NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Addiction Services and Supports | Department of Health

KATHY HOCHUL, Governor
ANN MARIE T. SULLIVAN, M.D., Commissioner
CHINAZO CUNNINGHAM, MD, Commissioner
MARY T. BASSETT M.D., M.P.H., Commissioner

New York State Medicaid Advantage Plus (MAP) Plans

Behavioral Health Billing and Coding Manual

July 1, 2022

Contents

I. Background 2
II. Rates 2
- **Services Covered by Medicaid Only** 2
- **Services Covered by Medicare and Medicaid** 3
- **Behavioral Health Services Carve-in Crosswalk** 3

III. Claims and Encounters 7
- **Medicaid Managed Care Plan Claiming** 7
- **Medicaid Encounter Reporting** 7
- **Claims Testing** 8

IV. Service Combinations 8
V. Ambulatory Mental Health Services 10
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)** 10
- **Assertive Community Treatment (ACT)** 10
- **Continuing Day Treatment (CDT)** 11
- **Comprehensive Psychiatric Emergency Program (CPEP)** 11
- **Partial Hospitalization (PH)** 11
- **Personalized Recovery Oriented Services (PROS)** 12

VI. Community Oriented Recovery and Empowerment (CORE) 13
VII. Crisis Intervention Services 13
- **Mobile Crisis Services** 13
- **Crisis Residence Services** 14

VIII. New York State Office of Alcoholism and Substance Abuse Services (OASAS) – Substance Use Disorder (SUD) Services and Billing 15
IX. FFS-Covered OMH/OASAS Services 16
X. Additional Resources 16

I. Background

New York State (NYS) is carving additional Behavioral Health (BH) services into the Medicaid Advantage Plus (MAP) Plan benefit package.

This guidance outlines the claiming requirements necessary to ensure proper BH claim submission with respect to MAP Plans. Each BH service transitioning to the Medicaid Managed Care reimbursement model is covered in detail below. This manual should be used in conjunction with the MAP coding taxonomy for BH which was prepared by the Office of Mental Health (OMH) for Plan and provider use.

MAP Plans are a type of Dual Eligible-Special Needs Plan (D-SNP) combined with a Medicaid Managed Long-Term Care (MLTC) Plan, which administer Medicare and Medicaid benefits, including Medicaid long-term care services. Utilization management and eligibility requirements for mental health and addiction services included in the MAP benefit package will be the same as the requirements in Medicaid Health and Recovery Plans (HARPs) and the Mainstream Managed Care benefits. For more details please see *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus* and Medicaid Advantage Plus (MAP) Model Contract.

Note: This manual only addresses MAP Plan BH billing guidance. 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.

II. Rates

➢ Services Covered by Medicaid Only

Beginning January 1, 2023, MAP Plans will be required to pay at least 100 percent of the mandated Medicaid rate for Medicaid-only covered procedures delivered to individuals enrolled in MAP Plans when the service is provided by an OASAS and OMH licensed, certified, or designated program.

Medicaid rates are required for the following three categories of services:

1) **OMH Government Rate Services**
   - Assertive Community Treatment (ACT)
   - Continuing Day Treatment (CDT)
   - Comprehensive Psychiatric Emergency Program (CPEP), including Extended Observation Bed (EOB)
   - Partial Hospitalization (PH)
   - Personalized Recovery Oriented Services (PROS), except the clinic component

2) **OMH/OASAS Government Rate Services**
   - Community Oriented Recovery and Empowerment (CORE) Services

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Family Support and Training (FST)
- Empowerment Services – Peer Supports (Peer Supports)

3) OASAS 1115 Waiver Demonstration Programs

- SUD Residential Treatment – Per Diem (Stabilization and Rehabilitation - and, upon CMS approval, Reintegration)

➢ Services Covered by Medicare and Medicaid

Beginning January 1, 2023, MAP Plans will pay the "higher of" what Medicare or Medicaid would pay for BH ambulatory services that are reimbursable under both Medicare and Medicaid. With the principle of Medicaid being the payer of last resort, Medicaid is responsible for the remaining balance after the Medicare payment, up to the Medicaid rate if the Medicaid rate for the service is higher than Medicare. Medicaid reimburses 100 percent of the patient cost-sharing responsibility if the Medicare rate is higher than the Medicaid rate. The "higher of" requirement applies to the following services:

- Mental Health Outpatient Treatment and Rehabilitative Services
- Personalized Recovery Oriented Services (PROS) (Clinic component)
- Outpatient Medically Supervised Stabilization and Withdrawal (Detox)
- Outpatient Chemical Dependence (CD) Clinic (aka Outpatient Addiction Rehab)
- Outpatient CD Rehabilitation (aka Outpatient Addiction Day Rehab)
- Opioid Treatment Program

NOTE: If the service and the professional performing the service are allowable under Medicaid, but not allowable under Medicare, MAP Plans must reimburse the service as a Medicaid-only service at the Medicaid rate. Typically, the practitioner in these programs is not allowable under Medicare, in which case the MAP Plan must reimburse the service at the Medicaid rate.

