New York State

Office of Alcoholism & Substance Abuse Services

Addiction Services for Prevention, Treatment, Recovery

DRAFT

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Ambulatory Patient Groups (APGS)

Policy and Medicaid Billing Guidance

For OASAS Certified Outpatient Chemical Dependence Programs

XX/XX/2010

The document is intentionally posted as draft. As items are finalized updated versions will be posted. However, programs should use this document to begin development and program readiness activities including forwarding to billing vendors to begin billing readiness activities.

Table of Contents

Section One: Background and Introduction to Ambulatory Patient Groups in OASAS Certified Outpatient Programs

Implementing Ambulatory Patient Groups (APGs) for behavioral health services is a key component of New York State's overall effort to reform Medicaid reimbursement[1] and rationalize service delivery.

Clinically, for the addiction field, the implementation of APGs is an integral part of the evolutionary move by the addictions field towards one outpatient system of care. APG's support a range of medically necessary clinic services for patients based on the evidence of what works to promote recovery from chemical dependency.

From a Medicaid reimbursement perspective the new APG reimbursement methodology will replace the current threshold visit reimbursement system for OASAS certified clinic and rehabilitation programs, opiate treatment, and outpatient chemical dependency for youth programs. The APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each service provided during a patient visit. In addition, APGs will: support discrete Medicaid reimbursement for some chemical dependence services that were not previously billable; and, allow for some services that are integral to the treatment of patients in chemical dependency treatment such as mental and physical health services.

Section Two: Manual Purpose

The purpose of this manual is to provide:

Clinical Guidance:

Support OASAS certified outpatient programs' understanding of the new APG service categories; their clinical intent; and, any restrictions on what level of practitioner may deliver a particular service.

Medicaid Policy and Billing Guidance:

Support OASAS certified outpatient programs' understanding of how to bill Medicaid under the APG payment methodology. Of immediate note is that under APGs, programs must use certain APG specific CPT and HCPCS codes to bill Medicaid and, programs will, for the same patient on the same visit date, be able to bill Medicaid for multiple services. APG specific category and general APG Medicaid rules will be discussed throughout the manual. The service definitions and associated CPT or HCPCS codes listed in this manual are for the purposes of billing the New York State Medicaid program. It is recognized that in some instances the OASAS service definition and applicable CPT or HCPCS codes may vary from: the service definition listed in the CPT or HCPCs manuals; and/or, be different from how the codes are used for commercial or Medicare billing. Programs should use the codes as listed in this manual for billing the New York State Medicaid program, and use Medicare or commercial coding as indicated by the relevant billing / coding guidelines.

[1] For information on the overall Department of Health APG initiative please see: http://www.health.state.ny.us/health_care/medicaid/rates/apg/

Section Three: Forward

OASAS Regulation - Part 822 provides the regulatory structure necessary for 822.4 outpatient clinic and 822.5 (formerly Part 828) outpatient opiate treatment programs to implement both the program and billing aspects of Ambulatory Patient Groups (APG). This guidance manual document provides more specific guidance on the clinical issues and Medicaid billing parameters for each APG and overall program implementation. It is the responsibility of each OASAS certified Part 822 program to ensure the appropriate clinical, documentation and billing parameters have been met and that billing claims meet all regulatory requirements. This document is meant to support programs in meeting this responsibility.

APG Service Categories:

OASAS worked with the Department of Health, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and providers to create APG billing categories that accurately reflect the scope of clinic services. APG's provide uniformity in Medicaid billing for behavioral health entities across disabilities and were also created to maintain service delivery patterns unique to each disability. The document will identify shared APG categories and categories unique to OASAS.

Specifically, under APGs the outpatient chemical dependence service array was disaggregated from the former large categories of: assessment, individual and group services and the previous methadone week into more discrete clinically related service delivery and billing categories. The new categories capture the major behavioral health service groupings that are delivered in the OASAS certified:822.4 outpatient chemical dependence clinic and outpatient rehabilitation programs; 822.5 opiate programs (formally Part 828); and, Part 823 Outpatient Chemical dependence for Youth clinics and include:

Service Category	
Screening, Brief Intervention and Brief Treatment	Individual Counseling Brief
Medication Administration and Observation	Individual Counseling Normative
Medication Management Routine	Group Counseling
Medication Management Complex	Collateral Visit
Assessment Brief	Complex Care Coordination
Assessment Normative	Peer Support
Assessment Extended	~~Outreach~~
Intensive Outpatient Rehabilitation	Day Rehabilitation
Note: Detailed rules regarding APG Medicaid billing and associated OASAS service delivery rules are discussed throughout this manual. However, of immediate understanding is that per OASAS regulation, Medicaid APG billing is generally limited to no more than two different services per visit date. For example, a program may bill and receive reimbursement for a group and an individual service on the same visit date but may not bill for two individual services on the same visit date.	

APG Service Parameters:

Diagnosis: Admitted patients must have a diagnosis of substance abuse or dependence. Due to the current social work exemption law, all clinical staff in a program are able to establish a diagnosis. Each patient should be presented and have the comprehensive treatment plan reviewed at the multidisciplinary team conference.

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

Medical Staff: physicians, nurse practitioners, registered physician's assistants, registered nurses, and licensed practical 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, and working with, or under the supervision of, a physician, if required by law.

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

Episode of care: For a Part 822.4 Outpatient Clinic an episode is the period of time between the first contact by a prospective patient that leads to a face to face service within 30 days and results in an admission to a chemical dependence outpatient treatment program and concluding ~~60~~ 30 -days following the discharge date.

For a Part 822.5 Opiate Treatment Program an episode is the period of time beginning with admission of a patient to the program and concluding every 12 months thereafter.

The episode of care applies to the treatment of the patient by the program and will not extend to previous or concurrent treatment at another program whether that treatment is known or unknown.

Clinical Justification: In some APG categories (Peer Services, Outreach, IOP, Collateral Services), a clinical justification is required beyond a set service number, for example, after five peer services, the clinical staff must provide a clinical rationale for additional visits. In the case of IOP the clinical staff must document the need for continuation in the level of care. When clinical justification is required the clinical staff person must document, in a progress note or treatment plan, the clinical reasons for the need for continued services in this category and identify the projected number of additional services. Clinical justification must include the following elements: Date, number of additional services projected, clinical reasons for the need for these services including a rationale for the level of care, and the signature of clinical staff person if IOP.

See the example below:

EXAMPLE:

> *Clinical Justification for additional Peer Services:*
>
> *Client A is in need of 6 additional peer services due to difficulty in finding adequate community supports for recovery. The peer advocate will work with Client A over the next quarter by introducing the client to three mutual assistance groups, attending the recovery center and identifying other natural supports in the environment.*

Co-occurring Disorder Treatment

Commissioner Carpenter-Palumbo (OASAS) and Commissioner Michael Hogan (OMH) convened a task force in 2008 to recommend action to improve access to integrated treatment for substance use and mental health disorders.

A summary of the recommendations of the task force, the Memorandum of Understanding signed by the Commissioners and supporting documentation can be found at this link :

http://www.oasas.state.ny.us/pio/collaborate/documents/co-occurring.pdf

The implementation of APG's will support the treatment of patients with co-occurring disorders, but will not change the billing for co-occurring disorder treatment in OASAS certified settings. The OASAS service category map includes services that will support treatment, medication evaluation and ongoing monitoring and other clinical services including group, individual and family treatment for meeting the patient's treatment plan. The comprehensive evaluation and treatment plan should include an assessment of mental health problems and plan for intervening. Providing that the staff are working within the scope of practice defined by the State Education Department and have the experience necessary to provide treatment for co-occurring mental health disorders, they may be provided directly and billed for in an OASAS certified outpatient clinic.

In most circumstances the OASAS service categories and HCPCS or CPT codes provided in this manual should be used for providing services for co-occurring treatment. When a program provides psychiatric evaluation, the program may use the E/M code for psychiatric evaluation (see table below). This must include a diagnosis.

Psychiatric Consultation – New/Established Patient – Select CPT Code from Range:

New		Established	
□ 99201	□ 99204	□ 99212	□ 99215
□ 99202	□ 99205	□ 99213	
□ 99203		□ 99214	

Smoking Cessation

Smoking cessation can be billed in a chemical dependency clinic by a clinical (including medical) staff person. Staff who provide this service need to have specific tobacco cessation. Documentation of the training should be kept in the clinical staff personnel file. No more than 3 smoking cessation services should be billed in an episode of care.

