



**Office of Addiction  
Services and Supports**

**Ambulatory Patient Groups (APG)  
Clinical and Medicaid Billing  
Guidance**

**SEPTEMBER 2021**

**OASAS Certified  
Outpatient Programs**

[www.oasas.ny.gov](http://www.oasas.ny.gov)

## Table of Contents

Section One: Introduction .....	4
Section Two: Updates .....	4
I. Reimbursement/Claiming .....	4
a. Crisis Intervention Services: .....	4
b. OTP Bundle Rate Approval: .....	4
c. Peer Service Rate Code Change: .....	5
d. Expansion of Telehealth Services: .....	5
e. OTP Medicare Crossover Claims: .....	5
f. Changes to E&M Codes: .....	5
g. OPRA Requirements: .....	6
h. Integrated Outpatient Service Claiming Clarification: .....	6
II. Clinical Updates .....	6
a. Treatment Plan Changes: .....	6
b. Mental Health Screenings during Assessment: .....	7
c. Services allowed Prior to Admission: .....	7
Section Three: APG Definitions .....	7
Section Four Behavioral Health Service Categories: .....	11
Screening/Brief Intervention .....	11
Admission Assessment .....	12
Individual Counseling .....	13
Brief Treatment .....	14
Group Counseling .....	15
Family Services .....	16
Peer Support Services .....	18
Medication Administration and Observation .....	19
Medication Management .....	21
Addiction Medication Induction/Ancillary Withdrawal .....	22
Complex Care Coordination .....	24
Crisis Intervention .....	25
Smoking Cessation Services .....	26
Intensive Outpatient Service (IOS) .....	27

Outpatient Rehabilitation Services .....	28
Section Five Physical Health Service Categories:.....	29
I. Evaluation and Management Services: .....	29
II. Laboratory services Not required by regulation .....	30
III. Lab Services Required by Regulations .....	31
Section Six: General Claiming Guidelines .....	32
Claiming Information: .....	32
a. General Medicaid Claiming: .....	32
b. Medicaid Fee for Service Claiming:.....	32
c. Medicaid Managed Care: .....	33
d. Common Claiming issues:.....	33
Section Seven: Tools and Resources .....	35
Tools .....	35
Regulations.....	35
Guidance.....	36
Section Eight Appendices .....	37
Appendix A APG Rate Codes: .....	37
Appendix B APG Procedure Codes and Limitations .....	38

## Section One: Introduction

The **Ambulatory Patient Group (APG)** billing process was implemented in **July 2011** as a first step in New York State's overall effort to reform Medicaid reimbursement. In **October 2015**, another step was taken with the implementation of **Medicaid Managed Care**. The [Medicaid Managed Care Contract](#) required the plans to reimburse the State APG Rates for the first two years of the contract. The State reimbursement rate has been extended since the original contract was signed. The most recent extension for the State rate is in place until **March 31, 2023**.

With both **Medicaid Fee for Service** and **Medicaid Managed Care** utilizing 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 Substance Use Disorder, including problem gambling treatment, Opioid Treatment Programs, and Integrated Services settings.

**Please note** this guidance is intended for standard reimbursement circumstances. Information specific to reimbursement during the COVID Emergency can be found in the [COVID Billing Addendum](#).

## Section Two: Updates

### I. Reimbursement/Claiming

#### a. Crisis Intervention Services:

**Effective September 1, 2021** programs will be able to seek reimbursement for Crisis Intervention Services. The H2011 Code which is billed in 15 minute units can be reimbursed for 6 units/90 minutes per day. S9485 is a 90 minute service that can be billed once per day. Full information on this service can be found in the [Crisis Intervention Service Section](#) of this manual and in the [OASAS Crisis Intervention Service Guidance Document](#).

#### b. OTP Bundle Rate Approval:

**Effective August 1, 2021** the state received approval from CMS to permit OTPs to bill weekly bundled rates for services delivered in OTPs. These weekly bundles are optional and are intended to better accommodate the costs of OTPs that provide more take home medication. Providers can bill for services based on the weekly bundles or they can utilize the APG billing for the individual services as listed in this manual. The [Provider Letter Regarding the OTP Bundle Rate](#) gives complete information regarding this change.

### c. Peer Service Rate Code Change:

Effective **January 1, 2021** the former Enhanced Peer Services Rate Code(s), **1072, 1074, 1076 and 1078**, were **zeroed out** and unavailable for reimbursement. OASAS in collaboration with DOH and OMH were able to include the enhanced amount by increasing the procedure weight for Peer Services from **.0756** to **.1134**. With this change providers will be able to claim for Peer Advocate Service using their **Standard Rate Codes** as found in [Appendix A](#).

Please note that reimbursement rates are subject to change.

### d. Expansion of Telehealth Services:

The [Proposed Part 830 Designated Services Regulation](#) allows for:

- The distant and originating sites to be any location that meets regulatory requirements for privacy and patient confidentiality and are approved by the Office.
- Other staff credentialed or approved by the Office to deliver services via Telehealth.
- Evaluation for appropriateness for Telehealth may be conducted *via* Telehealth. Please note once the COVID Emergency Order ends certain services, such as Buprenorphine Induction will return to the pre-COVID in person visit requirements.

### e. OTP Medicare Crossover Claims:

Beginning **January 1, 2020**, Medicare began paying a weekly bundle rate (plus add-ons) for services delivered in Opioid Treatment Programs (OTPs). **Effective January 1, 2021** OTP providers should not bill Medicaid for OTP services provided to an individual eligible for both Medicare and Medicaid (a “dual”) until a claim has been processed by Medicare. Additionally, providers must retroactively bill Medicare, to the extent possible, for all Medicare billable OTP services back to the effective date of the provider’s OTP enrollment in Medicare. Further information on Medicare/Medicaid OTP Crossover Claims can be found in the [Dual Billing Guidance for Opioid Treatment Programs](#)

### f. Changes to E&M Codes:

The Center for Medicare and Medicaid Services (CMS) in collaboration with the American Medical Association (AMA) have developed and approved changes in the way E&M codes services are configured. The revised guidelines within Medical Decision Making have expanded and clarified what elements should be considered in deciding the appropriate code to use. The guidelines also allow for E&M coding based on use of time. This change will allow practitioners to include

pre-service, intra-service, and post-service tasks in calculating time and determining the E&M code. Further information regarding these changes can be found In [The AMA E/M Code and Guideline Changes](#).

