimbursement.

Additionally, OASAS Certified programs are required to maintain service documentation in accordance with [Part 822 Outpatient](#) and [Part 820 Residential](#) regulations, and other regulations as appropriate to the level of care.

### 4. Non-Covered Services

- Within residential programs, services provided must not be job task oriented and must be directly related to treatment of the person's behavioral health needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, childcare, and laundry services) are non-covered.
- Services cannot be provided in an Institution for Mental Disease (IMD) with more than 16 beds.
- Room and board are excluded from addiction services rates.
- Medicaid will not reimburse for 12-step programs run by peers.

### 5. Court Ordered Services

Assessments and testing for individuals not in the custody of the penal system (e.g., not involuntarily residing in prison or jail overnight or detained awaiting trial) are Medicaid eligible, including any laboratory tests and urine tests. Drug court diversion treatment programs are eligible for Medicaid funding. Medicaid eligible individuals who are in the penal system and admitted to medical institutions, such as residential addiction treatment programs, are eligible for Medicaid funding for eligible medical institution expenditures. Laboratory procedures the practitioner refers to an outside laboratory must be billed by the laboratory to the Medicaid MMCP. Refer to [Managed Care and Court Ordered Treatment](#).

### 6. Medical Necessity and Utilization Review

All services must be medically/clinically necessary and documented as such within the case record. The [New York State Insurance Law](#) provides requirements for establishing and maintaining necessity utilizing the LOCADTR and Concurrent Review LOCADTR. In addition to clinical necessity the Insurance Law outlines both the plan and provider responsibilities in this process.

- a) [NYS - LOCADTR - Level of Care for Alcohol and Drug Treatment Referral](#)

LOCADTR is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of individuals within the New York State system of OASAS certified programs. [NYS Insurance Law](#) requires that insurers working under NYS jurisdiction must use the [LOCADTR](#) and [Gambling LOCADTR](#) for addiction level of care placement. The [Concurrent Review LOCADTR](#) must be used for continued stay determination.

A licensed practitioner or unlicensed counselor or assessor under the supervision of a QHP may complete the assessment. However, interpretation of the information must be within the assessor's scope of practice. Consultation with the interdisciplinary team is required whenever the individual completing the assessment is functioning outside of his or her scope of practice and expertise.

Level of care determinations are made through an individualized assessment of risks, resources, community support services and other clinical considerations through an interview process and the decision logic which can be found within the [LOCADTR tool](#).

- b) Utilization Review and Concurrent Review are processes for determining clinical need for treatment initially and as treatment progresses. As given above plans and providers are required to use the LOCADTR and Concurrent LOCADTR in making this determination. Utilization Review is prohibited within the first 28 days of continuous treatment. Plans and providers must participate in periodic consultation at a minimum once by the 14<sup>th</sup> day of treatment.

Plans are prohibited from requiring prior authorization for medically necessary in-network OASAS licensed, certified or otherwise authorized addiction inpatient services including detoxification, rehabilitation, residential treatment, intensive outpatient, outpatient clinic, outpatient rehabilitation, and outpatient opioid treatment. When Providers within two business days of admission submit:

- Notification that the enrollee is receiving services, and
- An initial plan of treatment.

## D. OASAS Program ASAM Crosswalk

OASAS Program Type	New York State Regulation	ASAM
<b>Outpatient</b>		
Outpatient Clinic	Title 14 NYCRR Part 822	<b>Level I</b>
Outpatient Day Rehabilitation	Title 14 NYCRR Part 822	<b>Level II.5</b>
Intensive Outpatient	Title 14 NYCRR Part 822	<b>Level II.I</b>
Opioid Treatment Programs	Title 14 NYCRR Part 822	<b>Level I</b>
Medically Supervised Outpatient Withdrawal	Title 14 NYCRR Part 822	<b>Level I-D</b>
<b>Clinical Services in a Residential Setting</b>		
Stabilization Services in a Residential Setting	Title 14 NYCRR Part 820	<b>Level III.5</b>
Rehabilitation Services in a Residential Setting	Title 14 NYCRR Part 820	<b>Level III.3</b>
Reintegration in a Residential Setting.	Title 14 NYCRR Part 820	<b>Level III.1</b>
<b>Inpatient</b>		
Medically Managed Inpatient Detoxification	Title 14 NYCRR Part 816	<b>Level IV-D</b>
Medically Supervised Inpatient Detoxification	Title 14 NYCRR Part 816	<b>Level III.7-D</b>
Inpatient Rehabilitation Treatment and Residential Rehabilitation Services for Youth	Title 14 NYCRR Part 818, Part 817	<b>Level III.7</b>

