Section 18
Behavioral Health

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6 Wellness Way • Latham NY 12110
(518) 641-3000 • 1-888-258-0477

BEHAVIORAL HEALTH SERVICES TIP SHEET

Contact Information

Behavioral Health Services	(518) 641-3600
Behavioral Health Services	1-888-320-9584
Behavioral Health Services fax	(518) 641-3601
Behavioral Health IP Admission Notification fax	(518) 641-5206
Network Services	(518) 641-3321
Provider Services	(518) 641-3500
Provider Services	1-800-926-7526
CDPHP Web site	www.cdphp.com
BH Provider Page	www.cdphp.com/providers/programs/behavioral-health
Electronic Data Interchange (EDI) Team	(518) 641-4EDI
EDI e-mail address	edi_team@cdphp.com
Pharmacy benefit information	1-888-292-6330

All consultations, laboratory testing, and treatments must be communicated back to the primary care physician (PCP).

Member Eligibility

These suggestions are not a guarantee of coverage.

Please remember to:

- Verify eligibility of all patients by checking the member's ID card or accessing CDPHP's secure online network, www.cdphp.com. For further assistance, please call the CDPHP behavioral health access center at 1-888-320-9584.
- Collect the applicable copayment for services rendered at the time of the visit.
- Deductibles and coinsurance should be collected after receipt of the CDPHP payment.

Authorizations

- The most up-to-date policies can be accessed by logging into the secure area of www.cdphp.com.
- Contact the behavioral health access center for prior authorization of services from non-participating physicians/providers.
- Some CDPHP products provide coverage for non-participating physician/provider services without the prior authorization requirement. These services may increase the member's out-of-pocket responsibility.

Medication Management

- Review the CDPHP formulary to determine which psychotropic medications are covered under the member's benefit plan.
- A complete list of medications is available by clicking the Rx Corner tab at the top of the provider page at www.cdphp.com. You will find the most recent drug plans and formulary updates.

Admissions

- Contact the CDPHP behavioral health access center at 1-888-320-9584 under the following circumstances:
  1. To notify of emergency admissions- CDPHP requires notification within 24 hours or the next business day. *Note: preauthorization requirements vary based on member contract.*
  2. Outpatient providers referring members to inpatient levels of care will contact CDPHP behavioral health services at 1-888-320-9584 and provide clinical information. CDPHP behavioral health services team will assist with referring the member to the appropriate facility and level-of-care.

Lab Services

All laboratory services must be performed at a CDPHP participating laboratory. You may access the list of participating laboratories in Find-A-Doc at www.cdphp.com.

Continued ▶

Form # 3004-0812

Revised May 2026

Claims

Not following these instructions may result in a delay in payment or a claim denial.

Please remember to:

- Submit all claims within established filing limits from the date of service to CDPHP, P.O. Box 66602, Albany, NY 12206-6602.
- Submit all COB claims within the established filing limits from the date of the primary carrier's EOP.
- Complete the following sections of the CDPHP claim form:
    1. CDPHP member ID# (include suffix number), name, and date of birth.
    2. CDPHP provider name, address, and tax ID#.
    3. Your national provider identification number (NPI). Clinics billing on a CMS 1500 form, please put your facility NPI only in box 33. Physicians, please indicate your NPI in column J and box 33.
    4. Valid ICD-10 diagnosis code(s) and description.
    5. Date(s) of service.
    6. Itemized charges.
    7. Place of service code(s).
    8. Use the "ET" modifier on your claim when billing for one follow-up visit when the member has been referred from the emergency room or urgent care center. (This visit must occur within 10 business days of the emergency visit.)
    9. Use the "AF" modifier if a physician (MD) is billing for services at a mental health, alcohol, or chemical dependency clinic.
    10. Inpatient E&M codes are allowed for psychiatrists and psychiatric nurse practitioners only.
    11. E&M codes for all outpatient/office setting are allowed for psychiatrists and nurse practitioners.
- Claims submitted by behavioral health providers for services in Medicaid–Select Plan and Medicaid–HARP must follow all relevant billing rules established by New York state.
- If submitting a paper claim, ensure the claim is clear and legible with a font size of 10 or greater.
- Avoid using a dot matrix printer.
- Do not highlight anything on the claim form or Provider Review Form.
- We recommend you include your specific patient account number in field #26 of the CMS 1500 form, when submitting paper or electronic claims. If billed, the information will appear on your weekly explanation of payment for account reconciliation purposes.
- Check your CDPHP *Payment Vouchers* weekly to determine the disposition of claims submitted.
- When submitting electronic claims, check your reject reports, make necessary corrections, and resubmit within established claim filing limits. *(See Section 9—Claim Submission.)*
- Please allow for the claim to appear as a paid or denied claim on your voucher before resubmitting the claim, to avoid duplicate claims in the system.
- If you are covering for another CDPHP participating physician, please notify the network services department regarding on-call arrangements in your practice.
- You have six months from the adjudication date of a claim to request a claim appeal. All claim appeals should be submitted on a fully completed Provider Review Form with additional supporting documents attached to CDPHP, Provider Services Department, 6 Wellness Way, Latham, NY 12110.
- Calling the provider services department to obtain the status of a claim is not considered acceptable follow-up. It is necessary to either provide additional information verbally that was not initially available or additional supporting documentation via the Provider Review Form to be considered acceptable follow-up within six months.
- Access the CDPHP secure online network to obtain the status of a claim or call the provider services department with any questions.
- Providers can only bill claims on CDPHP members that they have directly treated themselves. They cannot bill for members seen by other providers whether that provider is contracted with CDPHP or not contracted. The exception to this rule is an ABA paraprofessional (aide). Their services are billed under the Certified ABA Therapist.

For additional information, refer to the *Provider Office Administrative Manual*, Section 9: Claim Submission and Section 10: Claim Payment and Provider Appeals.

Capital District Physicians' Health Plan, Inc.
Capital District Physicians' Healthcare Network, Inc.
CDPHP Universal Benefits,® Inc.

Section 18

CDPHP Behavioral Health Overview

Important Phone Numbers

- Capital District Physicians' Health Plan, Inc. (CDPHP®) Behavioral Health Access Center: (518) 641-3600 or 1-888-320-9584.

Definitions

Mental Health Condition: This means mental disorders, as defined in the mental disorders section in the *International Classification of Disease Manual* (ICD-10), excluding those disorders designated by a "Z Code," Relationship Distress with spouse or intimate partner (V61.10) is not considered a mental health condition.

Mental health conditions also include the following "biologically-based mental illnesses" as defined in the ICD-10

- Schizophrenia Spectrum and other psychotic disorders
- Major Depressive Disorder
- Bipolar disorder
- Panic disorder
- Obsessive-compulsive disorder
- Anorexia Nervosa and Bulimia Nervosa
- Gambling disorder

Substance Related Addictive Disorders: This means the following disorders involving alcohol or substance use disorder listed within the mental disorders section of the ICD-10, including the following:

- Substance/Medication—Induced Psychotic Disorder
- Opioid Related Disorders
- Sedative-, Hypnotic-, or Anxiolyic-Related Disorders
- Stimulant—Related Disorders

Emergency Services/Condition

CDPHP defines emergency condition as a mental disorder or substance use disorder manifesting itself by acute symptoms of suffic nt severity that the absence of immediate behavioral health services could reasonably be expected to result in any of the following:

- Immediate harm to self or others
- Serious and permanent dysfunction to the member
- Serious impairment of the member's functioning
- Placing the member's health in serious jeopardy or, with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy

Access Standards and Coverage Arrangements

CDPHP network providers are required to ensure that members have access to care within the following standards*:

- Emergency - immediate access (may be referred to the ER)
- Care for non-life threatening emergency - within six hours (may be referred to the ER)
- Urgent appointment - within 48 hours
- Non-urgent initial appointments - within 10 business days
- Non-urgent routine appointments - within 20 business days
- Follow-up appointment from hospital/emergency room discharge - within seven calendar days
- Mental health or substance abuse ambulatory appointment - with seven days of request/discharge
- After-hours access - telephone response within one hour

**If you cannot comply with these standards, please notify out access center so we can provide our members with timely access to care by directing them to other providers.*

Appointment Waiting Times

The contract CDPHP has with the New York State Department of Health to manage the care of Medicaid–Select Plan and Medicaid–HARP members requires monitoring of appointment wait times. The contract states that "enrollees with appointments shall not routinely be made to wait longer than one hour . CDPHP monitors wait time through the member complaint process. Providers

in the CDPHP Medicaid–Select Plan and Medicaid–HARP must have policies and procedures to address members who present for unscheduled, non-urgent care with the aim of promoting member access to appropriate care.

Program Overview

The behavioral health utilization management process at CDPHP is a comprehensive program that includes triage, referral, and prospective, concurrent, and retrospective review of services delivered to CDPHP members .The behavioral health care services that are reviewed include inpatient hospitalizations, prior authorizations of out-of-network services, case management services, outpatient services (with exceptions applicable to certain providers in Medicaid–Select Plan and Medicaid–HARP; see also Section 3 for information on such services), and treatment related to a substance use disorder .The review process is not stringently based on medical necessity criteria, but takes into account risk of harm, functional status, co-morbidity, level of stress and support in the recovery environment, treatment and recovery history, and engagement and recovery status .The review process for children includes an evaluation of acceptance and engagement of the child and their caregivers.

Coverage determinations for inpatient behavioral health services are made in a manner consistent with accepted medical practices and federal and state behavioral health parity laws. The concurrent review process for behavioral health services includes application of criteria that are no more stringent than criteria used in the review of medical services, and the review process itself is comparable to, and no more stringent than, the process for reviewing medical services.