**Please note** Medicaid E/M Code Reimbursement rates for OASAS Certified Providers are a blended rate meaning that with the exception of 99211, all the codes within the range 99202-99205, and 99212-99215 are reimbursed at the same amount. The only variance in reimbursement is the individuals diagnosis. Nevertheless, OASAS Providers will need to document and substantiate the E/M code that is claimed.

#### **g. OPRA Requirements:**

Generally speaking, for all claims the Ordering/Referring practitioner NPI has to be enrolled in Medicaid for claims to be reimbursed.

In addition, practitioners who provide the service and whose NPI's are listed in the attending field must be affiliated with the Providers Medicaid Profile. Claims without an appropriate Medicaid practitioner in the Ordering field as well as those where the attending NPI is not affiliated with the facility are subject to payment denial or future take-backs. Further details can be found in the [Updated Medicaid OPRA Guidance](#).

#### **h. Integrated Outpatient Service Claiming Clarification:**

Integrated Outpatient Service (IOS) Providers should be utilizing the IOS rate code specific to the Host agency. Specific procedure code use remains dependent on the diagnosis being given. For example, Peer Support Services are not available for OMH use so for an OMH Hosted IOS program if a Peer Service H0038 is being claimed then a SUD diagnosis would need to be primary.

## **II. Clinical Updates**

### **a. Treatment Plan Changes:**

The [Part 822 Regulations](#) which became effective August 2, 2021, contain substantial changes in how treatment planning and admission decisions should be made. The new regulation makes clear that treatment, and treatment planning begin at the first patient contact. This means that the person who is providing a service will document in the note supporting the service a plan. This plan based on the first visit is not a comprehensive plan for the course of treatment, but will identify a goal and/or next steps and may be as simple as to continue gathering information to complete assessment, or to initiate medication for OUD or AUD via referral to medical staff.

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Appropriately qualified physicians, physician’s assistants, nurse practitioners, licensed psychologists, or Licensed Clinical Social Workers will take an active role in the assessment and diagnosis of individual’s coming for treatment. The approved assessment and initial plan will be the basis of all future treatment and treatment services, the contents of which will be included in progress notes as part of the on-going treatment planning process.

**b. Mental Health Screenings during Assessment:**

OASAS issued [Guidance for Mental Health Screenings](#) during the assessment process. The guidance provides direction on required mental health domains that providers should be screening as well as providing OASAS approved [Adult Screening Instruments](#) as well as approved [Adolescent Screening Instruments](#).

**c. Services allowed Prior to Admission:**

OASAS, in support of their focus on engagement and person-centered treatment has broadened the types of services that can be delivered prior to admission. Along with SBIRT and Assessment Services, providers may also deliver **Peer Support Services, Individual Counseling, Family Services, Complex Care Coordination, Addiction Medication Induction, Medication Admin/Observation, and Medication Management**. Providers will need to document the clinical necessity of these types of services for reimbursement.

## Section Three: APG Definitions

**Clinical Staff:** Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, working within the addiction counselor [Scope of Practice Guidelines](#).

**Continuing Care Services:** Services that are provided to individuals after discharge from the active phase of treatment in support of their continued recovery. Individuals can receive Counseling, Peer, and Medication Management services as clinically appropriate based on the individual’s Continuing Care Plan. For specific details review the [OASAS Continuing Care Guidance Document](#).

**Continuous treatment:** means any combination of services provided to an individual and/or collateral person after the four week time period has started. The four week period begins at the first service provided to an individual after an initial face to face contact with the person.

**Diagnosis:** Admitted individuals must have an primary Substance Use Disorder (SUD) diagnosis as given in the most recent version of the ICD/DSM or for gambling as defined in the [Part 857 Problem Gambling Regulations](#).

**Language Interpreter Services:** Medical language interpretation services for Medicaid Members with limited English proficiency (LEP) and/or hearing impairment. Procedure code T1013 can be added as the line level when interpretive services are provided in conjunction with a primary service. For reimbursement the Interpretation session must be provided by an individual who is duly licensed and/or certified to do so and **is not** the staff member delivering the primary service. For further information please consult the [2012-10 Medicaid Update](#).

**Level of Care:** process for determining the most appropriate level of treatment services based on assessment information. The Level of Care for Alcohol and Drug Treatment and Referral Tool ([LOCADTR 3.0](#)) or [LOCADTR for Gambling](#) are required by NYS Insurance Law for use by both providers and insurers in determining clinically appropriate treatment placement. A clinical staff needs to complete an assessment of the individual with a substance use or gambling presenting problem. The LOCADTR will produce a recommendation for level of care based on the way the counselor answers the questions, please note that the clinician can override the recommendation with justification, and in no case should the clinician use the LOCADTR recommended level of care solely, to discharge or withdraw care.

When assessing a significant other for admission or collateral contact, the LOCADTR **should not** be applied.

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

**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. Each claim must identify the Ordering/Referring Provider and attending Provider NPI. Further information regarding NPI requirements can be found in the [OPRA Guidance Document](#).

**Physician Add on Fee:** Fee added when a physician provides a service normally provided by a clinical staff member, e.g. individual/group counseling, assessment. Physician can either bill a separate physician fee claim or add AG modifier to increase the payment.

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

**Scope of Practice:** The identified skills and experience necessary to complete specific treatment services. For clinical staff see the [Scope of Practice Guidelines](#) or [Part 857 Problem Gambling Regulations](#). Licensed Professionals scope of practice can be found at the [NYS Office of Professions](#).

**Service Documentation:** For reimbursement purposes the person's patient record must include the name of the person receiving the service, duration of the service, date(s) of service, description of service and it's connection to the on-going plan of treatment, and the signature of the staff member who delivered the service.

**Services in the Community:** services that are not provided inside a Part 822 Program but are provided in a community setting, including a patients home. All services that can be provided in the clinic can be provided in the community. For further information please review the [Part 822 Services in the Community Guidance Document](#).

