Attachment A

Child Health Plus Benefits Package

No Pre-Existing Condition Limitations Permitted
No Co-payments or Deductibles
Effective April 1, 2023

General Coverage	Scope of Coverage	Level of Coverage
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the Advisory Committee on Immunization Practices recommended immunization schedule.	Includes all services related to visits. Includes immunizations which must be provided within 90 days from publication in the Morbidity and Mortality Weekly Report, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, lead screening, and reproductive health services, with direct access to such reproductive health services.
Inpatient Hospital or Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. A private room will be covered if medically warranted. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy: general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital.

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Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Inpatient Mental Health and Alcohol and Substance Use Services	Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	No limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.
Residential Rehabilitation Services for Youth (RRSY)	Services to be provided in a facility issued a Part 817 operating certificate from the Office of Addiction Services and Supports (OASAS), pursuant to Article 32 of the Mental Hygiene Law.	Includes all services provided by the RRSY, as described in OASAS Part 817. These services include, but are not limited to, clinical services, recovery support services, educational and vocational assessments and services, Medication for Addiction Treatment (MAT) and food and nutrition services. Clinical services include individual, group, and family counseling, assessment and referral services for patients and significant others (e.g., parent/guardian(s), sibling(s), partner(s), etc.), medical and psychiatric consultation, and HIV and AIDS, hepatitis C, tuberculosis, and other communicable diseases education, risk assessment, supportive counseling and referral. Services must be clinically indicated and specified in the individualized treatment/recovery plan and/or progress notes. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT	Coverage includes comprehensive and integrated combination of treatment, rehabilitation, case management, and support services primarily provided in the client's residence or other community locations by a mobile, multi-disciplinary mental health treatment team.	Services support individual recovery through an assertive, person-centered approach that assists individuals to cope with the symptoms of their mental illness or serious emotional disturbance and reacquire the skills necessary to function and remain integrated in the community. ACT Services are intended to benefit individuals with serious behavioral health challenges and a treatment history that includes psychiatric hospitalization and emergency room visits, involvement with the criminal justice system, alcohol or substance abuse, homelessness, at risk of, or history of institutional level of care or residential placement or lack of engagement in traditional outpatient services. Services must be referred by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. A full list of provider types covered under licensed practitioner of the healing arts can be found in Attachment 3.1-A of the New York Medicaid State Plan under Assertive Community Treatment in section 13.d Rehabilitative Services, or page five on the link below: https://www.health.ny.gov/regulations/state_plans/status/non-inst/approved/docs/app_2022-04-11_spa_21-15.pdf Coverage of ACT services is not covered if the child does not meet the criteria described below: (i) meet the definition of persons with serious mental illness as set forth in section 1.03 of the Mental Hygiene Law; (ii) have been referred or approved by the Single Point of Access entity for enrollment in ACT services; and (iii) are active clients of the ACT provider. No limitations. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the Office of Mental Health ACT Program Guidelines found here https://omh.ny.gov/omhweb/act/act_program_guidelines_2007_collateral.pdf for a more detailed description of services.	
Inpatient Rehabilitation	Acute care services provided by an Article 28 General Hospital	Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.

General Coverage	Scope of Coverage	Level of Coverage
Hospice Services and Expenses	Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.	Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which: - Can withstand repeated use for a protracted period of time; - Are primarily and customarily used for medical purposes; - Are generally not useful in the absence of illness or injury; and - Are usually not fitted, designed or fashioned for a particular person's use. DME intended for use by one person may be custom-made or customized.	Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME. DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to: Fitted/Customized leg brace — Not fitted/Customized cane Prosthetic arm — Wheelchair Footplate — Crutches
	Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.	Covered without limitation except that there is no coverage for cranial prosthesis (*i.e.* wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery
	Orthotic Devises are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body	No limitations on orthotic devices except that, devices prescribed solely for use during sports are not covered.

