

UnitedHealthcare Community Plan New York Medicaid Behavioral Health Manual



United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

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**Mainstream Medicaid
and
UnitedHealthcare Community
Plan Wellness4Me**

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Introduction

Welcome!

We are pleased to have you working with us to serve the individuals covered under Mainstream Medicaid and the Health and Recovery Plan of New York (Wellness4Me). We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, providerexpress.com, where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!



Important Notice

Optum provides this manual as a more focused resource for clinicians serving the UnitedHealthcare Community Plan [Wellness4Me](#) and Mainstream Medicaid membership. This manual does not replace the primary National Network Manual. Rather, this manual supplements the Network Manual by focusing on the core service array, roles and responsibilities as well as process and procedures specific to the State of New York HARP and Mainstream Medicaid programs. Topics or requirements that are specific to the Wellness4Me or Mainstream Medicaid programs as offered through UnitedHealthcare Community plan are detailed here. In addition, some sections of the primary Network Manual repeated for convenience. There is a link on the Optum provider website, Provider Express, to the Optum National Network Manual. Go to: Quick Links on the Provider Express (home page) > Guidelines /Policies & Manuals > Network Manual > [National Network Manual](#).

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.



Overview and Model of Care

New York State's goal is to create an environment where managed care plans, service providers, peers, families, and the state of New York partner to help Members prevent chronic health conditions and recover from serious mental illness and substance use disorders. This partnership will be based on the following values:

- **Person-Centered Care:** Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower Members, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the entirety of the person.
- **Recovery-Oriented:** The system should include a broad range of services that support recovery from mental illness and/or substance use disorders. These services support the acquisition of living, vocational, and social skills, and are offered in settings that promote hope and encourage each Member to establish an individual path towards recovery.
- **Integrated:** Service providers should attend to both physical and behavioral health needs of Members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness. If a provider renders both behavioral health and medical services in the same location, the Member may identify which provider (psychiatrist/addictionologist or other medical provider) functions as their PCP.
- **Data-Driven:** Providers and plans should use data to define outcomes, monitor performance, and promote health and wellbeing. Plans should use service data to identify high-risk/high-need Members in need of focused care management. Performance metrics should reflect a broad range of health and recovery

- **Evidence-Based:** The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices. New York State (NYS) intends to partner with plans to educate and incentivize network providers to deliver EBPs. The NYS Office of Mental Health will provide technical assistance through entities such as the [Center for Practice Innovations at Columbia University/New York State Psychiatric Institute](#) as well as the [Clinic Technical Assistance Center at New York University](#).
- **Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives.
- **Peer-Supported:** Peers will play an integral role in the delivery of services and the promotion of recovery principles.
- **Culturally Competent:** Culturally competent services that contain a wide range of expertise in treating and assisting people with Serious Mental Illness (SMI) and Substance Use Disorder (SUD) in a manner responsive to cultural diversity.
- **Flexible and Mobile:** Services should adapt to the specific and changing needs of each individual, using off-site community service delivery approaches along with therapeutic methods and recovery approaches which best suit each individual's needs. BH HCBS, where indicated, may be provided in home or off-site, including appropriate community settings such as where an individual works, attends school or socializes.
- **Inclusive of Social Network:** The individual, and when appropriate, family members and other key members of the individual's social network are always invited to initial meetings, or any necessary meetings thereafter to mobilize support.
- **Coordination and Collaboration:** These characteristics should guide all aspects of treatment and rehabilitation to support effective partnerships among the individual, family and other key natural supports and service providers. Additionally, the [Northeast Addiction Technology Transfer Center](#) provides technical assistance with EBP's for Substance Use Disorder programs.

UnitedHealthcare Community Plan of New York has been qualified to implement a Health and Recovery Plan for consumers residing in New York City and Rest of State. Optum works in close collaboration with UnitedHealthcare Community Plan to administer the behavioral health benefits for these beneficiaries.



Participant Information

Mainstream Medicaid

Membership encompasses all Mainstream Medicaid and Wellness4Me eligible and enrolled individuals 21 and over requiring behavioral health services. This manual applies to Members enrolled with UnitedHealthcare Community Plan of New York.

Health and Recovery Plan (Wellness4Me)

Membership encompasses adult Medicaid beneficiaries age 21 and over who are eligible for mainstream Managed Care Organizations (MCOs) and who meet one of two criteria sets outlined here:

- Target criteria and risk factors as defined according to the [New York State: Health and Recovery Plan \(Wellness4Me\) Adult Behavioral Health Home and Community Based Services \(BH HCBS\) Provider Manual](#); or
- Service system, or service provider, identification of individuals presenting with serious functional deficits as determined by:
 - A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
 - Completion of Wellness4Me eligibility screen

Wellness4Me Target Criteria

The State of New York defines Wellness4Me target criteria for Medicaid enrolled individuals 21 and over who are:



- Diagnosed with a Serious Mental Illness or Substance Use Disorder (SMI/SUD)
- Eligible to be enrolled in Mainstream MCOs
- Not enrolled in both Medicaid/Medicare ("duals")
- Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD)

Refer to the New York State: [Health and Recovery Plan \(Wellness4Me\) Adult Behavioral Health Home and Community Based Services \(BH HCBS\) Provider Manual](#) for more information about Wellness4me Eligibility.

Confidentiality

All providers are required to maintain policies and procedures that assure confidentiality of behavioral health and substance use related information. The policies should include but are not limited to the following information:



- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access to information and limits of that access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for behavioral health and substance use information and protocols to protect persons with behavioral health and/or substance use disorder from discrimination.

Mainstream and HCBS Treatment Record Documentation

Please refer to the Optum [National Network Manual](#) for information regarding Treatment Record Documentation requirements.