➢ Behavioral Health Services Carve-in Crosswalk

Please see charts below for clarification on OMH and OASAS services covered by Medicaid and/or Medicare.

All BH services that are not currently included but will be carved into the MAP Plan benefit package effective January 2023 are outlined in the chart below.

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Mental Health (MH) Services							
OMH Service	**OMH Regulation**	**MAP Medicaid Coverage (Before Jan 2023)**		**MAP Medicaid Coverage (Beginning Jan 2023)**		**MAP Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Psychiatric Inpatient	Parts 580, 582, and 587	Covered (days in excess of the Medicare 190-day lifetime maximum)		Covered		Covered (Medicare 190-day lifetime maximum)	
Mental Health Outpatient Treatment and Rehabilitative Services	Part 599	Covered	Covered	Covered	Covered	Covered	Covered
Assertive Community Treatment (ACT)	Part 508	Carved-out		Covered		Not Covered	
Continuing Day Treatment (CDT)	Sections 587.10 & 588.7	Carved-out		Covered		Not Covered	
Comprehensive Psychiatric Emergency Program (CPEP)	Parts 590 & Part 591	Carved-out		Covered		Not Covered	
Partial Hospitalization (PH)	Sections 587.12 & 588.9	Carved-out		Covered		Not Covered	
Personalization Recovery Oriented Services (PROS)	Part 512	Carved-out		Covered		Not Covered (except for the clinic component)	
Crisis Residence	Part 589	Carved-out		Covered		Not Covered	

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Substance Use Disorder (SUD) Services							
OASAS Service	**OASAS Regulation**	**MAP Medicaid Coverage (Before Jan 2023)**		**MAP Medicaid Coverage (Beginning Jan 2023)**		**MAP Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Medically Managed Detox – Inpatient	Section 816.6	Covered		Covered		Covered	
Medically Supervised Detox – Inpatient	Section 816.7	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Medically Supervised Detox – Outpatient	Section 816.8 and Part 822	Covered	Covered	Covered	Covered	Covered	Not Covered
Inpatient Rehabilitation	Part 818	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Addiction Treatment Center - State Operated Inpatient Rehabilitation	Part 818		Carved-out		Covered		Not Covered
Residential Services	Part 820		Carved-out		Covered		Not Covered
Outpatient Clinic	Part 822	Covered	Covered	Covered	Covered	Not Covered (see note*)	Not Covered (see note*)
Outpatient Rehabilitation	Part 822	Covered	Covered	Covered	Covered	Not Covered (see note*)	Not Covered (see note*)
Opioid Treatment Program	Part 822	Carved-out	Carved-out	Covered	Covered	Covered	Covered

***Medicare Coverage Note:** *Medicare eligible services like psychotherapy and some medication assisted treatment are covered only when delivered by a Medicare enrollable practitioner and billed as a practitioner claim.*

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Behavioral Health Services with Joint OMH and OASAS Oversight							
OMH and OASAS Service	**OMH/OASAS Regulation**	**Medicaid Coverage (Before Jan 2023)**		**Medicaid Coverage (Beginning Jan 2023)**		**Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Community Oriented Recovery and Empowerment (CORE) Services	N/A		Carved-out*		Covered		Not Covered
Mobile Crisis	N/A	Carved-out		Covered		Not Covered	

*Community Oriented Recovery and Empowerment (CORE) Services were implemented February 1, 2022. CORE Services are only available to eligible individuals enrolled in Medicaid Managed Care and will become available for eligible MAP enrollees January 1, 2023.

III. Claims and Encounters

➢ Medicaid Managed Care Plan Claiming

The MAP Plans shall support both paper and electronic submission of claims for all claim types. Claims will be submitted using the 837i (institutional) or UB-04 (paper) claim form. This will allow for use of rate codes which will inform the Plans of the type of BH program submitting the claim and the service(s) being provided.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field[1] 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. Any time the provider includes a rate code on the claim, the Plan should include it on the encounter record.