## E. Service Reimbursement and Coding for Addiction Services

### 1. Overview

Service reimbursement (negotiated versus government rates) and coding (application of government mandated codes / claim for submission requirements) will vary by service type / OASAS certification. This section will detail:

- which services / OASAS certified programs are paid via government rates and any applicable coding requirements.
- which service may be reimbursed via a negotiated rate between the MMCP and the provider and any applicable coding.
- when services are reimbursed via a negotiated rate, it is suggested that the



prevailing Medicaid FFS rate service is used as an initial starting point for rate negotiations.

**2. Withdrawal/Stabilization and Inpatient Providers:**

The Title 14 NYCRR OASAS Certified [Part 816 Withdrawal and Stabilization](#) services; and Title 14 NYCRR OASAS Certified [Part 818 Inpatient Rehabilitation Services](#) are already incorporated into the benefit package. Providers of Part 816 and Part 818 services should speak with the MMCP regarding the MMCP coding, contract, and reimbursement policies.

**Note:** It is suggested that the prevailing Medicaid FFS rate service is used as an initial starting point for rate negotiations

Service	Rate Code	Negotiated or Government Rate
<a href="#">Art. 28 Part 816 Medically Managed Withdrawal</a>	4800	Negotiated
<a href="#">Art. 28 Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Out Observation Days</a>	4801	Negotiated
<a href="#">Art. 28 Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/One Observation Days</a>	4802	Negotiated
<a href="#">Art. 28 Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Two Observation Days</a>	4803	Negotiated
<a href="#">Part 816 Medically Supervised Outpatient Withdrawal (MSOW).<sup>4</sup></a>		Negotiated
<a href="#">Art. 32 Part 816 Medically Supervised Inpatient Withdrawal (MSIW)</a>	4220	Negotiated
<a href="#">Art. 28 Part 818 Inpatient Rehabilitation</a>	2957/2993	Negotiated
<a href="#">Art. 32 Part 818 Inpatient Rehabilitation</a>	4213	Negotiated
<a href="#">Part 818 Inpatient Rehabilitation - State Operated (ATC)</a>	4202	Negotiated

Part 820 programs are reimbursed at the government rate (at a minimum). However, please note that at a minimum, MMCPs must include providers as indicated below to meet minimum network requirements. For the most up to date rates go to the [Part 820 Reimbursement Rates](#).

For claims submitted by Title 14 NYCRR Part 820 Residential Programs the following: rate codes should be used in the claim header; the following CPT / HCPCS codes should be used at the line level; and the MMCP should assign the indicated specialty code.

<sup>4</sup> Effective January 1, 2021, the reimbursement methodology for Part 816.8 programs - Medically Supervised Outpatient Withdrawal and Stabilization (MSOW) from a provider-specific fee to Ambulatory Patient Groups (APGs).

Title 14 NYCRR Part 820 Residential Program Type	Rate Code	CPT / HCPCS Code
Stabilization	1144	H2036 and modifiers: TG; and HF. May also submit E/M claims for ancillary withdrawal services.
Rehabilitation	1145	H2036 and HF modifier
Reintegration	1146	H2036 and HF modifier

### 3. Outpatient Providers Reimbursement:

MMCPs are required, at a minimum, to pay the Medicaid fee-for-service (FFS) “government rates” for OASAS-certified programs. The “government rate” is the reimbursement paid by Medicaid fee-for-service for each service (e.g., assessments; groups; individual; medication management) and refers specifically to the Ambulatory Patient Group Rates (APGs) for Freestanding and Hospital Based OASAS Certified Clinic (including intensive outpatient); Opioid; and Outpatient Rehabilitation Programs.

