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New York State
Community Oriented Recovery and Empowerment Services
Benefit and Billing Guidance

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Introduction: Community Oriented Recovery and Empowerment Services

In 2015, the New York State (NYS) Office of Addiction Services and Supports (OASAS) and Office of Mental Health (OMH), in collaboration with the Department of Health (DOH), transitioned much of the Medicaid behavioral health benefit into managed care to create a fully integrated mental health, addiction, and physical health delivery system providing comprehensive, accessible, and recovery-oriented services.

To improve access to rehabilitation services, NYS transitioned four Adult Behavioral Health Home and Community Based Services (BH HCBS)[1] to a new service array called Community Oriented Recovery and Empowerment (CORE) Services. **These services are Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training (FST), and Empowerment Services – Peer Support (Peer Support).**

This guidance collectively refers to Medicaid Managed Care Organizations with Health and Recovery Plans (HARPs), HIV Special Needs Plans (HIV-SNPs), and Medicaid Advantage Plus[2] (MAP) Plans as MCOs. CORE Services are available to all HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees as a covered benefit with a recommendation from a Licensed Practitioner of the Healing Arts (LPHA).

MCOs are required to manage CORE Services in accordance with this *CORE Benefit and Billing Guidance* and other applicable State-issued guidance. Until such time as the Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation and Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/ Health and Recovery Plan Model Contract *(Medicaid Managed Care Model Contract)* are updated to reflect requirements applicable to CORE Services, provisions contained therein regarding BH HCBS are applicable to CORE Services except in where this guidance differs, this guidance will control. CORE providers should refer to the CORE Services Operations Manual for Designated Providers *(CORE Services Operations Manual)* for detailed information on service definitions, documentation requirements, provider terms and conditions, and other information relevant to CORE Services provision.

[1] BH HCBS Short-term and Intensive Crisis Respite services were transitioned to Crisis Intervention Benefit Crisis Residence services at the time of the CORE transition, already available to all adult Medicaid Managed Care enrollees. See the Medicaid Managed Care Crisis Intervention webpage. All other existing BH HCBS remain available as BH HCBS with previously established requirements, workflows, and processes. BH HCBS access requirements, including the independent eligibility assessment and federal home and community-based settings restrictions, do not apply to CORE Services.

[2] MAP Plans cover CORE Services as of January 1, 2023, when specialty behavioral health benefits carved into the MAP benefit package.

This document is organized into the following sections:

I. Transition to CORE Services

On October 5, 2021, CMS approved NYS' 1115 MRT Waiver Amendment Request to transition CPST, PSR, FST and Peer Support from BH HCBS to CORE Services, and the transition became effective February 1, 2022. Transitional information included in October 2021 and April 2022 versions of this guidance has been archived, as the transition from BH HCBS to CORE Services is complete at the time of this update.

1. Access to CORE Services

An important aspect of the CORE Service demonstration is the "No Wrong Door" referral pathway which enables enrollees to easily access these services with as few barriers as possible. Enrollees may learn about and be referred to CORE Services through multiple sources, including the MCO, care manager, Health Homes, inpatient and outpatient clinicians, primary care practitioners, family and friends, or provider outreach and education efforts. Individuals may also self-refer to CORE Services. Referrals are not required to include an LPHA Recommendation.

i. Eligibility for CORE Services

To be eligible for CORE Services, an individual must meet the NYS BH high-risk criteria, commonly referred to as the HARP eligibility algorithm, **and** be enrolled in a HARP, HIV SNP, or MAP Plan. The following H-codes are used to determine CORE service eligibility:

- H1: indicates a member is enrolled in HARP and has met the BH high-risk criteria
- H4: indicates a member is enrolled in an HIV SNP and has met the BH high-risk criteria
- H9: indicates a member has met the NYS BH high-risk criteria[3]

[3] Individuals with an H9 are eligible to receive CORE Services when enrolled in a HARP, HIV SNP, or MAP Pan. Individuals with an H9 wishing to enroll in a HARP, HIV SNP, or MAP Plan may contact NY Medicaid Choice at 1-855-789-4277 for enrollment options.
Mainstream Medicaid Managed Care enrollees with an H9 code are not eligible for CORE Services. Please refer to the *Guide to Restriction Exception (RE) Codes and Health Home Services* for updates[4] MAP Plans cover CORE Services as of January 1, 2023, when specialty behavioral health benefits carved into the MAP benefit package.

