



**Office of Alcoholism and
Substance Abuse Services**

Ambulatory Patient Groups (APG) Policy and Medicaid Billing Guidance

**OASAS Certified
Outpatient Chemical Dependence Programs**

www.oasas.ny.gov

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Section One Introduction

The Ambulatory Patient Group (APG) billing process was implemented in July 2011 as a step in New York State's overall effort to reform Medicaid reimbursement. In October 2015 another step of the process was begun with the implementation of Medicaid Managed Care in New York City with the Rest of the State (ROS) implementation being slated for July 2016. As part of the transition to Medicaid Managed Care, the APG Rates will be used for the first two years after the transition date. During the transition providers in some instances will continue to bill on a fee for service basis with the APG Methodology.

Medicaid Managed Care Plans must contract with an OASAS Certified Provider having five or more of the Plan's enrollees in any combination of Clinic, Outpatient Rehabilitation, or Opioid Treatment Programs (OTP). The Plan must contract with the provider for all of the provider's program types. Plans must also contract with all OASAS-certified Opioid Treatment Programs in their service area, regardless on the number of Plan enrollees serve by that OTP.

Each Plan has already received a list of providers that meet this contracting requirement. Any OASAS provider that believes it meets the threshold requirement with a particular Plan, but who has not yet been contacted by that Plan should contact OASAS at PICM@oasas.ny.gov

Section Two: Purpose

With both Medicaid Fee for Service and Medicaid Managed Care utilizing at least in some part the APG Methodology this manual is meant to provide the most up to date information for both types of billing and to provide clinical guidance in the provision of these services.

This manual will provide rate codes, procedure codes and service description codes for both fee for service and managed care billing in Outpatient SUD, Opioid Treatment Programs and Integrated Services settings. Incorporating all in one manual will assist providers as they go through this transitional process.

Section Three Elements

APG Service Categories

Screening
Brief Intervention
Assessment
Individual Counseling
Group Counseling
Brief Treatment
Family/Collateral Visit

Peer Support
Complex Care Coordination
Medication Administration/Observation
Medication Management
Addiction Medication Induction
Intensive Outpatient Services
Outpatient Rehabilitation

APG Definitions

Clinical Staff: Staff, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide services directly to individuals. Clinical staff includes medical staff.

Diagnosis: Admitted individuals must have a diagnosis of substance use disorder as given in the most recent version of the ICD or DSM.

Episode of Care: For Fee for Service Outpatient Clinics, an episode is the period of time between beginning with first face-to-face service that leads to admission (to a chemical dependence outpatient treatment program) within 60 days and concluding 30 days following the discharge date. For Opiate Treatment Programs, an episode is the period beginning with admission of an individual to the program and concluding every 12 months thereafter.

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR 3.0 is **required** within New York State for authorization, utilization management, and concurrent review decisions for all Medicaid Managed Care.

Medical Staff: Physicians, nurse practitioners, registered physician's assistants, and registered nurses, licensed and/or certified by the State Education Department practicing within the scope of, and in accordance with, the terms and conditions of such licenses and certifications.

National Provider Identifier (NPI): is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Prescribing Professional: Is any medical professional appropriately licensed under New York State law and registered under federal law to prescribe approved medications.

Service Documentation: medical records that include a copy of the treatment plan, the name of the beneficiary, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary, are not eligible for Medicaid reimbursement.

Two service per day rule: Generally speaking providers can bill for only two different services per visit date, e.g. a group and an individual. The following services are exempt from the two service per day rule: Medication Administration, Medicaid Management, Addiction Medication Induction, Complex Care Coordination,

Visit: Means one or more services provided to an individual and/or collateral person on a single given day.

APG Rate Codes:

Outpatient Clinic/Rehab

Type of Program	Rate Code	Base Rate Downstate	Base Rate Upstate
Freestanding SUD Outpatient Clinic	1540	\$172.69	\$147.59
Freestanding SUD Outpatient Rehab	1573	\$172.69	\$147.59
Hospital Based SUD Outpatient Clinic	1528	\$183.53	\$146.57
Hospital Based SUD Rehab Clinic	1561	\$183.53	\$140.52

Physical Health Services in Outpatient Clinic/Rehab

Type of Program	Rate Code	Base Rate Downstate	Base Rate Upstate
Freestanding SUD Outpatient Clinic	1468	\$172.69	\$147.59
Freestanding SUD Outpatient Rehab	1570	\$172.69	\$147.59
Hospital Based SUD Outpatient Clinic	1552	\$183.53	\$146.57
Hospital Based SUD Rehab Clinic	1558	\$183.53	\$140.52

Opioid Treatment Program (OTP)

Type of Program	Rate Code	Base Rate Downstate	Base Rate Upstate
Freestanding OTP	1564	\$159.17	\$136.04
Hospital Based OTP	1567	\$183.53	\$157.14

Physical Health Services in Opioid Treatment Programs (OTP)

Type of Program	Rate Code	Base Rate Downstate	Base Rate Upstate
Freestanding OTP	1471	\$159.17	\$136.04
Hospital Based OTP	1555	\$183.53	\$157.14

Integrated Outpatient Services

Type of Program	Rate Code	Base Rate Downstate	Base Rate Upstate
Freestanding Article 32 Clinic Integrated Services	1486	\$172.69	\$147.59
OASAS Freestanding MMTP	1130	\$159.17	\$136.04
OASAS Hospital Article 32 Clinic Integrated Services	1132	\$183.53	\$146.57
OASAS Hospital MMTP Integrated Services	1134	\$183.53	\$157.14

APG Procedure Codes and Limitations

The following table is a brief summary of the APG procedure codes and service limits. A more comprehensive description of the service categories can be found in [Section 4 Service Categories and Guidance](#).

The service definitions and associated CPT or HCPCS codes listed in this manual are for the purposes of billing the New York State Medicaid program. It is recognized that in some instances the OASAS service definition and applicable CPT or HCPCS codes may vary from the service definition listed in the CPT or HCPCS manuals; and/or, be different from codes that are used with commercial or Medicare billing. Programs should use the codes as listed in this manual for billing the New York State Medicaid program, and then use Medicare or commercial coding as indicated by the relevant billing / coding guidelines.

