

OASAS APG Training Update

Reimbursement and Policy

Updated Clinical Guidance and Refresher



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Clinical Clarifications on:

- Psychiatric Evaluations
- Physical Examinations
- Screening and Brief Intervention
- Addiction Medication Induction
- Collateral Visits
- Adolescent Family Group
- Peer Support
- Intensive Outpatient Services
- Outpatient Rehabilitation



Psychiatric Evaluations

- Must be completed by a Psychiatrist or other MD with Psychiatric training.
- Must incorporate counseling to bill 90805 or 90807.
- May be provided pre or post admission.
- If provided pre-admission, the psychiatric evaluation service is counted towards the no more than three assessments may be billed prior to admission.
- If provided after admission, no limitation on billing; but must be clinically appropriate and sufficiently documented.
- May be billed on the same visit date day as an individual counseling session.
- Not exempt from second visit 10% discount.
- If there is no counseling, bill E/M codes in 99201 series – Problem Focused Physical Exam.



Physical Examinations 822-4 Hospital or Freestanding

- Not required by regulation in 822-4 Programs
- Must be delivered on-site at the OASAS certified location.
- Service will apply to the 5% Con Reform cap.
Where more than 5% of the total visits at an Article 32 clinic are for medical services or any visits are for dental services, certification from DOH is required. Medical services for the purpose of this provision, will not include medical services required under OASAS Part 822 regulations.
http://www.health.ny.gov/press/releases/2008/2008-03-04_con_reform_ambulatory_care_services.htm
- Must be billed using either the hospital or freestanding four digit APG medical visit rate code in the claim header.
- May not be billed for dates of service prior to 1/1/12 or 1/2/12 for freestanding programs.
- As of this taping, APG medical visit rate codes not yet active in hospitals.
- CPT codes 99201-99205 for new patients OR 99212-99215 for established patients used for problem focused physical exams.
- No restriction on specific codes, but physical health services should be within the scope of Substance Use Disorder services.



Physical Examinations 822-5 Hospital or Freestanding

- Initial and Annual Physical Exams are required by Part 822-5 regulation.
- Must be delivered on-site at the OASAS certified location to be billable.
- Service will apply to the 5% Con Reform cap if billed under the medical visit rate code.
- May be billed using either the four digit APG medical visit rate code or the clinic rate code in the claim header. If the program chooses to use the clinic rate code, the service will blend with legacy but will not count toward the 5% Con Reform limit.
- May not be billed for dates of service prior to 1/1/12 or 1/2/12 for freestanding programs.
- As of this taping, APG medical visit rate codes not yet active in hospitals.
- CPT codes 99201-99205 for new patients OR 99212-99215 for established patients.



Pre-Admission Screening HCPCS H0049

What it IS:

ON-site 15 minute pre-admission face-to-face meeting (e.g. not a phone interview) with a clinical staff member for the purpose of identifying alcohol or other drug (substance) use problems through the use of one of the following screening tools: AUDIT, CAGE, CAGEAID, CRAFFT, Simple Screen, GAIN Quick, ASSIST, DAST, RIASI 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.

What it is NOT:

Screening is not intended to be provided to all patients or where it is known that the patient is appropriate for admission (e.g. a court order); has an assessment from another program; or presents with circumstances that indicate that a SUD problem may be present. Mental health screening is not eligible for reimbursement under this category. Additionally, screening may not be provided in a group setting. Service is not off- site.

Note: No more than one screening per patient per episode of care.



Pre-Admission Brief Intervention HCPCS H0050

What it is:

On-site 15 minute minimum face-to-face, pre-admission meeting with the clinical staff when screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences, and motivates them to change their behavior. Must document an evidence-based or clinical intervention utilized; patient response; recommendations for follow-up or referral. A brief intervention may follow a screening where some risky use has been identified but the patient does not need or accept a referral to treatment.

What is not:

Brief Intervention is NOT intended to be provided to all patients. Brief Intervention may not be billed using this code if it is provided in a group setting. May not be delivered off site.

The program may bill up to three Brief Intervention visits prior to admission.



Post-Admission Brief Treatment HCPCS H0050

What it is:

On-site post-admission, face-to-face meeting with a clinical staff and active patient in chemical dependency treatment, 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. Evidence-based practices have empirical evidence to support their efficacy and effectiveness with substance abuse populations. Brief treatments can be used throughout the course of longer periods of treatment to meet specific goals, motivate patients; address emergent issues related to successful treatment; or support pharmacotherapy.

What is it not:

An individual counseling service.

The program may bill one Brief Treatment service per day.



Addiction Medication Induction H0014

Induction/Detox is to be used when a patient is new to an addiction medication or a medication is being used to treat withdrawal symptoms and significant history and patient observation is required by medical staff.