In conjunction with the Treatment Record Documentation standards outlined in the Optum National Network Manual, the HCBS documentation requirements for encounters specifically include:

- Name of Member
- Type of service provided
- Date of service provided
- Location of service
- Duration of service, including start and end times
- Description of interventions to meet Plan of Care goals



- Outcome(s) or Progress made toward goal achievement
- Follow up / next steps
- Your name, qualifications, signature and date

Quality Assurance

Quality Assurance reviews may occur for a variety of reasons:

- Quality Assurance reviews and claims audits will be conducted by NYS or its designee, including Local Government Units, to ensure providers comply with the rules, regulations, and standards of the program, and may be conducted without prior notice.
- The Quality Assurance reviews will focus on program aspects, but may include technical requirements such as billing, claims, and other Medicaid program requirements.
- Managed care plans may also be developing protocols to oversee the provision of these services in their provider networks.
- Sentinel events may result in quality reviews.

Sentinel Events and Critical Incident for Mainstream Medicaid, Wellness4Me and HCBS

Sentinel events are defined as a serious, unexpected occurrence involving a member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment. UnitedHealthcare Community Plan has established processes and procedures to investigate and address sentinel events. This includes a centralized review committee, chaired by medical directors within Community Plan, and incorporates appropriate representation from the various behavioral health disciplines. As a network provider, you are required to cooperate with sentinel event investigations and reporting.

Reporting Sentinel Events to the Quality Department:

- If you are aware of a sentinel event involving a Member, you must notify UnitedHealthcare Community Plan within one business day of the occurrence.
- Standardized reporting forms should be sent directly to the Quality Department through secure fax or email, below:

Fax: **1-844-342-7704** Attn: Quality Department
Email: NYBH_QIDept@uhc.com

The Sentinel Event reporting form is located on providerexpress.com. From the home page of Provider Express: Our Network > Welcome to the Network > New York > Quality Improvement > [Sentinel Event Reporting Form](#).

Network Participation Requirements

Providers must meet the Network Requirements as outlined in the Optum [National Network Manual](#).

When a provider is OMH-licensed, OMH-operated or OASAS-certified, credentialing is done at the group level; the individual employees, subcontractors and agents of such providers do not require separate credentialing. Optum is required to collect program integrity related information (the Disclosure of Ownership and Control Interest statement).

- Optum also requires that providers or agencies licensed by OMH, OASAS, or DOH, not employ or contract with any employee, subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
- Providers that are licensed by OMH or OASAS will not require an on-site audit as part of the credentialing and recredentialing process.

Optum is required to submit a quarterly report to OMH and OASAS outlining deficiencies in performance with respect to OMH and OASAS licensed certified or designated providers. Any serious or significant health and safety concerns will be reported to OMH and OASAS upon discovery.

Network Requirements

Network providers are required to maintain availability to Members as outlined in the [Access to Care standards](#) noted below. A Network provider’s physical site(s) must be accessible to all Members as defined by the [Americans with Disabilities Act \(ADA\)](#).

Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network providers must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, 7 days a week. You should inform Members about your hours of operation and how to reach you after hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Member regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician.

Network providers are required to notify us at providerexpress.com within ten (10) calendar days whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire). If your hours of operation change, contact Network Management at:

NYWellness4Me_ProvServices@optum.com or **1-866-362-3368**

- Providers are prohibited from balance billing any Member for any reason for covered services.
- Providers are expected to follow-up with Members who miss their after appointment, and document and track their outreach in those cases.
- Providers are expected to review and be familiar with the [Level of Care Guidelines](#) and [Best Practice Guidelines](#) posted on [Provider Express](#).

Go to: Provider Express “Home” page > Quick Links > Guidelines / Policies & Manuals > [Best Practice Guidelines](#) or [Level of Care Guidelines](#).

Guidelines/Policies & Manuals

Guidelines/Policies

▶ Behavioral Clinical Policies	
▶ Best Practice Guidelines	←
▶ Coverage Determination Guidelines	
▶ Credentialing Plans	
▶ Level of Care Guidelines	←
▶ Medicare Coverage Summaries	

Network Training Requirements

Mainstream Managed Medicaid Training Requirements

Providers are required to participate in a comprehensive provider training and support program to gain appropriate knowledge, skills, and expertise to comply with the requirements. A schedule of trainings will be available on the [New York "Home" page](#) of Provider Express which will be updated as needed.

The annual training program will address the following areas:

- Orientation to Optum:
 - Credentialing and Recredentialing
 - Provider Website Orientation
 - Member Eligibility Verification
 - Claims and Billing Guidelines
- Clinical Model:
 - Crisis Management
 - Treatment Planning
 - Use of Evidence-Based Practices
 - Care Coordination
 - Transitions:
 - Community Transition Support Services
 - Between Levels of Care
 - Transition Age Youth (TAY)
 - Recovery & Resiliency Principles
 - Use of Peer Support Services
- Understanding Home and Community-Based Services (HCBS)
- Cultural competency
- Documentation requirements
- Utilization requirements
- Technical Assistance for billing, coding, and data interface
- Treatment of co-occurring conditions
- Working with individuals with Serious Mental Illness (SMI) and functional limitations
- Substance Use Disorder (SUD) and the common medical conditions/challenges that accompany them

OMH, OASAS, and HCBS services providers are encouraged to become trained on the various evidence-based practices (EBPs). Free training modules on various EBPs are available on the Website of Columbia University's Center for Practice Innovation's website (CPI; [http://practiceinnovations.org/ Quick Links > CPI's Learning Community](http://practiceinnovations.org/QuickLinks)).