Medicaid APG Service Category	Procedure Code(s)	Procedure Description (minimum time requirements)	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Screening	H0049	SUD Screening using approved assessment tool (15 min)	Service pre-admission, one per episode of care
Brief Intervention	H0050	SUD intervention (15 min)	3 services per episode of care, 1 service per visit date
Assessment Brief*	T1023	Pre-admission assessment (15 min)	1 assessment visit per day, up to three visits prior to admission, (applies to MMC)
Assessment* Normative	H0001	Pre-admission assessment (30 min.)	1 assessment visit per day, up to three visits prior to admission (applies to MMC)
Assessment* Extended	H0002 or 90791	Pre-admission assessment (75 min)	1 assessment visit per day, up to three visits prior to admission (applies to MMC)
Individual Therapy – Brief*	G0396 or 90832	SUD counseling session (25 min)	No more than one individual counseling service per day
Psychiatric Assessment Brief	99201- 99205 New 99211- 99215 Existing	Psychiatric Assessment w/counseling (30 min)	No more than one service per day
Individual Therapy – Normative*	G0397 90834	SUD Interview (45 min)	No more than one individual counseling service per day
Psychiatric Assessment	99201- 99205 New 99211- 99215 Existing	Psychiatric Assessment with counseling (45-50 min)	No more than one service per day
Brief Treatment	H0004	Brief Treatment visit (15 min)	No more than brief treatment service per day, post admission, on-site
Family/Collateral Therapy	T1006/90846	Family/Couple Counseling (30 min)	Pre and post admission service, no more than 5 collateral visits per episode of care
Group Therapy*	H0005 90853	SUD Group counseling services (60min)	No more than one of the same group services per visit date
Multi-Family Group	90849	Multiple family group (adolescents)(60 min)	Can be billed for one family member per individual in treatment

Medicaid APG Service Category	Procedure Code(s)	Procedure Description (minimum time requirements)	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Medication Administration & Observation	H0033	Oral Medication administration, direct observation (no time minimum)	No more than one service per day, except when a medication injectable is ordered, in this case two services per day. Exempt from two service per day rule.
Medication Administration & Observation (1 st visit of week)	H0020 Use KP modifier	Methadone Administration first visit for week (no time minimum)	No more than one service per day, except when a non-injectable service is also required, in this case two services per day. Exempt from two service per day rule.
Medication Administration & Observation (additional visits during week)	H0020	Methadone Administration additional visits during the week (no time minimum)	No more than one Medication Management A&O service per day, except when a non-injectable service is also required, in this case two services per day. Exempt from two service per day rule.
Medication Management & Monitoring Routine	99201- 99205 New 99211- 99215 Existing	Visit for drug monitoring (10 min)	No more than one Medication Management Routine service per day. Exempt from two service per day rule. Must be provided by a Prescribing Professional.
Medication Management & Monitoring Complex	99201- 99205 New 99211- 99215 Existing	Comprehensive medication review for a new or complex individual (15 min)	No more than one Medication Management Complex service per day. Exempt from two service per day rule. Must be provided by a Prescribing Professional.
Addiction Medication Induction/Withdrawal Management	H0014	Induction to new medication requiring a period of individual observations (30 min)	No more than one Addiction Medication Induction/Withdrawal service per day. Exempt from two service per day rule. Must be provided by a Prescribing Professional.
Complex Care Coordination	90882	Environmental manipulation (45 min)	Must occur within 5 working days of another clinical service. Exempt from the two billable services per day rule. No more than 3 complex care coordination, unless there is written documentation of clinical need.

Medicaid APG Service Category	Procedure Code(s)	Procedure Description (minimum time requirements)	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Peer Advocate Services	H0038	Self Help/Peer Services (15 min)	No more than 4 units of Peer Advocate Services per day. Must be provided by a credentialed Peer Advocate as defined in the Part 822 regulations. Exempt from the two billable services per day rule.
Intensive Outpatient Services	S9480	3 hours on any given day, 9 hours of service each week.	Time limited, should not exceed 6 weeks without clinical justification. IOS but may not bill other service categories while an individual is in the IOS service. The only exception to this is if an individual attends IOS services for less than 3 hours on a given day, in which case, the program may bill for the discrete services delivered (<i>applies to MMC</i>)
Out Rehabilitation Half Day	H2001	2-4 hour duration	Must contain an individual counseling session of at least 25 minutes, or a 60 minute group service. May not bill for other service categories, e.g. individual, group, or IOS. Can bill for assessment services, medication administration/management, complex care, peer, and collateral services. Physical Health examinations are not included in OPR and must be billed separately using medical visit rate code.
Outpatient Rehabilitation Full Day	H2036	4+ hour duration	Must contain an individual counseling session of at least 25 minutes, or a 60 minute group service. May not bill for other service categories, e.g. individual, group, or IOS. Can bill for assessment services, medication administration/management, complex care, peer, and collateral services. Physical Health examinations are not included in OPR and must be billed separately using medical visit rate code.

Medicaid APG Service Category	Procedure Code(s)	Procedure Description (minimum time requirements)	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Smoking Cessation	99406	Behavior Change Smoking 3-10 min	Individual face to face intervention (not group). No more than three smoking cessation services per episode of care. Not third visit exempt.
Smoking Cessation	99407	Behavior Change Smoking 11+ min	Individual face to face intervention (not group). No more than three smoking cessation services per episode of care. Not third visit exempt.
Physical Health Specify Substance Use Disorder	99201- 99205 New 99211- 99215 Existing	Evaluation & Management no counseling	NA
Physical Health Specify Substance Use Disorder	99382-99387 New 99392-99397 Existing	Physical Exam New/Established	

***Physician Fees for service:** If a Physician provides a service typically provided by clinical staff, limited to assessment, individual or group counseling, the following options are available:

- Physician can bill a separate Physician Fee claim to increase the payment of the service to account for the additional cost for the service provider.

OR

- Provider can add the “AG” modifier when a physician provides a service typically provided by clinical staff.

Section 4 Service Categories and Guidance:

APG Service Category: Screening / Brief Intervention

Clinical Description

Screening is a face-to-face pre-admission meeting with a clinical staff member for the purpose of identifying alcohol or other substance use problems through the use of one of the following screening tools: **AUDIT, CAGE, CAGEAID, CRAFFT, Simple Screen, GAIN Quick, ASSIST, DAST, RIASI; MAST or other OASAS approved screening tool.** The screening tool can be completed through a computer or written format or conducted as a part of an interview. The results must be shared by the clinical staff in an individual face to face session. The focus of the screening session is on the results of the screening and feedback about the likelihood of a substance misuse problem.

Screening is not intended to be provided to all individuals or where it is known that the individual is appropriate for admission (e.g. a court order); has an assessment from another program; or presents with circumstances that indicate that a substance use disorder (SUD) problem may be present. Additionally, screening may not be provided in a group setting.

Brief Intervention is a face-to-face pre-admission meeting with the clinical staff **when screening results indicate at risk behavior.** The intervention educates them about their substance use, alerts them to possible consequences, and motivates them to change their behavior. A brief intervention may follow a screening session or a program may accept referrals from a primary care provider when the person has screened positive for a brief intervention or treatment. This category may also be used for individuals who have been screened for the Drinking Driver program and have a pattern of risky use, but do not meet the program's admission criteria.