II. CORE Benefit Management

Effective February 1, 2022, MCOs are required to include CORE Services in benefit packages for HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP Plan enrollees[4]. MCOs must manage the CORE Services benefit in compliance with State and federal mental health and addiction parity laws.

1. CORE Services Overview and Program Standards

CORE Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy promoting and facilitating community participation and independence. These services are not case management, personal care services, or a replacement for custodial care in an institutional setting.

CORE Services must be offered in the setting and modality best suited to support an enrollee's goal acquisition including in the enrollee's home and other community-based locations. The scope and intensity of CORE Services are based on the level of support needed to assist the individual in achieving their recovery goal(s) and sustaining recovery. The State has recommended CORE Service unit ranges, intended to illustrate the scope of services and program design, which may be exceeded when clinically appropriate. These CORE Service unit ranges can be found in the CORE Services Operations Manual.

Designated CORE providers may be approved by the State to deliver services via telehealth in accordance with applicable regulations and guidance. See telehealth guidance for OMH: Telehealth Services and OASAS: Telehealth Standards for OASAS Designated Providers.

For more information on CORE Service definitions, components, limitations and exclusions, staff and supervisory qualifications, and staff training requirements, please refer to the CORE Services Operations Manual.

A. Provider Travel Supplement

The Provider Travel Supplement (Staff Transportation) rate compensates provider agencies for staff travel costs directly related to CORE Service provision. Staff Transportation must only be used when services are delivered off-site and can only be reimbursed in conjunction with a completed CORE Service claim. Staff Transportation cannot be reimbursed for situations when providers travel off-site but a CORE Service was not delivered. Staff Transportation does not need to be included in an enrollee's individual CORE Service plan. Reimbursement for staff transportation can only be paid for one staff per off-site service provided, regardless of the number of staff who travel to the off-site location and shall not be limited except as provided in this guidance. Staff Transportation can be reimbursed per mile or per round trip.

Costs incurred for programs, services, or purposes other than CORE Services do not qualify for Staff Transportation reimbursement. Staff Transportation reimbursement may not be claimed for "staff time" while providers are traveling to deliver CORE Services, as costs associated with staff travel time are already factored into CORE Service reimbursement rates. Staff Transportation must be billed only when delivering a CORE Service and may not be billed as stand-alone CORE Service provision. Refer to the Rates and Billing Requirements section in this document for more information.

[4] MAP Plans cover CORE Services as of January 1, 2023, when specialty behavioral health benefits carved into the MAP benefit package.

B. Provider Designation and Oversight

CORE providers must be designated by OASAS and OMH to provide CORE Services. Designation is granted by service type and county. Providers may apply for designation to provide some or all CORE Services. Designated providers are subject to State oversight and monitoring.

Designated providers must adhere to the "CORE Service Standards and Terms and Conditions for Designated Providers" as outlined in the CORE Services Operations Manual. Designated providers may have their designation status suspended or terminated if the State determines a provider is not in compliance with the CORE Services Operations Manual. If a provider's designation is suspended or terminated the State will notify the provider's contracted MCOs. A list of designated CORE providers is regularly maintained on the CORE Provider Application and Designation webpage.

MCOs should continue to reference the designation list provided above to identify providers designated for CORE Services. NYS will notify MCOs if a provider's designation status is terminated. The CORE provider list is also available for MCOs in the Provider Network Data System (PNDS). However, provider terminations may not be immediately reflected in PNDS, as it is updated quarterly. NYS monitors CORE network development via quarterly PNDS submissions.

C. CORE Service Initiation Notification and Allowable Service Combinations

i. CORE Service Initiation Notification

CORE providers must notify an enrollee's MCO within three business days after the first date of initiating a new CORE Service, which includes CORE Service intake and evaluation. CORE Service intake and evaluation sessions must be conducted within either 30 days of the initial visit or the first five visits, whichever occurs later.

NYS developed a CORE Service Initiation Notification Template containing the information providers must submit to MCOs. MCOs may use this template or develop their own but can only include information contained in the template. MCOs must implement a secure electronic process for receiving and responding to CORE Services initiation notifications. MCOs are expected to clearly communicate and provide any necessary training to their CORE provider network about the MCO's notification process.