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

Clinical Guidance

Smoking cessation must be provided by trained staff and includes both counseling and access to medication including NRT's. OASAS has additional guidance on providing tobacco cessation including a link to free on-line training on the website at: http://www.oasas.state.ny.us/tobacco/index.cfm

Use the following HCPCS codes for smoking cessation treatment:

		APG	
G8402	Smoke preven interven counse	451	SMOKING CESSATION TREATMENT
G8403	Smoke preven nocounsel	451	SMOKING CESSATION TREATMENT
S9075	Smoking cessation treatment	451	SMOKING CESSATION TREATMENT

Nursing Staff

Nurses in OASAS clinics qualify as both medical and clinical staff. They are qualified to provide all clinical services and may qualify to bill E/M codes within the scope of their practice and as allowable within normal billing and coding practice within the scope of health services delineated in this manual.

Nurses may bill for nursing assessments by billing an assessment visit prior to patient admission or an individual counseling code after treatment as the purpose of the visit is to develop the treatment plan. To the extent that patients are provided counseling by nursing staff to meet the goals of the treatment plan, these counseling sessions can be billed according to the plan. Nurses may provide smoking cessation treatment and chronic condition education and management. These will generally be provided as a counseling service, per treatment plan.

APG Category Layout

Each APG category section will incorporate: service time duration; staff requirements; service definitions; clinical guidelines; category specific HCPCS / CPT billing codes; and APG category specific Medicaid billing requirements. Additionally, at the end of the overall APG Category Section there is a general APG Medicaid billing section, including a section with guidance on when a physician fee schedule claim may be submitted in addition to the APG service claim.

Section Four: APG Service Categories and Guidance

APG Service Category: Screening / Brief Intervention

Time Requirements

Time – 15 minute minimum. NOTE both the screening and brief intervention services and codes (H0049 and H0050) are for the purposes of chemical dependence services only and may not be used for Mental Health screens.

Delivering Staff

Staff -- Clinical and/or medical staff as defined in Part 822 (working within their scope of practice)

Service Definitions

Screening- A face to face meeting (e.g. not a phone interview) with a clinical staff member for the purpose of identifying alcohol or other drug (substance) use problems through the use of one of the following screening tools: AUDIT, CAGE, CAGEAID, CRAFFT, Simple Screen, GAIN Quick, ASSIST or other OASAS approved screening tool. The screening tool can be completed through a computer or written format or conducted as a part of an interview. The results must be shared by the clinical staff in an individual face to face session. The focus of the screening session is on the results of the screening and feedback about the likelihood of a substance misuse problem.

Screening is not intended to be provided to all patients or where it is known that the is appropriate for admission (e.g. a court order) or has an assessment from another program. Additionally, screening may not be provided in a group setting.

APG CPT / HCPCS Billing Code

H0049 15 minute minimum

Category Specific Medicaid Billing Limitations: Service is an on-site pre- admission service. No more than one screening per patient per episode of care.

Brief Intervention - A face to face pre-admission meeting with the clinical staff when screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences, and motivates them to change their behavior. A brief intervention may follow a screening where some risky use has been identified but the patient does not need or accept a referral to treatment. Brief Intervention *may not* be provided in a group setting.

APG CPT/HCPCS Billing Code
H0050 15 minute minimum

Category Specific Medicaid Billing Limitations

The program may bill up to three Brief Intervention visits prior to admission. Screening, Brief Intervention and Brief Treatment are not considered assessment visits and will not count against the assessment billing limits.

APG Service Category: Screening / Brief Intervention Continued

Brief Treatment - A post – admission face to face meeting with a clinical staff and active patient in chemical dependency treatment, must include a target behavior (for example, continued use of cocaine, attendance at group sessions, or identification of recovery supports) and identify the evidence-based or clinical practice that the intervention is based upon. Evidence-based practices have empirical evidence to support their efficacy and effectiveness with substance abuse populations. Brief treatments can be used throughout the course of longer periods of treatment to meet specific goals, motivate patients; address emergent issues related to successful treatment; or support pharmacotherapy.

APG CPT /HCPCS Billing Code

H0050 15 minute minimum

Category Specific Medicaid Billing Limitations

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

Clinical Guidance

Screening

This service category allows programs to bill for SBIRT activities. The definition includes both screening and brief interventions which may be delivered separately or together. Each service must meet all requirements identified in the definition to qualify as a reimbursable service. Programs that provide screening must utilize a validated screening tool to determine likelihood of a substance use disorder. Screening tool must have evidence supporting validity and reliability. Acceptable screening tools include but are not limited to:

ASSIST	Simple Screen	CAGE	RIAZI
AUDIT	MAST	CRAFFT	
CAGEAID	GAIN Quick	DAST	

The screening tool can be completed through a computer or written format or conducted as a part of an interview. The results must be shared with the patient by the clinical staff in an individual face- to- face session. The focus of the screening session is on the results of the screening and feedback about the likelihood of a substance misuse problem. The clinical staff should use a motivational approach to collaborate with the patient, offer options and elicit the patient's own concerns. The clinical staff person may offer a referral to treatment, if further assessment is indicated by the screening results, or offer a brief intervention to reduce risky use. Screening may be a distinct service or offered in conjunction with a brief intervention.

An example of the elements of a documented screening session follows: 15 minute session 8:30 am – 8:45 am
Patient A completed the AUDIT screening tool and met with clinical staff to discuss results. Clinical staff provided feedback on the patient's score of 10 which indicates that the patient is at risk of having a substance abuse problem. Reviewed positive responses and offered feedback on how this drinking pattern may have a negative impact on health, behavior or safety. Elicited patient's reaction and own concerns/ambivalence about drinking pattern and identified negative consequences. Patient was referred for an assessment appointment.

Brief Intervention

This service category is a pre-admission service for the purpose of educating patients with a risky substance use pattern to reduce use and to motivate those who have a need for a referral to treatment to accept a referral. A brief intervention may follow a screening session or a program may accept referrals from a primary care provider when the person has screened positive for a brief intervention or treatment. This category may also be used for individuals who have been screened for the Drinking Driver program and have a pattern of risky use, but do not meet the programs admission criteria. Programs may bill for up to three brief intervention sessions prior to admission. Following the pre-admission brief intervention services, the program must offer a referral to the individual to treatment or link to a primary care provider, e.g. Private practitioner, Federally Qualified Health Center or Public Health Clinic.

An example of the elements of a documented brief intervention session follows: 15 minute session 1:15pm – 1:30 pm Patient A scored positive for risky alcohol use on the ASSIST screening tool. Session focused on providing feedback about low/no-risk drinking patterns. Clinical staff worked with patient to Identify specific examples of risky use over past month and strategies for drinking within low-risk limits. Patient will keep a log of drinking and bring to next session.

Brief Treatment

This service category is a post-admission service. Individuals that meet the programs admission criteria and who present with impairment from the abuse or mild dependence on substances may benefit from a period of brief treatment targeted to reducing or eliminating substance use. Patients may be referred from primary care settings, drinking driver programs or other referral sources. They typically function well in most areas, and are able to make changes in substance use patterns with minimal support. The targeted substance use and evidenced based treatment must be delivered according to the treatment plan or must address emergent issues related to successful treatment.

Brief treatment may also be used in the course of ongoing substance abuse treatment. The clinical staff must identify a target behavior for example, use of a secondary substance; attendance at group; or developing a connection to recovery supports. The clinical staff member must also identify the evidence-based practice that was used, for example, BRENDA; FRAMES; Motivational Interviewing; or Contingency Management. Some brief treatment approaches such as BRENDA (Volpicelli, J. Pettinati, H. 2001) and Medical Management (Pettinati et al 2004) http://pubs.niaaa.nih.gov/publications/combine/combine%202.pdf have been developed to support pharmacotherapy. The focus of these brief treatments include: medication compliance; reduction or elimination of substance abuse or misuse; participation in recovery supports or treatment; emergent issues and increased healthy behaviors to support recovery.

An example of a documented brief treatment session follows: 15 minute session 9:00 am- 9:15 am Patient A continues take methadone as prescribed and has no cravings, urges or use of opiates. The patient has continued to abuse cocaine sporadically. This session focused on cocaine use. Clinical staff utilized motivational interviewing to identify patients ambivalence about discontinuing cocaine use and identified with the patient how the continued use interferes with the goal of reducing take-home medications. Clinical staff will continue to work with client to identify internal reasons to stop using cocaine.

APG Service Category: Medication Administration and Observation

Time Requirements

Time - No time minimum

Delivering Staff

Staff – Medical staff as defined in part 822 (working within their scope of practice). Note under the consolidated regulation Part 822 regulations apply to Outpatient Clinic (822.4) and Opiate Outpatient Programs (Part 822.5 under the consolidated regulations (Formally Part 828)). This and all other APG service are appropriate for delivery in either an outpatient clinic or an opiate treatment program.

Service Definitions

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

Administration is the act of giving the patient the medication – a liquid to be swallowed, a pill to be swallowed, a solution to be injected for immediate use. Dispensing is the act of giving the medication to the patient for use at a later date outside the clinic setting – a pharmacy dispenses.