Delivering Staff

Staff: Clinical and/or medical staff as defined in Part 800 (working within their scope of practice). Licensed providers reimbursed by Medicaid must complete an OASAS 4 hour approved training to bill Medicaid for SBIRT services. Unlicensed practitioners must complete at least 12-hours of training facilitated by an OASAS approved SBIRT training provider **prior** to offering SBIRT services. To learn more about SBIRT training requirements visit:

[Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#) on the OASAS Website.

APG CPT / HCPCS Procedure Code

Screening: H0049

Brief Intervention: H0050

Time Requirements

Screening or Brief: 15 minute minimum

Category Specific Medicaid Billing Limitations: No more than one screening per individual per episode of care. No more than 3 brief intervention services per episode of care; 1 service per visit date.

APG Service Category: Admission Assessment

Clinical Description

A face-to-face pre-admission service, between a prospective individual and a clinical staff member for the purpose of determining a preliminary diagnosis and initial plan of treatment including the type of services and level of care determination. Medical Staff may also meet with the individual during an assessment visit to review their physical health information.

Along with gathering information, the assessment process is an opportunity to engage the individual in the treatment process. Information gathering is important for making a preliminary diagnosis and level of care determination, but must be balanced with a focus on the individual's immediate needs. Programs should be clear in their philosophy of treatment so that the most important information is gathered first. Ancillary information can be gathered as needed over time.

For the level of care determination, OASAS Certified Providers whose SUD services are overseen by Medicaid Managed Care (MMC) MUST use the OASAS 3.0 Tool. Since all Part 822 Providers will be overseen by MMC by July 1, 2016, ALL OASAS Certified Providers are being encouraged to use the LOCADTR 3.0 as soon as possible.

Delivering Staff

Clinical staff (including medical staff) as defined in Part 800 (working within their scope of practice). The extended session may be comprised of 75 minutes of continuous time with multiple staff.

APG CPT / HCPCS Procedure Code

Assessment Brief: T1023

Assessment Normative: H0001

Assessment Extended: H0002 or 90791

Time Requirements

Assessment Brief: 15 minutes

Assessment Normative: 30 minutes

Assessment Extended: 75 minutes

Category Specific Medicaid Billing Limitations

Programs may only bill for one assessment visit per day. Programs may bill for up to three assessment visits prior to admission and per episode of care. Only one of those visits can be billed as an extended assessment visit. In no case should a program bill for more than one extended assessment visit within an episode of care.

Physician Fees for services: If a Physician provides a service typically provided by clinical staff, limited to assessment, individual or group counseling, the following options are available:

- Physician can bill a separate Physician Fee claim to increase the payment of the service to account for the additional cost for the service provider.

OR

- Provider can add the "AG" modifier when a physician provides a service typically provided by clinical staff.



APG Service Category: Individual Counseling

Clinical Description

A face-to-face visit between a clinical staff member and an admitted individual focused on their needs consistent with the treatment / recovery plan, its development, or emergent issues.

The counseling should be provided by a clinical staff member and based on accepted counseling theory and practice. The clinician is responsible to learn about evidence-based practices shown to have efficacy with substance use disorders and should be provided adequate supervision to competently provide this service. Each visit should be person centered and address material relevant to the treatment / recovery plan.

Delivering Staff

Clinical staff (including medical staff) as defined in Part 800 (working within their scope of practice). When a physician provides a counseling service he/she can bill a separate Physician Fee claim to increase the payment for the service to account for the additional cost for the service provider

APG CPT /HCPCS Billing Code

Individual Counseling Brief: G0396 or 90832
Individual Counseling Normative: G0397 or 90834

Time Requirements

Individual Counseling Brief: 25 minute minimum
Individual Counseling Normative: 45 minute minimum

Category Specific Medicaid Billing Limitations

Programs may not bill for more than one individual counseling service per day.

Physician Fees for services: If a Physician provides a service typically provided by clinical staff, limited to assessment, individual or group counseling, the following options are available:

- Physician can bill a separate Physician Fee claim to increase the payment of the service to account for the additional cost for the service provider.

OR

- Provider can add the “AG” modifier when a physician provides a service typically provided by clinical staff.

APG Service Category: Brief Treatment

Clinical Description

Brief Treatment is a post admission face-to-face meeting with a clinical staff and an active individual in substance use disorder treatment. The service must **include a target behavior** (for example, continued use of cocaine, attendance at group sessions, or identification of recovery supports) and identify the **evidence-based or clinical practice** that the intervention is based upon. The targeted issue and evidenced based treatment must be delivered according to the treatment / recovery plan and documented in the case record.

Delivering Staff: Clinical and/or medical staff as defined in Part 800 (working within their scope of practice)

APG CPT / HCPCS Billing Code Brief Treatment

Brief Treatment: H0004

Time Requirements

Time: 15-minute minimum.

Category Specific Medicaid Billing Limitations

One Brief Treatment service Per Day. Service is a post admission service. A brief treatment may be billed on the same day as other categories, including, but not limited to individual or group counseling services.

APG Service Category: Group Counseling

Clinical Description

A face-to-face counseling session in which one or more clinical staff treat multiple individuals at the same time, focusing on the needs of the individuals served and consistent with each individual's treatment / recovery plans, their development or emergent issues.

The purpose of group counseling is to attain knowledge, gain skills and change attitudes about substances to achieve and maintain recovery from substance use disorder. Individuals also gain direct support, learn to communicate with other members, and gain a sense of belonging to the group through the common goals of recovery.

The counselor focuses on both process (how the group is communicating and inter-relating) and content (what is being discussed/addressed) to fully realize the therapeutic value of group counseling. In order for each member to benefit from the process and content of group treatment the group size cannot exceed 15.

Adolescent Family Group:

Family members and significant others can participate in multi-family group as collaterals of a primary individual in treatment if that individual is an adolescent (between the ages of 10-21) and the group is a multi-family group for the purpose of providing support, guidance and education to families in support of each adolescents recovery from chemical dependency.

This type of group utilizes evidence-based multi-family groups, for example, Celebrating Families or Strengthening Families, if these services are provided per the treatment / recovery plan. If one or both parents are the primary individuals in treatment and the children are in treatment to address issues related to living with a parent with a Substance Use Disorder, the children should be opened as significant others with their own treatment / recovery plan.

If the child is the individual in treatment and the family group is to support the recovery of the child or children, the parent(s) may be seen as collaterals to the primary individual in treatment and the group visit may be billed to the child's Medicaid, or, the parents may be opened as significant other seeking treatment with their own treatment / recovery plan. This is a clinical decision that will be made by the multi-disciplinary team and will be documented in the treatment / recovery plan(s).