The MCO is responsible for confirming enrollees receiving CORE Services are not receiving a duplicative service, whether the service is in the managed care benefit or reimbursed fee-for-service[5]. It is strongly encouraged that MCOs confirm receipt of the CORE Service Initiation Notification with the submitting CORE Services provider. MCOs must notify relevant providers within three business days of notification receipt if the enrollee is receiving a duplicative service, such as the same CORE Service or a comparable service. Please refer to the Allowable Service Combination charts beginning on the next page for a list of duplicative services. CORE Service intake and evaluation sessions are billed using the CORE Service rate codes and are not considered duplicative of any other service. Until informing the CORE provider of a service duplication, MCOs are responsible for reimbursing CORE Service claims. MCOs may not recover payments made for services delivered prior to the MCO informing the provider of duplicative services.

If the enrollee is receiving a duplicative service the MCO must initiate a person-centered discussion between the enrollee, their providers, and their care manager (when applicable) to determine which service or program is the most appropriate for their needs. The MCO is responsible for

[5] To manage fee-for-service duplication review, such as with CCBHC services, MCOs should refer to the NYS DOH Fee-For-Service Claims Data Report as described in CCBHC Data Sharing with MCOs.

communicating with the enrollee and providers, in writing, the outcome of the person-centered discussion and the enrollee's decision regarding which services will continue.

Upon the culmination of services, providers are encouraged to share the discharge summary with the recipient's MCO as notification. This best practice is detailed in the CORE Services Operations Manual.

ii. CORE Allowable Service Combinations

Below are two charts for allowable service combinations with CORE Services. The first chart outlines allowable service combinations between CORE Services and BH HCBS. The second chart outlines allowable service combinations between CORE Services and other OASAS/OMH services.

CORE and BH HCBS: Allowable Service Combinations

BH HCBS	CPST	PSR (rate codes 7784 or 7785)	PSR with Education Focus (rate code 7811)	PSR with Employment Focus (rate code 7810)	FST	Peer
BH HCBS Habilitation	Yes	Yes[6]	Yes	Yes	Yes	Yes
BH HCBS Education Support Services	Yes	Yes	No	Yes	Yes	Yes
BH HCBS Pre-Vocational Services	Yes	Yes	Yes	No	Yes	Yes
BH HCBS Transitional Employment	Yes	Yes	Yes	No	Yes	Yes
BH HCBS Intensive Supported Employment	Yes	Yes	Yes	No	Yes	Yes
BH HCBS Ongoing Supported Employment	Yes	Yes	Yes	No	Yes	Yes

[6] Enrollees receiving both CORE PSR and BH HCBS Habilitation must receive services from a single designated provider whenever possible. Exceptions may be made if both services are not available or accessible from a single organization. In such cases the MCO is responsible for ensuring coordination between both providers to prevent a duplication of services. This coordination will include the sharing of ISPs between providers to ensure coordination of interventions.

CORE and Other OMH/OASAS Services: Allowable Service Combinations

OMH/OASAS Service	CPST	PSR	FST	Peer
OMH Clinic (now Mental Health Outpatient Treatment and Rehabilitative Services or MHOTRS)	Yes[7]	Yes	Yes	Yes[8]
Certified Community Behavioral Health Clinic (CCBHC)[9]- Sites Receiving NYS CCBHC Demonstration Medicaid Rate	Yes[10]	Yes[11]	Yes	Yes[12]
Certified Community Behavioral Health Clinic (CCBHC) Expansion Grant Awardees[13] – Sites Not Eligible for NYS CCBHC Demonstration Medicaid Rate	Yes[13]	Yes	Yes	Yes
OMH Assertive Community Treatment (ACT)	No	No	No	No
OMH Personalized Recovery Oriented Services (PROS)	No	No	No	Yes
OMH Continuing Day Treatment (CDT)	No	Yes	Yes	Yes
OMH Partial Hospitalization	No	Yes	Yes	Yes
OMH Licensed Housing	Yes	Yes	Yes	Yes
OMH Permanent Supportive Housing	Yes	Yes	Yes	Yes
OASAS Outpatient / Opioid Treatment Program (OTP)	Yes	Yes	Yes	Yes[14]
OASAS Permanent Supportive Housing (PSH)	Yes	Yes	Yes	Yes