General Coverage	Scope of Coverage	Level of Coverage
Medical Supplies	Medical Supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.	Medical supplies coverage examples include, but are not limited to: • Diabetic Supplies • Enteral Formulas and Supplies • Wound dressings and disposable care accessories • Airway clearance device filters • Disposable collection and storage bag for breast milk A fiscal order for medical supplies may be refilled when the prescriber has indicated on the order the number of refills and the member has requested the refill. All refills must be appropriately referenced to the original order by the dispenser.
	Diabetic Supplies and Equipment	Insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents. As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.
	Ostomy Equipment and Supplies	Ostomy equipment and supplies used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma). As prescribed by a health care provider legally authorized to prescribe under title eight of the education law.
	NOTE: Refer to New York State Medicaid Program Procedure Code Manual for a more detailed description of covered services. https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf	
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (*i.e.* chemotherapy) will also be covered.	No limitations. These therapies must be medically necessary and under the supervision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. No procedure or services considered experimental will be reimbursed.
	Hemodialysis	Determination of the need for services and whether home-based or facility-based treatment is appropriate.
	Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies	Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home by a home health care agency, a properly trained parent or legal guardian of a child, or a properly trained child that is physically and developmentally capable of self-administering such products.

General Coverage	Scope of Coverage	Level of Coverage
Speech and Hearing Services Including Hearing Aids	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If medically necessary, more than one hearing aid will be covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or nonrestorative.
Pre-Surgical Testing	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical Opinion	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.
Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Use	Services must be provided by certified and/or licensed professionals.	No limitations. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contract must provide 40 such visits in any calendar year, if such visits are medically necessary.
Diabetic Education and Home Visits	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.

General Coverage	Scope of Coverage	Level of Coverage
Prescription and Non-Prescription Drugs	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein, or which contain modified protein.
Emergency Medical Services	For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person.	No limitations.

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Ambulance Services	Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.	Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law. Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. *Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in:* • Placing the health of the person afflicted with such condition in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. ***Transportation Between Hospitals:*** When a Child Health Plus enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient. If the admitting hospital sends an inpatient round trip to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services. ***The following ambulance transports are considered emergency transports; therefore, prior authorization is not required***: - Transport from an Emergency Room to a Psychiatric Center - Transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center. - Transportation from an Emergency Room to an Emergency Room. - Transportation from an Emergency Room to Another Facility.

General Coverage	Scope of Coverage	Level of Coverage
Air Ambulance Services	Fixed wing air ambulance services and rotary wing air ambulance services	Air ambulance transportation must meet the following criteria: • The patient has a catastrophic, life-threatening illness or condition; • The patient is at a hospital that is unable to properly manage the medical condition; • The patient needs to be transported to a uniquely qualified hospital facility and ground transport is not appropriate for the patient; • Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; or • Life-support equipment and advanced medical care is necessary during transport. ***The following fixed wing air ambulance services are reimbursable when the transport physically occurs:*** • Base Fee (lift-off/call-out); • Patient loaded mileage; • Physician (when ordered by hospital); • Respiratory therapist (when ordered by the hospital, and only when the hospital is unable to supply); or • Destination ground ambulance charge (only when the destination is out of state). ***The following helicopter (rotary wing) air ambulance services are reimbursable:*** • Lift off from base; or • Patient occupied flight mileage.
	NOTE: Refer to the New York State Medicaid Program Transportation Manual Policy Guidelines for a more detailed description of services. https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf	

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Vision Care	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: - Case history - Internal and External examination of the eye - Opthalmoscopic exam - Determination of refractive status - Binocular balance - Tonometry tests for glaucoma - Gross visual fields and color vision testing - Summary findings and recommendations for corrective lenses
	Prescribed Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
	Contact Lenses	Covered when medically necessary.
Emergency, Preventive and Routine Dental Care	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

General Coverage	Scope of Coverage	Level of Coverage
	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but not limited to: ▭ Prophylaxis: scaling and polishing the teeth at 6-month intervals. ▭ Topical fluoride treatment: when professionally administered in accordance with appropriate standards. Services must be provided by: • Physicians and nurse practitioners for members 0 through 6 years of age. • Dentists and dental hygienists (under general supervision of the dentist) in the dental office through age 19. • Fluoride varnish is reimbursable to physicians and nurse practitioners once per three (3) month intervals under CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional). • For dentists and dental hygienists, benefit is limited to gel, foam, and varnish and must be a minimum interval of three (3) months between all fluoride treatments under CDT codes D1206 (Professionally applied fluoride varnish) and/or D1208 (Topical application of fluoride excluding varnish). Fluoride treatments that are not reimbursable under the program include: • Treatment that incorporates fluoride with prophylaxis paste; • Topical application of fluoride to the prepared portion of a tooth prior to • restoration; • Fluoride rinse or "swish"; and, • Treatment for desensitization ▭ Sealants on unrestored permanent molar teeth. ▭ Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintain space for normally developing permanent teeth.
	Routine Dental Care	▭ Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt) ▭ X-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt) ▭ All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care ▭ In office conscious sedation ▭ Amalgam, composite restorations and stainless steel crowns ▭ Other restorative materials appropriate for children
	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.