Delivering Staff

Clinical staff (including medical staff) as defined in Part 822 (working within their scope of practice)

APG CPT /HCPCS Billing Code

Group Counseling: H0005 or 90853

Multi-Family Group: 90849



Time Requirements

Time: Minimum of 60 minutes

Category Specific Medicaid Billing Limitations

Programs may not bill for more than one of the same group service per visit date e.g. two 90849 or two H0005 may not be billed. However, programs may submit for the same visit date a claim with one 90849 and one H0005. Group may contain no more than 15 individuals.

Physician Fees for services: If a Physician provides a service typically provided by clinical staff, limited to assessment, individual or group counseling, the following options are available:

- Physician can bill a separate Physician Fee claim to increase the payment of the service to account for the additional cost for the service provider.

OR

- Provider can add the “AG” modifier when a physician provides a service typically provided by clinical staff.

APG Service Category: Medication Administration and Observation

Clinical Description

Administration or dispensing of a medicine via oral or non-oral route by a medical staff person appropriate to scope of practice, to be delivered in conjunction with observation of the individual prior to the administration and after as appropriate to the medication and individual condition.

There must be an order from a prescribing professional who meets state and federal requirements for the medications dispensed to an individual. Medical staff should determine any contraindications for the administration and observe individuals following administration as clinically indicated by the individual history, novelty of the medication, dosage changes and medical conditions that may affect the way an individual responds to the medication.

Examples include the dispensing of methadone or the injection of Vivitrol by medical staff person.

Self-administration of a medication does not qualify for reimbursement under this APG category.

Delivering Staff

Medical staff as defined in the Part 800 regulations

APG CPT /HCPCS Billing Code Medication Administration and Observation

Oral medication, except methadone: H0033

Buprenorphine when given in an OTP requires a separate claim using dosage based rate codes.

- Rate code 1564.
- H0033 with KP modifier for first med service of the week
- 14 Units of J0592 or 2 (8 mg units) per day times the number of days
- Add NDC code and acquisition cost on medication line

Methadone Administration:

- H0020 + KP modifier for first visit of the week
- H0020 for additional visits during the week
- J1230 Methadone Injection

Vivitrol Intramuscular Injections: 96372, J code J2315

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication administration service per day for single or multiple oral medications. When an injectable medication is ordered, a second medication administration service may be billed for this additional administration. Medication administration is exempt from the two service per day rule.

APG Service Category: Medication Management Routine

Clinical Description

Face-to-face visit with a prescribing professional for the purpose of evaluation, monitoring, and management of prescribed medication.

Routine medication management involves the individual who has already been started on a medication and adjustment or monitoring of the medication needs to occur. A brief history is taken to determine:

- Is the individual taking the medication as directed
- Is the individual doing well on the medication
- Have there been any adverse effects from the medication
- Has the individual been prescribed other medications from a different practitioner
- Has the individual's medical/addiction history changed

Delivering Staff

Prescribing professional as defined in Part 822 (working within their scope of practice)

APG CPT /HCPCS Billing Code

99201-99205: NEW

99211-99215: ESTABLISHED

Reimbursement will pivot off of the diagnosis code shown on the claim and the complexity of the service. The current descriptions for each individual code can be found in the most recent version of the CPT Coding Guide or on the [Center for Medicare & Medicaid Services](#) website.

Time Requirements

Time – Minimum of 10 minutes

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Medication management routine as a service is exempt from the cumulative two services per day claim rule.

APG Service Category Medication Management Complex

Clinical Description

Face-to-Face non-routine service for the purpose of comprehensive medication review for a new or complex individual in treatment. Medication Management Complex involves an individual with one or more long term conditions who takes multiple medications. The service requires in-depth management of psychopharmacologic agents that have potentially serious side effects.

Delivering Staff

Prescribing professional as defined in Part 800 (working within their scope of practice)

APG CPT /HCPCS Billing Code

99201-99205: NEW

99211-99215: ESTABLISHED

Reimbursement will pivot off of the diagnosis code shown on the claim and the complexity of the service. The current descriptions for each individual code can be found in the most recent version of the CPT Coding Guide or on the [Center for Medicare & Medicaid Services](#) website.

Time Requirements:

Minimum of 15 minutes

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Medication Management Complex as a service is exempt from the cumulative two service per day claim rule.

Pharmacologic Management is, by definition, included in an E&M service and, therefore, procedure code 90862 may not be billed in addition to any E&M code (e.g., 99213) on the claim.

If pharmacologic management and psychotherapy with an E&M (i.e., 90805, 90807, 90809) are both provided on the same date of service (DOS), the pharmacological management is included in the E&M services and 90862 may not be billed separately for the same DOS.

APG Service Category Addiction Medication Induction/Ancillary Withdrawal

Clinical Description

Addiction Medication Induction: Complex medication management involves the new individual in treatment who is being considered for induction on an addiction medication, or the follow up of an individual to be induced on an addiction medication after the initial evaluation. The service may be used for starting suboxone; methadone; and, other addiction medicines where this level of observation is clinically indicated.

The visit should include:

- a comprehensive medical/psych and addiction history
- limited assessment of physical/health problems tailored to the individual
- a decision as to what the next course of action will be as far as using an addiction medication – possible alternatives should be discussed.
- linkage to behavioral treatment, as clinically appropriate for the individual is mandatory
- discussion with the individual as to the use of the medication, expected effects, possible adverse effects
- possible institution of a contract between practitioner and the individual in treatment
- possible ordering of laboratory testing to determine the presence of adverse medical issues that the medication could impact negatively.
- induction/follow up to the initial visit
- expanded problem focused/brief review of history including events that occurred between the initial visit and the present visit.
- Expanded problem focused physical exam if indicated
- For buprenorphine, Clinical Opiate Withdrawal Scale (COWS) would be used to determine the presence of withdrawal, which will include vital signs.
- Review of medication with the individual
- Administration or self-administration of medication direct observation of the individual (time required will vary with the specific medication)
- Reassess the individual and plan for return to the clinic for further refinement of the medication dose
- Counselor and/or practitioner engagement of the clinic – especially in the behavioral component of the treatment

Ancillary Withdrawal Services: Medication management for symptom relief of mild to moderate or persistent withdrawal as differentiated from acute detoxification services. Within the outpatient setting, the service may provide symptom relief and/or addiction medications for alcohol or opiate withdrawal, or a slow taper of sedatives. Programs are required to use withdrawal screening tools, including but not limited to, Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS)

For programs that wish to provide ancillary withdrawal services in a Part 822 Outpatient setting please see the related requirements on the [OASAS Addiction Medication Page](#).

Delivering Staff

Prescribing professional must direct the induction of addiction medication, medical staff working within the scope of their practice, may provide observation and monitoring of throughout the induction.

APG CPT /HCPCS Billing Code

H0014 Alcohol and/or drug services Ambulatory Detoxification

Time Requirements:

Minimum of 30 minutes (may be combined practitioner time on same visit date)

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Addiction Medication Induction as a service is exempt from the cumulative two service per day claim rule.

