

Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance

October 2024

**OASAS Certified
Outpatient Programs**

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Section One: Ambulatory Patient Groups (APGS) Introduction

The New York State Medicaid program utilizes the [Ambulatory Patient Group \(APG\)](#) classification, reimbursement and billing methodology to establish and provide Medicaid payment for outpatient programs including Art 32 Title 14 NYCRR Part 822 OASAS certified outpatient programs. APGs are classified and reimbursed using a software developed and published by 3M Health Information Systems (3M). The 3M “Grouper Pricer” software.

The APG methodology is used to reimburse providers for services delivered to individuals enrolled in the NYS Medicaid program and receiving service through straight Medicaid Fee- for-Service or via a New York State approved [Medicaid Managed Care Plan](#).

Managed Care Plans operating in New York State must reimburse ambulatory mental health and addiction services licensed and/or certified pursuant to Article 28 of the Public Health Law and / or Article 31, Article 32 (including outpatient and opioid treatment programs), or Article 36 of the Mental Hygiene Law at an amount equivalent to the payments established under the ambulatory patient group (APG) rate-setting methodology or any other fees established pursuant to the Medicaid state plan, as utilized by SDOH, the Office of Addiction Services and Supports or by the Office of Mental Health.

With both **Medicaid Fee for Service** and **Medicaid Managed Care** utilizing the APG Methodology this manual provides 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 Addiction Treatment, including problem gambling treatment, Opioid Treatment Programs, and Integrated Services settings.

Section Two: Updates

A: Current Updates: Items Newly Added to the October 2024 Manual

COLA Rate Increase: Effective April 1, 2024

The New York State (NYS) Division of the Budget approved Medicaid rate package(s) to establish new levels of reimbursement for the Part 822 Outpatient Addiction Services. The rate adjustment increases of 2.84% went into effect **April 1, 2024**. Updated base rates can be found in the [Rate Code Section](#) of this document.

OTP/OPC Integration, aka Comprehensive Outpatient Programs (COP)

Co-located Part 822 Outpatient Clinics and Opioid Treatment Programs can apply to OASAS to integrate services. Integration/COPs would allow individuals enrolled in one program to access staff and services (groups, counseling, ancillary services) available in the other program without being dually enrolled. Integrating 822 services expands

access to OTP treatment in underserved areas by situating OTP services within an existing clinic program. Integration/COPs increases services available for OTP patients while also providing access to MAT for patients enrolled in outpatient services. Integrating 822 services further allows the program to share staff and consolidate groups. Providers will continue to have two PRUs which will be placed on one operating certificate. For further information email SOTA@oasas.ny.gov.

Initial COP Implementation

Effective August 1, 2024, Comprehensive Outpatient Program (COP) that have integrated OASAS Part 822 Outpatient Services and OASAS Part 822 Opioid Treatment Programs (OTP) services were merged under one operating certificate in order to make all services available to all enrolled patients (i.e., services other than methadone). This change will initially affect only providers that have a comprehensive outpatient program. More information on COP and a list of providers who are currently COPs can be found in the [OASAS reimbursement page](#).

COP Rate Codes

- For service dates beginning August 1, 2024, up to and including November 3, 2024, COP providers can choose either of the following rate codes for claim submissions to Medicaid FFS and/or Medicaid Managed Care:
 - New COPS rate code – 1036
 - Historical APG rate codes – E.g. 1540, 1564
 - Covid bundled rate codes – E.g. (7969-7972)
- If a COP provider elects to use the historical APG rate codes or the Covid bundled rate codes between DOS August 1, 2024, to November 3, 2024, claim adjustments with the COP rate code will not be required retroactively.
- Further detail and lists of COPs can be found in the [OASAS reimbursement page](#).
- COP providers will be given new COP-specific rate codes, as listed below. The new rate codes are in the APG grouper. Base rates can be found in the Rate Code Section of this document.

Program Type	Rate Code
Freestanding COP	1036
Hospital-based COP	1039

APG Weight Changes for Psychotherapy (Group and Family)

Effective July 1, 2024, the APG weight for Group and Family Psychotherapy was adjusted in accordance with [joint guidance](#) issued by OASAS and Office of Mental Health (OMH)..