**Telehealth:** the use of two-way real-time interactive audio and/or video linkage system for supporting and providing certain addiction services at a distance. The [Part 830 Telehealth Regulation](#) has been updated and integrated into the [Part 830 Designated Services Regulations](#). The [Telepractice for OASAS Designated Providers](#) document supplements the regulations with additional guidance on their implementation.

Services being provided via Telehealth or any other method authorized under an existing emergency should bill utilizing the Rate Codes and Procedure Codes given in the OASAS Medicaid APG Clinical and Billing Guidance, **with the additional requirement** being the **inclusion of appropriate modifiers** for Telehealth (**95 or GT**).

Please note Point of Service (POS) is not needed for OASAS Claiming.

- **Modifier 95** is for codes listed in **Appendix P** of the **AMA's CPT Professional Edition Codebook**.

#### **OASAS Procedure Codes in Appendix P**

**90791** – Assessment Extended

**90832** – Individual Counseling Brief

**90834** – Individual Counseling Normative

**90847** – Family Service with Patient present

**99202-99205** – For New - Psychiatric Assessment (Brief), Medication Management, Physical Health

**99212-99215** – For Existing - Psychiatric Assessment(Brief), Medication Management, Physical Health

- **GT modifier** should be used where the modifier 95 cannot be used.

**Two service per day rule:** Unless otherwise specified, Providers can bill for only two different services per visit date, e.g. a group and an individual. However, the following services **are exempt** from the two service per day rule: **Medication Administration, Medicaid Management, Addiction Medication Induction, Complex Care Coordination, and Peer Support Services.**

**Visit:** The single date where one or more services were provided to an individual and/or collateral contact.



## Section Four Behavioral Health Service Categories:

### Screening/Brief Intervention

**Screening** is a pre-admission service between an individual and clinical staff member to identify potential addiction problems *in those without a previous addiction history or where it is known that the person is appropriate for admission.*

The screen is conducted through electronic or written format utilizing approved screening tools: **AUDIT, CAGE, CAGEAID, CRAFFT, Simple Screen, GAIN Quick, ASSIST, DAST, RIASI; MAST**, other OASAS approved screening for SUD. The **Lie-Bet, NODS-Clip, NODS-PERC, or Brief Bio-Social Gambling Screen** for gambling. The focus of the screening session is on providing the individual with the results of the screening and feedback about the likelihood of a misuse problem.

**Brief Intervention** is a pre-admission meeting with the clinical staff *to address at risk behavior.* The intervention educates individuals about their use, alerts them to possible consequences, and motivates them to change their behavior. A brief intervention *may* follow a screening session, a referral from a primary care provider when the person has screened positive for at risk behavior or to address other identified at-risk behavior identified without screening. 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

Clinical and/or medical staff. Licensed practitioners 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:

#### 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, only 1 brief intervention service per visit date. Brief Intervention *may not be used* as a medical follow up to an Addiction Medication Induction.

## Admission Assessment

### Clinical Description

Pre-admission service delivered either onsite or via Telepractice between an individual and clinical/medical staff member for determining appropriateness for and willingness to engage in treatment. Outcomes include preliminary diagnosis, appropriate level of care, and initial plan of treatment and/or referral to other services as indicated, along with identification of services that may be needed prior to admission, i.e. Medication Assisted Treatment, Peer Support Services. Providers are required to conduct an approved mental health screening within the assessment process as given in the [Guidance for Mental Health Screening](#) document. Level of Care is determined via the [LOCADTR 3.0 for SUD](#) and [LOCADTR for Gambling](#).

### Delivering Staff

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, working within the [Scope of Practice Guidelines](#).

**Please note** with the changes to the [Part 822 Regulations](#), effective August 1, 2021, the admission decision must be determined and documented by a [Medicaid Enrolled Practitioner](#).

### 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.

The extended session may be comprised of 75 minutes of continuous time with multiple staff.

### Category Specific Medicaid Billing Limitations

Programs may only bill for one assessment visit per day. Programs may bill for up to three assessment visits per continuous treatment episode. 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.

# Individual Counseling

## Clinical Description

A meeting between the individual and a clinical staff member to discuss issues of concern as well as work on identified areas for improvement. In addition to specific issue related discussion, Individual Counseling provides the person with the opportunity in a safe environment to learn self-awareness, communication, and problem-solving skills. The clinical staff member can use this opportunity to engage the individual in treatment by providing positive regard and respect for the individuals view of their treatment.

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 addiction disorders and should be provided adequate supervision and training to competently provide this service. Each visit should be [Person-Centered](#) and address material relevant to the person's on-going plan for treatment.

## Delivering Staff

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations working within their [Scope of Practice](#).

## 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.

## Brief Treatment

### Clinical Description

A post admission meeting with a clinical staff and an individual participating in addiction treatment utilizing an evidence based practice to focus on a specific behavior or need.

The clinician is responsible to learn about evidence- based practices shown to have efficacy with addiction and should be provided adequate supervision to competently provide this service. Each visit should be [Person-Centered](#) and address material relevant to the person's on-going plan for treatment.

### Delivering Staff:

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations 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. The 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.

## Group Counseling

### Clinical Description

A 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 the person's on-going plan for treatment. The purpose of group counseling is to attain knowledge, gain skills and change attitudes about addiction to achieve and maintain recovery from addiction. 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.

Groups have different purposes and size should be determined based on the goals and methods employed to reach the goals. For example, best practice is to limit therapy groups to less than 10 members in a closed psychodynamic group (new members cannot join); while psycho-educational groups<sup>1</sup> may have up to 20 members.

Group size, whether a group is open/or closed, facilitated by a single clinical staff or a dyad of staff should be clinically determined. Group size should conform to best clinical practice, and best practices such as those identified in the [SAMHSA TIP 41](#).

### Family Group

Family members and significant others can participate in multi-family group as collaterals of (in conjunction with) a primary individual in treatment and the group is a multi-family group for the purpose of providing support, guidance and education to families in support of each individual's recovery goals. See additional guidance on [Family FAQ](#).

### Delivering Staff:

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations working within their [Scope of Practice](#). Staff should be appropriately qualified to provide the service in question.

### 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.

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<sup>1</sup> Psycho-educational groups combine some form of education on a topic area followed by processing of that information within the group session.