APG Service Category: Collateral Visit

Clinical Description

An onsite (at the OASAS certified location) face- to-face visit delivered to a non-admitted collateral person, without the individual in treatment present, for the purpose of providing an intervention in the service of the primary individual's progress in treatment. Collateral persons are members of the individual's family or household, or significant others who regularly interact with the individual and are directly affected by or have the capability to affect his or her chemical dependence, and whose role in supporting the individual's recovery is reflected in the treatment / recovery plan, its development or identified as a collateral support as the result of emergent issues. The purpose for meeting with a collateral should be clearly identified in the treatment / recovery plan and/or progress note

Multi-family Group Treatment

Collateral visits are family visits, however, adolescents (age 10-21) treatment collaterals may be billed for group services when the group service is delivered as a time-limited multi-family group for the purpose of supporting the adolescents' recovery. See Group Counseling Service for further information.

Delivering Staff

Clinical staff (including medical staff) as defined in Part 822 (working within their scope of practice)

APG CPT /HCPCS Billing Code:

90846/T1006 Family / Couple Counseling - The program will bill this code to the admitted individual's claim and Medicaid client identification number.

Time Requirements

Time: 30-minute minimum

Category Specific Medicaid Limits

Collateral visits may take place prior to and after admission. No more than five collateral visits may be billed to Medicaid per individual episode of care. The program will bill the service using the admitted primary individual's or the prospective individual's Medicaid Client identification number.

APG Service Category: Complex Care Coordination

Clinical Description

Complex Care Coordination is an ancillary service, provided to a current individual in treatment when a critical event occurs or the individual's condition requires significant coordination with other service providers. Documentation must note the critical event or condition and the need for coordination and summarize the purpose of the coordination. Complex Care is distinguished from routine case coordination activities and must meet each of the following:

- The care coordination must occur within 5 working days of another treatment service (i.e. individual or group session)
- There must be a documented critical event or condition requiring coordination
- Coordination must require a minimum 45 minutes of clinician time, although this time does not have to be contiguous; it must be on the same visit date.

Complex care coordination is used to bring multiple service delivery providers together with or without the individual or by the clinical staff member to multiple service agencies. The purpose of these contacts is to develop or coordinate a plan to resolve the crisis or improve functioning. The complex care coordination does not need to occur face to face with the service provider.

Delivering Staff

Clinical staff as defined in the Part 800 working within the scope of their practice.

APG CPT/HCPCS Billing Code

90882

Time Requirements

Time: A minimum of 45 minutes (combined)

Category Specific Medicaid Billing Limits

Complex care coordination is exempt from the two billable services per day maximum rule, however, a program may not bill for more than three complex care services per individual within an episode of care, unless the clinical staff provides written clinical justification for additional complex care coordination services.

Each occurrence of complex care coordination that is provided, will need to bill three (3) units on their claim to receive proper reimbursement. If any number of units other than three (3) is entered on the claim, the provider will be subject to audit and disallowance.

APG Service Category: Peer Support Services

Clinical Description

Peer support services are face-to-face services for the purpose of connecting individuals in treatment to community based recovery supports in support of the treatment/recovery plan. The service is can be provided to individuals currently enrolled in the outpatient clinic or those receiving continuing care services. Peer advocates should be supervised by appropriate clinical staff member, however, they do not serve in a clinical role. Peer services are specifically designed to support the individual in recovery from the unique perspective of someone who shares similar experiences.

Peer support services must be provided by a peer advocate as defined in Part 800, and per Federal Medicaid reimbursement rules. Peer service providers / advocates must hold a national credential as a peer advocate or other credential as a peer advocate as recognized by OASAS. Programs may contact the Recovery Bureau at OASAS for clarification on other recognized credentials.

Delivering Staff

Peer advocate as defined in Part 800

APG CPT /HCPCS Billing Code

H0038 – Peer Services

Time Requirements

Time: minimum of 15 minutes

Category Specific Medicaid Billing Limits

Peer Support service is reimbursable only when delivered by an individual who holds a certification as a peer advocate from an OASAS recognized certifying authority.

Peer counseling H0038 is a procedure based weight that recognizes units; to bill the minimum of 30 minutes, the program would code two units. The code has a maximum of four units per visit date, which means that they will not get paid for more than an hour. Exempt from the two billable services a day rule.

APG Service Category: Intensive Outpatient Service (IOS)

Clinical Description

“Intensive outpatient services” (IOS) is an outpatient treatment service provided by a team of clinical staff for individuals who require a time-limited, multi-faceted array of services, structure, and support to initiate a period of recovery from their substance use disorder. Programs that offer intensive outpatient treatment schedule a minimum of 9 service hours per week delivered during the day, evening or weekends. The treatment service must make available individual and group counseling, family counseling when appropriate, relapse prevention and coping skills training, motivational enhancement, and drug refusal skills training.

These services may be provided in 3 hour blocks of time where individuals are seen in group, family and/or individual sessions. Intensive outpatient services may be provided in as little as a week or over a period of time, not exceeding 6 weeks without clinical justification.

Programs can bill for an individual session on a day when IOS has not been billed, however, this practice should be an exception and not routine.

Delivering Staff

Clinical staff (including medical staff) as defined in Part 800 working within their scope of practice.

APG CPT /HCPCS Billing Code

S9480 – Intensive Outpatient psychiatric services, per diem.

Time Requirements

The individual is scheduled to attend at least 9 hours of treatment sessions per week provided in 3 hours of daily service

Category Specific Medicaid Billing Limits

Programs may not bill for more than 6 weeks of intensive outpatient service without a clinical rationale included in the individual’s record in either a progress note or in the treatment / recovery plan. IOS is billed on a daily basis regardless of the total weekly attendance of any individual in treatment.

Programs can only bill for medication administration, medication management, complex care, peer services and for collateral contacts in addition to the daily IOS service. The only exception to this is if the individual attends IOS services for less than 3 hours on a given day, in which case, the program may bill for the discrete services delivered.

Outpatient Rehabilitation Services

Clinical Description

Services provided by a CD-OP which has been certified to provide outpatient rehabilitation services. Such services are designed to assist individuals with more chronic conditions emphasizing development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. This structured treatment is expected to improve functioning so that individuals may attain and sustain recovery with the possibility of advancing to a less intensive treatment setting.

Delivering Staff: Clinical staff including activities therapists and Medical Staff as defined in Part 800 working within their scope of practice.

APG CPT /HCPCS Billing Code

H2001: Outpatient Rehabilitation Half day, 2-4 hour duration

H2036: Outpatient Rehabilitation Full day, 4+ hour duration.

Time Requirements

Half Day 2-4 hours Full Day 4 + hours

Category Specific Medicaid Billing Limits

Outpatient Rehabilitation services can only be provided by programs who are specifically certified by OASAS to do so.