HCBS Provider Training Requirements

In addition to participation in all of the required trainings for Mainstream Medicaid, Wellness4Me HCBS providers are required to complete the following trainings:

- Individualized Service Planning
- Measuring social and recovery outcomes
- Eligibility, assessment, and referral
- Health Homes
- Plan of Care
- Authorization requirements
- Level of Care Guidelines
- Types of services
- Assessment Process:
 - Tier assignment
- Substance abuse and mental health
- Substance abuse or mental health and medical conditions
- Smoking cessation



Data Analysis and Reporting

Mainstream Medicaid and Wellness4Me Data Analysis and Reporting

Optum will collect and review data from a variety of sources including but not limited to claims, authorizations, appeals, complaints, and clinical audits. The data will be used to identify potential training needs and opportunities for improvement. Information will be shared with providers on a regular basis. When there are updates from OMH, we will communicate those to provider.

Optum is also required to submit reports to the State of New York as requested.

HCBS Data Analysis and Reporting

There is a dedicated staff member, the HCBS Administrator, who will work closely with the Accountable Care Health Home Team, Quality Management and Network Services to monitor recovery outcomes, over and underutilization of services, and to assess compliance with the federal elements for the Plan of Care. The HCBS administrator reports findings to the Wellness4Me.

Level of Care Guidelines

Mainstream Medicaid and Wellness4Me Level of Care Guidelines

Optum maintains a national library of Level of Care Guidelines along with state-specific guidelines. Level of Care Guidelines is an objective and evidence-based behavioral health guideline used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing. New York State has reviewed and approved the Level of Care Guidelines used for Medicaid services. Level of Care Guidelines are located on Provider Express: from the home page choose Clinical Resources > Guidelines/Policies & Manuals > [Level of Care Guidelines](#).

Level of Care Guidelines is derived from generally accepted standards of behavioral practice, including guidelines and consensus statements produced by professional specialty societies and guidance from government sources such as [CMS National Coverage Determinations \(NCDs\)](#) and [Local Coverage Determinations \(LCDs\)](#).

Each Level of Care Guideline includes these elements:

- A definition of the level of care
- Admission criteria
- Continued service criteria
- Discharge criteria
- Clinical Best Practices
- References (information sources for the document)



Level of Care Guidelines for Home and Community Based Services (HCBS)

The Level of Care Guidelines for Home and Community Based Services (HCBS) has been established by New York State (NYS) and include admission, continued stay and discharge criteria, for Wellness4Me enrolled members who have been assessed to be eligible for HCBS services.

For detailed information refer to page 7 in the Revised Version (December 2, 2016) of the NYS OMH and OASAS [Home and Community Based Services – Review Guidelines and Criteria](#) for detailed information.

The Level of Care for Alcohol & Drug Treatment Referral (LOCADTR) tool is used to make level of care determinations for all OASAS services. Information about [LOCADTR](#) may be found on the [OASAS website](#).

Benefit Plans, Authorization and Access to Care



As of October 1, 2015 the new Health Plan structure continued authorization of services for up to 24 months, unless the Member no longer meets medical necessity. In those cases, we will work closely with the provider and Member to identify an alternate level of care for the Member.

Benefits in Mainstream Medicaid:

- Medically Supervised Outpatient Withdrawal (OASAS Services)
- Outpatient Clinic and Opioid Treatment Program (OTP) Services (OASAS Services)
- Outpatient Clinic Services (OMH Services)
- Comprehensive Psychiatric Emergency Program
- Continuing Day Treatment
- Partial Hospitalization
- Personalized Recovery-Oriented Services (PROS)
- Assertive Community Treatment (ACT)
- Intensive Case Management/Supportive Case Management
- Inpatient Hospital Detoxification (OASAS Service)
- Inpatient Medically Supervised Inpatient Detoxification (OASAS Service)
- Inpatient Treatment (OASAS Service)
- Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)
- Inpatient Psychiatric Services (OMH Service)
- Rehabilitation Services for Residents of Community Residences
- Crisis Intervention



Refer to [the Department of Health Managed Care](#) webpage for more information about behavioral health services covered by Medicaid Managed Care.

Wellness4me HCBS Services for Adults Meeting Targeting and Functional Needs:



- Rehabilitation:
 - Psychosocial Rehabilitation
 - Community Psychiatric Support and Treatment (CPST)
- Empowerment Services - Peer Supports
- Habilitation:
 - Habilitation
- Family Support and Training
- Employment Supports:
 - Pre-vocational
 - Transitional Employment
 - Intensive Supported Employment
 - On-going Supported Employment
- Education Support Services
- Non-Medical Transportation
- Short-term Crisis Respite
- Intensive Crisis Respite

Refer to the NYS OMH [Health and Recovery Plan Adult Health Home and Community Based Services Provider Manual](#) for a detailed description of the Wellness4Me HCBS services for adults.

Authorization Requirements

Refer to the NY State Ambulatory Mental Health services grid referred to as: [Attachment 1](#) Ambulatory mental health services for adults for which Mainstream managed Care and Wellness4Me may require prior and/or Concurrent Authorization of Services

Ambulatory mental health services for Medicaid Members may require prior and/or concurrent authorization of services. For most services, Members have unlimited behavioral health assessments. Exceptions include ACT, inpatient psychiatric hospitalization, partial hospitalization and HCBS. Members may self-refer for services that have unlimited assessments.

Authorizations and notifications can be obtained:

Toll-free line: **1-866-362-3368**
Fax: **1-877-339-8399**
Email: NYHARPAuthorizations@uhc.com

A Care Advocate will contact you for additional information. You must be a registered user to submit authorization and notification requests.