The CDPHP behavioral health utilization management program is designed to ensure that members receive access to timely, appropriate, and affordable quality behavioral health care services. Our goal is total health management.

Key aspects of service addressed are:

- Medical necessity
- Appropriateness of care
- Availability of services
- Accessibility to care
- Efficiency of service
- Case management and coordination of care
- Neither overuse or underuse of the best therapeutic techniques
- Effectiveness of care

Members may get assistance in finding a network behavioral health provider by calling the CDPHP Behavioral Healt Access Center at our toll-free number. After hours, CDPHP members experiencing an urgent need or an emotional crisis can access Contact Lifeline by calling 1-888-320-9584 and selecting option 1, or by dialing 1-855-293-0785. Primary care physicians (PCPs) and behavioral health providers wishing to coordinate behavioral health services can call the CDPHP Behavioral Health Access Center on behalf of the member to arrange for an authorization.

Utilization Management (UM) Criteria

CDPHP uses guidelines developed at a national level to make decisions about whether care and treatment are medically necessary, appropriate, and provided at the least restrictive level. Except where otherwise mandated by state and federal regulations, CDPHP uses nationally recognized evidence and consensus-based practice guidelines:

- InterQual® level of care criteria for behavioral health
- New York State Level of Care for Alcohol and Drug Treatment Referral (“LOCADTR”).

For Medicaid–Select Plan and Medicaid–HARP, as well as Commercial member contracts renewed on or after January 1, 2017, CDPHP uses LOCADTR 3.0 for level of care determination. All medical necessity determinations for these products employ a person-centered approach, considering the individual’s strengths, needs, and preferences in order to support their recovery goals.

CDPHP does not offer any incentives, financial or otherwise as a reward for issuing approvals or denials of care or limiting care such that barriers to care or service are incurred or that under-utilization of services results.

Medically Necessary Behavioral Health Services

Authorization for treatment is determined by medical necessity as defined in the member s contract or by New York State for Medicaid–Select Plan and Medicaid–HARP, as applicable. In general, the term refers to care that is clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the member’s condition. The treatment must be required for the direct care and treatment or management of that condition in accordance with generally-accepted standards of medical practice. Care must not be provided primarily for the convenience of the member, family, or provider. The treatment must not be more costly than an alternative service or sequence of services. When setting or place of service is being considered, services performed in a higher cost setting will not be medically necessary if services can be safely provided at an available lower cost setting.

Psychotherapy

Psychotherapy serves as a treatment for mental illness or substance use disorders. While therapy may be beneficial for an individual, psychotherapy services are only covered by CDPHP when there is a medical necessity.

Intensive psychotherapeutic treatments may be required during periods where a member is experiencing an acute mental health condition or an acute exacerbation of a chronic condition. This might consist of weekly psychotherapy, Intensive Outpatient Program or Partial Hospital Program care several times per week. Once symptoms and functional improvements are stable, a member may no longer require acute therapy, and treatment may be tapered in frequency and intensity. Most members requiring psychotherapy to treat their behavioral health disorder are able to utilize the skills developed in therapy to "graduate" from an episode of treatment, although certainly they may develop symptoms in the future requiring another episode of care.

Some members may require maintenance sessions to prevent regression and impairment in functioning. In addition, some members may wish to continue in therapy for reasons of personal growth, which may be helpful but is not a covered benefit under the definitions of medical necessit .

Assessment and Triage – Mental Health and Substance Use

Members and providers may access care or get a referral to a network behavioral health provider by calling the CDPHP behavioral health access center at **(518) 641-3600** or **1-888-320-9584**, Monday through Friday, 8 a.m. to 6 p.m. or by visiting the Behavioral Health and Find-A-Doc web pages at www.cdphp.com to locate participating providers.

CDPHP provides 24-hour, seven-day-per-week telephonic assessment by experienced clinical services staff. The CDPHP clinical assessment is designed to rapidly determine acuity for purposes of locating an appropriate level of treatment. The assessment is modified as needed to meet the needs of specific population such as children, adolescents, and older adults.

The behavioral health access center team also live answers all incoming calls on the single source referral line and, based on assessments, will make referrals to medical care management, behavioral health care management, and community resources as needed.

Outpatient Services

- Member calls CDPHP behavioral health access center.
- CDPHP verifies member s eligibility
- CDPHP gathers demographic information
- CDPHP clinical intake specialist conducts assessment
- CDPHP will assess for behavioral health, substance use disorder and/or medical need, and triage to a CDPHP care manager if needed or requested by the member.
- CDPHP refers member to contracted provider
- Authorized services match services intended for member treatment. CDPHP generally refers to non-prescribing clinicians for psychotherapy services and to prescribing clinicians for evaluation and medication management services. CDPHP may make an exception and authorize psychotherapy services to a prescribing clinician.

Authorization Process

Authorization is dependent on the member's eligibility and contractual coverage. Please be aware of the following changes:

- There is no requirement for prior authorization for admission to inpatient mental health care for adults or children presenting in hospital emergency departments and determined by an emergency department physician to need inpatient care to stabilize and treat an emergency condition.
- There is no requirement that all inpatient mental health care is subject to concurrent utilization review. Inpatient mental health treatment will be subject to concurrent review only when specific quality or clinical triggers are me .
- CDPHP clinical reviewers offer coordination of care to all enrollees who are admitted for inpatient mental health and substance abuse treatment, regardless of whether or not utilization review or a coverage determination is required.
- Inpatient mental health care provided in New York State to enrollees age 18 and under is not subject to concurrent review until after calendar day 15 of the inpatient stay.* Concurrent review will be completed only when the enrollee meets a specific clinical or quality trigge . Care provided to enrollees who are discharged prior to calendar day 15 is subject to retrospective review if a specific clinical or quality trigger is me .
- Inpatient substance use disorder treatment rendered by a facility that is licensed, certified or otherwise authorized by the NYS Office of Addiction Services and Supports (OASAS) that participates in the CDPHP network is not subject to concurrent review until after calendar day 28 of the inpatient stay* if the provider notifies CDPHP of both th admission and the initial treatment plan within two business days of the admission. The facility must perform daily clinical review of the patient, including periodic consultation with CDPHP at or just prior to the fourteenth day of treatment, to ensure that the facility is using the evidence-based and peer-reviewed clinical-review tool utilized by CDPHP which is designated by the NYS Office of Addiction Services and Supports and is appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Care provided to enrollees

who are discharged prior to calendar day 28 is subject to retrospective review.

- Inpatient substance use services delivered in New York state is limited to facilities certified by ASAS and crisis stabilization centers licensed pursuant to Section 36.01 of the NYS Mental Hygiene Law. In other states, inpatient facilities must be accredited by the Joint Commission as substance use disorder treatment programs. In emergency situations, treatment of medical complications related to intoxication or withdrawal from alcohol or other drugs may be provided in a hospital setting and may be subject to medical necessity review.
- Outpatient substance use services in New York state are limited to facilities certified by ASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance use disorder programs. In other states, facilities must be accredited by the Joint Commission as substance use disorder treatment programs.
- Substance use treatment does not require prior authorization except when rendered by non-participating providers or providers outside of New York State.* *Most self-insured, FEHB, and Medicare Advantage products are excluded from this consideration and will follow standard prior authorization requirements. You may call the Behavioral Health Access Center to verify member benefits and eligibility.*

Outpatient Care

CDPHP does not require authorization for treatment of mental health or substance use disorder conditions by participating psychiatrists, psychiatric nurse practitioners, psychologists, licensed masters social workers, and mental health counselors.

CDPHP reserves the right to do both ambulatory and clinical quality review on all members' health care services.

Certain behavioral health services in Medicaid–Select Plan and Medicaid–HARP require prior authorization by calling the Behavioral Health Access Center at (518) 641-3600 or toll-free at 1-888-320-9584. A complete list of services requiring prior authorization can be found in the secure area of www.cdphp.com in the document titled Prior Authorization Guideline. The specific authorization requirements for the HARP Home and Community Based Services (HCBS) can also be found in t e Behavioral Health Home and Community Based Services for Adults policy (1370/20.000489) and CORE policy (1370/20.000510).

Inpatient Care

Providers are required to provide notification of admission within 24 hours by contacting CDPHP Behavioral Healt Services at (518) 641-3600 or 1-888-320-9584 , or by fax to (518) 641-5206. Prior authorization for emergent inpatient admissions is not required.

Residential Care

Residential care is an elective admission and therefore may be subject to preauthorization per the member's contract. CDPHP covers inpatient mental health care services received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to facilities that are licensed or certified to provide the same level of treatment. Residential mental health treatment requires prior authorization.

The following licensed residential/housing programs are accessible through the New York State Office of Mental Health and coverage for admission is not available through the CDPHP benefit

- Licensed Residential/Housing Programs (OMH)
- Apartment, Support Community Residence
- Apartment, Treatment Community Residence
- Children and Youth Community Residence
- Congregate, Support Community Residence
- Congregate, Treatment Community Residence
- Teaching Family Home
- Service-Enriched Single-Room Occupancy

Effective 12/1/20, CDPHP will cover OMH-licensed Crisis Residence Programs, which are single-site residences designed to provide 24-hour-per-day supervision, generally not to exceed 28 days, for adults or children/adolescents experiencing acute symptoms or a temporary disruption in community supports. Services are designed to avoid hospitalization and return the resident to a stable environment. Coverage for this level of care is available for Medicaid enrollees only.

Residential opportunities available through the NYS Office for People With Developmental Disabilities are not covered through the CDPHP benefi .