[7] Services comparable to CORE CPST are available through OMH Clinic, now known as MHOTRS. As detailed in MHOTRS Service Guidance: Enrollees may not access duplicative services through CORE CPST and a MHOTRS program in a single month. For example:

- Individuals may access a psychiatric prescriber (e.g., psychiatric assessment/evaluation, medication management, health monitoring) if the CORE CPST provider does not have a prescriber.
- Individuals cannot receive psychotherapy through a MHOTRS program and CORE CPST, as it is duplicative. Medication management and supporting activities through a MHOTRS program is duplicative if the CORE CPST provider has a prescriber on staff.
- Transition from CORE CPST to a MHOTRS program (including CCBHC), allowing for a warm handoff during the clinic pre-admission process (three sessions).

The CPST provider should maintain communication with the prescriber to ensure integrated treatment/care.

[8] As detailed in MHOTRS Service Guidance, MHOTRS programs should not be providing ongoing peer support services if the individual is also enrolled in CORE Peer Support services. Pre-admission MHOTRS Peer Support Services are allowable.

[9] These CORE/CCBHC allowable service combinations apply to sites where CCBHC providers receive the Medicaid Prospective Payment System reimbursement authorized under the NYS CCBHC Demonstration. Please refer to the OMH CCBHC website for a list of these NYS CCBHC Demonstration providers.

[10] Services comparable to CORE CPST are available through CCBHC. Enrollees may access nonduplicative services through CORE CPST and CCBHC in a single month for the following purposes:

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

There has been no change to the policy on CORE CPST and CCBHC Demonstration Sites.

[11] Effective November 15, 2023, per CORE Services and CCBHC Allowable Service Combinations guidance, services comparable to CORE PSR are available through CCBHC Psychosocial Rehabilitation Services. Individuals may access CORE PSR only if they are not receiving CCBHC Psychosocial Rehabilitation Services in the same time frame (i.e., if you are receiving CORE PSR, you should not engage in CCBHC Psychosocial Rehabilitation Services until or unless you are discharged from CORE). See also: CCBHC Data Sharing with MCOs.

[12] Effective November 15, 2023, per CORE Services and CCBHC Allowable Service Combinations guidance, services comparable to CORE Empowerment Services – Peer Support are available through CCBHC Peer Support. Individuals may access CORE Peer Support only if they are not receiving CCBHC Peer Support Services in the same time frame (i.e., if you are receiving CORE Peer Support, you should not engage in CCBHC Peer Support Services until or unless you are discharged from CORE). The following exceptions also apply:

- Individuals may receive both CORE Peer Support and CCBHC pre-admission peer support services to support engagement in the CCBHC. When the individual is admitted, they need to be supported in making an informed choice between continuing CORE Peer Support or transitioning routine peer support services to the CCBHC.

Individuals who receive CORE Peer Support may access CCBHC Peer Support Services in the event of a crisis. Refer to the CORE Services Operations Manual and the CCBHC Scope of Services Manual for Pre-Crisis and Crisis Support guidance. See also: CCBHC Data Sharing with MCOs.

[13] These CORE/CCBHC allowable service combinations apply to the OMH/OASAS clinic CCBHC expansion grant awardees funded by Substance Abuse and Mental Health Services Administration (SAMHSA) with sites not eligible for the Medicaid Prospective Payment System reimbursement authorized under the NYS CCBHC Demonstration.

[14] OASAS will allow 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.

OMH/OASAS Service	CPST	PSR	FST	Peer
OASAS Residential	Yes	Yes	Yes	Yes
OASAS Outpatient Rehabilitation	Yes	Yes	Yes	Yes[14]
OASAS Inpatient/Outpatient Detox	Yes	Yes	Yes	Yes

D. LPHA Recommendation

Eligibility for CORE Services is based on two criteria:

- An individual meeting NYS BH high-risk criteria is enrolled in a HARP, HIV-SNP, or MAP.
- An LPHA recommendation.