## Family Services

### I. Person with Addiction is the focus of the service

#### Clinical Description

A service delivered to **non-admitted** family members, **with or without** the individual in treatment present. The purpose of this service is to provide support to a person with addiction who is an admitted **or prospective** client of the program. Under these conditions the visit is billed to the admitted or prospective person with addiction's insurance.

- **Family Therapy:** In family therapy the family is the primary therapeutic grouping, and there is intervention in the system of family relationships. Family therapy for the most part adopts a **family systems model**. In addiction treatment the primary goal of family therapy is to change family interactions and dynamics to support new coping and communication patterns for all members of the family.

The person with the addiction is the identified person and the session(s) are billed to their payer. All members of the family are seen as being affected by and contributing to patterns and each can contribute to healthier ways of interacting to support the identified patient's recovery. It is this **focus on the system**, more than the inclusion of more people, that defines family therapy.<sup>2</sup>

- **Family Counseling:** Family counseling consists of psychoeducation and support of each member who learns about addiction use and is offered alternative ways of supporting and interacting with each other. The goal of counseling is similar to family therapy and includes supporting the recovery of the identified admitted person.
- **Collateral Visit:** Collateral visits are service visits by non-admitted family members to support an individual in treatment. Collaterals may be billed for a single collateral visit or as a group service when the group service is delivered as a time-limited **multi-family group** for the purpose of supporting the identified patient's recovery. See [Group Counseling Service](#) for further information. **Please note there can only be three Collateral Visits per the continuous treatment period.**

#### Delivering Staff:

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations working within their [Scope of Practice](#). Staff should be appropriately qualified to provide the service in question.

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<sup>2</sup> SAMHSA Quick Guide for Clinicians, Based on TIP 39 Substance Abuse Treatment and Family Therapy

## APG CPT /HCPCS Billing Code:

The program will bill the appropriate code to the admitted or prospective individual's claim and Medicaid client identification number.

- **T1006/90846** Without patient present
- **90847** With patient present

## Time Requirements Family Services

Time: 30-minute minimum

## Category Specific Medicaid Limits Family Services

No more than one Family Service per treatment date. The program will bill the service using the admitted primary individual's or the prospective individual's Medicaid Client Identification Number (CIN).

## II. Family Member Needs are focus of the session

Family members and/or significant others, may seek treatment for their own individual needs related to their connection to a person who has an addiction. Treatment, which can include individual and/or group counseling is focused on the family member(s), educates them about relationship patterns that typically can arise from trying to cope with or help a family member with an addiction.

There are several Evidence Based Practices (EBP's) such as CRAFT, Family Behavior Therapy (FBT), Adolescent Community Reinforcement (A-CRA), that can help support new behaviors that can be effective in helping the addicted person seek help and sustain recovery. Most often these are utilized when the family member's own needs are the focus of treatment – the goal is to improve family interactions in order to encourage recovery of the person with an addiction.

When the family member's own needs are the focus of treatment the:

1. Service is billed to **their own** payer with appropriate procedure code for service, and,
2. Family member is admitted and has their own on-going plan for treatment (see [Family FAQ](#)).

## Peer Support Services

### Clinical Description

Peer Support Services are connections between the individual and a [Certified Recovery Peer Advocate \(CRPA\)](#) meant to support the person's engagement in treatment and overall recovery. Peer Services can be provided before and/or after admission, as well as after discharge as part of Continuing Care. Peer Support Services are designed to support the individual in recovery from the unique perspective of someone who shares similar experiences.

### Delivering Staff

[Certified Recovery Peer Advocate](#) as defined in [Part 800](#), and per Federal Medicaid reimbursement rules. CRPA's must be supervised by a credentialed or licensed clinical staff member.

### APG CPT/HCPCS Billing Code

**H0038**

### Time Requirements

Time: minimum of 15 minutes

### Category Specific Medicaid Billing Limits

Peer Support Service, H0038, is billable in 15 minute units, **with a maximum of 12 units (3 hours)** per service date. The service does not have to be contiguous and should be billed based on the cumulative units given on a service date. Exempt from the two billable services per day rule.

## Medication Administration and Observation<sup>3</sup>

### Clinical Description

Administration of **a dispensed** medication via oral or non-oral route by a medical staff person appropriate to their scope of practice; delivered in conjunction with observation of the individual prior to the administration and after as appropriate.

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

**PLEASE NOTE:** For medication, and/or medication with an additional service OTPs may elect to bill either bundled rates or APGs so long as they only bill one methodology for a patient in a given week. As given in the [Provider Letter Regarding the OTP Bundle Rate](#) the bundle rate allows for reimbursement of take-home medication not otherwise allowed via APG's.

### Delivering Staff

Medical staff as defined in the [Part 800](#) regulations, with the exception of intramuscular injections which can be delivered by an LPN working within their scope of practice.

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

- Rate code 1564.
- **H0033 + KP modifier** for first med service of the week
- **H0033** for additional visits during the week.
- Units billed in 8 mg units (**J0592**<sup>4</sup>) per day times the number of days Maximum of 4 units per day (32 mgs)

**Sublocade Intramuscular Injections:** 96372, Q code Q9991 (100 mgs or less), Q9992 (100+mgs)

**Buprenorphine XR** -guidance will be issued when available

**Vivitrol Intramuscular Injections:** 96372, J code J2315

### Methadone Administration:

- **H0020 + KP modifier** for first visit of the week
- **H0020** for additional visits during the week

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<sup>3</sup> This service can only be reimbursed if the program is actually dispensing the medication

<sup>4</sup> **J0592** is normally used for injectable medications, but was assigned to **OASAS** specifically for Buprenorphine oral, since there was no other J code available at the time for oral administration.

## Requirements for Opioid Treatment Programs:

- **Fee for Service Medicaid**

- One weekly episode service claim per individual.
- Includes individual dates of service on the line level including procedure codes.
- Week defined as Monday – Sunday, billing date should be the Sunday date.
- Discounting determined by each day's services.
- KP modifier given on the line level of first medication administration service of the week.

- **Medicaid Managed Care**

- May use single visit claim for each date of service, or
- Use weekly submission.
- First Medication Administration still requires the KP Modifier.

## 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.

**Please Note: *Observation of Self-Administration is not reimbursable.***

## Medication Management

### Clinical Description

Visit with a prescribing professional for 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.
- **Complex Medication Management** 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 the [Part 800](#).