Key terms related to Authorizations:

Prior Authorization Request is a Service Authorization Request by the Member, or a provider on the Member's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the Member. Prior Authorization is required for:

- Inpatient Mental Health
- Non-routine outpatient care. Non-routine outpatient care includes, but is not limited to, psychological testing, and extended sessions of 53 minutes or more.
- HCBS services require prior authorization, except for Short-term Crisis Respite with stays of less than 72-hours.

Prior authorization should always be obtained prior to services being rendered or as soon as the Member is stabilized to ensure both proper care of the Member and coverage of services following initial stabilization.

A medically necessary admission following stabilization in an emergency room may require authorization or notification prior to the admission to a facility. Facilities should notify Optum immediately.

All staff members who make Service Authorization Determinations have received comprehensive training, which includes information about [OMH Clinic Standards of Care](#) and [OASAS Clinical Guidance](#). Service Authorization Determinations are made based on reviewing clinical information submitted by the provider against the [Level of Care Guidelines](#).

Concurrent Review Request is a Service Authorization Request by a Member, or a provider on Member's behalf for continued, extended or more of an authorized service than what is currently authorized by the Contractor within an existing authorization period.

Prior Notification is strongly recommended for OON providers. Prior Notification is requested for:

- Initial medically necessary emergency and post-stabilization. Services, including emergency behavioral health care.
- Urgent care.
- Crisis stabilization, including mental health.
- Comprehensive Psychiatric Emergency Program (CPEP).
- Post-stabilization care services.
- OMH and OASAS outpatient office and clinic services
- SUD Inpatient and Residential notification for Detox and Rehab required within 48hrs.

Substance Abuse

Under the insurance law changes effected by Chapter 69 and 71 of the Laws of 2016 (effective January 1, 2017), no prior authorization is necessary for in-network inpatient services for the treatment of any substance use disorders, including detoxification, rehabilitation and residential treatment. Medically necessary treatment is determined by the OASAS designated tool ([LOCADTR](#)) during admission and retrospective review.

In compliance with this new law, the Plan will not conduct concurrent utilization review for the first 14- days of treatment. During these initial 14 days, any consultation between provider and Plan is not a mechanism for utilization review but an opportunity for collaboration between the provider and the Plan. This limitation on utilization review continues to apply when a patient transfers from one inpatient or residential facility to another and when a patient steps down from one level of care to another.

Admissions are subject to an MCO retroactive review and can be denied retroactively. Members are to be held harmless.

A provider must give notice to the Plan any time a patient separates from treatment, including patients who are discharged, leave against medical or clinical advice, or are missing. The Program should provide notice to the Plan within 24-hours

Please note: requests for coverage at out of network inpatient or residential facilities are subject to review upon admission.

The following is the notification protocol:

1. The State developed initial treatment plan within 48 hours notification

(Please note: template can be found in Appendix A of the Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapters 69 and 71 of the Laws of 2016 at:

<https://www.oasas.ny.gov/mancare/documents/InsurancelawguidanceFINAL.pdf>

2. LOCADTR 3.0 Report

- Written notification can be sent via secure fax or email:

Fax: **1-877-339-8399**

Email: NYWellness4MeAuthorizations@uhc.com

- Inquiries should be directed to:

Toll-free line: **1-866-362-3368**

Peer-to-Peer Reviews

All denial, grievance and appeal decisions are subject to specific behavioral health requirements including peer-to-peer review. When there is disagreement about the frequency, duration, or level of care being requested, a peer-to-peer review is scheduled:

- A physician who is board certified in general psychiatry must review all inpatient denials for psychiatric treatment.
- A physician who is certified in addiction treatment must review all inpatient denials for substance use disorder treatment
- All other denials are reviewed by an independently licensed psychologist (PhD) and/or a board certified psychiatrist or physician who is certified in addiction treatment.

Emergency Pharmacy Protocols

When a provider prescribes a medication that is not on the Preferred Drug List (PDL), a five (5) day supply of the medication may be provided to the Member while the provider completes a Prior-Authorization request. This also includes immediate access to a seventy-two hour emergency supply of the prescribed drug or medication for an individual with a behavioral condition who experiences an emergency condition as defined in the contract.

Access to Care

Mainstream Medicaid and Wellness4Me Access to Care

Members with appointments shall not routinely be made to wait longer than one hour. Providers are encouraged to address all walk-in appointments (for non-urgent care) in a timely manner to promote access to appropriate care and actively engage the Member in treatment. Provider policies need to address both Member access to care and engagement in treatment. To ensure all Members have access to appropriate treatment as needed the following network access standards have been put into place. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.



HCBS Access to Care

Members with appointments shall not routinely be made to wait longer than one hour. Providers are encouraged to address all walk-in appointments (for non-urgent care) in a timely manner to promote access to appropriate care and actively engage the Member in treatment. Provider policies need to address both Member access to care and engagement in treatment.

To ensure all Members have access to appropriate treatment as needed the following network access standards have been put into place. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.