CDPHP covers inpatient substance use disorder treatment received at facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified facilities defined in 14 NYC 819.2(a)(1) and to services provided in such facilities in accordance with 14 NYCRR Parts 817, 819, and 820; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as al oholism, substance use disorder, or chemical dependence treatment programs to provide the same level of treatment. Note: please be

aware that CDPHP has experienced staff available to assist in navigating the Coverage and Utilization Review Changes Pursuant to Chapters 69 and 71 of the NYS Laws of 2016 (NYS Heroin and Opioid Addiction Legislation). If you have questions about coverage for members who are seeking mental-health or substance-use-disorder treatment, please call our Access Center at (518) 641-3600 or 1-888-320-9584 for assistance.

Standardized Documentation

CDPHP provides a framework for providers when it comes to submitting clinical documentation. The specific informatio requested will vary depending on the type of admission or request being made.

Note: When required by New York Insurance law, notification to CDPHP is required within two business days of admission. Submission of a completed LOCADTR and OASAS-sanctioned "Appendix A" will satisfy requirements for clinical documentation. However, the provider is welcome to provide the information below, as long as it is in addition to the LOCADTR and "Appendix A". Please note, this law prohibits CDPHP from conducting utilization review within the first 28 calendar days of the initial substance use disorder admission. If the inpatient or residential facility fails to notify CDPHP of either the inpatient admission or the initial treatment plan within two business days of the admission, CDPHP may begin concurrent review immediately upon learning of the admission, even if it is during the initial 28-day period. Under these circumstances, CDPHP may also perform a retrospective review of the days of treatment already provided.

CDPHP may perform utilization review of the inpatient treatment after the 28th day of the inpatient admission, and the utilization review may include a review of services provided during the first 28 days of the inpatient treatment. The provisions of the Insurance Law further provide that CDPHP may only deny coverage for any portion of the initial 28-day inpatient treatment on the basis that the treatment was not medically necessary if such treatment was contrary to the OASAS evidence-based and peer-reviewed clinical review tool, LOCADTR.

For psychiatric facilities in NYS licensed to treat children and adolescents under age 18, submission of the OMH-sanctioned "initial treatment plan" is required within two business days of admission. NYS law prohibits CDPHP from conducting utilization review within the first 15 calendar days of the adolescent's mental health admission. However, facilities are encouraged to contact CDPHP clinical reviewers regularly for coordination of care and assistance with discharge planning. If the inpatient facility fails to notify CDPHP of either the inpatient admission or the initial treatment plan within two business days of the admission, CDPHP may begin concurrent review immediately upon learning of the admission, even if it is during the initial 15-day period. Under these circumstances, CDPHP may also perform a retrospective review of the days of treatment already provided.

CDPHP may perform utilization review of the inpatient treatment after the 15th day of the inpatient admission, and the utilization review may include a retrospective review of services provided during the first 15 days of the inpatient treatment. Care for members discharged prior to day 15 will be reviewed retrospectively. For all behavioral health inpatient admissions, facilities are required to notify CDPHP of discharge within 24 hours of the discharge date.

1. Standard Preauthorization Request:

Ex: When a member is seeking admission to an elective, inpatient level of care and prior authorization is required:
Note: This information must be submitted prior to admission.

Request for Authorization

- Facility name
- UR reviewer name and contact info
- Proposed admission date
- Attending physician (psychiatrist or addictionologist)
- Diagnoses (please use ICD-10 or DSM-5 format)
- Reason for admission (precipitating event[s])
- Current symptoms and level of impairment
- Previous pertinent treatment history
- Mental status
- Psychosocial factors related to reason for admission (ex: legal status, substance use history, family dynamics, homelessness, employment issues, etc.)
- Social determinants of health that could be addressed during treatment or as part of the discharge plan
- Home medications
- Initial treatment plan with goals and objectives appropriate to requested level of care
- Estimated/requested length of stay
- Tentative discharge plans or recommendations

2. Notification of Urgent Admission:

Ex: When a member has already been admitted to an emergent level of care. *Note: This information must be submitted within 24 hours of admission. Please submit all admission notifications to CDPHP via fax: 518-641-5206.*

Inpatient Mental Health Admission

- Facility name
- UR Reviewer name and contact info

- Admission date
- Attending physician (psychiatrist or addictionologist)
- Diagnoses (please use ICD-10 or DSM-5 format)
- Psychiatric evaluation which should include the majority of the following:
- Reason for admission (precipitating event[s])
- Current symptoms and level of impairment
- Previous pertinent treatment history
- Mental status
- Psychosocial factors related to reason for admission (ex: legal status, substance use history, family dynamics, homelessness, employment issues, etc.)
- Social determinants of health that could be addressed during treatment or as part of the discharge plan
- Home medications
- Complicating medical conditions

All mental health treatment reviews will include a discussion of the following:

a. For adults:
   i. Risk of harm;
   ii. Functional status;
   iii. Co-morbidity;
   iv. Level of stress and support in the recovery environment;
   v. Treatment and recovery history; and
   vi. Engagement and recovery status.

b. For children/adolescents (information from all of the following domains must be considered in a developmentally appropriate context):
   i. Risk of harm;
   ii. Functional status;
   iii. Co-morbidity;
   iv. Environmental stress and support in recovery environment;
   v. Resiliency and treatment history; and
   vi. Acceptance and engagement in child/adolescent AND caregivers.

Inpatient Detox Admission
- Facility name
- UR Reviewer name and contact info
- Admission date
- Attending physician (psychiatrist or addictionologist)
- Diagnoses (please use ICD-10 or DSM-5 format)
- A completed LOCADTR-3 is required from all participating, OASAS-licensed facilities within NYS.
- Pertinent substance use history including:
  - o Substance(s) used; duration, frequency, last use
  - o Evidence of acute intoxication and assessment of withdrawal potential, including signs/symptoms of active withdrawal and vital signs
  - o Complicating medical or psychiatric concerns
  - o Assessment of recovery environment, including readiness to change and relapse risk factors
  - o Treatment history including medication assisted therapy
- Social determinants of health that could be addressed during treatment or as part of the discharge plan
- Home medications
- Initial treatment plan including medications used for withdrawal
- Estimated/requested length of stay
- Tentative discharge plans or recommendations

3. Concurrent Review:

Ex: When you are requesting continued coverage after obtaining initial authorization
- UR reviewer name and phone
- Attending physician (psychiatrist or addictionologist)
- Current symptoms and change in symptoms since last review
- Mental status and general overview of changes in mental status since last review Report on medications

- Current ICD-10 Diagnoses and DSM 5 Diagnoses
- Revisions to the treatment plan
- Revisions/update to discharge plan

Note: Provider should notify CDPHP immediately under these circumstances:

- *Level of care change for patient*
- *Diagnosis changes (e.g., mental health to chemical dependency)*
- *Significant changes in patient progress*
- *Serious injury or death of patient*
- *Discharge against medical advice*
- *Suicide attempt*

4. Discharge Review:

- Admission date
- Discharge date
- Level of care
- Attending physician (psychiatrist or addictionologist)
- Hospital course
- Mental status and symptoms at time of discharge
- Medications
- Discharge diagnoses
- Aftercare recommendations
    - o Discharge destination including address and contact phone number for the member. *Note: For adolescent discharges, contact information for parent/guardian is required.*
    - o Follow-up appointments (include date and time as well as contact information for providers). CDPHP will call the member one day before the appointment as a reminder. *Note: CDPHP requires all members discharged from an inpatient setting to be provided with an aftercare appointment within 7days of discharge.*

Important: CDPHP reserves the right to request medical records in full when the facility does not cooperate in care coordination activities during the course of treatment. Many retrospective reviews will require submission of full medical record.

Care Management

The CDPHP behavioral health care management (BHCM) program is designed to provide members with mental health and substance abuse issues the education and support necessary to better manage their condition. Care managers help members better understand their behavioral health diagnosis, assist members with achieving treatment goals that prevent inpatient admissions, coordinate care with providers, and help members access appropriate CDPHP behavioral health services. Certified peer recovery advocates are also available to support members with substance use disorder (SUD) related treatment needs, and care managers are able to facilitate connection to these supports. In addition, CDPHP care managers also respond to members experiencing a behavioral health crisis, assess risk, and provide support to the member. The BHCM team works with members telephonically and in person through CDPHP's Hospital to Home Program. Within the hospital setting, the team meets with members at the bedside to provide case management support, services, education and coordination of care. The goal of the BHCM is to help the member achieve a level of stability whereby they may continue to function in their own community.

Members are referred for behavioral health care management through several referral types. Members can call into the behavioral health access center and request care management on their own behalf. Provider offices including PCPs and behavioral health or community agencies, can call and submit a referral to the behavioral health access center. All members following a behavioral health inpatient admission will receive outreach post-hospitalization, if not sooner, by a behavioral health care manager. After a referral is placed, the behavioral health care manager will attempt outreach to the member as soon as possible if the need is warranted, but no later than 1-2 business days after the referral.

HARP

The New York State Office of Addiction Services and Supports (OASAS), Office of Mental Health (OMH) and Department of Health (DOH) transitioned Medicaid Fee for Service Behavioral Health Services to Medicaid Managed Care. Along with this transition came the inception of the Health and Recovery Plan (HARP). These carve in services and the HARP are for adults 21 years and older.