Minimum duration:

Half day, 2-4 hours, must include either:

- an individual counseling service of at least 25 minutes; or
- a 60 minute group counseling service.

With the exception of assessment services, medication administration and management, complex care, peer services, and collateral service, Programs may not bill for other service categories e.g. individual; group, or IOS while the individual is in the day rehab program.

The program may choose to utilize other services to meet the OPR time frame, and then deliver the exempt service outside of the 2-4 or 4+ hour time frames. In this case the program's claim would include the appropriate Outpatient rehab four digit rate code in the header; and at the line level both the OPR HCPCS code AND the CPT/HCPCS code for the delivered exempt service.

The Program may also deliver / utilize the exempt services towards accumulating the minimum OPR time frames; and, as such submit a single claim for the 2-4 or 4+ hour OPR service. The claim would include the appropriate Outpatient rehab four digit rate code in the header; and, at the line level the single appropriate OPR HCPCS code (H2001 2-4 hours; or, H2036 4+ hours).

Physical Health Services

Clinical Description

Physical Health services encompass a wide range of assessment and treatment procedures performed by medical staff for the purpose of identifying and treating physical problems associated with substance use disorder. Physical Health services are services provided outside of regulatory requirements, e.g. medical assessment, medication assisted treatment, physical examinations.

Delivering Staff:

Medical staff as required by the specific physical health service, working within the scope of their practice.

APG CPT /HCPCS Billing Code Physical Health

In billing for these services specify the specific substance use disorder as the weights are different depending on the substance.

99201-99205: New, Evaluation & Management, no counseling

99211-99215: Existing, Evaluation & Management, no counseling

99382-99387: New, Physical Exam

99392-99397: Existing Physical Exam

Please note that the rate codes for Physical Health claims are different than regular clinic/rehab or OTP claims. See [APG Rate Code chart](#) on page 5-6.

Time Requirements

Per individual Evaluation and Management (E/M) code description

Category Specific Medicaid Billing Limits

Programs would need to receive certification from DOH as a general health clinic, if more than 5% of their total visits are billed under physical health services.

Programs are limited to providing 5% (this percentage may be higher for integrated licensure models under DSRIP) of total visits for physical health visits.

Programs can bill for physical health services provided in chemical dependency settings for both acute and chronic conditions when those services are related to the treatment of chemical dependency. The goal of the clinic should be to have every individual in treatment connected to a primary care provider.

Programs are advised to consult the most current CPT coding manual for further guidance on which set of CPT codes to use when delivering a physical health service.

Ancillary Services

Laboratory services under OASAS Physical Health

When laboratory and radiology services are provided or ordered as a result of a physical health visit billed under the physical health medical visit rate codes, OASAS outpatient clinics are subject to the Article 28 hospital and free-standing ancillary policies briefly explained below.

Hospital Ancillary Policy: All ancillary services (laboratory and radiology procedures) ordered as a result of a hospital based physical health medical visit **MUST BE INCLUDED** on the APG claim for the physical health medical visit during which the ancillary service was ordered, even if the ancillary service was provided on a different date of service.

If the ancillary service is provided by a different institution (outside laboratory or radiology provider), the hospital clinic that submitted the claim for the physical health medical visit service is responsible for notifying the ancillary provider not to bill Medicaid directly for the ancillary service in addition to paying the ancillary provider for the ancillary services rendered.

Freestanding Ancillary Policy

All ancillary services (laboratory and radiology procedures) ordered as a result of a free-standing program's physical health medical visit **MUST BE INCLUDED** on the APG claim for the physical health medical visit during which the ancillary service was ordered, even if the ancillary service was provided on a different date of service. Including ancillary procedure codes on a physical health medical visit claim simply indicates to Medicaid that the ancillary services were ordered during the visit, not that the clinic is requesting reimbursement.

If the freestanding OASAS clinic provides ancillary services in house or is responsible for paying an ancillary provider for the ordered service, the freestanding clinic submits the clinic claim with modifier 90 next to the ancillary procedure code. Medicaid should not receive a fee-for-service claim for the ancillary service.

If the freestanding OASAS clinic did not provide the ancillary services and does not wish to pay the outside ancillary provider directly for the ancillary services order during the physical health medical visit, the freestanding OASAS clinic **SHOULD NOT** code modifier 90 on the physical health medical visit claim. Medicaid should receive a fee-for-service claim for the ancillary service directly from the ancillary service provider.

For more information see the [Freestanding Ancillary and/or Modifier 90 policy](#).

Lab Services Required by Regulations

Lab services provided to outpatient chemical dependence and individuals in Opioid treatment will not be the fiscal and/or contractual responsibility of the OASAS Certified Outpatient Chemical Dependence or Opioid program. Testing laboratories should continue to bill for laboratory services fee-for-service (FFS) directly to Medicaid; or, to the individual's managed care plan if applicable. They should not code the ancillaries (labs) on their APG claims.

The exception to this policy is toxicology provided in an Opioid setting.

These services are:

- already included in Opioid 2008 base year costs; and,
- are generally provided directly by the Opioid program; or
- by agreement with a laboratory, whereby the laboratory delivers the services and is paid directly by the Opioid program.

Therefore, neither Opioid programs nor testing laboratories should bill Medicaid FFS for toxicology services provided to an individual in the Opioid treatment program. They should NOT code the ancillaries (labs) on their APG claims.

PLEASE NOTE - This OASAS outpatient ancillary policy is different from the ancillary laboratory payment policy for services delivered in Article 28 general health clinics and for physical health services provided in OASAS outpatient programs under OASAS physical health medical visit rate codes.

[APG policy and billing guidelines for Article 28](#) provides information on Article 28 Hospital based outpatient clinics, ambulatory surgery centers, emergency departments, freestanding diagnostic centers, and free standing ambulatory.

Smoking Cessation Services

Clinical Description

Smoking Cessation is a specific face-to-face intervention provided to an individual in efforts to reduce or eliminated their tobacco use. This service can include both counseling and the provision of Nicotine Replacement Therapy (NRT). The inclusion of these codes in no way limits programs from addressing nicotine use disorder as a part of the overall chemical dependency treatment provided in either group or individual sessions according to the treatment / recovery plan.

Delivering Staff

Clinical/Medical Staff who have been specifically trained in smoking cessation. OASAS has additional guidance on providing tobacco cessation including a link to [free on-line training](#) on the website.

APG CPT /HCPCS Billing Code

99406 Behavior Change Smoking Cessation 3-10 minutes

99407 Behavior Change Smoking Cessation 11+ minutes

Time Requirements

99406 3-10 minutes

99407 11+ minutes

Category Specific Medicaid Billing Limits

For reimbursement the service must be provided by staff specifically trained in smoking cessation.