Collateral

- An onsite (at the OASAS certified location) face-to-face visit delivered to a non-admitted collateral person.
- Individuals who qualify as collaterals are not limited to family members. Many patients have primary and significant relationships with non-family members.
- This generally would not extend to a person in a professional or paraprofessional helping role, for example, probation officer, DSS caseworker, etc.
- Collateral visits may take place prior to and after admission. No more than five collateral visits may be billed to Medicaid per patient episode of care. The program will bill the service using the admitted primary patient's or the prospective patient's Medicaid Client identification number.
- Information discovered in a Collateral visit may be appropriate to prompt a complex care coordination visit.



Adolescent Family Group

- This service allows for a collateral (in this case a family member) to attend a family group without being opened as a significant other. This service is billed to the primary patient's Medicaid.
- Family members of adults can attend family groups for their own support or to learn to support a significant other who is in recovering from SUD, but they must be opened and the group must be billed to them directly or to their third party payer.



Peer Support

- On-site face-to-face service provided by a peer advocate to an active patient of an outpatient clinic.
- For the purpose of connecting patients to community based recovery supports consistent with the treatment / recovery plan.
- Must be provided by a peer advocate as defined in Part 822, and peer service providers / advocates must hold a national credential as a peer advocate or other credential as a peer advocate as recognized by OASAS.
- 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.
- Programs should not bill for more than 5 peer services (per service not per unit) per patient, within an episode of care, unless the treatment plan includes clinical justification.



Intensive Outpatient Services (IOS)

- Clinical treatment service for individuals who require a time-limited, multi-faceted array of services, structure and support to achieve and sustain recovery. Intensive outpatient treatment programs generally provide a minimum of 9 treatment hours per week delivered during the day, evening or weekends. A team of clinical staff must provide this service. The treatment program consists of, but is not limited to, individual, family and group counseling; relapse prevention and coping skills training; motivational enhancement; and drug refusal skills training.
- Intensive outpatient services are appropriate for patients who need more intensive treatment in order to attain or maintain recovery from chemical dependency, this also includes patients with a dual diagnosis and corresponding functional deficits.
- Intensive outpatient treatment is a time-limited service and should not exceed 6 weeks without clinical justification.



IOS Continued

- Programs that do not have a formal IOS program or have patients who cannot attend the IOS, may meet this level of care, admit and treat patients in need of IOS services, through a more intensive group, individual and family counseling at the outpatient clinic level of care providing the increased intensity/frequency of services is adequate to meet the needs of the patient.
- If a patient receives IOS on: Mon; Wed; and, Fri. On Tues and Thurs the patient may receive non-IOS services e.g. and individual or a group counseling service and the program can bill for those services. This is only permissible if the services are clinically appropriate; consistent with the treatment plan; and appropriately documented.
- If a patient is "scheduled" for IOS hours but misses a "scheduled" IOS day, the provider can bill for IOS services on the other scheduled IOS days in that week. Additionally, if a patient is scheduled to receive three hours of IOS services on a specific visit date but due to emergency has to leave early, the program may bill for the disaggregated services. E.g. an individual and a group service. NOTE: the program could bill for the two distinct service types but could not bill for two groups or two individuals.



Outpatient Rehabilitation

- Delivered by Certified Outpatient Rehab programs only.
- Billable in 2-4 hours or 4 hours+ increments.
- Within 2-4 or 4+ hours the patient must receive either an individual counseling of at least 25 minutes; or, a 60 minute group service, the remaining time may be comprised of other services as appropriate.
- All services must be delivered on-site at the certified location.



Outpatient Rehabilitation-Billing

- Claim using the appropriate four digit peer group rate code in the header and the correct single HCPCS code at the line level H2001 – 2-4 hour duration; and, H2036 -- 4hour and above.
- May not bill for other service categories e.g. individual; group, or IOS while the patient is in the day rehab program.
- May bill for medication administration and management, complex care, peer services and collateral contacts in addition to outpatient rehabilitation.
- It is the program's discretion to either: deliver / utilize the exempt services towards accumulating the minimum OPR time frames; and, as such submit a single claim for the 2-4 hour or 4+ hour OPR service; or...
- 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 frame. 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.



Outpatient Rehabilitation- Reweighting

Effective 4/1/12 Outpatient Rehabilitation services have been reweighted to more closely align with statewide average service costs.

- Previous Weight .5948 for 2-4 hours and .7931 for 4+ hours – this is for dates of service **before** 4/1/12.
- Revised weight .4937 for 2-4 hours and .6583 for 4+ hours -- this is for dates of service **after** 4/1/2012.



Questions

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