The state's goals for the Medicaid transition is to:

1. Improve health outcomes and reduced health care costs through managed care strategies and technologies.
2. Transform the Behavioral Health (BH) system from inpatient-focused to recovery-focused outpatient system.
3. Improve access to more comprehensive array of community-based services grounded in recovery principles, which include person-centered care management, member choice, member and family member involvement, and full community inclusion.
4. Integration of physical and behavioral health services and care coordination
5. Effective innovation through the use of evidenced-based practices
6. Improved system collaboration with state and local resources, including LGUs, state and locally funded MH and SUD services, housing subsidies and supports, the judicial system, and welfare programs
7. Delivery of culturally competent services
8. Assurance of adequate and comprehensive networks

The HARP product covers the same benefits as Select Plan plus the new Home and Community Based Services and Community Oriented Recovery and Empowerment Services. All Medicaid products included in the transition now include benefits for the State Plan Amendment (SPA) Services (ACT, PROS, CDT, and OP SUD). The HCBS services are exclusive to the HARP enrolled members only and must be requested through the expedited workflow process which includes the health home assessments and development of plan of care. CORE services are also exclusive to HARP enrolled members and do not need to be requested through the expedited workflow proces . A member can be referred through multiple pathways which include, but are not limited to, outpatient providers, hospitals, caregivers, and the individual themself. CORE services also require a recommendation from a Licensed Practitioner of the Healing Arts, which can be received anytime during the referral process. The HCBS and CORE services are designed to provide opportunities for members to receive services in their own home or community. These services are based on the following core principles:

1. Person-centered and recovery-oriented care
2. Integrated between mental health, substance use disorder, and physical health providers
3. Data-informed and evidence-based
4. Trauma-informed
5. Peer-supported
6. Culturally competent
7. Mobile and flexibl
8. Inclusive of social network

Children Medicaid Transition

In January 2019, the New York State Medicaid Redesign Team (MRT) implemented the Children's Medicaid System Transformation, impacting the delivery of Medicaid services to children younger than age 21. Key components of this transition include:

- Transition of six 1915(c) waivers to 1115 Waiver authority:
  - Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver;
  - Department of Health (DOH) Care at Home (CAH) I/II Waiver;
  - Office for People with Developmental Disabilities (OPWDD) CAH Waiver;
  - Office of Children and Family Services (OCFS) Bridges to Health (B2H) SE , Developmental Disability (DD) and Medically Fragile Waivers.
- Alignment of 1915(c) Waivers under one, consolidated array of Home and Community Based Services (HCBS) authorized under the 1115 Waiver.
- Removal of the Managed Care exemption for children receiving services in the six previous 1915(c) waivers.
- Transition of care management for children receiving services through the HCBS array to the Health Home.
- Transition of certain Behavioral Health benefits that were previously carved out for children into the Managed Car benefit packag .
- Six new Children and Family Treatment and Support Services available to all children on Medicaid and Child Health Plus plans who are younger than age 21.
- Lifting the exemption of children in Voluntary Foster Care Agency (VFCA) to Managed Care and carving in the services that these children receive into a Managed Care. (For more information on the transition of children in a VCFA to managed care, please see Section 3 of the Provider Office Administrative Manual.)

• Transitioning the Behavioral Health benefits received by children with Medicaid SSI into Managed Car .

The state's goals for the Children Medicaid Transformations are to:

1. Keep children on their developmental trajectory.
2. Maintain children at home with support and services.
3. Maintain children in the community in least-restrictive settings.
4. Identify needs early and intervene.
5. Focus on recovery and building resilience.
6. Prevent escalation and longer-term need for higher-end services.
7. Maintain accountability for improved outcomes and delivery of quality care.

Behavioral Health Outpatient Care

Fraud and Waste Prevention (Fraudscope) Program

A CDPHP behavioral health data specialist monitors claims and utilization with Fraudscope and refers any fraud and/or waste concerns to the CDPHP Special Investigation Unit for further review.

General Elements of Medical Necessity

Health plan contracts include provisions that plans will pay for services that are medically needed. It is the fiduciary responsibility of the health plan to ensure that its members' health insurance premium dollars are being spent on services that are safe, proven, and cost-effective as outlined in New York State insurance law. In addition, health plans are required by law to monitor for fraud and waste among providers in their network.

For insurance coverage, requested health services demonstrate their medical necessity by showing the following general elements:

a. The service(s) are required for the health needs of the patient and related to treatment of the patient's diagnosis.

b. The type of service(s), its frequency and duration of treatment are consistent with scientifically based clinical care guidelines as determined by medical research. CDPHP adopts best practice guidelines from groups such as the American Psychiatric Association, the Department of Veterans Affairs/Department of Defense, the American Academy of Child and Adolescent Psychiatry (AACAP), and other guidelines as promoted the NYS Office of Mental Health NYS Office of Addiction Services and Supports, and the U.S. Department and the U.S. Department of Health and Human Services. Resources include, as appropriate:

   1. SAMHSA's National Registry of Evidence-based Programs and Practices: https://www.samhsa.gov/ebpresource-center
   2. The Center for Practice Innovation at Columbia for agencies and practitioners needing training on Evidence Based Practice: http://practiceinnovations.org/
   3. American Academy of Child and Adolescent Psychiatry: https://www.aacap.org
   4. Veterans Affairs/DoD: https://www.healthquality.va.gov/
   5. American Psychiatric Association Practice Guidelines: http://psychiatryonline.org/guidelines.aspx.
   6. OMH Clinic Standards of Care: (https://omh.ny.gov/omhweb/clinic_restructuring/docs/standards-of-careanchor-tool-clinic.pdf).
   7. OASAS Clinical Guidance: (https://oasas.ny.gov/providers/clinical-support).
   8. OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf).
   9. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (https://ocfs.ny.gov/main/sppd/health-services/manual.php).
   10. OHIP Principles for Medically Fragile Children (https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf).

c. The service is required to treat the illness and not merely because it provides convenience to the provider, or comfort and convenience to the patient and his or her family (e.g., admitting a patient to a hospital to achieve family respite does not alone demonstrate medical necessity.)

d. The service is provided in the least intensive setting that is appropriate for the delivery of the service and there is a reasonable expectation that the services provided will improve the patient's condition in a meaningful and measurable manner. In some instances, such as for those with chronic, long-term psychiatric illness, services creating significant improvement can include services which maintain the member's functional level, or services which prevent relapse and promote functioning in the least restrictive environment.

For Medicaid-Select Plan and Medicaid-HARP, CDPHP adheres to the definition of medical necessity in its contract wi h the New York State Department of Health. As such, our prior authorization and concurrent review protocols comport with NYS Medicaid medical necessity standards, federal and State parity requirements, the New York State Model Medicaid Managed Care Contract, and other related standards that may be developed by OASAS and OMH. As a result, in addition to the factors listed above, CDPHP endeavors to follow a person-centered approach to care in which each enrollee's needs, preferences, and strengths are considered.

In situations where the medically necessary level of care does not exist (e.g., rural location), the health plan may make available the proper level of care in another location, or authorize a higher than otherwise needed level of care, to ensure that services will meet the member's essential needs for safe and effective treatment.

Practice Guidelines

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD practice guidelines can be requested by contacting the CDPHP provider services department at (518) 641-3500 or 1-800-926-7526.

- CDPHP will assist physicians in reaching out to members to remind them of follow-up appointments for medication management.
- CDPHP recommends that children newly prescribed ADHD medications have at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD prescription is dispensed.

Depression, Bipolar, and Schizophrenia

Guidelines are available and can be requested by contacting the CDPHP provider services department at (518) 641-3500.

New York State has also outlined additional evidence-based/promising practices as relevant to the carve-in of services for children transitioning from certain Medicaid Fee For Service (FFS) waiver programs. CDPHP encourages providers to familiarize themselves with these guidelines if they care for children with the service needs typical of these waiver programs:

- Trauma-Focused Cognitive Behavioral Therapy (TFCBT)
- Trauma Informed Child-Parent Psychotherapy (TI-CPP)
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Multi-Dimensional Treatment Foster Care (MDTFC)
- Dialectical Behavior Therapy (DBT)
- Multidimensional Family Therapy (MDFT)
- Seven Challenges
- Adolescent Community Reinforcement (ACR)
- Assertive Continuing Care (ACC)

More BH Resources on www.cdphp.com

Access the behavioral health section of our website to find additional practice guidelines and evidence based practice . Providers can access specific medical polices in the secure area of www.cdphp.com.

Provider Training

Visit https://www.cdphp.com/providers/learning-library/engagement-strategies to obtain information on webinars and local training opportunities for providers. For the transition of services and populations effective July 1, 2018, CDPHP shall develop provider education and training to prepare network providers for the transition. The training shall include: an initial orientation (for newly contracted providers); explanation of the expanded array of benefits any NYS-issued billing and coding requirements, data interfaces (as applicable), documentation requirements (as applicable), M requirements; g shall include processes for assessment for HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and POC development and review. CDPHP met with children providers and care management agencies prior to the Children Medicaid Transition to review the timeline, expectations, and the process for collaboration between the community providers and CDPHP.

Outpatient Behavioral Health Therapies: Individual Therapy, Group Therapy, and Family Therapy

1. General Elements for Admission into Outpatient Therapy:

a. Basic elements of medical necessity are met.

b. Clinical symptoms result in functional impairment.
Mental and substance use disorders needing treatment are associated with significant distress impairment or disability in social, occupational, or other important activities (activities of daily living) that are not characteristic of the person when not symptomatic. Please note that the diagnosis of a mental disorder is not equivalent to the need for treatment; the diagnosis should help determine prognosis, treatment plans, and potential treatment outcomes.
Need for treatment takes into account, among other things, the symptom severity; the level of distress and disability related to the symptoms; and the risks and benefits of available treatment .

c. The individual is motivated for outpatient treatment by a mental health professional.

2. General Elements for Continued Stay

a. Basic elements of medical necessity are met.
b. Continued psychiatric symptoms and functional impairment.
c. The individual is motivated for treatment, or amenable to treatment, by a mental health professional and the individual (and family/significant others when appropriate) participates in the treatment plannin . The treatment plan includes clearly defined measurable and realistic goals and discharge criteria with an expected timeframe for competitio .