The [OASAS Medicaid APG Clinical and Billing Manual](#) provides specific procedure codes, rate codes, and Medicaid Service minimums/descriptions. In addition to procedure based APG claiming, MMP are required to pay the [OTP Bundle Rates](#) that received permanent CMS approval effective August 1, 2021. Outpatient reimbursement rates can be found on the [OASAS Ambulatory Rate Page](#).

MMCPs will process provider claims through the [New York State APG 3M grouper](#) or an exact replica to ensure government rates are rendered to OASAS Certified Title 14 NYCRR Part 822 programs (Hospital or Freestanding). Providers utilize the 837i or UB04 form for claim submission.

Providers should include the Provider NPI, Ordering Practitioner NPI, and the Attending Practitioner NPI. In those instances where an Attending Practitioner does not have an NPI, i.e., a CASAC, the equivalent DOH-approved NPI alternative should be used in its place. For OASAS programs, this number is the OASAS unlicensed practitioner number: ID number 02249145. This number should be used when services are delivered by an appropriate program staff person who does not /cannot get an NPI number (i.e., a CASAC).

### 4. Additional Claim Submission Requirements for Opioid Treatment (OTP) Programs

**Note:** Historically OTPS claims were submitted with a visit-based claim that utilizes the four-digit weekly OTP APG rate code in the claim header. This single claim contains all visit dates and services delivered during the service week, including the first Medication Administration service delivered during the service week. This claim secured payment for the services delivered during the entire week, including the first Medication Administration service reimbursement and enhanced 1<sup>st</sup> day Medication Administration payment. This claim separately identified each visit date (defined as the calendar date) and services delivered to

the patient on the specific visit date.

**The program submitted the claim using:**

- a) The four-digit visit rate code 1564 in the claim header. With the episode week defined as Monday- Sunday.
- b) Line level visit date(s)
- c) The first Medication Administration H0020 for methadone or H0033 for buprenorphine with Modifier KP on the first occurrence of this service being provided.
- d) Line level appropriate HCPCS or CPT code for the delivered service(s) associated with the specific visit date including any additional Medication Administration services provided during that week. Additional Medication Administration services provided during the week may not be coded with a KP modifier.
- e) OTP programs must be reimbursed for additional cost Buprenorphine.

**Within a managed care claiming structure the OTP programs may either:**

- a) Immediately convert to daily process /claiming. Submitting a single visit claim for each date of service, or
- b) Continue to submit a single visit claim that codes all services delivered during the service week on the single visit claim. It is expected that over time the OTP programs will transition to submitting a single visit claim for each date of services.
- c) In either scenario the programs utilize:
  - the 837i;
  - the OTP APG rate code for their peer group in the headers;
  - the appropriate CPT /HCPCS / Modifier codes (including KP modifier for the first medication administration visit and the HF modifier for all line level procedure coding);
  - the claim is processed by the MMCP through the 3M grouper or its exact replica; and
  - OTP programs must be reimbursed for additional cost Buprenorphine.

## **F. OASAS Telehealth Service Reimbursement**

[OASAS Medicaid APG Clinical and Billing Guidance](#) provides a listing of Office approved services for Medicaid Reimbursement. For services delivered via telehealth, specific modifiers must be included on the claim.