Clinical Guidance

The administration or dispensing of a medication involves the actual delivery of a medicine to the patients. Examples include the dispensing of methadone or the injection of Vivitrol by medical staff person. There must be an order from a prescribing professional who meets state, and federal requirements for the medications dispensed to a patient. Medical staff should determine, any contraindications for the administration and observe patients following administration as clinically indicated by the patient history, novelty of the medication, dosage changes and medical conditions that may affect the way a patient responds to the medication.

Self administration of a medication does not qualify for reimbursement under this APG category. For example, a patient may bring suboxone from their own prescription to the clinic for an induction visit, this is a self-administration of a medication and does not qualify for a medication administration visit. (It does qualify as a medication management visit).

Documentation – A note signed by a medical staff person recording what medications were administered and/or dispensed. The note should reflect any symptoms, side effects or other medical concerns noted in the observation, actions taken and plan. The electronic log-in of the appropriate medical staff and record of dose delivered will meet the documentation requirement of a signed note for Medication Administration when there are no observed symptoms, side-effects or medical concerns noted.

APG CPT /HCPCS Billing Code

H0020 Methadone Administration - methadone administration only

H0033 Oral Medication administration – direct observation - all other oral medications NOTE: When service includes dispensing Buprenorphine, 822.5 programs submit a separate claim using the dosage indicated Buprenorphine rates codes indicated on page 36 of this manual. ~~Programs will indicate on the Medicaid claim the appropriate NDC code the corresponds to the dosage prescribed.~~

Medication Administration and Observation – Continued on Next Page

APG Service Category: Medication Administration and Observation

Continued from previous page

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. However, Medication administration is exempt from the two service per day rule. For example, if a patient receives an Individual, a Group and a Medication Administration and Observation service on the same visit date the program may submit a claim that codes to all three services.

When a delivered service includes dispensing Buprenorphine, OASAS certified OTP programs will use the existing dosage banded Buprenorphine rates codes as more full described in the APG billing section of this manual.

APG Service Category: Medication Management (Routine)

Time Requirements

Time – Minimum of ~~15~~ 10 minutes

Delivering Staff

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

Service Definitions

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

Clinical Guidance

Routine medication management involves the patient 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:

1. if the patient is taking the medication as directed
2. if the patient is doing well on the medication
3. if there have been any adverse effects of the medication
4. if the patient has been put on any other medications by other practitioners
5. if the medical/addiction history has changed (use, abstinence, etc)

Small changes in the regimen can be suggested and a note is written. A prescription is usually written as well noting a change in dose or continuation of the dose.

Documentation - A note signed by a prescribing professional with the time of the visit, summary of the medication management service, results of the service and the plan for treatment should be written in the patient record.

APG CPT /HCPCS Billing Code

~~H0034 Medication Training and Support per 15 minutes – Addiction Medicine~~

M0064 Visit for Drug Monitoring - Psychotropic

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Medication management routine as a service is exempt from the cumulative two service claim per day rule. For example, if a patient receives an individual, a group and a Medication management routine service on the same visit date the program may submit a claim that codes to all three services.

APG Service Category: Medication Management (Complex)

Time Requirements:

Minimum of 30 minutes

Delivering Staff

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

Service Definitions

Face- to -face service for the purpose of a comprehensive medication review for a new or complex patient or induction to a new medication requiring a period of patient observation.

Clinical Guidance

Complex medication management involves the new patient who is being considered for induction on an addiction medication, or the follow up of a patient to be induced on an addiction medication after the initial evaluation.

The assessment/initial visit should include:

1. a comprehensive medical/psych and addiction history
2. limited assessment of physical/health problems tailored to the addiction patient
3. a decision as to what the next course of action will be as far as using an addiction medication – possible alternatives should be discussed.
4. linkage to behavioral treatment, as clinically appropriate for the individual patient is mandatory
5. discussion with the patient as to the use of the medication, expected effects, possible adverse effects
6. possible institution of a contract between practitioner and patient
7. possible ordering of laboratory testing to determine the presence of adverse medical issues that the medication could impact negatively.

The induction/follow up to the initial visit should include:

1. expanded problem focused/brief review of history including events that occurred between the initial visit and the present visit
2. expanded problem focused physical exam if indicated
3. for buprenorphine a Clinical Opiate Withdrawal Scale (COWs http://www.csam-asam.org/pdf/misc/COWS_induction_flow_sheet.doc) withdrawal scale would be used to determine the presence of withdrawal which will include vital signs
4. review of medication with the patient.

Continues on next page

APG Service Category: Medication Management (Complex) – Continued from previous page

5. administration of medication
6. direct observation of the patient (time required will vary with the specific medication)
7. reassess the patient and plan for return to the clinic for further refinement of the medication dose
8. counselor and/or practitioner engagement of the clinic – especially in the behavioral component of the treatment

Documentation - A note signed by a prescribing professional in the patient record including the duration and date of the visit, summary of the medication management service, results of the service and the plan for treatment should be written in the patient record.

APG CPT /HCPCS Billing Code

90862 Medication Management

Category Specific Medicaid Billing Limitations

Programs may bill for only one medication management service per day. However, Medication management complex as a service is exempt from the cumulative two service claim per day rule. For example, if a patient receives an individual, a group and a Medication management complex service on the same visit date the program may submit a claim that codes to all three services.

APG Service Category: Assessment

Time Requirements

Time - Brief - 15 minute minimum / Normative - 30 minute minimum / Extended - 75 minute minimum

Delivering Staff

Clinical staff (includes medical staff) as defined in part 822 (working within scope of practice)

Definitions

A face- to- face pre-admission service between a prospective patient and a clinical staff member for the purpose of determining a preliminary diagnosis and initial plan of treatment including the type and level of services needed.

Clinical Guidance

The assessment process has two primary purposes, gathering patient information and history to determine the need for and likelihood of success in outpatient treatment, and the engagement of the patient in the treatment process. The gathering of patient information involves skillful interviewing of the patient, the review of records, conversations with referral sources and may include interviews with collateral contacts.

Through the assessment process the clinical staff person must evaluate data to support a Psychoactive Substance Use Disorder based on DSM (Diagnostic and Statistical Manual) of Mental Disorders or ICD (International Classification of Diseases) criteria. Through the assessment process the clinical staff person should determine the appropriate level of care for the patient including the appropriate level of intensity for the patient. Clinicians may use ASAM criteria, LOCADTR or provide a written rationale for the level of care recommended based on the patient's level of functioning. The patient's motivation and opinion about what would be most helpful should be considered regardless of the tool used for this purpose.

Assessment of Physical Health

An assessment of physical health and medical history is required as a part of the comprehensive evaluation. Medical staff may meet with the patient to gather medical history and identify any physical health problems to be addressed in treatment. This assessment should be billed as an assessment visit prior to admission. If this assessment occurs after admission to treatment it may be billed as an individual session. E/M codes should only be used when the focus of the session is for a specific medical screening, intervention or treatment service.

Documentation – A progress note including the duration, signed by the clinical staff member delivering the assessment service, describing the assessment visit, results and plan for next steps.

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APG Service Category: Assessment Continued from Previous Page

APG CPT /HCPCS Billing Code

Brief Assessment	15 minute minimum	T1023 To determine the appropriateness of an individuals participation in a specific program
Normative	30 minute minimum	H0001 Alcohol and/or drug assessment
Extended	75 minute minimum	H0002 - Behavioral Health Screening to determine eligibility for admission

Category Specific Medicaid Billing Limitations

Programs may only bill for one assessment visit per day. Programs may bill for up to three assessment visits prior to admission. Only one of those visits can be billed as an extended assessment visit. ~~In the event that the patient is lost to contact or discharged for at least 60 days an additional brief or normative assessment may be billed to re-assess appropriateness for outpatient treatment. If the patient is discharged or lost to contact for 90 days or more, the program may re-initiate the assessment process and may bill for three assessment visits, however,~~ In no case should a program bill for more than one extended assessment visit within ~~a 12 month period~~ an episode of care.

Medicare / Medicaid and use of CPT codes

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

Brief Assessment	15 minute minimum	No comparable weighted CPT / APG assignment. USE HCPCS code indicated above
Normative	30 minute minimum	No comparable weighted CPT / APG assignment. USE HCPCS code indicated above
Extended	75 minute minimum	CPT 90801

APG Service Category: Individual Counseling

Time Requirements

Brief – 25 minute / Normative – 45 minute

Delivering Staff

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

Definitions

A face- to -face visit between a clinical staff member and an admitted patient focused on the chemical dependency needs of the patient consistent with the treatment plan, it's development, or emergent issues.

Clinical Guidance

This is a face- to- face session focused on attainment of the goals and objectives identified in the treatment plan. The counseling should be provided by a clinical staff member and based on accepted counseling theory and practice. The clinician is responsible to learn about evidence-based practices shown to have efficacy with chemical dependence and abuse disorders and should be provided adequate supervision to competently provide this complex service. Each visit should address material relevant to the treatment plan and document progress toward goals identified in the plan or emergent material identified by the patient.