Access Standards for Mainstream Medicaid and Wellness4Me¹

Service Type	Emergency	Urgent	Non-Urgent MH/SUD	BH Specialist (Non- Urgent)	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
MH Outpatient Clinic PROS Clinic		Within 24 hours of request	Within 1 Week of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Community Mental Health Services					Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
ACT		Within 24 Hours of Request		Within 2-4 Weeks of Request	5 Days of Request or as Clinically Indicated	5 Days of Request or as Clinically Indicated
PROS		Within 24 Hours of Request		Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Continuing Day Treatment				Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Intensive Psychiatric Rehabilitation Treatment (IPRT)				Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Partial Hospitalization					Within 5 Days of Request or as Clinically Indicated	Within 5 days of request or as clinically indicated
Inpatient Psychiatric Services	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
Comprehensive Psychiatric Emergency Program (CPEP)	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated

Service Type	Emergency	Urgent	Non-Urgent MH/SUD	BH Specialist (Non-Urgent)	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
SUD Outpatient Clinic		Within 24 Hours of Request	Within 1 Week of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Inpatient Detoxification	Immediately Upon Presentation at Service Delivery Site				Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Inpatient Rehabilitation	Immediately Upon Presentation At Service Delivery Site	Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Residential Stabilization Treatment Services		Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Residential Rehabilitation Treatment Services		Within 24 Hours of Request		Within 2-4 Weeks of Request	Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
SUD Opioid Treatment Program		Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Crisis Intervention/ Respite	Immediately Upon Presentation at Service Delivery Site	Within 24 Hours of Request			Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Psychosocial Rehabilitation			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Community Psychiatric Services and Treatment			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated

Service Type	Emergency	Urgent	Non-Urgent MH/SUD	BH Specialist (Non- Urgent)	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
HCBS Habilitation			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Family Support and Training			Within 2 Weeks of Request		Within 5 Days of Request or as Clinically Indicated	Within 5 Days of Request or as Clinically Indicated
HCBS Educational Support Services			Within 2 Weeks of Request			
HCBS Employment Support Services (Prevocational, Transitional, Intensive, Ongoing)			Within 2 Weeks of Request			
HCBS Short Term and Intensive Crisis Respite	Within 24 Hours of Request	Within 24 Hours of Request	Within 24 Hours of Request	Within 24 Hours of Request	Within 24 Hours of Request	Within 24 Hours of Request
HCBS Peer Supports		Within 24 Hours of Request	Within 1 week of request		Within 5 Days of Request or as Clinically Indicated	

In addition to the access standards identified in the [chart](#) on page 20, HCBS providers must have policies and procedures addressing Members who present for unscheduled, non-urgent care with the aim of promoting access to appropriate care.



First Episode Psychosis (FEP)

The New York State Office of Mental Health has implemented a program to identify and intervene with New Yorkers who experience psychiatric symptoms associated with psychosis. [OnTrackNY](#) utilizes a “shared decision making model.” The program utilizes evidenced based practices and a multi-disciplinary clinical team who specialize in treating early symptoms of psychosis. OnTrackNY programs are located throughout New York State and New York City. The goals are to shorten the duration of untreated psychosis and immediately link the Member to early intervention services.

Providers are required to report anyone who meets criteria for First Episode Psychosis to New York State. The criteria for First Episode Psychosis are:

- Ages 16-30
- Recently began experiencing psychosis that has lasted less than 2 years

The purpose of this is to immediately link the Member to early-intervention services.

Compensation and Claims Processing

Unless otherwise directed by Optum, Providers shall submit claims using the current [1500 Claim Form \(v 02/12\)](#) or [UB-04 form](#), (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to, ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Please note that effective October 1, 2014 Optum implemented use of the DSM5 for assessment. Effective October 1, 2015, in compliance with federal regulations, ICD-10-CM billing codes were implemented.

Providers shall include all data elements necessary to process a complete claim including: the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number, National Provider Identifier (NPI), code modifiers and/or other identifiers requested. In addition, you are responsible for billing of all services in accordance with the nationally recognized [CMS Correct Coding Initiative \(CCI\) standards](#). Please visit the [CMS website](#) for additional information on CCI billing standards. Although claims are

reimbursed based on the network fee schedule or facility contracted rate, your claims should be billed with your usual and customary charges indicated on the claim.

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payer. You may choose any clearinghouse vendor to submit claims through this route.

Because Optum has multiple claim payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. **For Optum and UnitedHealthcare Community Plan claims use Payer ID 87726.**

Clinician Claim Forms: Paper claims can be submitted using the [1500 Claim Form \(v 02/12\)](#) the UB-04 claim form or their successor forms in accordance with your Agreement. The claims should include all itemized information such as diagnosis ([ICD-10-CM code](#) as listed in DSM-5), length of session, member and subscriber names, member and subscriber dates of birth, member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), credentials, Tax ID and NPI numbers. More information about the [CMS-1500 Claim Form](#) required fields can be found in the [“Claim Tip”](#) section on [providerexpress.com](#).

Facility Claim Forms: Paper claims should be submitted using the [UB-04 billing format](#), or its successor, which includes all itemized information such as diagnosis ([ICD-10-CM code](#) as listed in DSM-5), member name, member date of birth, member identification number, dates of service, procedure or revenue codes, name of facility and Federal Tax ID number of the facility, NPI of the facility and admitting physician, and billed charges for the services rendered. After receipt of all of the above information, participating facilities are reimbursed according to the appropriate rates as set forth in the facility’s Agreement. Facilities may file claims through an EDI vendor.

Agency claims that are subject to [Ambulatory Patient Group \(APG\) payment methodology](#) per New York State regulations must be submitted on the [UB-04 claim form](#) using the applicable coding as designated by New York State. More information about APG payment methodology can be found in the NYS Department of Health Policy and Billing Guidance [Ambulatory Patient Groups \(APGs\) Provider Manual](#).

Claims/Customer Service:

- Toll-free line: **1-866-362-3368**

Paper Claims:

- Behavioral Health Claims Mailing Address:

Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT
84130-0760

When billing for more than one service on the same day you must use modifier 25. Providers should refer to their Agreement with Optum to identify the timely filing deadline that applies. Electronic Clean claims, including adjustments, will be adjudicated within 30 days of receipt.

Paper Clean claims, including adjustments, will be adjudicated within 45 days of receipt. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.