- a) Modifier 95 is for codes listed in Appendix P of the AMA's CPT Professional Edition Codebook.
- b) OASAS Procedure Codes in Appendix P
  - 90791 – Assessment Extended

- 90832 – Individual Counseling Brief
  - 90834 – Individual Counseling Normative
  - 90847 – Family Service with Patient present
  - 99201-99205 – For New - Psychiatric Assessment (Brief), Medication Management, Physical Health
  - 99212-99215 – For Existing - Psychiatric Assessment (Brief), Medication Management, Physical Health
- c) GT modifier should be used for all other OASAS APG Codes where the modifier 95 cannot be used.
- d) The FQ modifier should be used for services delivered via telephone (audio-only) (when a telehealth service is furnished using audio-only communication).

Please see the [Telepractice Service Modifiers Crosswalk](#) for complete listing of Telehealth codes for all levels of care.

## V. Crisis Intervention

### [Mobile Crisis and Crisis Residence Authority and Reimbursement Changes](#)

On June 29, 2023, NYS received approval from the Centers for Medicare and Medicaid Services (CMS) for the Crisis Intervention State Plan Amendment. The Crisis Intervention benefit is comprised of three service components Mobile Crisis, Crisis Residence, and Crisis Stabilization Center services (CSC). The Crisis Intervention SPA consolidates and aligns Medicaid authority, coverage, and reimbursement policies for existing children and adults Mobile Crisis and Crisis Residence services. Initially, CSC will be covered under FFS, and NYS will issue guidance at such time it will carve-in to managed care.

### A. Mobile Crisis Services

#### [Mobile Crisis Program Guidance](#)

The Mobile Crisis component of the Crisis Intervention Benefit includes the following services and corresponding activities. Each service is eligible for reimbursement separately when delivered in accordance with State issued billing guidance.

- Telephonic triage and crisis response;
- Mobile crisis response;
- Telephonic crisis follow-up; and
- Mobile crisis follow-up

MMCPs must reimburse both participating and non-participating Mobile Crisis providers for services provided to their enrollees in accordance with the OMH billing guidelines. Mobile Crisis services are billed daily and use the rate code, CPT, and modifier combination to differentiate between services. For additional information on Mobile Crisis services in the Crisis Intervention Benefit please see the [Crisis Intervention Benefit: Mobile Crisis Component Benefit and Billing Guidance](#).

## B. Crisis Residence Services

[Crisis Residence Operation Guidance](#) (Part 589)  
[Adult Crisis Residence Benefit and Billing Guidance](#)

Only Crisis Residence providers licensed by NYS OMH are permitted to bill for Crisis Residence services provided to MMCP enrollees. Each Crisis Residence program type has its own rate code, procedure code, and modifier(s) combination that must be used. Crisis Residence programs are for adults ages 18 years and older must follow the [Adult Crisis Residence Benefit and Billing Guidance](#). Crisis Residence programs are not permanent housing arrangements. Programs are short-term (up to 28 days) and provide psychiatric crisis symptom stabilization in a safe and supportive environment.

Children's Crisis Residence services provided to youth ages 0 to 20, providers must follow the [Crisis Intervention Benefit: Children's Crisis Residence Program Benefit and Billing Guidance](#).

## VI. Adult Behavioral Health Home and Community Based Services (BH HCBS)

The Centers for Medicare and Medicaid Services (CMS) authorized Adult BH HCBS as a demonstration benefit under NYS' Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver. BH HCBS are rehabilitative services designed to assist adults (age 21 and over) with serious mental illness and/or addiction disorder to remain and recover in the community, and reduce preventable admissions to hospitals, nursing homes, or other institutions. Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV-SNPs) offer BH HCBS as a covered benefit for enrollees meeting eligibility criteria.

BH HCBS are only available to HARP enrollees who have been qualified through the NYS Eligibility Assessment process and to HARP-eligible individuals enrolled in HIV-SNPs and assessed as BH HCBS eligible.