Sessions that include the patient and family members should be billed using these codes. If the clinical staff is meeting with family members without the patient present, the visit should be billed as a collateral visit and is subject to the billing rules associated with the collateral service category.

Documentation - A progress note including the duration of the visit, signed by the clinical staff member delivering the counseling service. The note must include what the clinician did, how the patient responded, and plan for next steps.

APG CPT /HCPCS Billing Code

Individual Brief	25 minutes	G0396 Alcohol and / or Substance Abuse Service
Individual Normative	45 minutes	G0397 Alcohol and / or Substance Abuse Service

Category Specific Medicaid Billing Limitations

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

Use of the Physician Fee Schedule - When the physician provides a counseling service he/she can add the rate code to increase the payment for the service to account for the additional cost for the service provider. This may only occur if the physician provides a service typically provided by clinical staff. This includes: Individual counseling and group counseling. It excludes medication management services. Physicians cannot bill for a medication management visit on the same day that they bill for a physician fee schedule add on for counseling.

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APG Service Category: Individual Counseling Continued

Medicare / Medicaid and use of CPT codes

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

Individual Brief	25 minutes	CPT 90804
Individual Normative	45 minutes	CPT 90806

APG Service Category: Group Counseling

Time Requirements

Time – Minimum of 60 minutes

Delivering Staff

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

Definitions

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

Clinical Guidance

Group counseling is provided by one or more clinical staff and focused on goals of chemical dependency treatment. The counselor focuses on both process (how the group is communicating and inter-relating) and content (what is being discussed/addressed) to fully realize the therapeutic value of group counseling. In order for each member to benefit from the process and content of group treatment the group size cannot exceed 15. The purpose of group is to attain knowledge, gain skills and change attitudes about substances to achieve and maintain recovery from substance abuse. They 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.

Adolescent Family Group:

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

Documentation

A progress note should be placed in the patient chart including the duration and date of the visit, signed by the clinical staff member delivering the counseling service. The note must include the overall focus or topic of the group, the overall goal of the group visit, how each individual patient responded.

APG CPT /HCPCS Billing Code

90849 - Adolescent Family Group - Multiple family group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members under treatment. To be delivered by a practitioner who has training in providing family treatment. (adolescent family members only). If the family unit participates in more that 10 family group sessions, then individual family members should be evaluated for admission as a significant other.

H0005 – Alcohol and / or drug services Note: This category is used to bill for admitted significant others as well as primary patients with a substance use disorder diagnosis.

Continued on Next Page

APG Service Category: Group Counseling

Continued from previous page

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 data a claim with 90849 and H0005. Collateral patients attending multi-family group (90849) can be billed for one family member per patient. In this instance, for each family unit, the program one would submit a single service visit claim using the admitted patient's Medicaid client ID number. Group may contain no more than 15 people.

Use of the Physician Fee Schedule - When the physician provides a counseling service he/she can add the rate code to increase the payment for the service to account for the additional cost for the service provider. This may only occur if the physician provides a service typically provided by clinical staff. This includes: Individual counseling and group counseling. It excludes medication management services. Physicians cannot bill for a medication management visit on the same day that they bill for a physician fee schedule add on for counseling.

Medicare / Medicaid and use of CPT codes

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

Group	60 minutes minimum	CPT 90853

APG Service Category: Collateral Visit

Time Requirements

Time – 30 minute minimum

Delivering Staff

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

Definition

A face- to-face visit delivered to a collateral person, without the patient present, for the purpose of providing an intervention in the service of the primary patient's progress in treatment. Collateral persons are members of the patient's family or household, or significant others who regularly interact with the patient and are directly affected by or have the capability to affect his or her chemical dependence, and whose role in supporting the patients recovery is reflected in the treatment plan, it's development or identified as a collateral support as the result of emergent issues.

Clinical Guidance

Collateral visits are provided by a clinical staff to support the treatment of a primary patient and or admission assessment process. The purpose for meeting with a collateral should be clearly identified in the treatment plan and/or progress note (in the event that the collateral has been identified as the result of an assessment or emergent issue). Collateral visits generally occur without the patient and may occur in addition to an individual or family session. Collateral visits may include visits prior to admission to gather information to inform an admission decision. Post-admission collateral visits should be goal-oriented and focused on specific and practical skills for assisting the primary patient in the management of their chemical dependency.

Family members who are in need of treatment for problems associated with living with a person with chemical dependency should not be seen as collaterals, but opened as primary patients and treated per an individual treatment plan.

Individuals who qualify as collaterals are not limited to family members. Many patients have primary and significant relationships with non-family members. The clinical staff must clearly document the relationship of the collateral to the patient and how the collateral is clinically necessary to support the patient treatment plan. Contact with service providers or others with professional relationship with the patient would not typically meet the criteria for this service category.

Multi-family Group Treatment

Collateral visits are family visits, however, adolescents (age 10-21) treatment collaterals may be billed for group services when the group service is delivered as a time-limited multi-family group (see group clinical guidance) for the purpose of supporting the adolescents' recovery. Adult significant others may attend a group for similar purposes but must be admitted to the program, the program will then bill using the group code H0005.

Documentation

A progress note placed in the patient record including the duration and date of the visit, signed by the clinical staff member delivering the counseling service. The note should identify the purpose of the visit, strategy the counselor utilized in working with the collateral and how this strategy will support the patient's treatment goal(s). The note should be placed in the primary patient's file.

APG Service Category: Collateral Visit Continued

APG CPT /HCPCS Billing Code: T1006 Family / Couple Counseling The program will bill this code to the admitted's patient claim and medcaid client identification number.

Category Specific Medicaid Limits

Collateral visits may take place prior to and after admission. No more than five ~~three~~ collateral visits may occur ~~without a clinical justification included in the treatment plan and in no event can more than six collateral visits~~, per patient episode of care be billed to Medicaid. The program will bill the service using the admitted primary patient's or the prospective patient's Medicaid Client identification number

Medicare / Medicaid and use of CPT codes

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

Collateral		CPT 90846

APG Service Category: Complex Care Coordination

Time Requirements

Time – A minimum of 45 minutes (combined)

Delivering Staff

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

Definition

An ancillary service, provided to or on behalf of a current patient when a critical event occurs or the patient condition requires significant coordination with other service providers. Documentation must note the critical event or condition and the need for coordination of services. Complex care is distinguished from routine case coordination activities and must occur within 5 working days of another clinical service.

Clinical Guidance

Complex Care coordination occurs when the patient condition or a critical event in requires that the clinical staff member coordinate care between service providers. The coordination must be clinically necessary and in support of the treatment plan or provided to address a critical event related to the clinical treatment of the patient. The coordination service may be provided with or without the patient present and there should be a targeted outcome of the coordination, for example, referral to psychiatric or CD crisis service; placement in emergency housing.

Patients in need of complex care coordination have multiple service providers, dual diagnoses, and/or significant functional deficits. Complex care coordination is used to bring multiple service delivery providers together either in a face to face meeting which may occur with or without the patient 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 patient functioning. The complex care coordination does not need to occur face to face with the service provider.

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

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

Examples include:

- A patient who relapses and shows for appointment intoxicated – the clinician spends at minimum 45 minutes coordinating a referral to detox, negotiating with insurance company, and discussing incident with probation and DSS workers.
- A stable patient reports imminent loss of housing – the clinician spends a minimum of 45 minutes coordinating with multiple providers to find emergency housing and begin process for establishing permanent housing through DSS.

Continued on next page

APG Service Category: Complex Care Coordination

Continued from previous page

- A pregnant patient currently enrolled in Opiate Treatment Program reports an incident of Domestic Violence – the clinician spends a minimum of 45 minutes making a child abuse report; coordinating admission with domestic violence shelter; ensuring that the woman has a safety plan for getting to the shelter and securing her ability to continue to come to the clinic for medication pick-up.

Examples that would not meet criteria:

- An adolescent needs a referral to inpatient treatment – clinician spends 20 minutes coordinating with referral agency, family members and informs guidance counselor. This example does not meet the time criterion .
- Mandated patient has a positive toxicology test and the clinician informs the drug court through standard written and/or verbal communication. This example does not meet the time or complexity criteria.
- Outpatient clinical staff help coordinate an intensive residential placement for a patient who is completing inpatient treatment. The staff provide 45 minutes of coordination between, the residential staff, probation, and family members. This example does not meet the 5 day visit rule.

Documentation

The clinical staff person must provide a written signed progress note including the date(s) and duration spent in the care coordination, service providers, purpose of the coordination, results and plan for next steps and include the note in the patient record.

APG CPT / HCPCS Billing Code

90882 Environmental intervention for medical Management purpose on a psychiatric patient's behalf with agencies, employers, or institutions.