### APG CPT /HCPCS Billing Code

**99202-99205:** NEW

**99211-99215:** ESTABLISHED

Reimbursement will pivot off the diagnosis code shown on the claim and the complexity of the service. The range is assigned a blended reimbursement amount which means that all codes are reimbursed the same amount. 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 – based on AMA Coding guidelines

### Category Specific Medicaid Billing Limitations

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

**NOTE:** OASAS providers performing on-site laboratory testing (e.g. fingerstick glucose, urine pregnancy, drugs of abuse, dipstick urinalysis, breath alcohol) must obtain approval from the [Department of Health's Clinical Laboratory Evaluation Program](#) to be eligible to perform testing.

# Addiction Medication Induction/Ancillary Withdrawal

## Clinical Description

- I. **Addiction Medication Induction:** Complex medication management involves an individual 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 buprenorphine, methadone, and other addiction medicines where this level of observation is clinically indicated.

The *initial* visit should include:

- Comprehensive medical/psych and addiction history
- Limited assessment of physical/health problems
- Expanded problem focused physical exam if indicated
- Ordering of clinically appropriate laboratory testing to determine the presence of adverse medical issues that the medication could impact negatively.
- Use of Withdrawal Screen as indicated
- discussion with the individual as to the use of the medication, expected effects, possible adverse effects, course of action and possible alternatives

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.
- 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.

- II. **Ancillary Withdrawal Services:** Medication Management for symptom relief for the person in mild to moderate or persistent withdrawal which distinguishes this service from Addiction Medication Induction. Requires use of an appropriate Withdrawal Assessment Screen to determine the need for a higher level of care.

Programs who wish to provide this service must apply through the [OASAS Certification Unit](#) to have Ancillary Withdrawal added to their Operating Certification. The [Medical Protocols for Withdrawal Management Document](#) provides further information on the requirements.

## 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 throughout the induction.

## APG CPT /HCPCS Billing Code

**H0014** Alcohol and/or drug services Ambulatory Detoxification

## Time Requirements:

N/A

## Category Specific Medicaid Billing Limitations

Programs may bill only bill for a Medication Management OR Addiction Medication Induction on a service date. However, Addiction Medication Induction as a service is exempt from the cumulative two service per day claim rule.

**NOTE:** OASAS providers performing on-site laboratory testing (e.g. fingerstick glucose, urine pregnancy, drugs of abuse, dipstick urinalysis, breath alcohol) must obtain approval from the [Department of Health's Clinical Laboratory Evaluation Program](#) to be eligible to perform testing.

## Complex Care Coordination

### Clinical Description

Complex Care Coordination is an ancillary service, provided to a patient in treatment when a critical event occurs, or the individual's condition requires significant coordination with other service providers. Complex Care Coordination is distinguished from routine case coordination activities.

Complex care coordination is used to bring multiple service delivery providers together with or without the individual or by the clinical staff member only 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](#) and [Part 857](#) Regulations working within their [Scope of Practice](#).

### APG CPT/HCPCS Billing Code

**90882**

### Time Requirements

Time: Billed in 15 minute units. Maximum units per day is 4.

### 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 4 units of complex care service per day.

## Crisis Intervention

### Clinical Description

**Crisis Intervention** is a direct meeting by telephone , in-person or through telehealth with clinical and/or Peer staff and individuals in acute need of intervention. Crisis Intervention Services are indicated for those individuals whose behavior puts them or others at imminent risk of harm or death, including overdose, or whose mental health is deteriorating because or independent of substance use. Individuals in these situations may specifically state that they will harm themselves or others or they may have a history of at-risk behaviors, such as non-fatal overdose or self-injury, that may be exacerbated by substance use.

Clinical staff and/or Peers work with the individual, their family members, and other collaterals to identify a potential mental health or personal crisis, develop a crisis management plan, and/or as appropriate, seek other supports to restore stability and function. The staff member(s) assigned to an individual in crisis will be determined by the nature of the acute incident and the risk of harm to the individual and/or others. . Appropriate training and supervision should be provided to all staff who are performing this service.

For further information please review: [OASAS Crisis Intervention Service Guidance Document](#).

### Delivering Staff

Staff: Clinical and/or medical staff as defined in [Part 800](#) (working within their [scope of practice](#)) and Certified Recovery Peer Advocates (CRPA's).

### APG CPT / HCPCS Procedure Code

**Crisis Intervention:** H2011

S9485

### Time Requirements

**Crisis Intervention:** H2011, 15 minute units

S9485, 90 minute unit

### Category Specific Medicaid Billing Limitations:

Crisis Intervention H2011 services are billed per 15 minute units with a 6 unit per day maximum. S9485, 90 minute unit, one per day. Neither service is subject to the two service per day limitation.

## Smoking Cessation Services

### Clinical Description

Smoking Cessation is a specific 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 addiction treatment provided in either group or individual sessions per 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

### 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.

Individuals cannot be admitted into OASAS Certified Programs with a Tobacco Use Disorder primary diagnosis.

# Intensive Outpatient Service (IOS)

## Clinical Description

“Intensive Outpatient Service” (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 addiction. Rather than a set format of services IOS is meant to be specific to the person and what they need. Using evidence-based practices such as Coping Skills Training, Motivational Enhancement, Cognitive Behavioral Therapy, and Dialectical and Behavioral Training, counseling and support services are intended to stabilize individuals for their next step in treatment.

Intensive Outpatient treatment should allow for flexible scheduling so that services are delivered during the day, evening, or weekends. These services must be scheduled **for at least 3 hours total service time for a day** when the service is billed. Individuals are seen in group, family and/or individual sessions and may use up to one hour of this time for Peer Support Services. Based on the person’s needs, Intensive Outpatient Services may be provided in as little as a week up to but **not exceeding 6 weeks** without clinical justification.

## Delivering Staff

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations working within their [Scope of Practice](#).

## APG CPT /HCPCS Billing Code

**S9480** – Intensive Outpatient psychiatric services, per diem.

## Time Requirements

Minimum of three hours per service date

## Category Specific Medicaid Billing Limits

Programs **may not bill for more than 6 weeks** of Intensive Outpatient Service without a clinical rationale as indicated via the [Concurrent Review Level of Care Tool](#). IOS is billed daily regardless of the total weekly attendance of any individual in treatment.