### A. BH HCBS Utilization Thresholds

The [Adult BH HCBS Provider Manual](#) lists annual hourly limits for each Adult BH HCBS. However, the CMS approved 1115 Waiver Special Terms and Conditions defines utilization caps at the recipient level, which supersede the limits described in the Adult BH HCBS Provider Manual. These recipient level service thresholds are applied to each 12-month calendar year beginning on January 1st for every BH HCBS eligible member. HARPs and HIV-SNPs must adhere to the following Adult BH HCBS Utilization Thresholds:

1. Combined Tier 1 Adult BH HCBS (Employment Supports and Education Supports) will be limited to \$8,000 as a group. NYS has defined a 25 percent corridor on this threshold that will allow HARPs and HIV SNPs to reimburse up to \$10,000 per calendar year without a disallowance.
2. Combined Tier 1 AND Tier 2 Adult BH HCBS will have an overall annual cap of \$16,000 per eligible member. A 25 percent corridor will also be applied to this threshold to enable HARPs and HIV-SNPs to reimburse up to \$20,000 per calendar year without a disallowance.

HARPs and HIV-SNPs should track Adult BH HCBS use and are expected to abide by [BH HCBS Utilization Management Guidelines](#). If a member is projected to exceed an annual BH HCBS limit beyond the criteria noted in numbers 1 and 2 above, and continuation of these services is deemed as medically necessary by the HARP/HIV-SNP BH Medical Director, HARPs and HIV-SNPs may override these limits. The HARP/HIV-SNP BH Medical Directors must use clinical judgment to ensure service delivery is in line with the members' recovery goals, as listed in the Adult BH HCBS Plan of Care. These limits are to be monitored and imposed when Adult BH HCBS are determined not medically necessary.

## **B. BH HCBS Billing Guidelines:**

See the [Health and Recovery Plan \(HARP\) Adult BH HCBS Provider Manual](#) for program/clinical guidance.

### ➤ **Habilitation:**

- Billed daily in 15-minute increments with a limit of 12 units (3 hours) per day.
- There are no group sessions for this service.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

### ➤ **Education Support Services:**

- Billed daily in 1-hour units with a maximum of 2 units (2 hours).
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

### ➤ **Pre-Vocational Services:**

- Billed daily in 1-hour units with a limit of 2 units (2 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

### ➤ **Transitional Employment:**

- Billed daily in 15-minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

### ➤ **Intensive Supported Employment (ISE):**

- Billed daily in 15-minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is

done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

- Modifier is used to indicate “Complex Level of Care.”

➤ **Ongoing Supported Employment:**

- Billed daily in 15-minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **BH HCBS Staff Transportation:**

The staff transportation service covers the actual cost of provider staff travel to off-site service locations – and only for selected BH HCBS. Staff transportation is not billable in cases where a patient is given a ride to an on-site service location. Patient transportation is covered under medical transportation (see earlier section on medical and below section on non-medical transportation). There is no reimbursement for “staff time” while in travel status and that time is not billable under the other BH HCBS rates described above. The cost of “staff time” while in travel status has been built into the rates for the programs listed above.

Staff transportation is billed under the recipient’s Medicaid ID (CIN) and is only allowable for a single staff person for a single service. There is no travel reimbursement for additional staff persons traveling to the service location. If two or more unrelated trips are provided to the patient on the same day, the MMCP should pay each provider separately.

Staff transportation is divided into two types:

- **Per mile**
  - Billed daily in per mile units with a limit of 60 miles for a round trip.
  - Please reference the Adult BH HCBS and CORE Services fee schedule posted on the [OMH Medicaid Reimbursement](#) page for the per mile rate.
- **Per round trip**
  - Billed monthly using the first day of the month as date of service.
  - Each round-trip counts as one unit, with a limit of 31 units per calendar month.

**Note**<sup>5</sup>: If the provider is traveling from their home to the client reimbursement is allowable if it remains within the 60-mile cap. Please see the following reimbursement example of a practitioner traveling to multiple appointments on the same day:

- *Home to Client 1 - Bill to Client 1*
- *Client 1 to Client 2 - Bill to Client 2*
- *Client 2 to Home - Bill to Client 2*

<sup>5</sup> This note is also applicable for Provider Travel Supplement delivered with CORE Services.