Category Specific Medicaid Billing Limits

Complex Care coordination must occur within 5 working days of a clinical service. This could be 5 days prior or 5 days after the clinic service. Complex care coordination is exempt from the two billable service per day maximum rule, however, a program may not bill for more than three complex care visits per patient within an episode of care, unless the clinical staff provides written clinical justification for additional complex care coordination services.

APG Service Category: Peer Support Services

Time Requirements

Time - minimum of 30 minutes

Delivering Staff

Peer advocate as defined in Part 822

Definition

Face- to- face service provided by a peer advocate to an active patient of an outpatient clinic. Peer support services are clinic-based services for the purpose of connecting patients to community based recovery supports consistent with the treatment plan.

Clinical Guidance

Patients who attend mutual support groups have better outcomes than those who do not and there are a variety of peer support models and mutual support groups in the community. OASAS has defined peer support services in a clinic setting narrowly to support the clinical needs/goals of the patient within outpatient chemical dependency treatment. The Part 822 definition and this Medicaid billing category is in no way meant to limit the provision of other types or forms of peer support that clinics may support or provide. However, to meet the requirement for a Medicaid billable service, peer services must meet the requirements as set forth in this guidance and the Part 822 regulations.

Peer support services must be provided by a peer advocate as defined in Part 822, and per Federal Medicaid reimbursement rules, peer service providers / advocates must hold a national credential as a peer advocate or other credential as a peer advocate as recognized by OASAS. A credential as a CASAC or CASAC-T only does not meet the criteria for a peer advocate. Programs may contact the Recovery Bureau at OASAS for clarification on other recognized credentials or to suggest a credential that OASAS should consider. The service is limited to patients currently enrolled in the outpatient clinic when the patient's treatment plan indicates that self/mutual help or other recovery oriented service is indicated. Many patients can seek out and attend mutual support groups or other recovery services on their own, and others will benefit from meeting with a peer advocate for the purpose of learning about peer supports through personal experience.

Peer advocates should be supervised by appropriate clinical staff member, however, they do not serve in a clinical role. Peer services are specifically designed to support the individual in recovery from the unique perspective of someone who shares similar experiences. Therefore, the role of the peer advocate is less formal, focused on the patient's recovery support needs and based on a peer relationship. The supervision of peer should focus on providing guidance on boundaries, monitoring of ethical behavior, sharing information related to the patients' treatment plan and working within the policies and procedures of the clinic.

Programs choosing to employ peers advocates as paid or volunteer staff should have policies and procedures that address former patients: supervision; training; and, how the program will avoid dual relationships.

Documentation

The peer counselor should write a note including the date, duration of the visit and the peer support service that was delivered, the response of the patient and plan.

APG CPT /HCPCS Billing Code H0038 – Peer Services

Continued on Next Page

APG Service Category: Peer Support Services - Continued

Continued from previous page

Category Specific Medicaid Billing Limits

Note: The Peer Support code will not be activated until January 2011 as such, Medicaid reimbursement will not be available for Peer Support services until that time.

Programs should not bill for more than 5 peer services per patient, within an episode of care, unless the treatment plan includes clinical justification. This service is exempt from the two services per day rule.

APG Service Category: Outreach REQUIRES FEDERAL APPROVAL WHICH IS NOT AVAILABLE AT THIS TIME and OASAS WILL CONTINUE TO EXLPORE OPTIONS

30 minute minimum

Delivering Staff

Clinical staff (including medical staff) or Peer Advocates as defined in Part 822

Definition

A face- to- face off-site service with a patient for the purpose of increasing motivation to participate in treatment for chemical dependency that is clinically indicated. Patients identified for this service must be current patients who have not shown for sessions at the clinic or are judged to be at risk for prematurely discontinuing treatment or patients who are admitted to another OASAS certified service and are transitioning to the outpatient clinic.

Clinical Guidance

Patients are at risk of prematurely terminating treatment when they miss sessions or transition from one level of care to another. An outreach visit can identify issues that are barriers to treatment, help the patient to remove barriers, increase motivation and repair problems in the therapeutic alliance. Patients at risk of premature treatment drop out or patients at risk at of discontinuity of care represent a challenge to treatment staff. These patients have had enough concern about chemical dependence to seek treatment. We know that patients who remain connected to treatment for extended periods fare better than those who do not. Outreach efforts to re-engage patients or efforts to ensure continuity in care from one level to the next should result in improved outcomes. The definition of outreach for the purposes of APG reimbursement are neither meant to reflect all of the outreach and engagement models available nor to restrict programs from participating in broader outreach efforts. The definition is for the purpose of establishing a framework for outreach and engagement that is reimbursable through Medicaid as an outpatient clinic service.

Example of an outreach visit: Patient B was doing well in treatment and becoming a leader in the Tuesday morning group. He began to miss appointments without calling, and did not return phone calls from his clinician. A peer counselor goes out to meet the patient in the community. The peer counselor found that the patient had relapsed and was embarrassed to come back to the group where other patients looked up to him. The peer counselor shared some of his own personal experiences about a relapse early in his recovery where he avoided meetings. The patient recognized that the relapse didn't mean the end of his recovery and came to group the next week to share what he had learned.

Documentation

The clinical staff member or peer advocate must write a progress note including the date, duration and time of the face -to -face session, where it occurred, the purpose of the outreach service and the response of the patient served.

APG CPT /HCPCS Billing Code

H0023 Behavioral health outreach service, planned approach to reach a targeted population

Category Specific Medicaid Billing Limits: Note: Medicaid fee-for-service reimbursement for offsite services is dependent upon federal approval and will not be available until this approval is obtained.Programs should not bill for more than 3 outreach visits per person within an episode of care

APG Service Category: Intensive Outpatient Service (IOP)

Time Requirements

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

Delivering Staff

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

Definition

A clinical treatment service for individuals who require a time-limited, multi-faceted array of services, structure and support to achieve and sustain recovery. Intensive outpatient treatment programs generally provide a minimum of 9 treatment hours per week delivered during the day, evening or weekends. A team of clinical staff must provide this service. The treatment program consists of, but is not limited to, individual, family and group counseling; relapse prevention and coping skills training; motivational enhancement; and drug refusal skills training.

Clinical Guidance

Intensive outpatient is appropriate for patients who need more intensive treatment in order to attain or maintain recovery from chemical dependency, this also includes patients with a dual diagnosis and corresponding functional deficits. Patients should meet the level of care requirements as defined by ASAM or the OASAS LOCADTR tool or the program clearly summarizes the functional deficits that clearly identify the need for an intensive level of care. These services may be provided in 3 hour blocks of time where patients are seen in group, family and/or individual sessions that address multiple issues and are designed to help patients initiate a period of recovery from chemical dependency. Intensive outpatient services may be provided in as little as a week or over a period of time, not exceeding 6 weeks without clinical justification (e.g. ASAM or LOCADTR and in accordance with Part 822 regulations.).

Intensive outpatient services are not simply longer versions of outpatient programming, but structured group and individual interventions targeted to specific functional areas including: mental health functioning, vocational/educational, life skills and attainment of initial abstinence.

Documentation

A clinical staff person directly involved in providing the intensive outpatient treatment must provide a written note for each day of service that includes: the time of the service, what was delivered and how it addresses issues of early recovery, patient response to treatment and plan.

APG CPT /HCPCS Billing Code

S9480 – Intensive Outpatient psychiatric services, per diem

The IOP code will not be activated until January 2011. Prior to January, IOP two groups per day are permissible for IOP patients only. After January 2011, IOP services will be grouped / billed through their own APG and for IOP patients, programs may no longer bill two groups per day.

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APG Service Category: Intensive Outpatient Service (IOP) Continued

Continued from previous page

Category Specific Medicaid Billing Limits

Intensive outpatient treatment is a time-limited service and should not exceed 6 weeks without clinical justification. Programs may not bill for more than 6 weeks of intensive outpatient service without a clinical rationale included in the patient's record in either a progress note or in the treatment plan. (e.g. ASAM or LOCADTR and in accordance with Part 822 regulations.).

Programs bill for IOP daily and patients must attend at least 3 hours of service on any given day. Patients must be scheduled for 9 hours of service each week to meet the level of care requirement, however, IOP is billed on a daily basis regardless of the total weekly attendance of any individual patient.

Programs can bill for medication administration, medication management, complex care, peer services and collateral contacts in addition to IOP but may not bill other service categories while a patient is in the IOP service. The only exception to this is if a patient attends IOP services for less than 3 hours on a given day, in which case, the program may bill for the discrete services delivered.

Outpatient Rehab Services - Programs must be certified as an OASAS Part 822 Outpatient Rehabilitation program.

Time Requirements

Partial Day 2-4 hours

Full Day 4 + hours

Staff Delivering Service

Clinical staff including activities therapists as defined in Part 822 working within the scope of practice.