Billing Codes

In accordance with [Title 14 of New York State Codes, Rules, and Regulations](#) (14 NYCRR Department of Mental Hygiene), [APG billing](#) and reimbursement methodology will be applied to Medicaid Managed Care and Wellness4Me plans. New York State requires payment of government rates for the following categories of services:

OASAS Government Rate Services (Mainstream Managed Care and Wellness4me):

- OASAS Clinic
 - Opiate Treatment Programs (outpatient)
 - Outpatient Rehabilitation
 - Part 820 – OASAS per Diem Residential Services
- Refer to the [NYS HARP/Mainstream Billing and Coding Manual](#) for more information

For additional information about the APG Billing and reimbursement methodology for OASAS services, refer to the NYS OASAS [APG Policy and Medicaid Billing Guidance Manual](#).

OMH Government Rate Services

Mainstream Medicaid and Wellness4Me:

- Assertive Community Treatment (ACT)
- OMH Clinic (government rates are already mandated for Clinic – continue to use existing billing procedures)
- OMH Clinic Off-site Mental Health Services (aka, “licensed behavioral health practitioner”) Refer to the [NYS HARP/Mainstream Billing and Coding Manual](#) for more information.
- OASAS Clinic
- Comprehensive Psychiatric Emergency Program (CPEP)
- Continuing Day Treatment (CDT)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Crisis Intervention Services

New York State law historically required that Medicaid MCOs pay the equivalent of APG rates for OMH licensed mental health clinics. On October 1, 2015 in NYC and July 1, 2016 in counties outside of NYC, Plans were required to pay 100% of the Medicaid Fee-For-Service (FFS) rate (aka, “government rates”) for all authorized behavioral health procedures delivered to individuals enrolled in Mainstream Medicaid and Wellness4Me managed care plans, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement will remain in place for at least the first two years. For the new HCBS services, the government rate is the reimbursement listed for each program on the [HCBS Fee Schedule](#) located on OMH website.

Changes to State Medicaid Rates and Reimbursement Methodologies

With regard to all covered services that are reimbursed under your United Behavioral Health IPA of New York Participation Agreement (“Agreement”) that are based on state Medicaid rates and reimbursement methodologies, contracted rates and reimbursement methodologies will be adjusted consistent with changes made by New York State.

The timeline for implementation of changes to APG reimbursement will not be less than sixty (60) days. The information feed to Optum Insight grouper/pricer software takes up to forty-five (45) days. An additional fifteen (15) days is required for testing.

If a Facility receives written notification from the State of New York of a rate change, Optum will incorporate the changes into the Agreement within sixty (60) days from the date Optum was notified by the Facility.

Rate changes received directly from the State of New York will be automatically incorporated into your Agreement within sixty (60) days of notification. You do not need to take action to receive these rate changes.

There will be no retrospective rate adjustments unless mandated in writing by the State of New York.

Billing Requirements

These billing requirements do not apply to office-based practitioner billing (for example, outpatient professional claims). 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 HCBS services that will be delivered by OMH and OASAS “designated” providers.

Electronic claims will be submitted through the EDI using the 837i (institutional) claim form. This will support your use of required rate codes, which will inform the Plans regarding the type of behavioral health program 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 by first typing in “24” followed by the appropriate four digit rate code.

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

- Use of the 837i claim form
- Medicaid Fee-For-Service rate code
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service
- Unlicensed practitioners without an NPI, the OMH (02249154) or OASAS (02249145) unlicensed practitioner ID may be used.

Refer to the [New York State Health and Recovery Plan \(HARP\) / Mainstream BH Billing and Coding Manual](#) for any updates and additional information. The [UnitedHealthcare](#)

[Standard Companion Guide](#) provides more detailed information related to the 837i claim form.

Appeals

Mainstream and Wellness4Me Appeals

For additional information regarding Appeals and the Appeals process, please refer to the section titled “Our Claim Process” in the [UnitedHealthcare Administrative Guide](#),

HCBS Services Appeals

When a Member reaches the threshold for HCBS, additional claims will deny. The limits can be appealed to the OMH/OASAS Medical Director. If the appeal to exceed the limit is granted, a higher threshold will be established. If the appeal is denied, HCBS claims will be denied until a new calendar year begins.

General Information or Contractual Questions

For general information and contractual questions, contact Network Management or your Facility Contract Manager through Network Services at **1-866-362-3368**. Additional resources can be found on providerexpress.com including:

Optum [National Network Manual](#) :

- [Level of Care Guidelines](#)
- [Best Practice Guidelines](#)
- [Ability to update provider demographic information](#)

Care Advocate Questions

The Clinical Operation Site is open for standard business operations Monday through Friday from 8 a.m. to 6 p.m. Eastern time. In addition, Care Advocates are available twenty-four hours a day, seven days a week, including holidays and weekends, to

discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocate process.

When a Member in crisis contacts the Member call center during regular business hours the call will be warm-transferred to one of the care advocates located in Latham, NY. If a Member crisis call is received outside of business hours the call will be warm-transferred to the after-hours clinical team.

Crisis calls are triaged based on urgent or emergent need. Intervention is recommended based on the level of need. Emergent crises are addressed while the Member is on the phone with the care advocate. Member safety is confirmed through contact with mobile crisis, emergency services or a natural support. Urgent needs are addressed with adequate referrals to appropriate services agreed upon by the Member. The care advocate will contact the Member to ensure the Member has followed through and has access to the referral provider, including transportation, convenient location and appointment time.