Medication Administration, Medication Management, Complex Care, Peer and Collateral services can be billed in addition to the daily IOS service.

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.

## Outpatient Rehabilitation Services

### Clinical Description

A configuration of services designed to improve functioning for individuals with more chronic conditions emphasizing development of basic skills in prevocational and vocational competencies, personal care, nutrition, communication, and community competency. Individuals should be scheduled for between three and five days a week for a minimum of two hours.

### Delivering Staff

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations 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

Services can only be provided by OASAS Certified Outpatient Rehabilitation Program.

An Outpatient Rehabilitation Service must contain an individual counseling service of at least 25 minutes or a 60 minute group counseling service.

Programs may bill for Medication Administration and Management, Complex Care, Peer Support Services, and Collateral Service, **either** outside of the Outpatient Rehab Per diem **or** they can provide these services within the OPR Service. Unless the OPR daily duration **has not been** met, individual and/or group counseling cannot be billed outside of the Per Diem.

When an exempt service is being delivered outside of the OPR or when the daily time minimum has not been reached the program would utilize the OPR Rate Code at the Header level, and OPR Procedure Code when delivered, along with any other applicable procedures at the line level.

## Section Five Physical Health Service Categories:

**Physical Health services are services provided *outside of regulatory requirements*.** Physical Health Services encompass a wide range of assessment and treatment procedures performed by medical staff for identifying and treating physical problems associated with addiction. Examples of Physical Health services may include but are not limited to immunizations, hepatitis, TB/HIV testing, pregnancy test, preventative care. Laboratory services not required by regulation would also fall under the physical health rate code.

Programs are limited to providing 5% (this percentage may be higher for integrated licensure models under DSRIP) of total visits for physical health visits. If providers go above the 5% they would need to receive certification from DOH as a general health clinic.

### I. Evaluation and Management Services:

#### Clinical Description

Services provided in addiction settings for both acute and chronic conditions when those services are related to the treatment of addiction. The goal of the clinic should be to have every individual in treatment connected to a primary care provider.

#### Delivering Staff:

Medical staff as required by the specific physical health service and E/M code, working within their scope of their practice. Programs are advised to consult the current CPT coding manual for further guidance on which set of CPT codes to use when delivering a physical health service.

#### APG CPT /HCPCS Billing Code Physical Health

In billing for these services specify the primary substance/addiction as weights vary based on the diagnosis. Physical Health Claims should be submitted separately from Behavioral Health Claims utilizing the [Physical Health Rate Code](#).

**99202-99205:** New, Evaluation & Management, no counseling

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

**99382-99387:** New, Physical Exam

**99392-99397:** Existing Physical Exam

#### Time Requirements

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

## II. Laboratory services Not required by regulation

When laboratory and radiology services are provided or ordered outside of specific regulatory requirements a **physical health visit** is billed utilizing the **Physical Health Rate Code**. OASAS Outpatient Clinics are subject to the Article 28 Hospital and Article 32 Free-standing ancillary policies briefly explained below.

- a. **Hospital Ancillary Policy:** All ancillary services (laboratory and radiology procedures) ordered because of a **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.
  - For ancillary services provided outside of the hospital clinic:
    - The provider that provided the physical health service precipitating the ancillary service **must** notify the ancillary provider **not to bill** Medicaid directly for the ancillary service, and
    - **Must** reimburse the ancillary service provider for their services rendered.
- b. **Freestanding Ancillary Policy:** All ancillary services (laboratory and radiology procedures) ordered because 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.
- Please note** 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 separate fee-for-service claim for the ancillary service when modifier 90 is on the claim.
  - 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 ordered during the physical health medical visit, the freestanding OASAS clinic:
    - **SHOULD NOT** code modifier 90 on the physical health medical visit claim, and,
    - 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](#).

### III. Lab Services Required by Regulations

Lab services provided to Outpatient Clinic/Rehabs and individuals in Opioid treatment:

- **Will not** be the fiscal and/or contractual responsibility of the OASAS Certified Outpatient 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.
- Outpatient Providers should not code the ancillaries (labs) on their APG claims.

**The exception to this policy is toxicology provided in an Opioid Treatment Program 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 or Medicaid Managed Care for toxicology services provided to an individual in the Opioid treatment program, **AND**
- **should NOT** code the ancillaries (labs) on their APG claims.

**PLEASE NOTE** - Article 28 Hospital based outpatient clinics, ambulatory surgery centers, emergency departments, freestanding diagnostic centers, and free standing ambulatory utilize a different reimbursement strategy which can be found in the [APG policy and billing guidelines for Article 28](#).

**NOTE:** OASAS providers performing on-site laboratory testing (e.g. fingerstick glucose, urine pregnancy, drugs of abuse, dipstick urinalysis, breath alcohol) must obtain approval from the [Department of Health's Clinical Laboratory Evaluation Program](#) to be eligible to perform testing.

## Section Six: General Claiming Guidelines

Medicaid claims are processed using the **837I** form for electronic transmittals, and the **UB04** form for paper submission. Though the information on the claims form is generally the same there are differences in some areas between Medicaid Fee for Service claiming and Medicaid Managed Care Plan claiming. The following section will give information applicable to both and specific to each. In addition, under each, Medicaid Fee for Service and Medicaid Managed Care, there are links to tools that provide claiming specifics, i.e. how to fill out claims forms.

Please note, information specific to reimbursement during the COVID Emergency can be found in the [COVID Billing Addendum](#).

### Claiming Information:

#### a. General Medicaid Claiming:

- Ensure filing of claims within 90 days of service provided i.e. 90 days timely filing
- Proper use of Rate Codes and Procedure Codes
- Appropriate treatment plan or admission decision signatures<sup>5</sup>
  - **Only** physicians, physician's assistants, nurse practitioners, licensed psychologist, and Licensed Clinical Social Workers who are enrolled in Medicaid
- Medicaid Service time duration and limitations
- Visit Date/Services
  - One claim per individual per day of actual visit
  - One Rate Code per claim
  - Only one of the same service per day.
  - Only two services per day with the exception of: medication administration, medication management, complex care coordination, collateral visit, and peer support service.
  - Second and third service of the day will be discounted by 10 % except for: Medication administration, Medication management, Peer Support Service, Smoking Cessation, Collateral, Physical Health and Physical Exam.