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	Prosthodontics	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Fixed: Fixed bridges are not covered unless 1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
	Orthodontics for severe physically handicapping malocclusions	Prior approval for orthodontia coverage is required. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday. Procedures include but are not limited to: - Rapid Palatal Expansion (RPE) - Placement of component parts (e.g. brackets, bands) - Interceptive orthodontic treatment - Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) - Removable appliance therapy - Orthodontic retention (removal of appliances, construction and placement of retainers) With the exception of D8210 (Removable appliance therapy), D8220 (Fixed appliance therapy) and D8999 (Unspecified orthodontic procedure, by report), orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.
	NOTE: Refer to the New York State Medicaid Dental Policy and Procedure Code manual for a more detailed description of services.	

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Other Licensed Practitioner (OLP)	Services performed by a non-physician behavioral health practitioner for treatment necessary to address the prevention (to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable behavioral health disorder and reduce risk factors that can lead to the development of a behavioral health disorder), diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity. An assessment of needs may result in the recommendation of further medically necessary services, such as rehabilitative services. Services are delivered in a trauma informed, culturally and linguistically competent manner.	Includes services delivered by a Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. The clinical services provided under OLP are intended to help prevent the progression of behavioral health needs through early identification and intervention and may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed. Services are also intended to provide treatment for children/youth with an existing diagnosis for whom flexible community-based treatment is needed to correct or ameliorate conditions identified during an assessment process, such as problems in functioning or capacity for healthy relationships. Limits/Exclusions: • Group limit refers to number of participants, regardless of payor. Groups should not exceed eight. Consideration may be given to smaller limit of members if participants are younger than eight years of age. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. • Groups may include family/collaterals, as long as the contact is directly related to the child/youth's treatment plan goals, for the benefit of the child/youth. • Inpatient hospital facilities are allowed for licensed professional other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visits and may not be billed separately. • Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered. • All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free-standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Child Health Plus. • If a child requires medically necessary services that are best delivered in the school setting by a community provider, the service needs to be detailed on the treatment plan. • If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child´s Individualized Education Plan (IEP) (504 plan services are not reimbursable by Child Health Plus). • Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Outpatient and Residential Crisis Intervention (CI)	Services for children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g., collateral, provider, community member) to effectively resolve it. A child/youth in crisis may be referred by a family member or other collateral contact who has knowledge of the child/youth´s capabilities and functioning.	Includes services for engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Crisis Intervention includes five modalities: Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Residential Crisis Support and Intensive Residential Crisis. Limits/Exclusions: • The following activities are excluded: financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature. • Services may not be primarily educational, vocational, recreational, or custodial (i.e., for the purpose of assisting in the activities of daily living such as bathing, dressing, eating, and maintaining personal hygiene and safety; for maintaining the recipient´s or anyone else´s safety, and could be provided by persons without professional skills or training). Services also do not include services, supplies or procedures performed in a nonconventional setting including: resorts, spas, therapeutic programs, and camps. • The child/youth´s chart must reflect resolution of the crisis which marks the end of the episode. Warm handoff to follow up services with a developed plan should follow. Substance Use should be recognized and addressed in an integrated fashion as it may add to the risk and increase the need for engagement in care. Crisis services cannot be denied based upon substance use. Crisis Team members should be trained on screening for substance use disorders. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Community Psychiatric Supports and Treatment (CPST)	Services that are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth´s treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.	Services include the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g., provider office sites), and/or socializes. Limits/Exclusions: • The provider agency will assess the child prior to developing a treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A child with a developmental disability diagnosis without a co-occuring behavioral health condition is ineligible to receive this rehabilitative service. • Groups may be delivered under Rehabilitative Supports and Rehabilitative Psychoeducation • Group limit refers to number of participants, regardless of payor. Groups cannot exceed eight. • Consideration should be given to smaller limit of members if participants are younger than eight years of age. • Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator • Groups may include family/collaterals, with or without the child present, as long as the contact is directly related to the child/youth's goals and treatment plan • Evidence-Based Practices (EBP) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State The Institute of Medicine (IOM) defines ´evidence-based practice´ as a combination of the following three factors: 1. best research evidence, 2. best clinical experience, and 3. consistent with patient values (IOM, 2001). Implemented interventions using evidence-based techniques may ameliorate targeted symptoms and/or recover the person´s capacity to cope with or prevent symptom manifestation Services shall be reimbursed in accordance with government rate-setting methodology.