3. Continued stay elements are not met and discharge elements are met if any of the following is true:

a. The individual is not involved in the treatment and absence of treatment poses no imminent risk of harm to the welfare of the individual or others.

b. The individual's history provides evidence that additional outpatient therapy will not create further symptom relief and/or change.

c. Treatment is primarily supportive in nature. From time to time, individuals may occasionally have other unresolved problems, but their level of functioning has been restored to baseline. The presence of unresolved issues does not necessarily indicate that continued outpatient therapy is medically necessary.

d. Treatment is focused on phase of life or quality of life issues (i.e., career dissatisfaction, adjusting to new life circumstances in the absence of functional impairments) rather than on treating a psychiatric illness or a substance use disorder.

Behavioral Health Ambulatory Review

CDPHP behavioral health specialists, using Codoxo (formerly Fraudscope, an AI claims tool), will monitor and make appropriate referrals to the CDPHP special investigations unit on the following:

1. Monitor the quality of outpatient therapy treatments given to our members;
2. Assess the medical need (medical necessity) of treatment provided to our members;
3. Monitor for fraud and waste in our behavioral health network; and
4. Educate our provider network on evidence-based treatments that improve the quality of care delivered, as well as improve the member's experience of receiving care from our network providers.

The ambulatory review process focuses on those members whose treatment, in terms of frequency and quantity of therapy sessions, represent the top 1% of outliers. Providers caring for these outliers will be required to demonstrate:

1. medical necessity for continued care;
2. the member is at the appropriate level of care and making significant progress in therapy; an
3. services are neither under- nor over-utilized.

CDPHP reserves the right to monitor members whose outpatient treatment protocols make them outliers in terms of the frequency and quantity of care received when compared to those receiving care under standard and accepted guidelines. CDPHP will utilize the benchmarks set forth by the Office of Mental Health (OMH) and the Office o Addiction Services and Supports (OASAS). For services rendered in OMH clinics and from an independent therapist, these benchmarks indicate reviews for services exceeding 30 visits per calendar year. With relation to OASAS services, CDPHP will review for members exceeding 50 visits per calendar year in a certified Part 822 clinic services and exceeding 200 visits per calendar year on any member enrolled in Part 822 Opioid Treatment Program (OTP). For those members who do not meet these benchmarks, CDPHP will follow its standard ambulatory review procedures. (http://www.omh.ny.gov/omhweb/bho/docs/prior-concurrent-auth-ambulatory-bh.pdf).

The process of determining outliers is conducted by our Behavioral Health Medical Director and lead health data statistician and informatics team, using SAS software. The final statistical sample of outliers selected for the ambulatory review is generate

by a Random Counter, and will be done by line of business, as follows: Commercial (including ASO) and Star Advantage Plans; Medicaid-Select Plan; and Medicaid-HARP.

In addition to New York State benchmarks, research on dose and outcome in psychotherapy describes a curvilinear relation between dose and effect. Krause & Orlinsky found that between 60% and 65% of people experienced significant symptomati relief within one to seven sessions.[1] Research also shows a course of diminishing returns with more and more effort required to achieve just noticeable differences in patient improvement as time in treatment lengthens.[2] Thus, much of the therapy's effect occurs in a brief period for a large proportion of patients.[3, 4, 5, 6, 7]

If selected for the Behavioral Health Ambulatory Review, CDPHP will send a letter to the provider that serves as a formal request for clinical documentation. The provider will have the option to submit an updated treatment plan along with the six most recent progress notes, or fill out the "Request for Additional Medical Information form" that can be found on the CDPHP website (also found below). A letter is also sent to the member alerting them that their treatment is being reviewed to ensure quality of care. The provider will have 45 days from the date the letter is sent to comply with the request for clinical documentation. Upon receipt of the requested material, the Behavioral Health Medical Director will review the documentation and make a determination based on medical necessity and quality of care. A letter will then be sent to the provider that details the determination as well as any additional suggestions for treatment. Potential suggestions may include referrals to: a higher level of care, a provider to address co-morbid illnesses, evaluation for medication assisted treatment or medication management, group therapy, peer supports, or discharge from care. Failure to submit the requested clinical documentation to CDPHP will result in a hold on any claims submitted and may result in non-renewal of the provider's contract and/or an investigation by CDPHP's legal department.

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[2] Howard, K.I., Kopte, S.M., Krause, M.S., & Orlinsky, D.E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist*, 41, p. 361.

[3] Hales, Robert, MD, MBA; Yudofsky, Stuart, MD; and Gabbard, Glen, MD.: The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition; American Psychiatric Publishing, Inc. Washington, DC,2008, pgs 1155-1168.

[4] Brown, J., Dreis, S., & Nace, D.K. (1999). What really makes a difference in psychotherapy outcome? Why does managed care want to know? In M.A. Hubble, B.L. Duncan, and S.D. Miller (eds.). *The Heartand Soul of Change: What Works in Therapy* (pp. 389-406). Washington, D.C.: APA Press.

[5] Hansen, N.B., & Lambert, M.J. (2003). An evaluation of the dose-response relationship in naturalistic treatment settings using survival analysis. *Mental Health Services Research*, 5, 1-12.

[6] Whipple, J.L., Lambert, M.J., Vermeersch, D.A., Smart, D.W., Nielsen, S.L., Hawkins, E.J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment and problem-solving st ategies in routine practice. *Journal of Counseling Psychology*, 50, 59-68.

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Request for Additional Medical Information Form

CDPHP Member's Name (First/MI/Last):		**CDPHP ID #**
DOB:	**Provider Name:**	
Date:	**Admission Date:**	**Page:** **of**
Psychiatric and Substance Use Diagnoses (Actively being treated):		
Psychiatric and Substance Use Diagnoses Currently in Remission:		
Medical Diagnoses:		
Current symptoms. Please describe the member's current symptoms and their effects on the day-to-day functioning of the member. Please include whether or not there are a.) psychotic symptoms; or b.) thoughts, plan, or intent of suicide or harm to self or others.		

Treatment Planning—Review Top Two Goals of Therapy	
GOAL 1	**GOAL 2**
Start Date:	**Start Date:**
Target Completion Date:	**Target Completion Date:**
Adjusted Target Date:	**Adjusted Target Date:**
Intervention(s)/Method(s)/Action(s)	**Intervention(s)/Method(s)/Action(s)**
Service Description/Modality	**Service Description/Modality**
Frequency	**Frequency**
Outcome	**Outcome**

Please complete reverse of form

1. Is there a recent substantial deterioration of self-care, ability to receive adequate care, or age-appropriate social functioning? Please provide details.

2. Please describe the member's motivation and capacity to improve or stabilize as a result of treatment. Comment on member's completion of homework, no show, and cancellation rates.

3. Are there any current issues with compliance to medication therapy and/or adverse medication effects?

4. Please discuss why the member is still in maintenance treatment and what will be achieved by the member remaining in treatment.

5. Have you considered group therapy as an alternative to, or adjunct to, your current treatment?

Provider Signature Date

Send to Behavioral Health Services, c/o CDPHP, 6 Wellness Way, Latham, NY 12110 or fax to (518) 641-3601.

Specialized Services—Autism Treatment

Effective November 1, 2012, New York State law required coverage for the screening, diagnosis, and treatment of the DSM5 diagnosis of Autism Spectrum Disorder. The law applies to HMO and UBI Commercial, Child Health Plus, and NYSHIP plans, and Medicaid plans effective 10/1/2021. The law does not apply: Medicare, ASO, and FEHBP.

Coverage is plan specific and at minimum is available to members who have a diagnosis of Autism Spectrum Disorder or Rhett Syndrome and includes the following:

- Screening and Diagnosis: Coverage will be provided at the appropriate office visit copay/coinsurance, depending on provider type.
- Applied behavior analysis—Coverage is not subject to a maximum benefit and the individual is covered until the services are no longer medically necessary.
- Psychiatric and psychological care—When provided by a licensed psychiatrist or psychologist, and certain licensed clinical social workers.
- Therapeutic care (PT, OT, ST).
- Pharmacy care—When such coverage is provided for under the contract or policy.
- Assistive communication devices—Requirements are defined in Resource Coordination policy #1370/20.000476. Referral Services will take requests for assistive communication devises and speech therapy via:
  - Fax: (518) 641-3207
  - Mail: CDPHP Referral Services, 6 Wellness Way, Latham, NY 12110
  - Phone: (518) 641-4100 or 1-800-274-2332

Applied behavior analysis (ABA) services must be provided by or supervised by a NYS-licensed, board-certified behavior analyst (BCBA/BCBA-D). CDPHP has a network of plan providers for ABA treatment who meet credentialing requirements.

Members are responsible for any applicable deductible, copayment, or coinsurance amounts under their contract.

Billing codes for applied behavioral analysis are as follows:

CPT Codes	CPT/HCPCS Code Description
97151	Behavior identification assessment administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professionals time face-to-face with patient and/or guardian(s)/caregiver(s), administering assessments and discussing findings and recommendations and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
97152	Behavior identification supporting assessment administered by one technician under the direction of a physician or other qualified health care professional face-to-face with the patient, each 15 minutes.
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional face-to-face with one patient, each 15 minutes.
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional face-to-face with two or more patients, each 15 minutes.
97155	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) face-to-face with multiple sets of guardians/caregivers, each 15 minutes.
97158	Group adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional face-to-face with multiple patients, each 15 minutes.

For additional information on ABA codes and limits, please see the complete policy by logging in securely at https://provider.cdphp.com/login.

Specialized Services—Electroconvulsive Therapy

CDPHP has established policies and procedures for authorizing electroconvulsive therapy (ECT). For details, see the complete medical policy by logging in securely at www.cdphp.com.