Definition

Services for more chronic individuals emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. These services are in addition to basic outpatient services. To provide this level of service programs must have OASAS certification as a Chemical Dependence Outpatient Rehabilitation program.

Clinical Guidance

Rehabilitative services are appropriate for patients who have significant functional impairment and meet the ASAM, LOCATDR or other placement criteria for this level of care. The purpose of this level of care is to provide a structured program that supports recovery in the community and provides specific treatment in group, individual and/or family formats to improve functioning in social, vocational/educational/ activities of daily living, behavioral and physical and mental health areas. This structured treatment is expected to improve functioning so that patients may attain and sustain recovery.

Employment, stable housing and social support for recovery have all been shown to improve outcomes in chemical dependency treatment. To the extent that patients lack skills or resources to attain employment or otherwise support recovery, outpatient rehabilitative services are designed to build skills and connect patients to resources in this area. Many patients who are appropriate for this level of care have co-occurring physical or mental health disorders. Programs that treat this population must have appropriate staff with experience including medical and clinical staff. Outpatient rehabilitation models should provide integrated care to the extent possible, and in all cases should have the capacity to identify, assess and coordinate treatment for these co-occurring disorders.

Documentation

A daily attendance note must be written and a responsible clinical staff member must write a progress note no less often than once per week.

APG CPT /HCPCS Billing Code

~~Under Development~~

H2001 – 2-4 duration; and,
H2036 - four hour and above duration.

Category Specific Medicaid Billing Limits

Programs can bill for medication administration and management, complex care, peer services and collateral contacts in addition to outpatient rehabilitation. However programs may not bill for other service categories while patient is in the day rehab program. The Outpatient Rehab codes will not be available for APG billing until Jan 2011.

Physical Health Services

Time Requirements

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

Staff Delivering Service

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

Definition

Physical Health services encompass a wide range of assessment and treatment procedures performed by medical staff for the purpose of identifying and treating physical problems associated with chemical dependency.

Clinical Guidance

Many patients admitted to chemical dependency treatment have significant medical problems associated with their use of substances and lifestyle. Many of these patients are not aware of acute or chronic health problems and are not connected to a primary care provider. Medical staff in chemical dependency programs can assess and treat a wide variety of addiction related acute and chronic conditions and receive reimbursement through Medicaid. Patient's must be seen directly by the medical staff performing and billing for the service and the program should attempt to link patients to a primary care provider for ongoing care, if the patient does not have a primary care provider.

Chemical dependency programs certified by OASAS only are not designed to provide primary care services and are not intended to deliver health care services as a primary mission. Programs should identify policies and procedures on identifying, assessing and treating physical health disorders and integrate that care through patient-centered treatment planning and interdisciplinary case conferencing. Consistent with the overall state certification reform effort, where more than 5% of total visits at an OASAS Certified Outpatient Chemical dependence are for medical services, or any visits are for dental services, certification from DOH as a general health clinic is required. Medical services, for this provision, do not include medical services required under OASAS Part 822 regulations. The DoH link to information on CON reform link which contains information about certifications from the various health & behavioral health agencies:

http://www.nyhealth.gov/press/releases/2008/2008-03-04_con_reform_ambulatory_care_services.htm

Documentation

Staff must document each physical health service delivered including the date of the service, duration, diagnosis, treatment provided and sign each note.

Continued on Next Page

Physical Health Services

Continued from previous page

APG Billing for Physical Health Services

Programs will submit a physical health specific claim using the appropriate OASAS APG medical service rate code listed on page 41, and the E/M code appropriate for the delivered medical service. For those visit dates when a program delivers both chemical dependence treatment services (eg. Individual or group counseling) AND physical health services the program would submit: one claim using the appropriate OASAS APG chemical dependence rate code and corresponding chemical dependence CPT /HCPCS service codes indicated in this manual; AND, a separate claim using the appropriate OASAS APG medical service rate code and the E/M code appropriate for the delivered medical service.

However, any medical visit related to an OASAS regulatory requirement (i.e., an annual physical) must be billed under the rate code used for chemical dependence services (also listed on page 41) and not the medical visit rate code. These sorts of medical visits should be coded on the same claim that was used for any chemical dependence services that may also have been delivered during the same visit.. In this instance the OTP program would include the appropriate CPT code on the same episode claim that is used for the chemical dependence services.

Physical Exam New/Established Patient

APG 840-843	99382 – 99387 New Patient 99392 – 99397 Established Patient

Other Physical APG's

OASAS has included a list of physical health APG's (see next page in manual). Programs must bill using the physical health services rate code and the appropriate procedure code and diagnosis. All physical health services must be delivered per DOH unless otherwise specified.

403 ORGAN OR DISEASE ORIENTED PANELS
413 CARDIOGRAM
428 PATIENT EDUCATION, INDIVIDUAL
429
527 PERIPHERAL NERVE DISORDERS
529 SEIZURE
534 NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARC
574 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
596 PERIPHERAL & OTHER VASCULAR DISORDERS
597 PHLEBITIS
599 HYPERTENSION
604 CHEST PAIN
623 ESOPHAGITIS
628 ABDOMINAL PAIN
630 CONSTIPATION
633 ALCOHOLIC LIVER DISEASE
635 DISORDERS OF PANCREAS EXCEPT MALIGNANCY
636 HEPATITIS WITHOUT COMA
639 LEVEL I HEPATOBILIARY DIAGNOSES
654 OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS
663 PAIN
670 SKIN ULCERS
673 CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS
674 CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE
710 DIABETES WITH OPHTHALMIC MANIFESTATIONS
711 DIABETES WITH CIRCULATORY DIAGNOSES
712 DIABETES WITH NEUROLOGIC MANIFESTATIONS
713 DIABETES WITHOUT COMPLICATIONS
714 DIABETES WITH RENAL MANIFESTATIONS
786 IRON DEFICIENCY ANEMIA
807 FEVER
826 ACUTE ANXIETY & DELIRIUM STATES
827 ORGANIC MENTAL HEALTH DISTURBANCES
850 ALLERGIC REACTIONS
880 HIV INFECTION
881 AIDS

SECTION SIX: APG Medicaid Billing

History – Transition from the Rate Based Single Threshold Visit to APG billing.

Prior to APG Implementation the Medicaid reimbursement system for OASAS ambulatory service (outpatient and methadone) clinics utilized a rate based threshold visit payment that supported one service claim per per day (Part 822) or one claim weekly (Part 828) regardless of the number or type of services provided in a visit. Under the rate based system OASAS certified providers billed Medicaid used the rate codes listed in the table below[2].

!! Upon conversion to the APG payment structure these rate codes will be eliminated and providers must bill Medicaid using the CPT / HCPCS codes discussed in the APG General Medicaid Billing Section and as shown with each of the APG categories specified in section four of this manual !! The only exception are the banded Buprenorphine codes as noted below.

Service	Pre- APG Art 28 Threshold Rate Code	Pre – APG Art 32 Threshold Rate Code
Part 822 Outpatient Clinic	4273 Assessment 4274 Individual 4275 Group	4214 Assessment 4215 Individual 4216 Group
Part 822 Outpatient Rehabilitation	4276 Assessment 4277 Full Day / 4 hours 4278 Half Day 2-4 hours	4217 Assessment 4218 Full Day / 4 hours 4219 Half Day 2-4 hours
Part 823 Outpatient Youth Clinic	4283 Assessment 4284 Individual 4285 Group	4280 Assessment 4281 Individual 4282 Group
Part 828 Methadone	1671 weekly 2973 weekly	N/A
NOTE : Part 828 Buprenorphine: Under APGs the dosage based Buprenorphine codes will be maintained . and used by the Opiate Treatment Programs (OTP) for the purpose of billing Medicaid and receiving payment for JUST for the patient specific weekly dispensed dosage. OTP claiming for counseling services will be billed using the APG construct described in this manual.	2531 Low dose 2532 Medium dose 2533High dose 2534 Max dose	N/A

[2] For billing or adjusting dates of service prior to APG implementation XX/XX/2010 use old threshold rate codes.

Medicaid Claim Submission Under APGS

This manual is intended to provide guidance on Chemical Dependence Medicaid billing changes that are prompted by the APG conversion. This manual is not intended to be a comprehensive overview of all components of Medicaid billing. For a full understanding of all Medicaid claiming components, including claim data field entry, OASAS certified programs should review information available on eMedny website: the http://www.emedny.org/ and or seek assistance from Computer Sciences Corporation (CSC), the New York State Department of Health contract Medicaid fiscal intermediary, CSC can be contacted at
1- 800 343 -9000.

Prior Threshold Billing

Previously, under the threshold rate system programs used one of the codes listed on page 41 to bill for Medicaid. OASAS certified Part 822 Outpatient Chemical Dependence or Part 823 Outpatient Chemical Dependency for Youth programs would submit one service claim per patient per day, and OASAS Certified Part 828 Opiate Treatment Programs submitted one weekly claim per patient.