Clinical Operations Site Location and Phone:

13 Cornell Road, 2nd Floor
Latham, NY 12210
1-866-362-3368

Home and Community-Based Services (HCBS)

HCBS Service Eligibility and Assessment Process

[Wellness4Me](#) Members who meet the following [Need-based Criteria](#) (listed below) will have access to an enhanced benefit package of Home and Community Based Services (HCBS). A Member is referred to their [Health Home](#) care coordinator or assigned to a Health Home (if they are not already enrolled) for the HCBS Eligibility Assessment and development of a Plan of Care. If the Member refuses a Health Home referral, they will be referred to a [Recovery Coordination Agency](#) for completion of the assessment.

Need-Based Criteria

A Member's eligibility for HCBS is determined based on a brief evaluation using the New York State Community Mental Health Assessment, which is an independent evaluation tool. Individuals meeting one of the Needs-Based Criteria identified below will be eligible for HCBS:

- An individual with at least “moderate” levels of need as indicated by a State designated score on a tool derived from the New York State Community Mental Health Assessment, or
- An individual with a need for HCBS as indicated by a face-to-face assessment with the New York State Community Mental Health Assessment and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia (herein called individuals with [First Episode Psychosis](#) or FEP); individuals with FEP may have minimal service history, or
- A [Wellness4Me](#) Member who either previously met the needs-based criteria above or has one of the needs-based historical risk factors identified above and who is assessed to be at risk for decline to prior levels of need unless HCBS are initiated (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).

If you assess that a Member meets HCBS criteria but is not currently enrolled in a Health Home you may request an Eligibility Assessment be completed by contacting us. The Eligibility Assessment is a subset of questions from the New York State Community Mental Health Assessment:

- Assessments must be conducted by a Health Home or state-designated entity in compliance with conflict-free case management requirements
- The Eligibility Assessment must be completed face-to-face
- The assessment determines the medical and psychosocial necessity and level of care need for specific services within HCBS; it is used to establish a written, person-centered, individualized Plan of Care

The results of the Assessment will be incorporated into the individual's person-centered Plan of Care.

The Members level of service request must be submitted for review and approval prior to the delivery of HCBS. Once the level of service request is reviewed and approved each HCBS provider is required to notify us when the Member presents for their initial appointment.

Reassessment of the plan of care (including need for HCBS) must be done:

- At least annually
- When the individual's circumstances or needs change significantly, or
- At the request of the individual



Plans may require more frequent reviews of plans of care to evaluate progress towards goals, determine whether goals have been achieved or the plan of care requires revision.

Health Homes

Health Homes work to improve the quality and integration of care. An individual will not be enrolled in more than one care management program funded by the Medicaid program. General expectations for Health Homes include compliance with the NY DOH Health Home Standards and Requirements. Refer to the [Department of Health](#) website and [Health Home Standards and Requirements](#):

A Member does not have to be enrolled in [Wellness4Me](#) to receive Health Home services.

Criteria for referrals to Health Homes include, but are not limited to any of the following:

- Use of both physical and behavioral health services. Newly-emerged psychotic disorder suggestive of Schizophrenia (herein called individuals with First Episode Psychosis or FEP)
- Individuals with FEP may have minimal service history
- Transition Age Youth who are at high risk for readmission, medication non-adherence or re-entry into the criminal justice system

HCBS Person-Centered Planning Process

Based on an independent assessment of functioning and informed by the individual, the written service plan must meet the outlined in Section IV of the New York State Health and Recovery Plan (Wellness4Me) Adult Behavioral Health Home and Community based Services (BH HCBS) [Provider Manual](#).

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HCBS Person-Centered Plan Content (table)

The Person-Centered Plan of Care must:	
1.	Indicate that the Member freely chooses the setting in which they reside
2.	Identify the Member's strengths and preferences
3.	Describe clinical and support needs identified through an assessment of functional needs
4.	Include individually identified goals and desired outcomes
5.	Identify the services and supports (paid and unpaid) that will assist the Member to achieve goals
	a. Identify the providers of those services and supports, including natural supports
	b. Natural supports are unpaid supports that are provided voluntarily to the Member in lieu of HCBS waiver services and supports
6.	Identify risk factors and establish measures to minimize those risks, including Individualized back-up plans and strategies when needed
7.	Be provided to the Member and, when appropriate their support system, in a manner that is clear and understandable:
	a. Written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited proficiency in English
8.	List the individual(s) and/or entity(ies) responsible for monitoring the plan of care
9.	Be finalized and agreed to, with the written informed consent of the Member and signed by all individuals and HCBS providers responsible for its implementation (the POC itself doesn't have to be signed):
	a. A form can be sent and signed that affirms and attests that the HCBS provider has received the POC and agrees to provide the services
10.	The POC must be distributed to the Member and other people involved in the POC
11.	Include those services, the purpose or control of which, the individual elects to self-direct (when applicable) *Awaiting further guidance from CMS and OMH to implement this.
12.	Prevent the provision of unnecessary or inappropriate services and support
13.	Include documentation of modifications to the POC made based on risk assessments; this is risk mitigation for the back-up plans identified in #6:
	a. Identify specific and individualized assessed needs
	b. Document the positive supports/interventions previously used that were unsuccessful to address the needs
	c. Document less intrusive methods previously used that were unsuccessful to address the needs
	d. Describe the condition that is connected to the specific need or risk
	e. Collect ongoing data to monitor effectiveness of new modification(s)
	f. Identify established time limits for periodic reviews to determine if the modification is still necessary or can be discontinued
	g. Document the informed consent of the individual
	h. Include an assurance that interventions and supports will cause no harm to the individual

HCBS Service Definitions:

Below are some introductory definitions to the services. For complete information please see New York State Wellness4me/HCBS Provider Manual located on the NYS Office of Mental Health website <https://www.omh.ny.gov/>, see the “HCBS Services Applications” page.