Specialized Services—Transcranial Magnetic Stimulation

CDPHP has established policies and procedures for authorizing transcranial magnetic stimulation (TMS). For details, see the complete medical policy by logging in securely at www.cdphp.com.

Specialized Services—Opioid Treatment Programs

Opioid Treatment Centers (OTP) are OASAS-certified sites where medication to treat opioid dependency is administere . These medications can include methadone, buprenorphine, and suboxone. Authorization requirements are based on members' benefits and eligibilit .

As it relates to Buprenorphine-containing products (Suboxone, Zubsolv, Sublocade), prior authorization is not required for oral/transmucosal formulations. Sublocade requires a prior authorization through the pharmacy department.

Specialized Services—Psychological Testing

CDPHP has established policies and procedures for covering psychological testing for purposes of establishing differential diagnosis and behavioral health care treatment planning. For details, see the complete medical policy by logging in securely at www.cdphp.com.

- Provider submits the claims.
- When billing for testing please be aware of the following:
- Please note, some codes capture 30 minutes of testing, whereas others capture 60 minutes. Please refer to your fee schedule and/or the American Psychological Association for more information.
  - Neuropsych testing is a medical benefit not a behavioral health benefi . CDPHP has established policies and procedures for covering neuropsychological testing for the purposes of establishing differential diagnosis and behavioral health care treatment planning.
  - Provider conducting tests shall consult with the referring therapist if available to collect relevant clinical history.

Behavioral Health Complex Case Management (CCM) Program

CCM is the CDPHP program for case management of members who have chronic comorbid disorders and experience personal challenges maintaining independent living in the community. CCM targets chronically ill members who also have comorbid mental health and substance abuse disorders. These members may have frequent emergent admissions as a result of their inability to adhere to an appropriate outpatient treatment plan. Members newly diagnosed bipolar disorder, schizophrenia, or psychosis NOS are referred for case management for first episode psychosis (FEP) treatment program engagemen . FEP referral is also made when first admission for other diagnoses with psychotic feature .

The goal of CCM is to foster an optimal level of functioning in the community and reduce the member's reliance on hospital care by facilitating engagement with a full range of outpatient resources. CDPHP behavioral health complex case managers will work collaboratively with CDPHP medical complex case managers to develop comprehensive treatment plans to treat the member's comorbid disorders. Members typically participate in CCM from six to 12 months with a goal of removing the member from CCM when there has been no readmission to the hospital for six months.

The CCM case manager, a person licensed as a behavioral health care professional, will work in collaboration with the treating provider(s), the member, and the member's family or support system.

The CCM case manager is responsible for:

- Contacting the member and treating provider(s) to discuss how the program operates and the potential value to the member. At this time, the member must agree to enroll in the program before any further involvement can occur.
- Developing a comprehensive case management plan that includes the following:
  - Short-term goals
  - Long-term goals
  - Timeframes for re-evaluation or follow-up activities and the member's responses to services Resources to be utilized both internal and external to the CDPHP contracted network
  - Collaborative approaches to be used, including the participation of the member's PCP when appropriate
- Maintaining telephonic contact with the member based on two levels of intensity:
  - Monitoring contact—less intensive contact maintained primarily to monitor ongoing risk of decompensation or relapse
  - Stabilizing contact—more intensive contact during period of instability or crisis for the member
- Maintaining liaisons with social service agencies, courts, schools, and other community-based organizations to ensure that the member has access to the range of supports necessary to maintain adequate community functioning
- Understanding eligibility requirements and funding arrangements in order to facilitate the member's access to all necessary services, and to authorize services that meet the member's clinical need to make the most effective use of the available benefi
- Coordinating care with the CDPHP medical CCM and develop comprehensive treatment plans to treat comorbid disorders
- Maintaining case management responsibility across all levels of care until the member is free of hospitalization for a period of six months or the member no longer agrees to case management
- The behavioral health provider is responsible for assisting in the coordination of care.

Behavioral Health Case Management for Medicaid–HARP

New York State intends that all HARP enrollees will be enrolled, with their consent, in Health Homes. The Health Home will serve as the case manager for all HARP services including the new Home and Community Based Services and Community Oriented Recovery and Empowerment Services . If a HARP member is not enrolled in a Health Home, CDPHP will work with the individual to select a Health Home or will assume the roll as case manager in instances where a member chooses not to enroll in a Health Home.

Sentinel Event Reporting

CDPHP maintains programs that reduce and prevent risk and assure the safety of members through ongoing processes of risk identification risk analysis, action implementation, and action evaluation. Sentinel events are defined as unexpected occurrences involving death or serious physical or psychological injury, or "risk thereof." "Risk thereof" includes actions or situations for which a recurrence would carry a significant chance of a serious adverse outcom .

As a CDPHP provider, you are required to report to CDPHP any of the following events when the member is currently in treatment authorized by CDPHP or any member for whom treatment was authorized by CDPHP within 12 months prior to the incident:

- Death/completed suicide
- Homicide
- Suicide attempt requiring medical intervention
- CDPHP assumes the provider will initiate appropriate legal action.

Coordination of Care with PCPs

CDPHP is committed to ensuring that behavioral health care and primary care services are well coordinated. Appropriate, confidential and timely information sharing and careful medication monitoring are especially important when the member is receiving psychotropic medications and/or has a new or continuing medical problem.

- It is the provider's responsibility to help the member understand the importance of coordinating care among appropriate health care providers. Provider will encourage members to sign consent to release information for coordination of care.

Coordination of Care Within Behavioral Health

CDPHP is committed to ensuring that behavioral health care is well coordinated among behavioral health clinicians when more than one provider is involved in a member's care. If your patient is in the hospital, the hospital will share information with you and work collaboratively in the discharge planning process.

Communication among practitioners is an essential component of quality medical care. Written or verbal communications can help promote effective follow-up care and improve patient safety. It can be as simple as a phone call, progress note, or discharge summary. To help you do this, CDPHP has created a simple Exchange of Information Form. A PDF can be downloaded by typing in "Exchange of Information Consent Form" in the search bar at www.cdphp.com. CDPHP recognizes that even after a discussion of the importance of coordination of care, some patients may not allow their behavioral health information to be shared with their PCP. If this should occur, the refusal should be documented in the member's medical record.

Preventive Behavioral Health

CDPHP has behavioral health resources available within the Wellness section of our Web site at www.cdphp.com.

HEDIS and NQF Tip Sheets

CDPHP maintains tip sheets to help our network providers comply with Healthcare Effectiveness Data and Information Set (HEDIS®) guidelines. For an in-depth look at the data collection process and tips on achieving higher HEDIS and NQF scores, please log into the CDPHP secure provider portal to access and read our HEDIS and NQF Effectiveness Tool for CDPHP Providers summary booklet.

Provider On-Site Visits/Reviews/Audits

CDPHP maintains policies and procedures that address on-site provider visits/audits and reviews.

- Providers agree that, according to contractual terms, CDPHP shall be granted access to provider physical sites to conduct site reviews, treatment record reviews, medical chart-to-claim audits, and/or fraud investigation audits.
- Provider offices may be subject to take-back . CDPHP reserves the right to recoup overpayments based on over-coding.

Behavioral Health Home and Community Based Services (HCBS) – Medicaid – HARP

For detailed information on Home and Community Based Services and Community Oriented Recovery Services that are available to Medicaid – HARP members, please see Section 3 of this manual.

Assisted Outpatient Treatment (AOT) Orders

Courts may order certain Medicaid members to participate in assisted outpatient treatment (AOT) programs. Information on the AOT program can be found on New York Office of Mental Health s website: https://omh.ny.gov/. For these members, services must follow the AOT Order and/or the integrated treatment plan created by the member's case manager, as well as CDPHP protocol. In the event, an individual does not show for an appointment, the provider must follow state and CDPHP protocol, including calling the member's case manager immediately. See the behavioral health page on www.cdphp.com for an AOT tip sheet for providers.

Exchange of Information Form

This is not a request for medical records.

CDPHP requires contracted behavioral health providers to coordinate treatment with primary care practitioners (PCPs) and other behavioral health providers involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

Patient Name: _____ **DOB:** _____

Date mailed or faxed to other clinician/facility: _____

Treating Behavioral Health Clinician/Facility Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

PCP or Other Behavioral Health Clinician/Facility/Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

Please be advised that I saw a patient from your practice for a medical/mental health/substance evaluation:

Diagnostic description: _____

_____

Medications: _____

_____

Other treating health care professionals involved in this patient's treatment: _____

_____

Treatment recommendations:

- ☐ Individual Therapy
- ☐ Medication Management
- ☐ Family Therapy
- ☐ Medical Treatment
- ☐ Group Therapy
- ☐ Substance Abuse Treatment
- ☐ Couples Therapy
- ☐ Other: _____

If you have any questions, please feel free to contact me.

Sincerely,

_____ _____ _____

Print Name | Credentials | Phone Number

To the party receiving this information: If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42 CFR Part 2), those rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

Member Consent: I hereby authorize the behavioral health clinician/facility listed above to release the information contained on this form to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent in writing at any time except to the extent that the practitioner or entity which is to make the disclosure has already acted in reliance on it. I understand that my treatment is not conditional in any way on my consenting to this disclosure.

Place a completed copy of this form in the patient's medical record and provide signed copy to the patient.

I do not want to have information shared with:

- ☐ My PCP/medical practitioner.
- ☐ My other behavioral health practitioner(s)/provider(s)
- ☐ I am not currently receiving services from a PCP/other medical practitioner.
- ☐ I am not currently receiving services from any other behavioral health practitioner/provider.