APG Billing for Part 822 Chemical Dependence Clinics – Visit /Single Date of Service

Under APGS programs will now be able to submit one claim per patient per day AND that claim will reflect multiple services lines. The claim will correspond with the actual visit date and the multiple lines will represent all the services delivered on one day. For example, if for a single patient, on a single visit date, a program delivers a group and an individual service, the program will submit to Medicaid a single claim that requests payment, indicated by the appropriate OASAS APG rate code listed on page 41, and the CPT or HCPCS code, for each discrete service.

All services within the same visit date and OASAS APG rate code must be billed together on a single claim. If two claims are submitted, with the same OASAS APG rate code for the same visit date, only the first claim submitted will pay. The second claim will be denied.

APG Billing for Part 822 Opiate Treatment Programs – Weekly Episode of Care

OTP claims will be submitted using a weekly episode of care of care construct. As with the prior weekly threshold claims process, under APGS one weekly episode claim per opiate patient will be submitted. However, under APGS the single episode claim must include the discrete visit dates and the multiple CPT or HCPCS codes to reflect the services that are delivered on the individual days encased within the episode

As it was pre APGs, the episode will be defined as the from / thru date for the calendar week (Mon – Sun) and the OTP Sunday billing (claim submission) date should reflect the Sunday that closed that weekly episode.

Example: If the episode dates of service were Monday Jan 1, through Sunday, January 7, the actual billing (claim submission) date would be Sunday, January 7. To receive payment for services delivered within the episode, the program will submit to Medicaid a single episode claim, indicated by the appropriate OASAS APG rate code listed on page 41, and the claim will reflect the CPT or HCPCS code, for each discrete service that is delivered on a specific dates within the weekly billing range. The episode payment will be equal to the sum of the lines, by visit date, that are encompassed within the episode. This calculation will be done by the Medicaid system and take place at the State level

APG Buprenorphine Billing by Part 822 Opiate Treatment Programs

APG Buprenorphine Billing for Part 822 Opiate Treatment Programs will:

- Utilize the existing Buprenorphine weekly rate codes, with the reimbursement set to reflect only the cost of the Buprenorphine for the specific dosage band:

2531	Low Dose 2-10mg
2532	Medium Dose 12-20mg
2533	High Dose-22-26 mgs
2534	Max. Dose-28+mgs

- OASAS certified OTP programs will submit a single episode claims that includes the:

  - The program should always bill at the last dosage amount provided during the weekly billing cycle e.g., if a patient receives different dosages over the course of a billing week, the program would bill the rate code associated with the last dosage level.
  - multiple date of service lines for all the dates of service encompassed in the week; and
  - the HCPCS code H0033 - Oral Medication Administration on each date of service line

Note: Billing is done after the fact, so, even if a patient's dosage level changed during the week, the last daily dosage for the weekly billing period would dictate the rate code to use for that week.

- Under APGS, in addition to the dosage only Buprenorphine claim for the cost of the drug, the program would also submit an additional APG weekly episode of care claim to receive payment for the actual counseling or medication services.

APG Billing for Physical Health Services delivered in OASAS Certified Outpatient Clinic and Opiate Programs

Programs will submit a physical health specific claim using the appropriate OASAS APG medical service rate code indicated on page 41, and the E/M code appropriate for the delivered medical service. For those visit dates when a program delivers both chemical dependence treatment services (eg. Individual or group counseling) or outpatient rehabilitation services AND physical health services the program would submit: one claim using the appropriate OASAS APG chemical dependence rate code and corresponding chemical dependence CPT /HCPCS service codes indicated in this manual; AND, a separate claim using the appropriate OASAS APG medical service rate code and the E/M code appropriate for the delivered medical service. All physical health services should only be delivered as appropriate to a practitioner's license and its corresponding scope of practice.

NOTE: The only exception to the separate physical claim rule is when an OASAS Certified opiate treatment program delivers an annual physical. In this instance the OTP program would include the appropriate CPT code on the same episode claim that is used for the chemical dependence services.

APG Claim Components

Essentially, the minimum change required to bill and get paid under APGs is to code claims using one of the new OASAS APG rate codes listed on page 40 below and the appropriate HCPCS /CPT code (listed on page 42) for the service that is being delivered.

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

- the new OASAS APG rate codes (listed in the APG Rate Code Table on page 41)
- a valid, accurate ICD 9 CM primary diagnosis code*; and
- valid CPT and/or HCPCS procedure codes. (listed in the APG HCPCS / CPT Coding Table on Page 42)

* The primary diagnosis code is the ICD 9 code describing the diagnosis , condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. In some cases, the first listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

APG reimbursement for an Evaluation and Management (E /M) visit will be determined by the primary ICD 9 CM diagnosis code and the level of the E / M visit CPT code. Diagnosis and procedure coding and billing must be supported by the documentation in the medical record. Note: Secondary diagnoses or additional codes that describe any coexisting conditions should also be coded, since if any of these codes group to APG 510, "major signs, symptoms and findings," then that diagnosis will be used in place of the primary diagnosis to group the medical visit

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

Programs will not be reimbursed for more than two different services provided in a single visit date with the exception of medication administration, medication management, complex care management and peer support services. Additionally, the second and third service (where permitted) in each visit will be discounted by 10% with the exception of the "always pay" APG service categories (Medication Administration, Medication Management, Complex Care Coordination). Additionally, there are APG category specific Medicaid billing parameters that providers must understand, these parameters are discussed in the clinical guidance section of this manual.

Ancillary Medicaid Billing for:

Laboratory Services Ordered by OASAS Certified Outpatient Clinic and Opiate Treatment Program

Under the APG pricing structure will laboratory services become the fiscal and contractual responsibility of the OASAS certified outpatient chemical dependence or opioid program?

Answer: For OASAS Certified Hospital and Freestanding Outpatient Clinic and Opiate Treatment Program APGS do not change / impact the current policy for the ordering or payment of lab services. Consistent with pre APG policies lab services for outpatient chemical dependence and opioid patients will not be the fiscal and / or contractual responsibility of the OASAS certified outpatient chemical dependence or opioid program. The exception would be toxicology in an opioid setting as these services are already included in opioid 2008 base year costs and are currently provided directly or by agreement with a laboratory by opioid programs

NOTE: This policy is different from the ancillary laboratory payment policy for services delivered in general health clinics. For additional information on this and other APG policy and billing guidelines for Article 28 providers hospital-based outpatient, ambulatory surgery, and emergency departments, and to free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers please go to: http://www.health.state.ny.us/health_care/medicaid/rates/apg/

Prescription Pharmaceuticals Ordered by OASAS Certified Outpatient Clinic and Opiate Treatment Programs.

Under the APG pricing structure will prescription pharmaceuticals the become the fiscal and contractual responsibility of the OASAS certified outpatient chemical dependence or opioid program?

Answer: APGS will not change / impact the prescribing or payment of prescription pharmaceuticals that are ordered by hospital or freestanding OASAS certified clinic or opiate treatment programs. Programs should continue to follow pre APGs practices as appropriate to: patient medical necessity; the prescribing practitioner's scope of license; and, any associated state or federal laws or regulations.

Transportation Claims for NYC Opiate treatment programs patients

The APG claiming applies only to counseling / treatment services. As such, The APG exercise should not have an impact on, or require a change in the process the program currently uses for submitting transportation claims for NYC opiate treatment patients. For example, if when generating an 837 EDI service claim file, the program / vendor currently appends a separate transportation claim, the program / vendor may continue that process.