An LPHA is a Licensed Practitioner of the Healing Arts. LPHA qualifications are found in the LPHA Recommendation Form (Fillable LPHA Recommendation). An LPHA must complete the LPHA recommendation form to document medical necessity and indicate appropriate CORE Services. The licensed clinical professional completing the LPHA recommendation may be, but is not required to be, employed by the designated CORE provider[15]. CORE providers must ensure an LPHA recommendation is obtained for all new referrals within 30 days of the initial visit or the first five visits, whichever occurs later. It is the CORE provider's responsibility to retain a copy of the LPHA recommendation form in the member's CORE case record. LPHA recommendations last through an enrollee's episode of care. Enrollees previously discharged and re-engaging in a CORE Service will need a new LPHA recommendation. MCOs may not require providers to submit a copy of the LPHA recommendation to initiate or be reimbursed for services. MCOs may request a copy of an LPHA recommendation for provider quality management or member care management purposes. MCOs are only permitted to complete Part 1 of the LPHA Recommendation Form.

As outlined in previous guidance, during the CORE transition, individuals determined eligible for and receiving CPST, PSR, FST or Peer Support as BH HCBS prior to February 1, 2022, were eligible to continue receiving the same service(s) under CORE. For continuity of care purposes these individuals could transition to CORE Services without an LPHA recommendation.

2. MCO Responsibilities and Provider Oversight

A. Utilization Management (UM)

MCOs may not conduct prior authorization or concurrent review for CORE Services. This includes all CORE Services and Staff Transportation. LPHAs will determine whether an individual meets medical necessity to receive CORE Services through the LPHA recommendation process. MCOs may conduct outlier management for purposes of enrollee care management and provider education.

MCOs are required to work collaboratively with CORE providers to share relevant information supporting the member's treatment, care management, and discharge planning. The frequency of communication should reasonably reflect the complexity of the member's treatment and care management needs.

[15] If the LPHA recommendation is completed by a member of the CORE staff, the time spent by the LPHA with the member for the purposes of making an initial recommendation may be billed at the service-specific rate code, even if the LPHA is not otherwise qualified to deliver the service. For example, if an LPHA meets with a member face-to-face to determine medical necessity for Empowerment Services – Peer Support, that time would be billable in 15-minute increments using rate code 7794, even if the LPHA is not a certified peer.

B. Member Services

MCOs must ensure Member Services staff responsible for providing intake, referral, or crisis response referrals to enrollees, whether employed by the MCO directly or through subcontracts, have access to updated training materials and receive adequate CORE Services training.

C. Quality Management

As outlined in Section 16 of the *Medicaid Managed Care Model Contract*, MCO Behavioral Health UM Committees are charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization data, interpret any variances, review outcomes, develop interventions, and approve interventions based on the findings in under and overutilization of behavioral health services and cost data. MCOs shall develop and implement protocols for identifying participating providers that do not adhere to practice guidelines and for making reasonable efforts to improve the performance of these providers.

MCOs should implement processes to ensure participating CORE providers are delivering services to enrollees according to State-issued guidelines. For State-issued guidelines for CORE Service providers, including information on service intensity guidelines, please refer to the CORE Services Operations Manual. MCOs may conduct outlier management for purposes of enrollee care management and provider education.

MCOs shall have effective mechanisms to obtain information from CORE providers, and report such information and related analytical data in a manner and format to be determined by the State, as required to support the NYS Section 1115 Medicaid Redesign Team (MRT) Waiver and related additional CMS requirements to evaluate the enrollee's level of care, adequacy of service plans, provider qualifications, enrollee health and safety, financial accountability, and compliance with the terms of this guidance and the *Medicaid Managed Care Model Contract*.

3. Network Requirements

A. Credentialing

MCOs must accept the CORE provider's State designation or provisional designation to fulfill the MCOs' credentialing requirements. MCOs may not individually credential staff employed by CORE provider agencies. MCOs must ensure CORE provider agencies are designated by the State and provider staff have not been excluded or de-barred from participation in any other federal or State program.

MCOs maintain responsibility to ensure program integrity pursuant to federal law. The MCO's credentialing committee shall develop and adhere to procedures consistent with 42 CFR 455.436 and Sections 18.9 and 21.4(a)(ii) of the *Medicaid Managed Care Model Contract*. If an MCO determines a practitioner providing a CORE service is excluded, any claims submitted for services provided by such practitioner should be denied.

B. Network Adequacy Requirements and Reporting

MCOs must ensure access to CORE Services for their enrollees as outlined in this guidance. The State will conduct ongoing network adequacy reviews for CORE Services.

MCOs must meet statewide CORE Service network adequacy requirements of a minimum of two providers of each CORE Service per county (as available).