For more information go to:

<https://www.omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf>

HCBS Service Limits

The Eligibility Assessment will determine if an individual is eligible for Tier 1 or Tier 2 services:

- Tier 1** – services include employment, education and peer supports services.
- Tier 2** – includes the fully array of HCBS

The proposed limits consist of three elements:

1. Patient-specific Tier 1 limit of \$8,000
2. Patient-specific overall HCBS (i.e., Tier 1 and Tier 2 combined) limit of \$16,000
3. Short term crisis respite and intensive crisis respite are individually limited to 7 days per episode and 21 days per year.

Providers must have a procedure in place to monitor HCBS utilization for each Member to ensure that the limits are not exceeded without prior approval.

HCBS Settings

HCBS can only be provided in settings which are considered integrated community settings, as established in the [CMS Settings Final Rule](#).

HCBS Provider Qualifications

The entity must be designated as an HCBS provider by the state. We will accept that designation for credentialing purposes. Credentialing is done at the group level.

Employees, subcontractors, and agents of the designated group are not individually credentialed.

Employees of the designated HCBS entity may include:

- Professional staff
- Paraprofessional/Non-licensed staff
- Certified Peer
- State Credentialed Staff
- Other Credentialed Staff

Optum is required to collect program integrity related information (the Disclosure of Ownership and Control Interest statement). Optum also requires that providers not employ or contract with any employee, subcontractor or agency who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

HCBS providers are expected to adhere to recovery-oriented principles which include Development of a person-centered Individualized Service Plan (ISP) with specific and measurable goals developed with the Member and Member identified supports. The provider collaborates with the Member to:

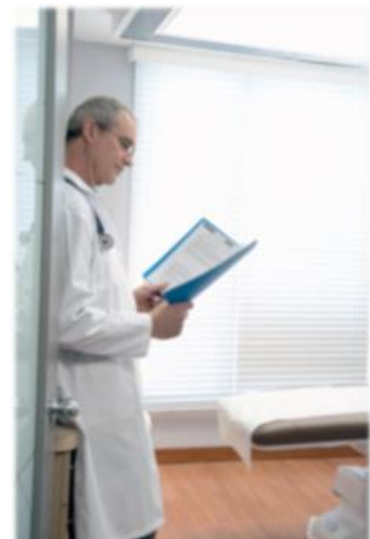
- Monitor progress and utilization of services
- Work with the Health Home Care Coordinator, when applicable, to review and adjust the ISP to reflect progress and current goals

Any increase in frequency and duration of the services provided require prior notification.

HCBS Medical Necessity Criteria

Medical necessity includes consideration of: appropriateness, health care setting, and level of care or effectiveness of a covered benefit. New York law* defines “medically necessary medical, dental, and remedial care, services, and supplies” in the Medicaid program as those “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished by an eligible person in accordance with state law”.

* N.Y. Soc. Serv. Law, § 365-a



HCBS Network Providers

The list of agencies designated to provide HCBS is available at:

<https://www.omh.ny.gov/omhweb/bho/provider-designation.html>

Licensed, non-licensed and certified peers who provide HCBS services are encouraged to become trained on the various evidence-based practices (EBPs). Free training modules on various EBPs are available on the Website of Columbia University's Center for Practice Innovation's website (CPI; <http://practiceinnovations.org/> [Quick Links > CPI's Learning Community](#)). The New York State Office of Mental Health (OMH) and the Department of Psychiatry, Columbia University, established the Center for Practice Innovations at Columbia Psychiatry and New York State Psychiatric Institute in November, 2007, to promote the widespread use of evidence-based practices throughout New York State. CPI uses innovative approaches to build stakeholder collaborations, develop and maintain practitioners' expertise, build agency infrastructures that support implementing and sustaining evidence-based practices and direct staff competence. CPI is available to collaborate with agencies to increase the use of EBPs and improve staff clinical competencies.

HCBS Site and Record Audits



We will conduct routine on-going monitoring audits of HCBS providers. These audits will focus on the physical environment, policies and procedures, and quality of documentation in the treatment records. The [National Optum Network Manual](#) outlines the scoring parameters as well as additional reasons other on-site audits may occur.

To see all of the auditing tools available on Provider Express go to: [Our Network > Welcome to the Network > New York "Home" page > New York Medicaid Provider Resources > Quality Improvement > \[New York Medicaid Audit Tools\]\(#\)](#).

HCBS Prior Authorization Requirements

HCBS services require prior authorization, except for Crisis Respite services for admissions longer than 72-hours. For HCBS services that require prior authorization, providers are expected to follow the workflow previously reviewed and adhere to State guidance including assessments and Plan of Care (POC) requirements. HCBS Crisis Respite services do not require prior authorization however; notification is required when a Member is admitted to this service.

UnitedHealthcare Community Plan (UHC) is using the universal [HCBS Prior Authorization](#). Request form created by the State. You may find this form on Provider Express.

HCBS Provider should fill out the form and send to UHC via email or fax. Instructions on how to send it are listed on the form.

Contact Information

Network Management

Behavioral health providers can reach their Network Management support in the following ways:

Toll-free line:	1-866-362-3368
Fax:	1-877-958-7745
Email:	NYWellness4Me_ProvServices@optum.com

Technical Support for Provider Express

For questions about using this site, issues with requesting a user ID and password, or for technical issues, call the **Provider Express Support Center** at **1-866-209-9320** (toll-free) from 7:00 a.m. to 9:00 p.m. Central Time.

Appendix A

References and Resources

New York State Department of Health. (October 1, 2015). Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan/ Health And Recovery Plan Model Contract [.https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf)

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