NYS will give MAP Plans a complete listing of all existing providers and the rate codes they bill under, as well as the rate amounts by Medicaid Management Information System (MMIS) ID (aka Provider ID) and locator code and/or National Provider ID (NPI) and zip+4. This list will also be posted on the OMH[2] and OASAS websites.

Billing requirements depend on the type of service provided; however, every electronic claim submitted will require, at minimum, 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); and
- Units of service.

➢ Medicaid Managed Care Plan Encounter Reporting

Rate code will be an element to be submitted to the Encounter Intake System (EIS) for all inpatient and outpatient Mental Health (MH)/ Substance Use Disorder (SUD) 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. MAP Plans must accept rate codes on all BH inpatient and outpatient claims and include those rate codes on encounters submitted to the EIS.

All Medicaid encounters submitted for MAP enrollees must include both Medicare and Medicaid expenses. MAP Plans shall submit all encounters as a Medicaid encounter regardless of whether there is a Medicaid share. Plans are not to submit a separate Medicare encounter. All other services will be reported to the EIS using the appropriate X12 837 Post Adjudicated Claims Data Reporting format.

---

[11] This field is already used by Plans to report the weight of a low-birth-weight baby.

[2] Billing Behavioral Health Medicaid services under Managed Care (ny.gov)

- **Claims Testing**

  To facilitate a smooth transition to Managed Care billing, the MAP Plans will reach out and offer billing/claim submission training to newly contracted providers and providers in active negotiation to contract. This will include testing claims submission and processing, and issuance of MAP Plans' contact and support information to assist providers with claims submission.

  Providers are expected to test the claims submission process with MAP Plans for all delivered services prior to the service implementation date and upon executing a new contract. This should begin at least 90 days prior to the implementation date. Even when providers already bill Medicaid Managed Care Plans for behavioral health services, claims testing is strongly encouraged, especially for those services that are dually covered by Medicaid and Medicare (see sections V-VIII) as there are unique processes for billing these services.

IV. 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 Billing Combinations of OMH State Plan Services and CORE Services											
	MHOTRS	ACT [1]	CDT	PHP	PROS w. Clinic[5]	PROS w/o Clinic[5]	CORE CPST	CORE PSR	CORE FST	CORE Peer Support	Crisis Intervention
Mental Health Outpatient Treatment & Rehab Services (MHOTRS)	N/A	No[4]	No[4]	No	No[4]	Yes	Yes[3]	Yes	Yes	Yes[4]	Yes
Assertive Community Treatment (ACT) [1]	No[4]	N/A	No	No	No[2]	No[2]	No	No	No	No	Yes
Adults Continuing Day Treatment (CDT)	No[4]	No	N/A	No	No	No	No	Yes	Yes	Yes	Yes
Partial Hospitalization Program (PHP)	No	No	No	N/A	Yes	Yes	No	Yes	Yes	Yes	Yes
Personalized Recovery Oriented Services (PROS) with Clinic[5]	No[4]	No[2]	No	Yes	N/A	No[4]	No	No	No	Yes	Yes
PROS without Clinic[5]	Yes	No[2]	No	Yes	No[4]	N/A	No	No	No	Yes	Yes
CORE Community Psychiatric Support and Treatment (CPST)	Yes[3]	No	No	No	No	No	N/A	Yes	Yes	Yes	Yes
CORE Psychosocial Rehabilitation (PSR)	Yes	No	Yes	Yes	No	No	Yes	N/A	Yes	Yes	Yes
CORE Family Support and Training (FST)	Yes	No	Yes	Yes	No	No	Yes	Yes	N/A	Yes	Yes
CORE Empowerment Services - Peer Support (Peer Support)	Yes[4]	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A

[1] Assertive Community Treatment (ACT) services includes Adult, Young Adult and Youth ACT.

[2] ACT and PROS enrollment, 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.

[3] 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.

[4] See regulations for exceptions: https://omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf

[5] 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.

V. Ambulatory Mental Health Services

- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)[8]**
  OMH Medicaid Clinic Regulations (Part 599)[9]
  Medicare Billing Guide

  OMH MHOTRS is already included in the MAP Plan benefit package for both hospital-based and free-standing facilities. For the MHOTRS procedures allowable under Medicare, MAP Plans currently pay the Medicare negotiated rate, and Medicaid's responsibility is 100% of the enrollee's cost sharing, encompassing all deductibles, co-pays and co-insurance amounts. After January 2023, MAP Plans will pay the "higher of" what Medicare or Medicaid would pay for MHOTRS services and procedures allowable under both Medicare and Medicaid, and will pay the Medicaid rate if the service and the professional performing the service are allowable under Medicaid, but not allowable under Medicare[10].