For OASAS programs only: providers will be required to code one of the following three modifiers- AH (clinical psychologist), AJ (clinical social worker), or HO (master's level)- when submitting claims for 90853 or 90849 to receive the reimbursement enhancements outlined in [the guidance](#). Procedure codes 90853 and 90849 billed with modifiers AF (psychiatrist), AG (physician), or SA (psychiatric nurse practitioner) will continue to increase the weight for group services by an additional 20%, on top of the new enhancements.

Group Psychotherapy services (procedure codes 90853 and 90849) may be delivered by the following practitioners, as it is within their scope of practice: Master's-Level health care clinicians (i.e., Credentialed Alcoholism and Substance Abuse Counselor (CASAC) with a master's degree in a health-related field), Licensed Clinical Social Workers (LCSWs), Licensed Mental Health Counselors (LMHCs), Psychologists, Nurse Practitioners (NPs), and Physicians licensed in New York State through the State Education Department.

Detailed information can be found in the linked memo: OMH and OASAS [APG Weight Adjustments for Psychotherapy \(Group and Family Group\) and Peer Support Group Services](#)

Adding OTP Bundles to APGs

Effective July 1, 2024, OTP bundle services were bought under the APG methodology. To receive the bundle payment under APGs, OTP/COP programs must use the appropriate CPT codes (G2067, G2068, G2078, G2079) when providing qualifying bundle services. Additionally, they may bill for substance use disorder (SUD) services that fall outside of the OTP bundle on the same APG claim. Claims for APG billing for OTP services will continue to be submitted weekly. Providers will still have the option of using the bundle rate codes, rather than billing the bundles through APGs, until November 4, 2024. After this date, the bundle rate codes (7969 – 7976) will be zeroed out for all providers, except Federally Qualified Health Centers (FQHC) that have opted out of APG billing. This transition period allows providers to adjust their billing systems to accommodate bundle codes under APGs.

This change enables providers offering services in the community, including through mobile medication units, to bill the bundles under APG rate codes 1080 or 1088 and receive the enhanced reimbursement associated with those codes.

FQHCs that have opted out of APG billing will continue to use the bundle rate codes (7969 – 7976) or rate code 1671, but not both in the same week.

B: Prior Updates: Previously added to the manual

OTP Parity Rate Changes:

As part of OASAS's initiative to integrate OTP and Clinic programs an adjustment was made to the base rates of all programs except the Freestanding Outpatient Clinics. The rate adjustment is effective January 1, 2024, and will create a reimbursement structure where Clinic, Rehab, and OTP's will reimburse at the same base rate for their region. Along with the change in base rate, the procedure weights for H0020 and H0033 have been adjusted from 0.1335 to 0.1179, effective January 1, 2024. Updated base rates can be found in the Rate Code Section of this document.

Brixadi (extending release buprenorphine) Approval:

Effective January 1, 2024, Brixadi (buprenorphine extended-release injection for subcutaneous use) to treat moderate to severe opioid use disorder is reimbursable through APG's. Brixadi is available in two formulations, a weekly injection that can be used in patients who have started treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine, and a monthly version for patients already being treated with buprenorphine. Further claiming

information can be found in the [Medication Administration/Observation Section](#) of this document.

Freestanding Off Site Services Increase:

As of January 1, 2023, Freestanding Programs received a 40% differential for services provided in the community. For providers to receive the increase they must use the Off-Site Services Rate codes, OP Clinic/Rehab rate code 1080, OTP rate code 1088. Rate increases are reflected in the [Base Rate listing](#) in this document.

Nursing Services Clarification:

Providers may use the 99211 E/M Code for services provided by medical staff including: RN, LPN, Medical assistant for services that are provided on days when no other E/M code is being used. For further information on the types of activities 99211 will cover please see the following link to: [When is it Proper to Bill Nurse Visits using 99211 - Find-A-Code Medical Coding and Billing Articles \(findacode.com\)](#)

Nurse Practitioner Modifier:

Providers can now use the SA Modifier when a Nurse Practitioner provides a service under APG#'s 315, 316, 318, and 323. Individual Therapy, Group Therapy, and Assessment would qualify for the modifier. The SA modifier adds 20% to APG 318 (Group Therapy), and 45% for all the other identified APG #'s.

Dual OASAS Outpatient Program Enrollment:

A person should be getting services in one location in most cases. However, there are times when specialty services or services specific to the needs of the individual are not available at the program where they are being served. In those instances, a person may be admitted to one site and receive services in another.

Dual enrollment can be a situation where:

- if someone were admitted to an OTP and Outpatient Clinic/Outpatient Rehab at the same time.
- If someone were admitted to an Outpatient Clinic but went to some services at a different Outpatient Clinic

If someone is admitted to both programs, then:

- All regulatory requirements must be met at both sites.
- The same service, etc. individual counseling or group counseling can't be offered and reimbursed in both places on the same service date.

If under the same provider ID reimbursement should be done through the

location to which the person is admitted.

If the services are being delivered by different providers, then each should seek reimbursement of the service provided at their location.

Documentation should follow 42 CFR and be agreed upon between the different programs providing the service.

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 a primary addiction diagnosis as given in the most recent version of the ICD/DSM or for gambling as defined in the [Part 857 Problem Gambling Regulations](#).

Facility Charge: OASAS Certified Outpatient providers can seek reimbursement when a person utilizes their facility to receive Telehealth services from a different provider at another location. Within the APG Methodology providers can utilize procedure code Q3014 for \$25.76 reimbursement. The **25 modifier** must be appended to the claim for reimbursement.

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 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 an addiction 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.

NOTE: When assessing a significant other for admission, working with family members as collateral contacts or in providing family or multi-family therapy the LOCADTR **should not** be utilized.

Medical Staff: Physicians, nurse practitioners, physicians' 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 (as defined in the [Part 800](#) regulations).

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 OASAS OPRA Guidance.

Nurse Practitioner Add on Fee: Fee added when a **Nurse Practitioner, acting within their scope of practice**, provides a service **normally provided by a clinical staff member**, e.g., individual/group counseling, assessment. To receive the additional rate the SA modifier must be affixed to the claim.

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.

Preadmission Services: 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, Crisis Intervention, Addiction Medication Induction, Medication Admin/Observation, and Medication Management**. Providers will need to document the clinical necessity of these types of services for reimbursement.

OPRA Requirements for all claims the Ordering/Referring practitioner NPI has to be enrolled in Medicaid for claims to be reimbursed. 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 takebacks. Further details can be found in the [OASAS OPRA Guidance](#).

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 its 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 provided in a community setting, including a patient's home, in a mobile unit, and other settings that are appropriate for outreach, engagement and to initiate or continue treatment for SUD. All services that can be provided in the clinic can be provided in the community. **NOTE: Services provided via telehealth are not considered in-community services.** 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 was updated and integrated into the [Part 830 Designated Services Regulations](#). The [Telehealth Standards](#) 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.
- The **FQ modifier** should be used for services delivered via **telephone (audio-only)** (when a telehealth service is furnished using audio-only communication)

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; or an Assessment and a treatment service such as an individual or group service. However, the following services **are exempt** from the two service per day rule: **Medication Administration, Medicaid Management, Addiction Medication Induction, Complex Care Coordination, Crisis Intervention 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 unknown that the person is appropriate for admission.***

The screen is conducted through electronic or written format utilizing approved screening tools: **AUDIT, CRAFFT, Simple Screen, GAIN Quick, ASSIST** other OASAS approved screening for SUD. The **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 Telehealth between an individual and clinical/medical staff for determining appropriateness for 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 by the [LOCADTR 3.0 for SUD](#) and [LOCADTR for Gambling](#).

See additional guidance on [Preadmission Services](#).

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 by a QHP and confirmed by a [Medicaid Enrolled Practitioner](#). Treatment services can begin once the QHP has made the decision to admit.

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. In no case, should a program bill for more than one extended assessment

visit within an episode of care. Programs may provide another treatment service on the same day of an assessment, this includes nursing visits, medication management, individual, family or group counseling, and complex care coordination.

Individual Counseling

Clinical Description

A counseling session delivered either in person or via Telehealth between an individual and clinical staff member to develop and carry out a plan of treatment. 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.

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 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 Guidelines](#).

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 delivered either in person or via Telehealth between an individual and clinical staff member 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 Guidelines](#).

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 delivered in person or via Telehealth 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 make changes in use of substances to reduce risk and to attain and maintain recovery. 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 groups¹ 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

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

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 [Services for Family and Significant Others](#).

Delivering Staff

Clinical Staff² as defined in the [Part 800](#) and [Part 857](#) Regulations working within their [Scope of Practice Guidelines](#). 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 procedure code 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.

Family Services

I. Person with Addiction is the focus of the service Clinical Description

A service delivered either in person or via Telehealth to **non-admitted** family members, **with or without** the individual in treatment present for the service. 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. There is no limit to the number of family therapy visits that can be delivered.

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.³

² Certified Recovery Peer Advocates may not bill Medicaid for the delivery of group services.

³ SAMHSA Quick Guide for Clinicians, Based on TIP 39 Substance Abuse Treatment and Family Therapy

- **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/ or individual(s) who have the best interest of patient's well-being in mind, with the purpose of supporting 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: A person who is being seen for their own treatment reasons should be admitted to the program with their own plan of treatment.

Delivering Staff

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

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) issues and concerns arising from the relationship with a person with a substance use disorder. In this case, the family member should be admitted to the program and have their own treatment plan.

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. Most often these are utilized when the family member's own needs are the

focus of treatment – the goal is to improve family interactions 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 [Services for Family and Significant Others](#)).

Peer Support Services

Clinical Description

[Peer Support Services](#) are connections delivered either in person or via Telehealth 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. Peer Support Services are intended to be provided to individuals **not in group settings**.

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/HCPSC 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 24 units (6 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 Observation⁴

Clinical Description

Administration of **a dispensed** medication via oral or non-oral route by a medical staff person appropriate to their [NYS Office of Professions SOP](#); 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 within the APG methodology or APGs so long as they only bill one methodology for a patient in a given week. As given in the [OASAS OTP Billing Bundle guidance](#) 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 [NYS Office of Professions SOP](#).

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.

Code	Units	Maximum Units
J0571	\$0.24 per unit (1mg) ⁵	168
J0572	\$4.05 per unit (2 mg/.5 mg tab/film)	21
J0573	\$5.01 per unit (4mg/1mg tb/film)	7
J0574	\$7.01 per unit (8 mg/2mg tab/film)	28

⁴ This service can only be reimbursed if the program is actually dispensing the medication

⁵ Billing unit is 1 mg, but this comes as a 2 mg pill which equates to 2 units (2 mg)

Brixadi*: Buprenorphine extended-release injection for subcutaneous use.

April 1, 2024, Guidance

NDC	NDC Name	Dose Duration	Procedure Code ⁶	Units of Service	APG Fee Schedule Payment
58284020801	BRIXADI WEEKLY 8 MG/0.16ML SYR	7 Day or Less	J0577	8	\$ 401.31
58284021601	BRIXADI WEEKLY 16MG/0.32ML SYR	7 Day or Less	J0577	16	\$ 401.31
58284022401	BRIXADI WEEKLY 24MG/0.48ML SYR	7 Day or Less	J0577	24	\$ 401.31
58284023201	BRIXADI WEEKLY 32MG/0.64ML SYR	7 Day or Less	J0577	32	\$ 401.31
58284026401	BRIXADI MONTH 64 MG/0.18ML SYR	8 to 28 Days	J0578	64	\$ 1,542.37
58284029601	BRIXADI MONTH 96 MG/0.27ML SYR	8 to 28 Days	J0578	96	\$ 1,542.37
58284022801	BRIXADI MONTH 128MG/0.36ML SYR	8 to 28 Days	J0578	128	\$ 1,542.37

***Please note:** To receive payment, the NDC must be coded on the claim line along with the procedure code. **If the NDC is not coded on the claim the claim line will not pay. In addition, procedure code 96372 is to be used for the injection itself.**

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

Buprenorphine is billed under the following procedure codes (but only if the buprenorphine bundle is not being billed):

HCPCS Code	HCPCS Code Description	Reimbursement Amount (per unit)	Max units
J0572	Bupren/nal up to 3mg bupreno	\$ 4.09	21
J0573	Bupren/nal 3.1 to 6mg bupren	\$ 5.01	7
J0574	Bupren/nal 6.1 to 10mg bupre	\$ 7.08	28

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

⁶ Effective April 1, 2024, J0576 was replaced with J0577 and J0578

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.

Non-APG Medicaid Bundle Rates 7:

Rate Code	Rate Code Description
7969/7973	Methadone Full Bundle <ul style="list-style-type: none"> • In person medication dispensing; AND/OR • Any OTP Service delivered via Telehealth
7970/7974	Methadone Take Home Supply – week with previously dispensed methadone.
7971/7975	Buprenorphine Full Bundle <ul style="list-style-type: none"> • In person medication dispensing; AND/OR • Any OTP Service delivered via Telehealth
7972/7976	Buprenorphine Take Home Supply - week with previously dispensed buprenorphine

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. Observation of Self-Administration is not reimbursable.

Medication Management

Clinical Description

⁷ Full description in [Medicaid Billing Guidance for OTP’s](#) and [Permanent Approval Letter](#)

Visit either in person or via Telehealth 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

99212-99215: ESTABLISHED

99211 Used as given in the most recent version of the [AMA Coding Handbook](#).

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

- 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 [NYS Office of Professions SOP](#), 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 provided to a patient in treatment when the individual's condition requires significant coordination with other service providers. Complex Care Coordination is distinguished from routine case coordination activities by the distinct episode/event.

Complex care coordination is used when there are multiple outside service delivery providers and care needs to be coordinated. These services may include but are not limited to:

- Facilitating level of care change when there are mitigating circumstances e.g., health status, income, need for specialized treatment services/needs or other barriers to placement,
- Social determinants of health that compromise the individual's ability to live content and productive lives, e.g.,
 - employment, unemployment, job insecurity
 - education
 - Food insecurity
 - Housing, basic amenities
 - Access to healthcare
 - Transportation

The complex care coordination does not need to occur face-to-face with the service provider. May involve coordination with **other** service providers or with any employment, housing, or governmental entity.

For additional Information please review: [Complex Coordination Guidance Document](#).

Delivering Staff

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

APG CPT/HCPCS Billing Code:
90882

Time Requirement:

Time: Billed in 5-minute units. Maximum units per day is 4 (20 min) with a 12 unit (1 hour) per week limit.

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 Guidelines](#) and [NYS Office of Professions SOP](#)) and Certified Recovery Peer Advocates (CRPA's).

APG CPT / HCPCS Procedure Codes

Crisis Intervention:

H2011: Crisis Intervention-Brief

S9484: Crisis Intervention-Complex-Hourly

S9485: Crisis Intervention-Complex- Per Diem

Time Requirements

Crisis Intervention:

H2011: 15-minute unit, max 6 units, available to new or existing patients

S9484: 1 to 2.5 hours billed as a single unit, existing patients only.

S9485: 3 or more hours, billed as a single unit, existing patients only.

Category Specific Medicaid Billing Limitations

Crisis services are not 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

eliminate 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 online 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 30% 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 either in person or via Telehealth 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 Guidelines](#).

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 delivered either in person or via Telehealth 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 Guidelines](#).

APG CPT /HCPCS Billing Code

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

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

Time Requirements

H2001: Half Day 2-4 hours

H2036: 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: Opioid Treatment Programs (OTP)

OTP services delivered to patients / residents of skilled Nursing Facilities (SNF), Long term care facilities (LTCF), and OASAS bedded programs that do not have methadone on-site.

For Medicaid enrollees and/or Medicaid/Medicare enrollees, OTP's may bill for services provided to individuals in a SNF, LTCF, or in OASAS bedded program if the SNF, LTCF or OASAS bedded program does not have methadone on-site.

Services may be billed whether the resident(s)/patient(s) are transported to the OTP or if the OTP delivers services on-site at the SNF/bedded location (including via mobile units).

Bundle Billing:

Effective July 1, 2024, OTP bundle services will be billed under the APG methodology. To receive the bundle payment under APGs, OTP/COP programs must bill the CPT codes G2067 (Medication Assisted Treatment Methadone Weekly), G2068 (Medication Assisted Treatment Buprenorphine Oral Weekly), G2078 (Methadone - Take Home Supply Weekly) or G2079 (Buprenorphine - Take Home Supply Weekly) when providing bundle qualifying services. Additionally, substance use disorder (SUD) services that fall outside of the OTP bundle may also be billed on the same APG claim.

To qualify for bundle billing under APG, one of the following services must be provided:

- Brief Treatment
- Individual Counseling
- Group Counseling
- Medication Administration/Observation
- Medication Management
- Toxicology Testing

For complete billing guidance, refer to the [OTP Bundle Billing Guidance](#).

Note: Federally Qualifies Health Centers (FQHCs) that have opted out of the APG methodology will

continue to use the 7969 - 7972 series bundle rate codes or rate code 1671, but not both 1671 and a bundle rate code within the same week.

Section Six: Physical Health Service Categories:

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.

Physical Health procedures are reimbursed using the Physical Health Rate Code and appropriate E/M code (most commonly CPT codes in the range 99202-99205, 99211- 99215). Each claim should include the diagnosis of the issue being treated as the primary diagnosis code.

For example, Hep C treatment would utilize an E/M code in conjunction with an appropriate primary diagnosis (Dx) code, typically:

Diagnosis Code	Description
B1710	Acute hepatitis C without hepatic coma
B182	Chronic viral hepatitis C
B1920	Unspecified viral hepatitis C without hepatic coma

SUD diagnosis codes would not necessarily be the primary diagnosis code on a physical health claim unless that is specifically what is being treated. If the E&M is not problem-focused, the provider could code an SUD Dx or a “well visit” Dx.

Programs are limited to providing 30% of total visits for physical health visits. If providers go above the 30%, they will need to receive certification from DOH as a general health clinic. For complete details, please refer to the [NYS DOH Updated Licensure Threshold Guidance](#).

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 [NYS Office of Professions SOP](#). 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 used 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.

99212-99215: Existing, Evaluation & Management, no counseling.

99382-99387: New, Physical Exam

99392-99397: Existing Physical Exam

99211: Nursing Services as given in the most recent version of the [AMA Coding Handbook](#).

In addition to the above codes, E/M codes given in the [DOH APG Fee Schedule](#) are available as clinically appropriate for the setting for OASAS Provider's use.

Time Requirements

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

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.

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 Program⁸ 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:

⁸ Laboratories may bill for fentanyl testing separately from OTP Service Rate.

- **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.

Fentanyl Testing:

Presumptive Toxicology testing (screening) is covered under the OTP bundle. The lab should not bill Medicaid for the screen, but instead bill the OTP for the service. **There will be one exception, for Fentanyl**, which was approved for April 1, 2023. Since August 2021, Fentanyl has been included in the toxicology screens (drug test(s), presumptive, any number of drug classes), and thus was no longer separately billable to the Medicaid lab fee schedule, as it had been under the April 2017 policy (to G0480 as a drug for which no specific screen existed as a billable service within Medicaid).

As of April 2023, confirmatory testing was added to the Medicaid lab fee schedule. As such, Fentanyl confirmatory testing has been carved out of the OTP APG rate and the OTP bundle. Labs can bill Medicaid directly for Fentanyl confirmatory testing (80354).

Please direct any inquires to the SOTA mailbox at: oasas.sm.SOTA.Mailbox
SOTA.Mailbox@oasas.ny.gov

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 Seven: 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.

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.

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

Claiming Information:

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 signatures⁹
 - ***Only*** physicians, physicians 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 services 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.

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

Medicaid Managed Care:

- [Medicaid Managed Care Contract 2024](#)

⁹ The [Part 822 Regulations](#) designate the admission decision document for reimbursement.

- [Top Denial Reasons with Resolutions](#)
- [Utilization Review for Addiction Services](#)
- [LOCADTR: modules include:](#)
 - LOCADTR 3.0
 - Concurrent LOCADTR
 - LOCADTR for Gambling Treatment

OASAS OPRA Requirements:

[OASAS OPRA Guidance](#): 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.

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.
- 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 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 your [plan contacts](#).
- 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 Eight: Tools and Resources

Tools

- [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](#)
- [NYS DOH 3M Grouper/Pricer](#)

Regulations

- [Part 822 General Standards for Substance Use Disorder Outpatient Programs](#)
- [Part 841 Medical Assistance for Addiction Services – Medicaid Regulations](#)
- [Part 857 Problem Gambling Treatment and Recovery Services](#)
- [Gambling Free Services LSB](#)
- [Part 830 Telepractice Regulations](#)

Guidance

- [Family Treatment Services](#)
- [Chapter 57 Insurance Laws of 2019/updated 2022 Guidance](#)
- [Continuing Care Guidance](#)
- [Person Centered Care](#)
- [Person Centered Medication Treatment](#)
- [Pre-admission Services](#)
- [Services in the Community](#)
- [Standards for OASAS Certified Programs](#)
- [Telehealth Standards 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.

Section Nine Appendices

Appendix A: APG Rate Codes: Freestanding Outpatient APG Base Rates

Service	BH/PH Rate Code	Region ¹⁰	4/1/2023	1/1/2024	4/1/2024	8/1/2024
Outpatient Clinic	1540/1468	Upstate	\$172.78	\$172.78	\$177.69	\$177.69
Outpatient Clinic	1540/1468	Downstate	\$202.16	\$202.16	\$207.90	\$207.90
IOS Outpatient Clinic	1486/1468	Upstate	\$172.78	\$172.78	\$177.69	\$177.69
IOS Outpatient Clinic	1486/1468	Downstate	\$202.16	\$202.16	\$207.90	\$207.90
Outpatient Rehab	1573/1570	Upstate	\$173.24	\$172.78	\$177.69	\$177.69
Outpatient Rehab	1573/1570	Downstate	\$202.71	\$202.16	\$207.90	\$207.90
OTP (Visit-Based)	1564/1471	Upstate	\$159.19	\$172.78	\$177.69	\$177.69
OTP (Visit-Based)	1564/1471	Downstate	\$186.25	\$202.16	\$207.90	\$207.90
IOS OTP (Visit-Based)	1130/1471	Upstate	\$159.19	\$172.78	\$177.69	\$177.69
IOS OTP (Visit-Based)	1130/1471	Downstate	\$186.25	\$202.16	\$207.90	\$207.90
Off-site OP Clinic/Rehab	1080	Upstate	\$241.89	\$241.89	\$248.76	\$248.76
Off-site OP Clinic/Rehab	1080	Downstate	\$283.02	\$283.02	\$291.06	\$291.06
Off-site OTP	1088	Upstate	\$241.89	\$241.89	\$248.76	\$248.76
Off-site OTP	1088	Downstate	\$283.02	\$283.02	\$291.06	\$291.06
Comprehensive Outpatient	1036/1468	Upstate	-	-	-	\$177.69
Comprehensive Outpatient	1036/1468	Downstate	-	-	-	\$207.90

¹⁰ Counties in downstate region are NYC (Bronx, Kings, New York, Queens, and Richmond), Long Island, Putnam, Rockland, Westchester, Dutchess and Orange. Counties in upstate region are All counties not listed in the downstate region list above.

Freestanding OTP Weekly Bundle Rates

Service	Rate Code	Region ¹⁰	1/1/2023	4/1/2023	4/1/2024
Methadone Dispensing or Counseling	7969	Upstate	\$197.88	\$205.80	\$211.64
Methadone Dispensing or Counseling	7969	Downstate	\$231.51	\$240.77	\$247.61
Methadone Take-home Supply	7970	Upstate	\$39.05	\$40.61	\$41.76
Methadone Take-home Supply	7970	Downstate	\$39.05	\$40.61	\$41.76
Buprenorphine Dispensing or Counseling	7971	Upstate	\$246.50	\$256.36	\$263.64
Buprenorphine Dispensing or Counseling	7971	Downstate	\$288.39	\$299.93	\$308.45
Buprenorphine Take-home Supply	7972	Upstate	\$95.47	\$99.29	\$102.11
Buprenorphine Take-home Supply	7972	Downstate	\$95.47	\$99.29	\$102.11

Hospital APG Base Rates

Service	BH/PH Rate Code	Region ¹⁰	4/1/2023	1/1/2024	4/1/2024	8/1/2024
Clinic	1528/1552	Upstate	\$171.58	\$197.45	\$203.06	\$203.06
Clinic	1528/1552	Downstate	\$214.84	\$231.02	\$237.58	\$237.58
IOS Outpatient Clinic	1132/1552	Upstate	\$171.58	\$197.45	\$203.06	\$203.06
IOS Outpatient Clinic	1132/1552	Downstate	\$214.84	\$231.02	\$237.58	\$237.58
OP Rehab	1561/1558	Upstate	\$164.94	\$197.45	\$203.06	\$203.06
OP Rehab	1561/1558	Downstate	\$215.44	\$231.02	\$237.58	\$237.58
OTP (Visit-Based)	1567/1555	Upstate	\$183.88	\$197.45	\$203.06	\$203.06
OTP (Visit-Based)	1567/1555	Downstate	\$214.76	\$231.02	\$237.58	\$237.58
IOS OTP (Visit-Based)	1134/1555	Upstate	\$183.88	\$197.45	\$203.06	\$203.06
IOS OTP (Visit-Based)	1134/1555	Downstate	\$214.76	\$231.02	\$237.58	\$237.58
Comprehensive Outpatient	1039/1552	Upstate	-	-	-	\$203.06
Comprehensive Outpatient	1039/1552	Downstate	-	-	-	\$237.58

Hospital OTP Weekly Bundle Rates

Service	Rate Code	Region ¹⁰	1/1/2023	4/1/2023	4/1/2024
Methadone Dispensing or Counseling	7973	Upstate	\$197.88	\$205.80	\$211.64
Methadone Dispensing or Counseling	7973	Downstate	\$231.51	\$240.77	\$247.61
Methadone Take-home Supply	7974	Upstate	\$39.05	\$40.61	\$41.76
Methadone Take-home Supply	7974	Downstate	\$39.05	\$40.61	\$41.76
Buprenorphine Dispensing or Counseling	7975	Upstate	\$246.50	\$256.36	\$263.64
Buprenorphine Dispensing or Counseling	7975	Downstate	\$288.39	\$299.93	\$308.45
Buprenorphine Take-home Supply	7976	Upstate	\$95.47	\$99.29	\$102.11
Buprenorphine Take-home Supply	7976	Downstate	\$95.47	\$99.29	\$102.11

Appendix B: APG Procedure Codes and Limitations

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
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 assessment service per visit date, 3 assessment services, only 1 Extended assessment service per continuous treatment period
Assessment Normative	H0001	Pre-admission assessment (30 min.)	
Assessment Extended	H0002 or 90791	Pre-admission assessment (75 min)	
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
Family/Collateral Services w/o patient	T1006 or 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)	24-unit (6 hour) maximum per day. Exempt from two service per day rule
Psychiatric Assessment Brief	99202- 99205 New 99212- 99215 Existing PLUS Add-	Psychiatric Assessment w/counseling (30 min)	No more than one service per day

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
	On Code 90833		
Psychiatric Assessment	99202- 99205 New 99212- 99215 Existing PLUS 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) Buprenorphine ¹¹	H0033, J0571, J0572, J0573 or J0574 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 Buprenorphine ¹¹	H0033, J0571, J0572, J0573 or J0574	Oral Medication administration, direct observation (no time minimum)	No more than one service per day, Exempt from two service per day rule.
Medication Administration & Observation Sublocade	96372, Q9991 or Q9992	Intramuscular Injection (no time minimum)	Can have two services on the same date if medically necessary.
Medication Administration & Observation Vivitrol	96372, J2315	Intramuscular Injection (no time minimum)	Can have two services on the same date if medically necessary.
Medication Administration & Observation (1st visit of week) Methadone ¹¹	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 &		Methadone Administration additional visits	No more than one Medication Management A&O service per day. Exempt from two service

¹¹ Bundle Rate information in [Medication Administration Observation Section](#).

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
Observation (additional visits during week) Methadone ^{11 above}	H0020	during the week (no time minimum)	per day rule.
Medication Management	New 99202- 99205 Existing 99212- 99215	Specific code determined by the duration or 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.
Complex Care Coordination	90882	5-minute units.	Exempt from the two billable services per day rule. Maximum units per day is 4 (20 Minutes), 12 units (1 hour) per week.
Crisis Intervention Service - Brief	H2011	15 Minute Units	Exempt from two billable services per day rule. 6 unit per service date limit. Available to new and existing patients.
Crisis Intervention – Complex-Hourly	S9484	1 to 2.5 hours billed as a single unit	Exempt from two billable service per day rule. Available to existing patients only.
Crisis Intervention Service Complex-Per Diem	S9485	3 or more hours, billed as a single unit	Exempt from two billable service per day rule. Available to existing patients only.
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,

Medicaid APG Service Category	Procedure Code(s)	Procedure Description	Medicaid Billing Limitations Fee for service only unless otherwise indicated
			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.
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	New 99202- 99205 Existing 99212- 99215	Evaluation & Management no counseling	For Services Required by regulations use Behavioral Health Rate Code For Services not Required by regulations use Physical Health Rate Code.
Physical Health Specify Diagnosis	New 99382- 99387 Existing 99392- 99397	Physical Exam New/Established	