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<tr><th>General Coverage</th><th>Scope of Coverage</th><th>Level of Coverage</th></tr>
<tr><td>Children and Family Treatment and Support Services (CFTSS): Psychosocial Rehabilitation (PSR)</td><td>Services are designed for children/youth and their families/caregivers to assist with implementing interventions outlined in the treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth´s behavioral health needs.</td><td>Includes services for restoration, rehabilitation, and support for a child/youth´s functional level as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. PSR activities are focused on addressing the rehabilitative needs of the child/youth as part of a treatment plan and can be provided in coordination with treatment interventions by a licensed practitioner (e.g., OLP) or provider of CPST. Services are delivered in a trauma informed, culturally and linguistically competent manner.

Limits/Exclusions:
The provider agency will assess the child prior to developing a treatment plan for the child with the PSR worker implementing the intervention identified on the treatment plan.
A child with a developmental disability diagnosis without a co -occurring behavioral health condition is ineligible to receive this rehabilitative service.
Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth.
Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator
Groups may include family/collaterals, with the child present, as long as the contact is directly related to the child/youth’s goals and treatment plan
Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visit
Services shall be reimbursed in accordance with government rate-setting methodology.</td></tr>
</table>

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Family Peer Support Services (FPSS)	Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community.	Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community. Services are delivered in a trauma informed, culturally and linguistically competent manner. Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth´s treatment plan. Limits/Exclusions**:** • The provider agency will assess the child prior to developing the treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service. • A group cannot exceed more than 12 individuals in total. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. Services shall be reimbursed in accordance with government rate-setting methodology.

General Coverage	Scope of Coverage	Level of Coverage
Children and Family Treatment and Support Services (CFTSS): Youth Peer Support (YPS)	Youth Peer Support (YPS) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills.	Youth Peer Support activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth´s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood. Limits/Exclusions: • The provider agency will assess the child prior to developing the treatment plan for the child. • Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. • A youth with a developmental disability diagnosis without a co-occuring behavioral health condition is ineligible to receive this rehabilitative service. • Group limit refers to number of child/youth participants, regardless of payor. Groups cannot exceed eight children/youth. Consideration for group limits, or, the inclusion of an additional group clinician/facilitator, should be based on, but not limited to: the purpose/nature of the group, the clinical characteristics of the participants, age of participants, developmental level and severity of needs of the participants, inclusion of family/collaterals in group; as well as the experience and skill of the group clinician/facilitator. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the New York State Children's Behavioral Health Transition to Managed Care website for additional information on covered services and billing guidance: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/index.htm	

General Coverage	Scope of Coverage	Level of Coverage
29-I Health Facility Core Limited Health-Related Services	Services include the five Core Limited Health-Related Services listed below: 1. Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates) 2. Nursing Services 3. Treatment Planning and Discharge Planning 4. Clinical Consultation/Supervision Services 5. VFCA Child Health Plus Liaison/Administrator	The child's/youth's health/behavioral health record, treatment plan, service plan and/or plan of care must reflect that the services provided: • were medically necessary and appropriate, and • were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law Health/behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. These standards include: • State-mandated licensure requirements any other State-mandated certification and programmatic requirements that impact: o the types of providers that can deliver the services; o the specific nature of the services; and o the programmatic framework within which the services can be delivered, including supervision requirements. Services shall be reimbursed in accordance with government rate-setting methodology.
	NOTE: Refer to the New York Medicaid Program 29-I Health Facility Billing Guidance for a more detailed description of covered services and billing guidance https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm	
Diagnosis and Treatment of an Autism Spectrum Disorder	Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders	Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • Behavioral health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and • Pharmacy care. Applied behavioral analysis shall be covered. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.

The following services will NOT be covered:

- Experimental medical or surgical procedures.
- Experimental drugs.
- Drugs which can be bought without prescription, except as defined.
- Prescription drugs used for purposes of treating erectile dysfunction.
- Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
- Private duty nursing.
- Home health care, except as defined.
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
- Services in a skilled nursing facility.
- Cosmetic, plastic, or reconstructive surgery, except as defined.
- In vitro fertilization, artificial insemination or other means of conception and infertility services.
- Services covered by another payment source.
- Personal or comfort items.
- Services which are not medically necessary.