  OMH MHOTRS uses Ambulatory Patient Groups (APGs) as the basis for Medicaid fee-for-service and Medicaid Managed Care Plan (MMCP) payments for mental health services (aka, Medicaid mandated rate for OMH MHOTRS). The most up-to date mental health service weights, diagnosis weights, and APG peer group base rates can be found at the OMH website. For more information on OMH Clinic, please see NYS OMH 14 NYCRR Part 599 Clinic Treatment Programs Interpretive/Implementation Guidance.

  MAP Plans will determine if a service is medically necessary in accordance with the procedures and requirements outlined in the MAP Model Contract, Appendix F.1.1 Section titled Organizational Determinants.

- **Assertive Community Treatment (ACT)**
  ACT Regulations (Part 508)
  ACT Program Guidelines

  ACT services are billed once per month using one rate code for the month's services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial, or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact is defined as a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral. The attached crosswalk indicates the procedure code (H0040) and modifier combinations to be used with the ACT rate codes. For more information on ACT rate codes, please see page 7

[8] Formerly known as OMH Clinic.
[9] The updated regulation for MHOTRS is forthcoming.
[10] Medicare eligible benefits like psychotherapy are covered only when delivered by a Medicare enrollable practitioner. For the list of Medicare eligible professional type, please refer to page 7-15 in this Medicare Mental Health reference.

section titled: Assertive Community Treatment (ACT) in the New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual.

- **Continuing Day Treatment (CDT)**

  CDT Operational Regulations (Section 587.10)
  CDT Reimbursement Regulations (Section 588.7)

  Continuing Day Treatment (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 across two types of visits: full day (4 hours minimum) and half-day (2 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 provider of service 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), for more information on CDT rate codes, please see page 8 section titled: Continuing Day Treatment (CDT) in the New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual.

- **Comprehensive Psychiatric Emergency Program (CPEP)**

  CPEP Operational Regulations (Part 590)
  CPEP Reimbursement Regulations (Part 591)

  CPEP is claimed on a daily basis. A patient may receive one brief 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 brief 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). For more information on CPEP rate codes, please see page 9 section titled: Comprehensive Psychiatric Emergency Program (CPEP) in the New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual.

- **Partial Hospitalization (PH)**

  PH Medicare Billing Guide
  PH Medicaid Operational Regulations (Section 587.12)
  PH Medicaid Reimbursement Regulations (Section 588.9)

  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 for 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 on the MAP 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 (4357-4359, 4349-4352) - Visits of one to three hours are billed using the 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 crosswalk, the UA modifier is required on all partial hospitalization pre-admission claims.

- **Personalized Recovery Oriented Services (PROS)**

PROS Regulations (Part 512)
PROS Program Guidance
PROS Medicare Billing Guidance

For all PROS services other than clinic treatment, billing will follow the Medicaid billing procedures. 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. To see and table for the Calculation of “PROS Units” (based on “program hours” and “number of services”), please see page 13 of the New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual. This table is used on a daily basis to calculate the PROS units for the day. At the end of the month, the daily units for each day in the month are accumulated to determine the total units for the month. For any additional questions regarding PROS services other than clinical treatment services please see page 12 section titled: Personalized Recovery Oriented Services (PROS) in the New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual.

For PROS clinic treatment services, providers will use the Medicare required procedure code and/or revenue codes as well as the Medicaid required rate codes. Institutional claim form (837i) must be used to allow rate codes to be reported. Currently PROS clinic in MAP is reimbursed at the Medicare negotiated rate and Medicaid's responsibility is 100% cost sharing, encompassing all deductibles, co-pays, co-insurance amounts, and any subscriber premiums. Effective January 1, 2023, MAP Plans will pay the "higher of" what Medicare or Medicaid would pay for PROS clinic services and procedures that are allowable under both Medicare and Medicaid and will pay the Medicaid rate if the service and the professional performing the service are allowable under Medicaid, but not allowable under Medicare.

For more information on Medicare billing, please see the Medicare Claims Processing Manual.

VI. Community Oriented Recovery and Empowerment (CORE) Services

The Centers for Medicare and Medicaid Services (CMS) authorized Adult Behavioral Health Home and Community Based Services (BH HCBS) as a demonstration benefit under NYS' Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver. To improve access to services, NYS has transitioned four (4) BH HCBS 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). All other existing BH HCBS remain available as BH HCBS with previously established requirements, workflows, and processes. Medicaid Advantage Plus (MAP) Plans will offer CORE Services as a covered benefit for eligible enrollees.