_____ _____

Patient Signature *(If other than patient, state relationship to patient)* **Date**

_____ _____

Clinician/Facility Representative Signature **Date**

18-6604 • 02/2018

Revised May 2026

Document Guidelines for Outpatient Behavioral Health Procedures/Services

These guidelines outline the documentation requirements for psychotherapy services in the fields of psychiatr , psychology, clinical social work, and substance use disorders (SUD) for the diagnosis and treatment of various mental and substance use disorders and/or diseases.

Indications:

A. Approved Providers of Service

a. Licensed Physicians (MD/DO)
b. Licensed Clinical Psychologists
c. Licensed Clinical Social Workers
d. Licensed Psychiatric Nurse Practitioners (NPP)
e. Licensed Mental Health Counselors
f. Licensed Marriage and Family Therapist
g. Board-Certified Behavior Analysts (BCBA/BCBA-D)

B. General Coverage Requirements:

Outpatient psychiatric services must be reasonable and necessary for the diagnosis or treatment of the patient's condition. Psychiatric and SUD services must be rendered by individuals licensed or otherwise authorized by the state in which they practice and are qualified by their training to perform these service .

Coverage Criteria. The documentation must demonstrate the following:

Individualized Treatment Plan. Services are provided under an individualized written plan of treatment established by an approved licensed provider. The documentation must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. For Medicaid–Select Plan and Medicaid–HARP, such treatment plans shall reflect a person-centered approach considering the individual's strengths, need, and preferences in order to sup-port his/her recovery goals.

Reasonable Expectation of Improvement. Services are for the purpose of diagnostic study or reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric or SUD symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant progress is not expecte . When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary.

Frequency and Duration of Services. There are no specific limits on the length of time that services may be covere . There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the documentation shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

When documentation shows that the patient has reached a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of significant improvement the outpatient services are no longer considered reasonable or medically necessary.

C. Specific C verage Requirements:

Information in this part of the guideline has been divided into four (4) sections. These sections address the following CPT/HCPCS procedure codes:

I. Psychiatric Diagnostic Procedures(90791, 90792)
II. Interactive Complexity (90785)
III. Psychotherapy (90832-90840, 90846-90853)
IV. Electro-Convulsive Therapy (ECT) (90870)

Section I: Psychiatric Diagnostic Interview Examination (90791-90792):

Description: The psychiatric diagnostic procedure codes require the elicitation of a complete medical (including past, family, social) and psychiatric history, a mental status examination, establishment of an initial diagnosis, an evaluation of the patient's ability and capacity to respond to treatment, and an initial plan of treatment. Information may be obtained from not only the patient, but also other physicians, health care providers, and/or family if the patient is unable to provide a complete history.

Note: Codes 90791 and 90792 may not be reported on the same day as an E&M (evaluation and management) service performed by the same individual for the same patient.

Documentation: The medical record must reflect the elements outlined in the above description and must be rendered b a qualified provide .

Comments: For an individual provider, the Psychiatric Diagnostic Interview Exam is covered once, at the outset of an illness or suspected illness and subsequently, it is covered once during any 12 month period. Note: If there is a 90 day break in treatment, another Psychiatric Diagnostic Interview Exam may be billed. In addition, Medicaid members are allowed three diagnostic interviews per calendar year per provider.

Section II: Interactive Complexity (90785):

Description: "Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients." (CPT 2013, Professional Edition, p.483)

The interactive complexity component code 90785 may be used in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792) and psychotherapy (90832, 90834, 90837), psychotherapy when performed with an evaluation and management service (90833, 90836, 90838), and group psychotherapy (90853).

The code is used principally to evaluate children and also adults who do not have the ability to interact through ordinary verbal communication. The health care provider uses inanimate objects, such as toys and dolls for a child, physical aids and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or one who does not speak the same language as the healthcare provider.

- Interactive complexity may also be used in the evaluation of adult patients with organic mental deficits or for those who are catatonic or mute.
- Interactive complexity may be reported with psychotherapy when at least one of the following is present:
- Maladaptive communication (e.g., high anxiety, high reactivity, repeated questions or disagreement)
- Emotional or behavioral conditions inhibiting implementation of treatment plan
- Mandated reporting/event exists (e.g., abuse or neglect) or
- Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional.

Documentation: The medical record must reflect the elements outlined in the above description and must be rendered b a qualified provider and must indicate that the person being evaluated does not have the ability to interact through normal erbal communicative channels. Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. If the patient is capable of ordinary verbal communication, this code should not be used. The medical record must include treatment recommendations.

Section III: Psychotherapy Psychiatric Therapeutic Procedures (90832-90840, 90846-90853):

Information in this part of the guideline has been subdivided into two (2) sections. These sections address the following CPT/HCPCS procedure codes:

Codes 90832-90840—Insight oriented, behavior modifying, supportive, and/or interactive psychotherapy

Codes 90846-90853—Group psychotherapy, family psychotherapy, and/or interactive group psychotherapy

1. Codes 90832-90838 represent insight-oriented, behavior modifying, supportive, and/or interactive psychotherapy

Description: Procedures 90832-90838 (psychotherapy) are defined as "the treatment for mental illness and behavioral disturbances in which the physician or other qualified health care professional through definitive therapeutic commu cation attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development." (CPT 2013, Professional Edition, p.485)

Documentation: The medical record must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification supportive or interpretive interactions that were applied to produce a therapeutic change. Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy. Additionally, a periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record. Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.

Procedure codes 90832-90838 (psychotherapy for 30 to 60 minutes)—report the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838. Procedure codes 90833, 90836 and 90838 are add on codes that should be used in conjunction with evaluation and management (E/M) codes 99201-99205, 99211-99215.

Comments: While a variety of psychotherapeutic techniques are recognized for coverage under these codes, the services must be performed by persons authorized and licensed by the state in which they practice.

To report both an E/M code and a psychotherapy add-on code (+90833, +90836, +90838), the two services must be significant and separately identifiabl . Psychotherapy codes that include an E&M (evaluation and management) component are payable only to physicians and NPPs. The E&M (evaluation and management) component of the services must be documented in the record. A psychotherapy code should not be billed when the service is not primarily a psychotherapy service, that is, when the service could be more accurately described by an evaluation and management or other code.

The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.

2. **Codes 90839-90840 represent Psychotherapy for Crisis.**

Description: Procedures 90839-90840 capture psychotherapy for crisis, which involves an urgent assessment and history of a crisis state, a mental status exam, and disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life-threatening or complex and requires immediate attention to a patient in high distress.

Documentation: The medical record must document the crisis state(s) described under the "Description" section relative to codes 90839 and 90840.

Comments: Codes 90839 and 90840 are used to report the total duration of time the provider rendering psychotherapy for crisis spends face-to-face with the patient and/or family, even if the time spent on that date is not continuous. The patient must be present for all or some of the service. Codes 90839 and 90840 cannot be reported with codes 90791 or 90792.

Code 90839 is used to report the first 30-74 minutes of psychotherapy for crisis on a given dat . It should be used only once per date even if the time spent by the provider is not continuous on that date. Psychotherapy for crisis of less than 30 minutes' total duration should be reported with code 90832 or 90833. Code 90840 is used to report additional block(s) of time, of up to 30 minutes each, beyond the first 74 minute . (CPT 2020, Professional Edition, p.649-650).

3. **Codes 90846, 90847, and 90853** family psychotherapy without the patient, family psychotherapy with the patient, and group psychotherapy, respectively.

Codes 90846 and 90847:

Description: Procedure codes 90846 and 90847 describe the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary s mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. Code 90846 is used when the patient is not present. Code 90847 is used when the patient is present.

Documentation: The medical record must document the conditions described under the "Description" and "Comments" sections relative to codes 90846 and 90847.

Comments: Family psychotherapy services are covered only where the primary purpose of such psychotherapy is the treatment of the patient's condition. Examples include:

- When there is a need to observe and correct, through psychotherapeutic techniques, the patient's interaction with family members (90847).
- Where there is a need to assess the conflicts or impediments within the famil , and assist, through psychotherapy, the family members in the management of the patient (90846 or 90847).
- Psychotherapy codes used for individual therapy are "with patient and/or family." In an individual session family members may ask to speak with the provider alone or together with the patient. Providers may also request particpation of family in the individual session either with the patient or without the patient. Individual sessions that include family should not be billed as both individual therapy and family. A family therapy session could occur on the same day as an individual therapy session but must be a separate distinct service, utilizing different modalities of treatment.

- The term "family" may apply to traditional family members, live-in companions, or significant others involved i the care of the patient.

Codes 90846 and 90847 are not timed but are typically 45 to 60 minutes in duration; CDPHP requires documentation of the time involved in rendering the 90846 and 90847 service to support medical necessity.

Codes 90846 and 90847 do not pertain to consultation and interaction with paid staff members at an institution. Facility staff members are not considered "significant others for the purposes of these guidelines.

Code 90853:

Description: Codes 90853 represent psychotherapy administered in a group setting, facilitated by a trained therapist simultaneously providing therapy to multiple patients. The group therapy session lasts 60-90 minutes. Personal and group dynamics are discussed and explored in a therapeutic treatment setting allowing emotional catharsis, instruction, insight, education and support.

Documentation: The medical record must reflect a summary of the group discussion and the individual s participation and any information pertinent to the individual's participation.

Comments: Group therapy, since it involves psychotherapy, must be led by a person who is licensed or certified by his or her licensing state to perform this service. This will usually mean a psychiatrist, psychologist, clinical social worker, licensed mental health counselor, or other person licensed or certified (and registered) to do psychotherap .

*See below for additional information on code 90785.

Section IV. ECT (90870)

Description: Code 90870, electroconvulsive therapy (ECT), is described as the application of electric current to the brain, through scalp electrodes to produce a seizure. It is used primarily to treat major depressive disorder when antidepressant medication is contraindicated and for certain other clinical conditions.