➤ **Non-medical Transportation (only for HARP enrollees and individuals in HIV-SNPs meeting the HARP eligibility criteria and qualifying under a BH HCBS needs assessment):**

This is a BH HCBS that is carved-out of the HARP benefit in order to garner the benefits provided by the use of a transportation manager. It will be billed and managed in the same way as medically necessary transportation; it will be billed directly to the State on an FFS claim submitted by the transportation provider. All other HCBS services are detailed at the end of this document. Non-medical transportation is an ad hoc, time-limited service. Examples of transportation as a non-medical service would be travel to job interviews or to a GED course. Travel to BH HCBS is generally considered medically necessary transportation. Approval mechanisms and reimbursement to transportation providers is the same for both medical and non-medical transportation, except the non-medical transportation is not reimbursable outside of a HARP.

## **VII. Community Oriented Recovery and Empowerment (CORE) Services**

Community Oriented Recovery and Empowerment (CORE) Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

CORE Services provide opportunities for eligible adult Medicaid beneficiaries with mental illness and/or addiction disorders to receive services in their home or community. CORE designated providers work together with MMCPs, service providers, enrollees, families, and government partners to help members prevent and manage chronic health conditions and recover from serious mental illness and addiction disorders.

CORE Services are available to all HARP and HARP-eligible HIV-SNP enrollees based on a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).<sup>6</sup>

For additional CORE Services claiming and billing resources, please see the [CORE Benefit and Billing Guidance](#). For program and clinical guidance, please see the [CORE Operations Manual](#).

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<sup>6</sup> CORE services are also available to HARP-eligible MAP enrollees. Billing guidance for MAP can be found in the [New York State Medicaid Advantage Plus \(MAP\) Plans Behavioral Health Billing and Coding Manual \(ny.gov\)](#)



### VIII. Service Combinations

Only certain combinations of CORE and State Plan services are allowed by Medicaid within an individual's current treatment plan. The grid below shows the allowable service combinations. Allowable combinations for Adult BH HCBS and State Plan services can be found here: [Home and Community Based Services – Review Guidelines and Criteria \(ny.gov\)](#).

**Allowable Billing Combinations of OMH State Plan Services and CORE Services**

	MHOTRS	ACT <sup>1</sup>	CDT	PHP	PROS w. Clinic <sup>5</sup>	PROS w/o Clinic <sup>5</sup>	CORE CPST	CORE PSR	CORE FST	CORE Peer Support	Mobile Crisis	Crisis Residence	CSC	CCBHC
Mental Health Outpatient Treatment & Rehab Services (MHOTRS)	N/A	No <sup>4</sup>	No <sup>4</sup>	No	No <sup>4</sup>	Yes	Yes <sup>3</sup>	Yes	Yes	Yes <sup>4</sup>	Yes	Yes	Yes	No
Assertive Community Treatment (ACT) <sup>1</sup>	No <sup>4</sup>	N/A	No	No	No <sup>2</sup>	No <sup>2</sup>	No	No	No	No	Yes	Yes	Yes	No
Adults Continuing Day Treatment (CDT)	No <sup>4</sup>	No	N/A	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Partial Hospitalization Program (PHP)	No	No	No	N/A	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Personalized Recovery Oriented Services (PROS) with Clinic <sup>5</sup>	No <sup>4</sup>	No <sup>2</sup>	No	Yes	N/A	No <sup>4</sup>	No	No	No	Yes	Yes	Yes	Yes	No
PROS without Clinic <sup>5</sup>	Yes	No <sup>2</sup>	No	Yes	No <sup>4</sup>	N/A	No	No	No	Yes	Yes	Yes	Yes	No
CORE Community Psychiatric Support and Treatment (CPST)	Yes <sup>3</sup>	No	No	No	No	No	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CORE Psychosocial Rehabilitation (PSR)	Yes	No	Yes	Yes	No	No	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes
CORE Family Support and Training (FST)	Yes	No	Yes	Yes	No	No	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes
CORE Empowerment Services - Peer Support (Peer Support)	Yes <sup>4</sup>	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes
Mobile Crisis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes <sup>8</sup>