#### b. Medicaid Fee for Service Claiming:

- [eMedny Institutional Billing Guidelines](#) – provides field by field information on how to fill out the 837i and UB04 form fields
- Reimbursement avenue for dually eligible
- [OPRA Requirements](#):
  - Medicaid Enrolled Ordering/Referring/Prescribing Practitioner **required** on claim

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<sup>5</sup> [Current OASAS Part 822 Regulations](#) advise that treatment plan is the sign off document for reimbursement. The [Updated Part 822 Regulations](#) designate the admission decision document for reimbursement.

- Attending and Ordering/Referring/Prescribing Practitioner **must be** affiliated with Provider Medicaid Profile.

### c. Medicaid Managed Care:

- [OPRA Requirements: as of 2018 for MMC](#)
  - Medicaid Enrolled Ordering/Referring/Prescribing Practitioner **required** on claim
  - Attending and Ordering/Referring/Prescribing Practitioner **must be** affiliated with Provider Medicaid Profile.
- [Medicaid Managed Care Contract 2019](#)
- [Billing Tool](#)
- [Clean Claims and Revenue Cycle Management Training](#)
- [Clean Claims and Revenue Cycle Management Training Video](#)
- [Top Denial Reasons with Resolutions](#)
- [Working with MMCP's](#)
- [Chapter 57 Insurance Law Changes of 2019:](#)
  - Authorization
  - [LOCADTR 3.0, LOCADTR for Gambling](#) and
  - [Concurrent Review LOCADTR](#)

### d. Common Claiming issues:

#### a. Eligibility

- Individual not enrolled in Medicaid, and/or the identified Managed Care Plan
- Eligibility changed after initial ePaces check, and/or later on in treatment
- Individual has Medicaid and another plan, e.g. Medicare, Commercial Insurance and should have been billed via fee for service.

#### Solutions:

- Check, re-check, and continue checking eligibility
- Know the rules, if a person is dually enrolled then they have to be disenrolled from their Medicaid Managed Care Plan and claimed via Fee for Service
- Medicaid is the last payor of resort; all other types of insurance must be billed prior to submission to Medicaid.

#### b. Pre-Paid Capitation Plans

- Individual not in the Mainstream Plan
- Plans have different service types

#### Solutions:

- Check eligibility through [ePaces/Mevs](#)
- Know the different [types of Medicaid Managed Care Plans](#).

### c. OPRA Issues

- Attending NPI not associated with the facility
- OPR NPI not associated with the facility
- OPR NPI not enrolled in Medicaid
- OPRA excluded from Medicaid

#### Solutions:

- [Update your Medicaid Facility information](#) with new staff.
- Make sure your OPR's are [enrolled in Medicaid](#)
- Ensure you are checking [excluded provider lists](#) regularly
- Review and follow [OASAS Updated OPRA Guidance](#).

### d. Address Issues

- Zip + 4 does not match what's on the claim
- LOC's on Provider ID not updated when addresses change

#### Solutions:

- [Update your Medicaid Provider Profile](#)
- Verify your zip codes in the [3M Grouper](#)
- Use the zip code on your OASAS Operating Certificate as the zip code on the claim.
- Notify the [OASAS Certification Unit](#) of any changes to your location

### e. Rate Codes

- Rates for new sites not loaded in eMedny or 3M Grouper
- Rates for existing sites are not up to date
- Rate zeroed out on given rate code and/or LOC

#### Solutions:

- Verify your site information in the [3M Grouper](#)
- Reach out to the [OASAS Healthcare Finance Unit](#) for status of your rates, or rate changes.
- Use valid, up to date Rate Codes

### f. Outside of 90 day Timely Filing Limit

#### Solutions:

- Having processes in place to warn you if claims are approaching the end of the 90 day claiming window

- Understand and utilize [Delay Codes](#), when appropriate to file claims outside of the window

#### g. Managed Care Specific

- Out of Network Provider
- No authorization
- Clinical Necessity Denials

#### Solution:

- Know who your [plan contacts](#) are
- Build relationships with your contacts don't wait until there is a problem
- Authorization is not "pre-authorization." The [Insurance Laws of 2019](#) require providers to notify plans within 48 hours that one of their enrollees are receiving treatment. Check with your plans to see how best to provide this information if at all.
- Clearly understand the logic of the [LOCADTR 3.0](#), and [LOCADTR for Gambling](#) to be better able to communicate clinical necessity with the plans.
- If clinical necessity issues cannot be resolved with the plan, contact [NYS Department of Financial Services](#) to file an appeal
- For broader concerns effecting multiple claims please contact the [PICM Mailbox](#)

## Section Seven: Tools and Resources

### Tools

- APG Revenue Calculator:
  - [Freestanding APG Revenue Calculator](#)
  - [Hospital Based APG Revenue Calculator](#)
- [NYS HARP Mainstream Behavioral Health Billing Manual](#)
- [MCTAC Billing Tool](#): UB04 Form with information on field entries
- [Medicaid Managed Care Plan Directory](#)
- [Peer Integration Organizational Readiness Self-Assessment](#)
- [Peer Integration Tool-Kit](#)
- [NYS DOH 3M Grouper/Pricer](#)

### Regulations

- [Part 822 General Standards for Substance Use Disorder Outpatient Programs](#)
- [Part 841 Medical Assistance for Chemical Dependence Services – Medicaid Regulations](#)

- [Part 857 Problem Gambling Treatment and Recovery Services](#)
- [Gambling Free Services LSB](#)
- [Part 830 Telepractice Regulations](#)

## Guidance

- [COVID Billing Addendum](#)
- [Family Treatment Services](#)
- [Chapter 57 Insurance Laws of 2019 Guidance](#)
- [Continuing Care Guidance](#)
- [Person Centered Care](#)
- [Person Centered Medication Treatment](#)
- [Pre-admission Services](#)
- [Services in the Community](#)
- [Standards for OASAS Certified Programs](#)
- [Telepractice for OASAS Designated Providers](#)
- [Crisis Intervention Service Guidance](#)