No more than three smoking cessation services should be billed in an episode of care. Additionally, smoking cessation is not a third visit exempt billable service.

Smoking cessation will not be reimbursed as such, if provided in a group setting.

Smoking cessation will be billed under the APG clinic rate code, not the health services rate code and will, therefore, not apply to the 5% medical visits rule.

Section Five General Claiming Guidelines

This manual is intended to provide guidance on Substance Use Disorder Medicaid billing. This manual is not intended to be a comprehensive overview of all components of Medicaid billing. For a full understanding of all Medicaid claiming components, including claim data field entry, OASAS certified programs should review information available on [eMedNY's](#) website: and or seek assistance from Computer Sciences Corporation (CSC), the New York State Department of Health contract Medicaid fiscal intermediary, CSC can be contacted at 800 343 - 9000.

APG Claiming Restrictions / Limits on Payable Daily Units of Service:

Visit Date/Services

Under APG's, programs submit one claim per individual per day AND that claim will reflect multiple services lines. The claim will correspond with the actual visit date and the multiple lines will represent all the services delivered on one day. For example, if for a single individual, on a single visit date, a program delivers a group and an individual service, the program will submit to Medicaid a single claim that requests payment, indicated by the appropriate OASAS APG rate code and the CPT or HCPCS code for each discrete service.

Programs will not be reimbursed for two of the same services a day (e.g. two individual sessions, two group sessions) or more than two different services provided in a single visit date with the exception of medication administration, medication management, complex care management, collateral visit, and peer support services.

Discounting: The second and third service (where permitted) in each visit will be discounted by 10% with the exception of the "always pay" APG service categories (Medication Administration, Medication Management, Peer Support Services, Smoking Cessation, Collateral, Physical Health, and Physical Exam). There are APG category specific Medicaid billing parameters that providers must understand, these parameters are discussed in the clinical guidance section of this manual.

Fee for Service APG Billing for Part 822 Opioid Treatment Programs

OTP claims will be submitted using a weekly episode of care construct. As with the prior weekly threshold claims process, under APGs one weekly episode service claim per individual in opiate treatment will be submitted. However, under APGS the single episode claim must include:

- the discrete visit dates and
- the multiple CPT or HCPCS codes for services that are delivered on the individual days within the period. The week is delineated as Monday- Sunday.

Example: If the episode dates of service were Monday, January 3, through Sunday, January 9, the actual billing (claim submission) date would be Sunday, January 9. To receive payment for services delivered within the episode, the program will submit to Medicaid a single episode

service claim and the claim will reflect the CPT or HCPCS code for each discrete service that is delivered on specific dates within the weekly billing range / episode. The episode payment will be equal to the sum of the lines, by visit date (APG billing rules and discounting methodology is applied to each day within the episode), that are encompassed within the episode. This calculation will be done centrally by the Medicaid system.

BILL WITH KP MODIFIER: OTP programs will submit APG claims using the KP modifier, entered at the dated service line associated with first medication administration service (H0020) delivered during a service week

Medicaid Managed Care Requirements for Opioid Treatment (OTP) Programs

Within a managed care claiming structure the OTP programs may either:

- A. Immediately convert to daily process /claiming. Submitting a single visit claim for each date of service, or
- B. Continue to submit a single visit claim that codes all services delivered during the service week on the single visit claim. It is expected that over time the OTP programs will transition to submitting a single visit claims for each date of services.

In either scenario the programs utilize:

- the 837i;
- the OTP APG rate code for their peer group in the headers;
- the appropriate CPT /HCPCS / Modifier codes (including KP modifier for the first medication administration visit and the HF modifier for all line level procedure coding);
- the claim is processed by the plan through the 3M grouper or its exact replica; and
- OTP programs must be reimbursed for additional cost Buprenorphine.

APG Billing for Physical Health Services

Programs will submit a physical health specific claim using the appropriate OASAS APG medical service rate code, and the E/M code appropriate for the delivered medical service. For those visit dates when a program delivers substance use disorder treatment services (e.g. individual or group counseling) or outpatient rehabilitation services AND physical health services the program would submit:

- one claim using the appropriate OASAS SUD rate code, and
- corresponding chemical dependence CPT /HCPCS service, AND
- a separate claim using the appropriate OASAS APG medical service rate code, and
- the E/M code appropriate for the delivered medical service.

Medicare / Medicaid and use of CPT codes

In those instances where an individual is dually enrolled in Medicaid /Medicare and the service and practitioner are reimbursable by Medicare the program may bill using a CPT code that corresponds to the service delivered AND the associated APG service category and weight.

APG Claim Components

To ensure appropriate reimbursement under the new APG payment methodology, all claims must include:

- OASAS APG rate codes
- a valid, accurate ICD CM primary diagnosis code
- a valid CPT and/or HCPCS procedure codes.
- the primary diagnosis code is the ICD code describing the diagnosis, condition, problem or other reason for the encounter/

APG reimbursement for an Evaluation and Management (E/M) visit will be determined by the primary ICD CM diagnosis code and the level of the E / M visit CPT code. Diagnosis and procedure coding and billing must be supported by the documentation in the medical record.

NOTE: Secondary diagnoses or additional codes that describe any coexisting conditions should also be coded, since if any of these codes group to APG 510, “major signs, symptoms and findings,” then that diagnosis will be used in place of the primary diagnosis to group the medical visit

Fee for Service Claim Components: Medicaid service claims and documentations for individuals who have been admitted to a clinic program shall include, at a minimum:

Component	Description
Patient Medicaid ID	The Medicaid identification number of the recipient.
Diagnosis Code	The designated substance use disorder diagnosis
HCPCS/CPT Code	The procedure code or codes corresponding to the procedure or procedures provided,
Program NPI	The Program National Provider Identifier (NPI)
Attending Practitioner NPI as appropriate of the attending clinician	<p>NPI of provider is not accepted as an Attending Provider NPI. The claim must include the practitioner specific NPI.</p> <p>For practitioners without an NPI (e.g. CASACs), the equivalent DOH-approved alternative should be used in its place.</p> <p>The OASAS unlicensed practitioner ID Number is 02249145. Use this number when services are delivered by an appropriate program staff person who does not have and/or cannot get an NPI numbers. For more NPI information go to the eMedNY website.</p>
Service Location ZIP plus	The licensed location where the service was provided. The location of services as indicated by the ZIP plus four address that is on file with the Medicaid billing system.