Medicaid Recipient Restriction Exception (RRE) code H9 will be used to identify MAP enrollees eligible for CORE Services. 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 submit claims for an in-person visit and telehealth visit for the same rate code in the same day.

The rate code, procedure code, and modifier combinations are listed in the MAP Plan coding taxonomy. For additional CORE Services claiming and billing resources, including allowable service combinations, please see the CORE Benefit and Billing Guidance.

VII. Crisis Intervention Services

The Crisis Intervention benefit is comprised of three service components available to adults aged 21 and older: Mobile Crisis, Crisis Residence, and Crisis Stabilization services. The State will release guidance regarding Crisis Stabilization services at a later date[11].

- **Mobile Crisis Services**
  Mobile Crisis Program Guidance

[11] MAP Plans will cover Crisis Stabilization Services when specialty behavioral health benefits carve into the MAP benefit package or when Crisis Stabilization Services are implemented, whichever is later.

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

MAP Plans 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 for adults age 21 and over in the Crisis Intervention Benefit please see the Crisis Intervention Benefit: Mobile Crisis Component Benefit and Billing Guidance.
Mobile crisis services provided to youth ages 18 to 20 will not be the responsibility of the MAP Plans and will be covered by Medicaid Fee-for Service. For additional information for recipients age 18 to 20 please see page 26 and 51 in the New York State Children's Health and Behavioral Health Services Billing and Coding Manual.

- **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 a MAP enrollee. 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 aged 18 years and older. For adults ages 21 and over, providers must follow the Adult Crisis Residence Benefit and Billing Guidance.

Crisis residence services provided to youth ages 18 to 20 will not be the responsibility of the MAP Plans and will be covered by Medicaid Fee-for-Service. For more information, refer to the Crisis Intervention Benefit: Children's Crisis Residence Program Benefit and Billing Guidance.

VIII. New York State Office of Alcoholism and Substance Abuse Services (OASAS) – Substance Use Disorder (SUD) Services and Billing

For OASAS services, providers will use the Medicaid required rate codes shown in the table below. Shaded fields are not applicable. Less commonly used rate codes are in parenthesis. Additional information on OASAS services can be found at Mainstream/HARP Behavioral Health Billing and Coding Manual and OASAS Billing Guidance. Part 841 is the OASAS reimbursement regulation.

		Rate Codes	
Service	**OASAS Reg**	**Hospital**	**Freestanding**
Medically Managed Detox - Inpatient	Section 816.6	4800	
Medically Supervised Detox - Inpatient	Section 816.7	4801, 4802, 4803	4220
Medically Supervised Detox - Outpatient	Section 816.8 and Part 822	1528	1540
Residential Rehabilitation for Youth	Part 817		4210
Inpatient Rehabilitation	Part 818	2957, 2993	4213
Addiction Treatment Center - State Operated Inpatient Rehabilitation	Part 818		4202
Residential Services	Part 820		1144, 1145, (and 1146 upon CMS approval)
Outpatient Clinic	Part 822	1528 (or 1118, 1132, 1552)	1540 (or 1114, 1468, 1486) FQHCs: 4273, 4274, 4275
Outpatient Rehabilitation	Part 822	1561 (or 1558)	1573 (or 1570) FQHCs: 4276, 4277, 4278
Opioid Treatment Program	Part 822	1567 (or 1120, 1134, 1555) Bundles: 7973, 7974, 7975, 7976	1564 (or 1116, 1130, 1471) Bundles: 7969, 7970, 7971, 7972 FQHCs: 1671

IX. FFS-Covered OMH/OASAS Services

The following services will remain in Medicaid Fee-for-Service after the January 1, 2023 transition and will not be the responsibility of the MAP Plans until otherwise informed.

- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- OASAS Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)
- Crisis Intervention Services for Youth ages 18-20
- Children and Family Treatment Services and Supports (CFTSS) for Youth ages 18-20
- Children's Home and Community Based Services (HCBS) for Youth ages 18-20

X. Additional Resources

Medicaid:

- Mainstream/HARP Behavioral Health Billing and Coding Manual
- Community Oriented Recovery and Empowerment (CORE) Benefit and Billing Guidance
- OMH Medicaid Reimbursement Page
- OASAS Billing Guidance

Medicare:

- Medicare Claims Processing Manual
- Medicare Mental Health

MAP:

- Medicaid Advantage Plus (MAP) Model Contract

For billing questions please reach out to the OMH Managed Care Mailbox (OMH-Managed-Care@omh.ny.gov) or the OASAS mailbox (PICM@oasas.ny.gov).