	MHOTRS	ACT <sup>1</sup>	CDT	PHP	PROS w. Clinic <sup>5</sup>	PROS w/o Clinic <sup>5</sup>	CORE CPST	CORE PSR	CORE FST	CORE Peer Support	Mobile Crisis	Crisis Residence	CSC	CCBHC
<b>Crisis Residence</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes
<b>Crisis Stabilization Centers (CSC)</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A <sup>6</sup>	Yes <sup>8</sup>
<b>Certified Community Behavioral Health Clinic (CCBHC)</b>	No	No	No	No	No	No	Yes <sup>7</sup>	Yes <sup>7</sup>	Yes <sup>7</sup>	Yes <sup>7</sup>	Yes <sup>8</sup>	Yes	Yes <sup>8</sup>	N/A

<sup>1</sup> Assertive Community Treatment (ACT) services includes Adult, Young Adult and Youth ACT.

<sup>2</sup> ACT and PROS co-enrollment is permitted for up to 3 months in a 12-month period. A PROS provider may bill at Level 1, 2 or 3 of the PROS Monthly Base Rate. An ACT provider may bill for the partial step-down payment level of services.

<sup>3</sup> Services comparable to OMH Mental Health Outpatient Treatment and Rehabilitative Services are available through CORE CPST. Enrollees may access non-duplicative services through CORE CPST in a single month for the following purposes:

- Access to a psychiatric prescriber (e.g., psychiatric assessment/evaluation, medication management, health monitoring) if the CORE CPST provider does not have a prescriber. Receiving psychotherapy through OMH Mental Health Outpatient Treatment and Support Services and CORE CPST is duplicative. Medication management and supporting activities through OMH Mental Health Outpatient Treatment and Support Services is duplicative if the CORE CPST provider has a prescriber on staff.
- Transition from CORE CPST to OMH Mental Health Outpatient Treatment and Support Services (including CCBHC), allowing for a warm handoff during the clinic pre-admission process (3 sessions).
- The CORE CPST provider should maintain communication with the prescriber to ensure integrated treatment/care.

<sup>4</sup> See regulations for exceptions: [MHOTRS Service Guidance - 7/18/2023 \(ny.gov\)](#)

<sup>5</sup> There are no co-enrollment restrictions for an individual in pre-admission status at PROS. Individuals who are in pre-admission do not have the PROS RE codes on their file.

<sup>6</sup> CSC partial and full visits cannot be billed in the same day.

<sup>7</sup> See the [CORE Services and CCBHC Allowable Service Combinations \(ny.gov\)](#) or the [CORE Benefit and Billing Guidance](#) regarding the exceptions to co-enrollment with CCBHC and CORE.

<sup>8</sup> Services comparable to Mobile Crisis, Crisis Residence, and Crisis Stabilization services are available through CCBHCs. Enrollees may access non-duplicative services through CCBHCs.

### Allowable Billing Combinations of OASAS State Plan Services and CORE Services

	CORE CPST	CORE PSR	CORE FST	CORE Peer Support
<b>OASAS Outpatient/Opioid Treatment Program (OTP)</b>	Yes	Yes	Yes	Yes <sup>1</sup>
<b>OASAS Permanent Supportive Housing (PSH)</b>	Yes	Yes	Yes	Yes
<b>OASAS Part 820 Residential Programs</b>	Yes	Yes	Yes	Yes
<b>OASAS Outpatient Rehabilitation</b>	Yes	Yes	Yes	Yes <sup>1</sup>
<b>OASAS Inpatient/Outpatient Withdrawal and Stabilization</b>	Yes	Yes	Yes	Yes

<sup>1</sup> OASAS will allow for patients admitted to an outpatient program certified pursuant to 14 NYCRR Part 822 receiving peer support services to also receive CORE Peer Empowerment Services. The providers should work together to ensure there is no service duplication. The allowable peer services shall complement, not duplicate.