V. Utilization Management Guidelines for Children's State Plan and Demonstration Services for Medicaid Managed Care Plans

Service	Prior Authorization	Concurrent Authorization	Additional Guidance
Outpatient Clinic: Services including initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy, and Licensed Behavioral Practitioner (LBHP).	No	Yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations).
Mental Health Clinic Services: Psychiatric Assessment; Medication Treatment	No	No	MH clinic visits exclusively for Medication Management or Psychiatric Assessment will not count towards the 30 visits per calendar year.
Psychological or neuropsychological testing	Yes	N/A	
Mental Health Partial Hospitalization	Yes	Yes	
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit

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PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when Individual Service Recommendation (ISR) is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: • Clinical Treatment; • Intensive Rehabilitation (IR); or • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or BH HCBS providers.
PROS Active Rehabilitation	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following NYS guidelines. New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA to facilitate referrals. In NYC, the referring provider contacts MMCO/HARP to request ACT referral. Provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. The MMCO/HARP notifies the referring provider a level of service determination (LOSD) to the referring provider that a level of service determination for ACT admission has been made. The provider sends the referral and LOSD to SPOA. In ROS, the referring provider makes a SPOA referral and contacts MMCO/HARP to request an ACT level of service determination. The referring provider and MMCO/HARP care manager review whether the member meets ACT level of care admission criteria. Simultaneously, SPOA reviews the referral and assesses for capacity/availability of ACT

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			slot. The MMCO/HARP notifies the referring provider and LGU/SPOA that a level of service determination for ACT admission has been made.
OASAS outpatient rehabilitation programs	No	Yes	
OASAS outpatient and opioid treatment program (OTP) services	No	Yes	
Outpatient and Residential Addiction services	No	Yes	
Residential Supports and Services	No	Yes	
Other Licensed Practitioner (OLP)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.

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			* Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Crisis Intervention	No	No	None
Community Psychiatric Supports and Treatment (CPST)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.

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Psychosocial Rehabilitation (PSR)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Family Peer Supports and Services (FPSS)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable

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			intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit. * Treatment plan in this context indicates the needed clinical or functional information the MMCO needs from the treating provider in order to evaluate medical necessity for each service in the applicable MMCO benefit package.
Youth Peer Support and Training (YPST)	No	Yes	As indicated in the SPA all treatment plans* must have authorization from DOH or its designee, in this case that designee is MMCP. Therefore, the MMCP will review the treatment plan, inclusive of the provider assessment, at least before the 4th visit to evaluate medical necessity for authorization prior to receipt of further services. Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits. The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child's treatment plan and/or Health Home plan of care. The MMCP must ensure that prior and concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication

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