PLEASE SEND ANY ADDITIONAL QUESTIONS REGARDING MEDICAID BILLING TO THE PICM MAILBOX AT: [PICM@oasas.ny.gov](mailto:PICM@oasas.ny.gov)

## Section Eight Appendices

### Appendix A APG Rate Codes:

Type of Program	Behavioral Health Rate Code	Physical Health Rate Code	Base Rate Upstate	Base Rate Downstate
Freestanding <b>OP Clinic</b>	1540	1468	\$150.11	\$175.64
Freestanding <b>OP Rehab</b>	1573	1570	\$150.52	\$176.12
Freestanding <b>OTP</b>	1564	1471	\$138.31	\$161.82
Hospital Based <b>Op Clinic</b>	1528	1552	\$149.07	\$186.66
Hospital Based <b>Op Rehab</b>	1561	1558	\$143.31	\$187.18
Hospital Based <b>OTP</b>	1567	1555	\$159.76	\$186.59

### Integrated Outpatient Services (IOS)

Type of Program	Behavioral Health Rate Code	Physical Health Rate Code	Base Rate Upstate	Base Rate Downstate
Freestanding IOS <b>OP Clinic</b>	1486	1468	\$150.11	\$175.64
Freestanding IOS <b>OTP</b>	1130	1471	\$138.31	\$161.82
Hospital Based IOS <b>Clinic</b>	1132	1552	\$149.07	\$186.66
Hospital Based IOS <b>OTP</b>	1134	1555	\$159.76	\$186.59

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
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### Appendix B APG Procedure Codes and Limitations

Screening	H0049	Screening using approved assessment tool (15 min)	pre-admission, one per continuous treatment period.
Brief Intervention	H0050	Interventions (15 min)	1 service per visit date, 3 services per continuous treatment period.
Assessment Brief	T1023	Pre-admission assessment (15 min)	1 service per visit date, 3 services per continuous treatment period.
Assessment Normative	H0001	Pre-admission assessment (30 min.)	1 service per visit date, 3 services per continuous treatment period.
Assessment Extended	H0002 or 90791	Pre-admission assessment (75 min)	1 service per visit date, 1 per continuous treatment period.
Individual Therapy – Brief	G0396 or 90832	Counseling session (25 min)	No more than one individual counseling service per day
Individual Therapy – Normative	G0397 or 90834	Counseling (45 min)	No more than one individual counseling service per day
Brief Treatment	H0004	Brief Treatment visit (15 min)	No more than one brief treatment service per day, post admission.
Group Counseling	H0005 or 90853	Group counseling services (60min)	No more than one group service per visit date
Multi-Family Group	90849	Multiple family group (60 min)	Can be billed for one family member per individual in treatment

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Family/Collateral Services w/o patient	T1006/90846	Family/Collateral Services (30 min)	No more than one Family/Collateral Service per day
Family Service with patient present	90847	Family Service (30 min)	No more than one Family Service per treatment date
Peer Support Service	H0038	Peer Support Service (15 min)	12 unit (3 hour) maximum per day. Exempt from two service per day rule
Psychiatric Assessment Brief	99202-99205 <b>New</b> 99212-99215 <b>Existing PLUS</b> Add-On Code 90833	Psychiatric Assessment w/counseling (30 min)	No more than one service per day
Psychiatric Assessment	99202-99205 <b>New</b> 99212-99215 <b>Existing PLUS</b> Add-On Code 90836	Psychiatric Assessment with counseling (45-50 min)	No more than one service per day
Medication Administration & Observation (1st visit of week) <b>Buprenorphine</b>	H0033, J0592 Use KP modifier	Oral Medication administration first visit for week (no time minimum)	No more than one service per day. Exempt from two service per day rule.
Medication Admin & Observation		Oral Medication administration, direct observation (no time minimum)	No more than one service per day, Exempt from two service per day rule.

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
<b>Buprenorphine</b>	H0033, J0592		
Medication Administration & Observation <b>Sublocade</b>	96372, Q9991 or Q9992	Intramuscular Injection	Can have two services on the same date if medically necessary.
Medication Administration & Observation <b>Vivitrol</b>	96372, J2315	Intramuscular Injection	Can have two services on the same date if medically necessary.
Medication Administration & Observation (1st visit of week)	H0020 Use KP Modifier	Methadone Administration first visit for week (no time minimum)	No more than one Medication Management A&O service 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. Exempt from two service per day rule.
Medication Management	<b>New</b> 99202-99205 <b>Existing</b> 99211-99215	Specific code determined by the complexity of service.	No more than one Medication Management service per day. Exempt from two service per day rule. Must be provided by a Prescribing Professional.
Addiction Medication Induction and Withdrawal Management	H0014	Induction to new medication requiring a period of individual observations	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.

<b>Medicaid APG Service Category</b>	<b>Procedure Code(s)</b>	<b>Procedure Description</b>	<b>Medicaid Billing Limitations Fee for service only unless otherwise indicated</b>
Complex Care Coordination	90882	Environmental manipulation	Exempt from the two billable services per day rule.
Crisis Intervention Service	H2011	15 Minute Unit	Exempt from two billable services per day rule. 6 unit per service date limit
Crisis Intervention Service Extended	S9485	90 minute minimum	Exempt from two billable service per day rule. 1 service per service date.
Intensive Outpatient Services	S9480	3 hours on any given day	Time limited, should not exceed 6 weeks without clinical justification. IOS may not bill other service categories on the same day that they bill for IOS.
Outpatient 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.
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.
Smoking Cessation	99406	Behavior Change Smoking 3-10 min	Individual intervention (not group). No more than three smoking cessation services per continuous treatment period. Not third visit exempt.

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Smoking Cessation	99407	Behavior Change Smoking 11+ min	Individual (not group). No more than three smoking cessation services per continuous treatment period. Not third visit exempt.
Physical Health Specify Diagnosis	<b>New</b> 99202-99205 <b>Existing</b> 99211-99215	Evaluation & Management no counseling	For Services Required by regulations use Behavioral Health Rate Code
Physical Health Specify Diagnosis	<b>New</b> 99382-99387 <b>Existing</b> 99392-99397	Physical Exam New/Established	For Services not Required by regulations use Physical Health Rate Code.