Documentation: When a psychiatrist performs both the ECT and the associated anesthesia, no separate payment is made for the anesthesia. Code 90870 is limited to use by physicians (MD/DO) only.

Limitations: Severe and profound mental retardation (ICD-9 codes 318.1, 318.2, 319,) is never covered for psychotherapy services (CPT codes 90832-90838). In such cases, rehabilitative, evaluation and management (E/M) codes, or pharmacological management codes should be reported.

Patients with dementia represent a very vulnerable population in which co-morbid psychiatric conditions are common.However, for such a patient to benefit from psychotherapy services requires that their dementia to be mild and that they retain the capa ity to recall the therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit fro psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

Any diagnostic or psychotherapeutic procedure rendered by a practitioner not practicing within the scope of his/her licensure in New York state or other state authorization will be denied.

Limitations to Psychotherapy Codes

The following services do not represent reasonable and necessary outpatient psychotherapy services and/or coverage is excluded:

- programs attempting to enhance emotional wellness, e.g., day care programs;
- day care programs, which provide primarily social, recreational, or diversional activities, custodial or respite care;
- services to a skilled nursing facility resident that should be expected to be provided by the nursing facility staff;
- vocational training when services are related solely to specific employment opportunities work skills, or work settings;
- biofeedback training for psychosomatic conditions;
- recovery meetings such as Alcoholics Anonymous, 12 Step, Al Anon, Narcotics Anonymous, due to their free availability in the community;
- telephone calls to patients, collateral resources and agencies;
- evaluation of records, reports, tests, and other data;
- explanation of results to family, employers, or others;
- preparation of reports for agencies, courts, schools, or insurance companies, etc. for medico-legal or informational purposes;
- screening procedures provided routinely to patients without regard to the signs and symptoms of the patient's mental illness.

Source:
These Document Guidelines are based on the federal government's CMS National Coverage Policy for Medicare Part A and Part B services in the fields of psychiatry, psychology, clinical social work, and psychiatric nursing for the diagnosis and treatment of various mental disorders and/or diseases.

Quality Management Program Committees

1. Behavioral Health Utilization Management Committee:

Participating providers, representing the behavioral health specialties, provide advice and recommendations concerning utilization management related to behavioral health, as well provides expert opinions on behavioral health issues. Discussions include: the development, approval, and review of policies; recommending procedures for benefit coverage by assessin technologies, medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the membe benefit package; monitoring utilization trends; development/selection of industry standard medical necessity/clinicall appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

The committee members are responsible for sharing information relative to trends in the behavioral health industry, and exchanging ideas on how to affect better outcomes with specific population . Their scope includes all CDPHP lines of business except Medicaid HARP.

The primary goal is to impact the behavioral health community by moving them toward the fulfillment of the CDPH health value strategy. The committee meets four times a year, is chaired by the CDPHP behavioral health medical director, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment. Committee minutes are reported to the UMC, QMC, and then to the board of directors.

2. HARP Utilization Management Committee

The HARP UM Committee consists of participating providers, representing behavioral health specialties, and provides advice and recommendations concerning utilization management related to behavioral health for the members of the CDPHP Medicaid HARP product, and provides expert opinions on behavioral health issues. Discussions include: the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit packag monitoring utilization trends; development/selection of industry standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

The committee meets four times a year, is chaired by the CDPHP behavioral health medical director, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment.

The committee shall submit results of its activities to the Utilization Management committee, which reports through the Quality Management committee to the Board of Directors.

3. HARP Quality Stakeholder Advisory Group

The HARP Quality Stakeholder Advisory Group (QSAG) shall be chaired by the Behavioral Health Medical Director and led by the Behavioral Health Quality Management Administrator; will meet at least quarterly; will report to the HARP UM Committee; and will maintain records documenting attendance, findings recommendations, and actions. It will be responsible for carrying out the planned activities of the HARP Behavioral Health Quality Management program and be accountable to and report regularly to the HARP Behavioral Health UM Committee concerning BH QM activities for the Medicaid HARP line of business only.

The HARP QSAG members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and case management activities. They provide expert opinions on behavioral health issues, encourage and promote communication between CDPHP and the BH provider network, review and provide input for satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations for effecting better outcomes with specific population . The committee's mission is to exchange ideas on how to affect better treatment outcomes, and review the findings of BH-specific quality improvement initiative performance improvement projects and focused studies.

State requirements for the CDPHP HARP product include the involvement of stakeholders which shall include in an advisory capacity; members, family members, peer specialists, providers, plan subcontractors, RPC, and/or other member serving agencies. Satisfaction of this requirement is met by the creation of the HARP QSAG, which will report to the HARP UM Committee.

4. Quality Stakeholder Advisory Group

The Quality Stakeholder Advisory Group (QSAG) shall be chaired by the Behavioral Health Medical Director and led by the Behavioral Health Quality Management Administrator; will meet at least quarterly; will report regularly to the Behavioral Health UM Committee; and will maintain records documenting attendance, findings recommendations, and actions. It will be responsible for carrying out the planned activities of the Behavioral Health Quality Management program and be accountable to and report regularly to the Behavioral Health UM Committee concerning BH QM activities for all lines of business except HARP.

The QSAG members are responsible for sharing information relative to trends in the behavioral health industry, and exchanging ideas on how to affect better outcomes with specific population . The QSAG shall review the findings of BH specific quality improvement initiatives (QIAs) performance improvement projects and focused studies.

5. Children's Advisory Committee

The Children's Advisory Committee (CAC) is responsible for advising and assisting CDPHP in identifying and resolving issues related to the management of children's health and behavioral health benefit . The CAC shall be co-chaired by the Behavioral Health Medical Director for Children and the CDPHP pediatric Medical Director and led by the CDPHP Director of Case Management and Behavioral Health Clinical Director for Children's Services; will meet at least quarterly; will report regularly to the Utilization Management Committee; and will maintain records documenting attendance, findings recommendations, and actions.

The CAC will be responsible to provide expert opinions on children's health issues, including but not limited to: service or quality monitors, including HCBS for medically fragile children and children with serious emotional disturbance; preventative and clinical practice guidelines; medical/behavioral health integration and case management activities; suggestions for medical policies and procedures; and member and provider satisfaction surveys.

The CAC shall be composed of representatives with expertise in children's services and familiarity with children eligible for HCBS, including children with medical fragility, developmental disability, serious emotional disturbance, and children in foster care. The members will be responsible for sharing information relative to trends in the delivery of health care for children and exchanging ideas on how to achieve better outcomes for the various subpopulations of children.

Consent Rules for Part 2 Substance Use Disorder Treatment Programs

Effective February 16, 2026, providers and facilities that qualify as Part 2 programs are required to obtain written patient consent before disclosing substance use disorder (SUD) treatment information for claims submission to the Health Plan. This update is in line with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and will allow for easier continuity of care for members as they continue through the treatment program.

For your convenience, we have created a template patient consent form (below) for your use. The form is available on our Provider Portal under Resources/Forms & Tip Sheets. Please note use of this template is optional. You may use any form template that meets the requirements outlined in 42 CFR §2.31, which specifies the necessary elements of a valid patient consent under the final rule.

Consent only needs to be given once, and that form can be used in conjunction with treatment for the member going forward. Claims submissions for Part 2 SUD treatment will act as attestation that you have obtained consent to treat the member.

Part 2 Patient TPO Consent

Confidentiality of Substance Use Disorder Patient Records
42 C.F.R. Part 2

TPO Consent for Disclosure of Part 2 Records

A. PATIENT INFORMATION

_____
Patient's name (*please print*):

_____ _____
Health Plan ID#: Date of Birth:

_____
Address:

_____
City/State/Zip

_____ _____
Phone number E-Mail address

B. PERSON(S) PERMITTED TO MAKE DISCLOSURES

_____("Provider")
Part 2 Program Name (*i.e.*, provider furnishing treatment to patient)

C. RECIPIENT OF AND PURPOSE FOR DISCLOSURE

Provider may use and disclose information about me to my treating health care providers, my health plans (health insurers), other third-party payers, and their business associates (vendors) for the provider's treatment, payment, and health care operations. The information may then be redisclosed as permitted by the HIPAA Privacy Rule, including (but not limited to) for treatment, payment, and health care operations, ***except that***:

The information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.

D. INFORMATION THAT MAY BE DISCLOSED

All information necessary to process my claims and coordinate my care. This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), my prescriptions, dates of treatment, and names of health care practitioners or other providers who treat me.

E. EXPIRATION OR REVOCATION OF CONSENT

This consent will not expire.

You may revoke this consent at any time by contacting Provider at the address provided below. Your revocation will not be effective, however, to the extent that Provider or others have already acted in reliance on the consent.

F. IMPORTANT INFORMATION ABOUT THIS CONSENT

Although the records described above will continue to be protected by the HIPAA Privacy Rule, once Provider discloses records as permitted by this consent, the records will no longer be protected by the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2).

If you do not sign this consent, however, Provider will not provide treatment to you and your health plan (health insurer) cannot pay claims for your treatment because it will not be allowed to use or disclose information about you.

G. SIGNATURE AND DATE

I have read the contents of this form. I agree to allow the disclosures of my information as described above.

_____
Signature of Patient

_____
Signature of person authorized to provide consent under 42 C.F.R. §§ 2.14 or 2.15, if applicable.

_____
Relationship of person authorized to provide consent, if applicable.

_____
Today's Date

To revoke this consent, you may contact:

_____
Part 2 Program Name:

_____
Address:

_____
City/State/Zip:

_____ _____
Phone number: E-Mail address: