



# Office of Addiction Services and Supports

## Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance February 2020

**OASAS Certified  
Outpatient Programs**

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

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## Section One: Introduction

The Ambulatory Patient Group (APG) billing process was implemented in July 2011 as a 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.

## Section Two: Elements

### APG Definitions

**Clinical Staff:** Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

**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](#).

**Diagnosis:** Admitted individuals must have an 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](#).

**Episode of Care:** In Outpatient Clinic/Rehab, an episode is the period of time beginning with first face-to-face service that leads to admission (to the Outpatient Treatment Program) within 60 days and concluding 30 days following the discharge date. For Opioid Treatment Programs, an episode is the period beginning with admission of an individual to the program and concluding every 12 months thereafter.

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

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**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 Provider and attending 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 [OASAS SUD Scope of Practice Guidelines](#) or [Part 857 Problem Gambling Regulations](#) and for medical staff visit the [NYS Office of Professions](#).

**Service Documentation:** For reimbursement purposes the person's case record must include the person's name, an appropriately approved plan of treatment, date(s) of service, description of service and it's connection to the plan of treatment, duration, signature of staff member who provided the service.

**Services in the Community:** a mechanism for providing services outside of the four walls of the Part 822 Program. 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](#).

**Telepractice:** the use of two-way real-time interactive audio and video linkage system for supporting and providing certain addiction services at a distance. The [Part 830 Telepractice Regulations](#) which were updated on **December 18, 2019**. The [Telepractice for OASAS Designated Providers](#) supplement the regulations while giving guidance on their implementation.

**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 Advocate Services.

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

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## Section Three: General Claiming Guidelines

This section will give information regarding General Claiming for Medicaid APG Reimbursement. For exact information providers should consult their Provider Manual on the [eMedny website](#). Provider's can also find additional training on Billing on the [MCTAC Website](#).

Medicaid claims are processed using the 837I form for electronic transmittals, and the UB04 form for paper submission. The [MCTAC Billing Tool](#) gives specific information on filling out form fields. The information includes but is not limited to:

### I. Claiming Information:

#### a. Provider Information:

- Name: As given in Medicaid Profile.
- Address: Street Address, City, State and zip code. **Medicaid reimburses based on the zip+4 code provided.** If the zip+4 code on the claim does not match the zip+4 code listed for the site in eMedny the claims may be denied.
- Telephone, Fax, and Country Code
- Federal Tax ID
- Program National Provider Identifier (**NPI**)

#### b. Patient Information:

- Name
- Address
- Date of Birth
- Sex
- Insured's Medicaid ID #
- Diagnosis code based on most recent ICD or DSM manual. For **problem gambling** if the person **does not meet** the full DSM Criteria for the disorder, submit the **mental health diagnosis as primary with Z72.6 in the subsequent position** on the claim.

#### c. Claim specific information:

- Rate Code of the type of program that delivered the service
- Value Code "24"
- Date of Service, actual visit date(s)
- Procedure Code for the service. OASAS Provider's can only use the HCPCS/CPT/E&M codes as given in this manual.
- Attending Practitioner NPI: this would be the NPI of the person who provided the service. For those practitioners without their own NPI, (CASACs, CASAC-T's, CRPAs, other unlicensed clinical staff) the claim should include the **OASAS Unlicensed Practitioner NPI: 02249145**. For complete information on the use of NPI's review the [OASAS OPRA Guidance Document](#).

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## II. Claiming Restrictions/Limits

- a. 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 visit, physical health and physical exam.
- b. Claims must be submitted for reimbursement within 90 days of the service date. eMedny's website has further information on the [Timely Claiming Process](#).

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## Section 3 Service Categories and Guidance:

### APG Service Category: Screening/Brief Intervention

**Screening** is a face-to-face pre-admission service between an individual and clinical staff member to identify potential substance use problems *in those without a previous substance use disorder 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 face-to-face 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:

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

#### APG CPT / HCPCS Procedure Code

Screening: H0049

Brief Intervention: H0050

#### Time Requirements

Screening or Brief: 15-minute minimum

**Category Specific Medicaid Billing Limitations:** No more than one screening per individual per episode of care. No more than 3 brief intervention services per episode of care, only 1 brief intervention service per visit date. Brief Intervention *may not be used* as a medical follow up to an Addiction Medication Induction.

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## **APG Service Category: Admission Assessment**

### **Clinical Description**

Pre-admission service delivered face-to-face including Telepractice between and individual and clinical/medical staff member for determining appropriateness for and engagement 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 Advocate.. 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, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

### **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 episode of care. Only one of those visits can be billed as an extended assessment visit. In no case, should a program bill for more than one extended assessment visit within an episode of care.

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## **APG Service Category: Individual Counseling**

### **Clinical Description**

Post admission one on one 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 treatment/recovery plan.

### **Delivering Staff**

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

### **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.

## **APG Service Category: Brief Treatment**

### **Clinical Description**

A post admission one on one 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 treatment/recovery plan.

**Delivering Staff:** Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

### **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.

## APG Service Category: Group Counseling

### Clinical Description

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

The purpose of group counseling is to attain knowledge, gain skills and change attitudes about 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.

The counselor focuses on both process (how the group is communicating and inter-relating) and content (what is being discussed/addressed) to fully realize the therapeutic value of group counseling. Group size should conform to regulation, evidence and best practices such as those identified in the [SAMHSA TIP 41](#).

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 group (new members cannot join); while psycho-educational groups 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.

### 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, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals. Staff should be appropriately qualified to provide the service in question.

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## **APG CPT /HCPCS Billing Code**

Group Counseling: H0005 or 90853  
Multi-Family Group: 90849

## **Time Requirements**

Time: Minimum of 60 minutes

## **Category Specific Medicaid Billing Limitations**

Programs may not bill for more than one of the same group service per visit date e.g. two 90849 or two H0005 may not be billed. However, programs may submit for the same visit date a claim with one 90849 and one H0005. Group size should be based on the type of group and the clinical needs of its members.

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## APG Service Category: Family Services

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

#### Clinical Description

A post-admission 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>1</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.

**Delivering Staff:** Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals. Staff should be appropriately qualified to provide the service in question.

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<sup>1</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.

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

Family members, 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 a treatment plan of their own (see [Family FAQ](#)).

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## APG Service Category: Peer Advocate Services

### Clinical Description

Peer Advocate Services are individual, in-person connections between the individual and a [Certified Recovery Peer Advocate](#) 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 Advocate Services are designed to support the individual in recovery from the unique perspective of someone who shares similar experiences.

### Delivering Staff

[Certified 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 Advocate Services **must be billed** the utilizing the Peer Service Rate Code specific to their service type as given in the below table.

Peer Advocate 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 the service date. Exempt from the two billable services per day rule.

### Peer Services Rate Codes

Type of Program	Rate Code	Base Rate Upstate	Base Rate Downstate
Freestanding OP Clinic/Rehab	1072	\$225.17	\$263.46
Hospital Based Op Clinic/Rehab	1074	\$223.61	\$279.99
Freestanding OTP	1076	\$207.47	\$242.73
Hospital Based OTP	1078	\$239.64	\$279.89

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## APG Service Category: Medication Administration and Observation<sup>2</sup>

### Clinical Description

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

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

### 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 with KP modifier for first med service of the week
- Units billed in 8 mg units (J0592<sup>3</sup>) per day times the number of days Maximum of 4 units per day (32 mgs)

### Methadone Administration:

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

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

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

### 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 days services.

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<sup>2</sup> This service can only be reimbursed if the program is actually dispensing the medication

<sup>3</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.

- KP modifier given on 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. ***Observation of Self-Administration is not reimbursable.***

### **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 days services.
  - KP modifier given on 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.

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## APG Service Category: 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

**99201-99205: NEW**

**99211-99215: ESTABLISHED**

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

### Time Requirements

Time – Minimum of 10 minutes

### Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Medication Management 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.

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## APG Service Category: Addiction Medication Induction/Ancillary Withdrawal

### Clinical Description

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

The *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.

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**Delivering Staff**

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

**APG CPT /HCPCS Billing Code**

H0014 Alcohol and/or drug services Ambulatory Detoxification

**Time Requirements:**

none

**Category Specific Medicaid Billing Limitations**

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

**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.

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## **APG Service Category: Complex Care Coordination**

### **APG Service Category: Complex Care Coordination**

#### **Clinical Description**

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

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

#### **Delivering Staff**

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

#### **APG CPT/HCPCS Billing Code**

90882

#### **Time Requirements**

Time: Billed in 15 minute increments. 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 one complex care service (4 units) per day,

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## **APG Service Category: 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 Advocate 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, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

### **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 services 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.

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## APG Service Category: 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. An Outpatient Rehabilitation Service must contain at least a 25 minute individual counseling service or a 60 minute group counseling service.

### Delivering Staff

Clinical Staff as defined in the [Part 800](#) and [Part 857](#) Regulations, including licensed staff, credentialed staff, non-credentialed staff, and student interns who provide counseling services directly to individuals.

### 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 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.

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## **APG Service Category: Physical Health Services**

### **Clinical Description**

**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, TB/HIV testing, pregnancy test, preventative care.

### **Delivering Staff:**

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

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

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

99201-99205: New, Evaluation & Management, no counseling 99211-99215: Existing, Evaluation & Management, no counseling

99382-99387: New, Physical Exam 99392-99397: Existing Physical Exam

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

### **Time Requirements**

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

### **Category Specific Medicaid Billing Limits**

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

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

Programs can bill for physical health services provided in 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.

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

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## APG Service Category: Ancillary Services

### I. 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 medical visit rate codes](#). OASAS Outpatient Clinics are subject to the Article 28 hospital and free-standing ancillary policies briefly explained below.

**Hospital Ancillary Policy:** All ancillary services (laboratory and radiology procedures) ordered 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.

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

### Freestanding Ancillary Policy

All ancillary services (laboratory and radiology procedures) ordered 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. 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.

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

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

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## II. 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. They should not code the ancillaries (labs) on their APG claims.

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

These services are:

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

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

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

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

**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.

## III. Language Interpreter Services – T1013

Effective October 1, 2012, Medicaid fee-for-service will reimburse Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Effective December 1, 2012, medical language interpreter services will also be reimbursed by Medicaid Managed Care and Family Health Plus plans in accordance with rates established in provider agreements or, for out-of-network providers, at negotiated rates. For further information please consult the [2012-10 Medicaid Update](#).

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## **APG Service Category: Smoking Cessation Services**

### **Clinical Description**

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

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## Section Four: 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

- [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](#)

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

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## Section Five Appendix

### 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	Rate Code	Base Rate Upstate	Base Rate Downstate
Freestanding IOS <b>OP Clinic</b>	1486	\$150.11	\$175.64
Freestanding IOS <b>OTP</b>	1130	\$138.31	\$161.82
Hospital Based IOS <b>Clinic</b>	1132	\$149.07	\$186.66
Hospital Based IOS <b>OTP</b>	1134	\$159.76	\$186.59

### Outpatient Clinic/Rehab/OTP Peer Services Rate Code<sup>4</sup>

Type of Program	Rate Code	Base Rate Upstate	Base Rate Downstate
Freestanding OP Clinic/Rehab	1072	\$225.17	\$263.46
Hospital Based Op Clinic/Rehab	1074	\$223.61	\$279.99
Freestanding OTP	1076	\$207.47	\$242.73
Hospital Based OTP	1078	\$239.64	\$279.89

<sup>4</sup> Rate code only for use with H0038 Peer Advocate Services

## 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 episode of care
Brief Intervention	H0050	Interventions (15 min)	1 service per visit date, 3 services per episode of care,
Assessment Brief	T1023	Pre-admission assessment (15 min)	1 service per visit date, 3 services per episode of care,
Assessment Normative	H0001	Pre-admission assessment (30 min.)	1 service per visit date, 3 services per episode of care,
Assessment Extended	H0002 or 90791	Pre-admission assessment (75 min)	1 service per visit date, 1 per episode of care,
Individual Therapy – Brief	G0396 or 90832	Counseling session (25 min)	No more than one individual counseling service per day
Individual Therapy – Normative	G0397 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, on-site
Group Counseling	H0005 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	T1006/90846	Family/Collateral Services (30 min)	Pre-and post-admission service, 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
<b>Peer Advocate</b> <sup>5</sup> Services	H0038	Peer Advocate Service (15 min)	12 unit (3 hour) maximum per day. Exempt from two service per day rule

<sup>5</sup> Reimbursement for H0038 requires the use of the [New Peer Services Rate Code](#).

<b>Medicaid APG Service Category</b>	<b>Procedure Code(s)</b>	<b>Procedure Description (minimum time requirements)</b>	<b>Medicaid Billing Limitations Fee for service only unless otherwise indicated</b>
Psychiatric Assessment Brief	99201-99205 New 99211-99215 Existing PLUS Add-On Code 90833	Psychiatric Assessment w/counseling (30 min)	No more than one service per day
Psychiatric Assessment	99201-99205 New 99211-99215 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)	H0033 Use KP modifier	Oral Medication administration first visit for week (no time minimum)	No more than one service per day, except when a non-injectable service is also required, in this case two services per day. Exempt from two service per day rule.
Medication Administration & Observation	H0033	Oral Medication administration, direct observation (no time minimum)	No more than one service per day, except when a medication injectable is ordered, in this case two services per day. Exempt from two service per day rule.
Medication Administration & Observation (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, except when a non-injectable service is also required, in this case two services per day. Exempt from two service per day rule.
Medication Administration & Observation (additional visits during week)	H0020	Methadone Administration additional visits during the week (no time minimum)	No more than one Medication Management A&O service per day, except when a non-injectable service is also required, in this case two services per day. Exempt from two service per day rule.

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<b>Medicaid APG Service Category</b>	<b>Procedure Code(s)</b>	<b>Procedure Description (minimum time requirements)</b>	<b>Medicaid Billing Limitations Fee for service only unless otherwise indicated</b>
Medication Management	<b>New</b> 99201-99205 <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/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	Environmental manipulation	Exempt from the two billable services per day rule. .
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.

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

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