The State will update PNDS with the list of designated CORE providers by services and county. MCOs will continue network reporting through quarterly PNDS submissions. NYS may request additional network information directly from MCOs.

C. Culturally and Linguistically Competent Provider Networks

Pursuant to Section 15 of the *Medicaid Managed Care Model Contract*, MCOs must maintain a culturally competent provider network capable of delivering services to all enrollees including those with limited English proficiency. MCOs must arrange for language assistance services and adequately reimburse CORE providers for language assistance services when network providers cannot meet an enrollee's language needs. MCOs are also responsible for informing CORE providers how to access and be reimbursed for language assistance services for enrollees with limited English proficiency.

4. Rates and Billing Requirements

A. Rates

Pursuant to Chapter 57 of the Laws of 2022, Medicaid MCOs must reimburse CORE providers in accordance with the State-mandated rates in the *CORE Services Fee Schedule,* found on the Medicaid Reimbursement Rates webpage.

B. Billing

Only CORE providers designated by NYS are permitted to bill MCOs for CORE Services provided to HARP enrollees, HARP-eligible HIV-SNP enrollees, and HARP-eligible MAP enrollees. Claims for CORE Services must be submitted using the appropriate combination of rate codes, procedure codes, and modifiers detailed in the tables below. Providers serving an enrollee may submit one claim per day for each rate code/procedure code/modifier combination. In accordance with the CORE Services Operations Manual, and if clinically indicated, providers may also submit one claim containing both the in-person and telehealth visit for the same rate code ensuring the appropriate units are billed to reflect both visit types. Providers should also ensure the appropriate diagnosis codes are included on the claim. Providers can use ICD-10 codes R69 and F99 for claiming when diagnosis codes are unknown. However, should a more appropriate diagnosis code be identified throughout the course of treatment, providers should bill using that code.

For additional Medicaid Managed Care claiming and billing resources, please see the New York State Health and Recovery Plan (HARP)/Mainstream Behavioral Health Billing and Coding Manual (see *Claims* section for details on MCO claiming and encounter reporting processes), and information available on the Managed Care Technical Assistance Center (MCTAC) website and the MCTAC Interactive Billing Tool. For telehealth guidance, see OMH Telehealth Services and OASAS Telehealth Standards for OASAS Designated Providers.

Psychosocial Rehabilitation (PSR)

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Psychosocial Rehabilitation (On-site)	Individual	7784	H2017	U1	15 Minutes
Psychosocial Rehabilitation (Off-site)	Individual	7785	H2017	U2	15 Minutes
Psychosocial Rehabilitation- Employment Focus (On-site or Off-site)	Individual	7810	H2017		15 Minutes
Psychosocial Rehabilitation- Education Focus (On-site or Off-site)	Individual	7811	H2017	TF	15 Minutes
Psychosocial Rehabilitation	Group (2-3)	7786	H2017	UN or UP **AND** • Education Focus - TF **OR** • Employment Focus - TG	15 Minutes
Psychosocial Rehabilitation	Group (4-5)	7787	H2017	UQ or UR **AND** • Education Focus - TF **OR** • Employment Focus - TG	15 Minutes
Psychosocial Rehabilitation	Group (6-10)	7788	H2017	US **AND** • Education Focus - TF **OR** • Employment Focus - TG	15 Minutes

PSR is offered both individually and in groups:

- **Individual (PSR, PSR with an Education Focus, or PSR with an Employment Focus)**
  - Billed daily in 15-minute units.
  - Individual service may be billed the same day as a PSR group session.
  - Individual PSR may be billed with PSR-Employment or PSR-Education in the same day (services must be documented in separate progress notes).
  - May be provided on or off-site (separate rates may apply).
- **Group**
  - Billed daily in 15-minute units.
  - Group sessions may be billed on the same day as a PSR individual per 15 minutes.
  - Service must be offered in the setting best suited for desired outcomes.
  - Payment for group sessions is broken into various levels using modifier codes to distinguish the number of individuals present in the session (i.e., 2-3, 4-5, 6+). The rate code/procedure code/modifier code combinations are shown on the services coding crosswalk above.
  - Modifiers must be used to indicate if group has an Education Focus or Employment Focus.