Revenue Code and Bill Type	Utilize the revenue codes that were used Pre APG, e.g. 0510 (clinic). Report the revenue code on each line of the claim that indicates a specific procedure code. The revenue code would be the same for every line. All revenue codes are part of the UB04 manual that is the National Uniform Billing Committee (NUBC) Additional Revenue Code information, along with information on purchasing the specifications manual can be found at nubc.com .
Crossover Claims	eMedNY website
Medically Necessary	All claimed Medicaid services must be medically necessary.
Face to face	All claimed services must be for a documented face to face encounter. Complex care is the exception.
Appropriate Practitioner	All services must be delivered by staff working within their scope of practice, and as identified in OASAS regulation.
Service Documentation	Case record documentation must be completed in compliance with OASAS regulatory requirements for each of the services provided. OASAS Part 822 Regulations can be found on the OASAS Website.
Date and Duration	The date the service was provided and the time spent in completion of the given service. Duration can be identified by total minutes and/or state/end times.

For Medicaid Managed Care

Electronic claims will be submitted using the 837i (institutional) claim form. This will allow for use of rate codes which will inform the Plans as to the type of behavioral health program submitting the claim and the service(s) being provided. Rate code will be a required input to MEDS (the Medicaid Encounter Data System) for all outpatient MH/SUD services. Therefore the Plan must accept rate code on all behavioral health outpatient claims and pass that rate code to MEDS. All other services will be reported to MEDS using the definitions in the MEDS manual.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing. This field is already used by Plans to report the weight of a low birth weight baby.

Every electronic claim submitted will require at least the following:

- Use of the 837i claim form;
- Medicaid fee-for-service rate code;
- Valid procedure code(s);
- Procedure code modifiers (as needed); and
- Units of service.

The format for billing and reimbursement in Managed Care is the same as FFS. The MCO Plans will use the APG methodology to calculate payments. In addition to the CPT/HCPS codes, all

line level service coding for SUD services must also include the “HF” modifier.

Plans will process provider claims through the New York State APG 3M grouper or an exact replica to ensure government rates are rendered to OASAS Certified Title 14 NYCRR Part 822 programs (hospital or Freestanding).

Additional Claim Submission Requirements for Opioid Treatment (OTP) Programs

Within a managed care claiming structure the OTP programs may either:

- A. Immediately convert to daily process /claiming. Submitting a single visit claim for each date of service, or
- B. Continue to submit a single visit claim that codes all services delivered during the service week on the single visit claim. It is expected that over time the OTP programs will transition to submitting a single visit claims for each date of services.

In either scenario the programs utilize:

- the 837i;
- the OTP APG rate code for their peer group in the headers;
- the appropriate CPT /HCPCS / Modifier codes (including KP modifier for the first medication administration visit and the HF modifier for all line level procedure coding);
- the claim is processed by the plan through the 3M grouper or its exact replica; and
- OTP programs must be reimbursed for additional cost Buprenorphine.

837i Coding Claims Submissions Requirements for all OASAS Certified Clinic, Opioid, and Outpatient Rehabilitation Medicaid Managed Care Billing:

Claim Component	Description	Notes
Claim Form	837i	Required format; plans must accept
Rate Code	Value code “24”; Assigned four digit rate code in header	See table one below: The Rate Codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 I claim
CPT / HCPCS Codes	Line level CPT/ HCPCS procedure code(s). HCPCS codes are utilized by OASAS certified programs when service rendered by non-licensed professionals e.g. CASACS.	See table two below: the CPT / HCPCS codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 I claim

ICD 10	Programs should utilize the appropriate ICD 10 coding.	
Procedure Modifiers	CPT / HCPCS specific Modifier and HF modifier for all services delivered in a Title 14 NYCRR Part 822 OASAS Certified Outpatient Program (clinic and opioid).	KP Modifier: Opioid Program only The KP modifier must be included KP with the date service CPT / HCPCS coding line associated with first medication administration service (H0020) delivered during a service week. The program will also include the HF modifier.
	The HF modifier should be attached to each coded (Line level) service on the claim.	The modifier codes are entered by the program on the 837 I claim Note the program should code the HF modifier to allow for data collection; however, plans should not deny claims for failure to include.
Service delivery date.	Corresponds to date service delivered and associated CPT / HCPCS coding	The dates are entered by the program on the 837i claim
Service Units	where applicable	The codes are entered by the program on the 837i claim
OASAS CASAC ID / Number:	ID number 02249145.	In those instances where a practitioner does not have an NPI, e.g. a CASAC, the equivalent DOH-approved NPI alternative should be used in its place. For OASAS programs, this number is the OASAS unlicensed practitioner number: ID number 02249145. This number should be used when services are delivered by an appropriate program staff person who does not / cannot get an NPI number (e.g., a CASAC).

Section Six Tools and Resources

The following tools are available on line to assist providers in projecting APG revenue:

Tools

[Medicaid APG per Service Rate Chart](#): This chart gives the current base weight, peer group base rates, an updated list of APG/CPT services, definitions and weights. The schedule also includes payment amounts for the CPT coded services based on current peer group rates and procedure weights.

APG Revenue Calculator: This tool enables users to calculate the projected revenue for CPT procedures based on projected service delivery, current service weights and peer group base rates.

[Freestanding Program APG Revenue Calculator \(Microsoft Excel\)](#)

[Hospital Based Program APG Revenue Calculator \(Microsoft Excel\)](#)

Resources

To qualify as a Medicaid billable service, the occasion of service must at a minimum meet the standards established in this guideline manual:

- **[OASAS Part 822 CD Outpatient and Opioid Treatment Program Regulation](#)**;
- **[OASAS Part 841 Medical Assistance for CD Services](#)**
- **[NYS DOH 18 NYCRR 505.27](#)**; and
- Additional regulations as necessary.

Additionally, the provider must adhere to overall Medicaid billing requirements. Information may be found at:

[NYS HARP/Mainstream Behavioral Health Billing and Coding Manual](#): provides Medicaid Managed Care Billing Guidance.

[eMedny Website](#): provided as a service for providers and the general public, as part of the offerings of the electronic Medicaid system of New York State.

[ePaces Manual](#): Link to the on line ePaces manual.

Edit and Error Knowledge Base: Link to the Edit / Error Knowledge Base this is a tool for providers to use in their efforts to analyze the claim edit codes and/or claim status codes that they receive. The links to the four volumes of the edit dictionaries is particularly helpful and it gives you the definition of a particular edit, what the problem is being caused by, and if you can fix it.

Medicaid Eligibility Verification: New York State operates a Medicaid Eligibility Verification System (MEVS) as a method for providers to verify recipient eligibility prior to provision of Medicaid services.

New York State Department of Health Medicaid Update Articles, Provide updates on Medicaid policies.

HIPAA: NYS Department of Health HIPAA site provides HIPAA billing information:

OASAS Managed Care Webpage: provides information for the many aspects of Medicaid Redesign.

**PLEASE SEND ANY ADDITIONAL QUESTIONS REGARDING MEDICIAD BILLING TO THE
PICM MAILBOX AT: PICM@oasas.ny.gov**