Community Psychiatric Support and Treatment (CPST)

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Community Psychiatric Support and Treatment (Physician)	Individual	7790	H0036	AF	15 Minutes
Community Psychiatric Support and Treatment (NP, Psychologist, Physician's Assistant)	Individual	7791	H0036	SA, AH, or U1	15 Minutes
Community Psychiatric Support and Treatment (RN, LMHC/MHC-LP, LMFT/MFT-LP, LCSW, LMSW/MSW-LP, LCAT/CAT-LP, Psychoanalyst, CRC)	Individual	7792	H0036	TD or AJ	15 Minutes
Community Psychiatric Support and Treatment (LPN)	Individual	7793	H0036		15 Minutes

- Billed daily in 15-minute increments.
- Payment for CPST services is broken into various levels using modifier codes indicating the type of staff providing the service (i.e., physician, psychologist, NP, RN, all other professions).
  - For rate code 7791 use the following modifiers:
    - Nurse Practitioner: SA
    - Psychologist: AH
    - Physician's Assistant: U1
  - For rate code 7792 use the following modifiers:
    - Registered Nurse: TD
    - All other allowable professions: AJ
- There are no group sessions for this service.
- May only be provided off-site unless there is documentation in the member's CORE case record indicating a strong clinical rationale for onsite service delivery (see CORE Services Operations Manual).

Empowerment Services – Peer Support

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Peer Support (Credentialed staff)	Individual	7794	H0038	HE or HF	15 Minutes

- Billed daily in 15-minute units.
- May be provided on or off-site.
- Use the HF modifier for an OASAS service or the HE modifier for an OMH service.

Family Support and Training (FST)

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure
Family Support and Training	Individual	7799	H2014	HR or HS	15 Minutes
Family Support and Training	Group (2-3)	7800	H2014	HR or HS, UN or UP	15 Minutes

- **FST session provided to one family**
  - Billed daily in 15-minute increments.
  - FST is detailed by using modifiers indicating whether the service was provided to the family with the recipient present or to the family without the recipient present.
  - If FST is delivered one-on-one with the individual only, no modifier is needed.
  - May be provided on or off-site.
- **Group FST (two to three families)**
  - Billed daily in 15-minute increments.
  - Group sessions may be billed on the same day as an FST one-on-one family session.
  - May be provided on or off-site.
  - Payment for FST group sessions is differentiated using modifier codes to distinguish the number of families present in the session (i.e., two or three).
    - HR - Family/couple with client present
    - HS - Family/couple without client present
    - UN - Two patients/families
    - UP - Three patients/families
  - Billing is at the recipient family level (e.g., if the group consists of the families of three recipients and, for purposes of this example, eight people are in the group, there would be only three claims submitted).

Provider Travel Supplement (Staff Transportation)

Service Name	Individual or Group	Rate Code	HCPCS Code	Modifier	Unit Measure	Unit Limit
Provider Travel Supplement (Per mile)	Individual	7808	A0160	U2	Per Mile	60
Provider Travel Supplement (Public Transport)	Individual	7809	A0160	U3	Per round trip	31

CORE providers bill Staff Transportation under an enrollee's Medicaid ID (CIN) and are only allowed to submit one claim per service regardless of the number of staff persons or practitioners traveling. If two or more unrelated trips are provided to the enrollee on the same day by multiple providers, the MCO should pay each provider separately.

Staff travel time cost is built into the CORE Service rates. As outlined in the CORE Operations Manual, there is no reimbursement for "staff time" while in travel status. Staff transportation time may not be billed as CORE Service provision. Travel related to unsuccessful contacts in which the individual isn't available cannot be reimbursed, as reimbursement is intended to be an add-on to a completed CORE Service. Refer to the *CORE Services Fee Schedule* for reimbursement rates.

There are two types of Staff Transportation:

- **Per mile**
  - Per mile is used when provider is driving.
  - Billed daily in per mile units with a limit of 60 miles for a round trip. This includes travel to and from an off-site setting as well as any travel during the delivery of CORE Services. If the provider is traveling from their home to the client, reimbursement is allowable if it remains within the 60-mile cap.
  - Per mile reimbursement rate is dictated by federal guidelines. See the *CORE Services Fee Schedule* for current rate.
- **Public Transport (Per round trip)**
  - Per round trip is used when provider is using public transportation (i.e., bus, subway, etc.).
  - 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.