APG Coding and Billing Rule Summary Tables:

Table One – OASAS APG Rate Codes		
Code Table	APG RATE CODE	Former Medicaid Rate Code
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program	1528 Visit Code	4273 Assessment 4274 Individual 4275 Group
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program	1561 Visit Code	4276 Assessment 4277 Full Day / 4 hours 4278 Half Day 2-4 hours
Part 822 Hospital (Art 28 and Art 32) Outpatient Youth Programs	1528 Visit Code	4283 Assessment 4284 Individual 4285 Group
Part 822 Hospital (Art 28 and Art 32) Opiate Treatment Program	1531 Episode Code	2973 Weekly Visit
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program	1540 Visit Code	4214 Assessment 4215 Individual 4216 Group
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1573 Visit Code	4217 Assessment 4218 Full Day / 4 hours 4219 Half Day 2-4 hours
Part 822 Community (Art 32 only) Outpatient Youth Programs	1540 Visit Code	4280 Assessment 4281 Individual 4282 Group
Part 822 Community (Art 32 only) Opiate Treatment Program	1543 Episode Code	1671 Weekly Visit
Medical Services		
Part 822 Hospital (Art 28/ 32) Chemical Dependence Outpatient Program	1552 Visit code	N/A
Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program	1558 Visit Code	N/A
Part 822 Hospital (Art 28/32) Opiate Treatment Program	1555 Visit Code	N/A
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program	1468 Visit Code	N/A
Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program	1570 Visit Code	
Part 822 Community (Art 32 only) Opiate Treatment Program	1471 Visit Code	N/A

Table Two OASAS APG HCPCS /CPT

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

APG Category	HCPCS / CPT CODE	APG Category	HCPCS /CPT CODE
Screening , Brief Intervention and Treatment 15 minute minimum	H0050 H0049	Individual Counseling Brief 25 minute minimum	G0396 Alcohol and / or Substance Abuse
Medication Administration and Observation	H0020 – Methadone H0033 - Oral Medication	Individual Counseling Normative 45 minute minimum	G0397 Alcohol and / or Substance Abuse
Medication Management Routine 15 minute minimum	H0034 Medication Training and support M0064 Visit for Drug Monitoring	Group Counseling 60-90 minutes	90849 Multiple Family – only for use with adolescent family collateral group session. H0005 Alcohol and/or drug services
Medication Management Complex 30 minute minimum	90862 Medication Management	Collateral Visit 30 minute minimum	T1006 Family / Couple Counseling – occurs w/o patient present
Assessment Brief 15 Minute Minimum	T1023 To determine the appropriateness of an indivuals participation in a specific program	Complex Care Coordination 45 minute minimum	90882 Environmental intervention for medical Management purpose on a psychiatric patient's behalf with agencies, employers, or institutions.
Assessment Normative – 30 minute minimum	H0001 – Alcohol and/or drug assessment	Peer Counseling 30 minute minimum	H0038 – Peer Services 2011 Start Date
Assessment Extended – 75 minute minimum	H0002 – Behavioral Health Screening to determine eligibility for admission	~~Outreach and Engagement~~ ~~30 minute minimum~~	~~H0023 Behavioral health outreach service, planned approach to reach a targeted population~~
Intensive Out Program Jan 2011 Start date	S9480 – Intensive Outpatient psychiatric services , per diem	Outpatient Rehabilitation Jan 2011 Start date	~~Code to be determined~~ H2001 – 2-4 duration; H2036 - four hour and above duration.

Table Three –Billing Rule Summary Table

1) General Claiming Rules:
Two billable services per patient visit date:

- Per OASAS regulation, Medicaid APG billing is generally limited to no more than two different service categories per visit date. For example, a program may bill and receive reimbursement for a group and an individual service on the same visit date, but may not bill for two individual services on the same visit date.
- * Exemption: The following services are exempt from the above two billable service rule: complex care coordination, medication administration, medication management and peer support services, e.g. an individual, group and medication management may be claimed on the same visit date and the program would receive reimbursement for all three service.
- ! NOTWITHSTANING THE EXEMPTIONS, PROGRAMS SHOULD NOT SUBMIT A MEDCAID CLAIM FOR A SAME VISIT DATE THIRD SERVICE. !

APG Category	Service Specific Billing Limitations	APG Category	Service Specific Billing Limitations
Screening and Brief Intervention and Brief Treatment 15 minute minimum	Brief Screening: one per patient / episode Brief Intervention: up to three visits prior to admission Brief Treatment: Occurs prior to admission, one per day limit.	Individual Counseling Brief 25 minute minimum Individual Counseling Normative 45 minute minimum	Programs may not bill for more than one individual service per day.
Medication Administration and Observation	One medication administration service per day for single or multiple oral medications. A second same visit date medication administration service may be billed for an injectable * Exemption applies		
Medication Management Routine 15 minute minimum Medication Management Complex 30 minute minimum	Only one medication management routine service may be billed per day. * Exemption applies	Group Counseling 60-90 minutes	Programs may not bill for more than one group service per day.
		Collateral Visit 30 minute minimum	Collateral visits, occurs w/o patient present, and may take place prior to and after admission but there should be no more than five ~~three~~ collateral service per patient, per episode of care. ~~without a clinical justification included in the treatment plan.~~
Assessment Brief 15 Minute Minimum Assessment Normative 30 minute minimum Assessment Extended 75 minute minimum	Programs may only bill for one assessment visit per day. Programs may bill for up to three assessment visits prior to admission. Only one of those visits can be billed as an extended assessment visit.	Complex Care Coordination 45 minute minimum (time does not need to be contiguous)	Must occur within 5 working days prior or 5 days after the clinic service. No more than three complex care visits per patient within an episode of care, unless clinically justified. * Exemption applies
		Peer Support 30 minute minimum	No more than 5 peer services, within an episode of care, per patient unless the treatment plan includes clinical justification.
		~~Outreach~~ ~~30 minute minimum~~	~~No more than 3 outreach visits per person within an episode of care~~

Table Three –Billing Rule Summary Table Continued on Next Page

Table Three –Billing Rule Summary Continued from Previous Page			
Intensive Out Program: The IOP billing code will not be activated until January 2011. Prior to January, IOP two groups per day are permissible for IOP patients only. After January 2011, IOP services will be grouped / billed through their own APG and for IOP patients, programs may no longer bill two groups per day.	Programs can bill for medication administration and management, complex care, peer services and collateral contacts in addition to IOP but may not bill other service categories while a patient is in the IOP service. The only exception to this is if a patient attends IOP services for less than 3 hours on a given day, in which case, the program may bill for the discrete services delivered.	Outpatient Rehabilitation Partial Day 2-4 hours Full Day 4 + hours	Programs can bill for medication administration and management, complex care, peer services and collateral contacts in addition to outpatient rehabilitation. However programs may not bill for other service categories while patient is in the day rehab program. Programs must be certified as an OASAS Part 822 Outpatient Rehabilitation program.
The service definitions and associated CPT or HCPCS codes listed in this manual are for the purposes of billing the New York State Medicaid program. It is recognized that in some instances the OASAS service definition and applicable CPT or HCPCS codes may vary from: the service definition listed in the CPT or HCPCs manuals; and/or, be different from codes the are used with commercial or Medicare billing. Programs should use the codes as listed in this manual for billing the New York State Medicaid program, and then use Medicare or commercial coding as indicated by the relevant billing / coding guidelines.			

Table Four

Scenarios for Coding - Potential Treatment / Freestanding Clinic Billing Case Samples

Scenario #1: Lucy is a 14 year old referred by probation after an arrest for possession of marijuana. Her parents attend the assessment interview and report that Lucy has been truant from school, has left the house without permission and stayed out all night. They are concerned about the drug use, her behavior and report that they have just about given up on her. Her grades have dropped significantly from high 80's to just passing and she reports she hates school.

In addition to the HCPCS / CPT codes below the program would enter their OASAS APG Rate Code. Eg. A Freestanding program outpatient clinic would use the 1540 daily visit code.

	Monday		Tuesday		Wednesday		Thursday	
Week One	Service Assessment Extended Collateral Contact	Code H0002 T1006	Service Assessment Brief	Code T1023	Service Individual Normative 45 mins Group Collateral Contact	Code G0397 90849 10% discount applies	Service Multi- family Group - Collateral visit	Code 90849
Week Two	Service Individual Session Complex Care Coordination	Code G0397 90882			Service Group	Code H0005	Service Multi-family Group – Collateral visit	Code 90849

Scenarios Continued on Next Page

Scenario #2: Potential Treatment / Freestanding Clinic Billing Case Samples

Joe is a 45 year old married man with two children ages 9 and 12. He made an appointment for an alcohol abuse screening at the request of his family physician. He has high blood pressure and reports feeling tired, irritable, no appetite and chronic pain since losing his job 3 months ago. He is drinking every day and is concerned about his health and his family. When Joe is screened he scores in the high risk category and agrees to enter treatment. The program develops a preliminary plan of care and begins to engage him in treatment. However, by the second week Joe has missed several scheduled visits and it becomes apparent that he is in need of detoxification. Joe agrees and the program coordinates care between his family, the detox unit, and his family physician.

In addition to the HCPCS / CPT codes below the program would enter their OASAS APG Rate Code. Eg. A Freestanding program would use the 1540 daily visit code.				
Monday	Tuesday	Wednesday	Thursday	Friday
Week One Screening CODE H0050 Brief Intervention CODE H0049	Assessment Extended (75 minutes) CODE H0002	Individual Normative (45 mins) CODE G0396 Collateral Contact CODE T1006 (10% discount)	Group CODE H0005	Individual Brief (25 mins) CODE G0396 Group CODE H0005 (10% discount)
Week Two	Individual Normative (45 mins) CODE G0397 Group CODE H0005 (10% discount)		Individual Normative (45 mins) CODE G0397 Complex Care Coordination CODE 90882 (10% discount)	

Scenarios Continued on Next Page

Scenario #3 Potential Treatment / Opiate Treatment Program (OTP) Billing Case Samples

Scenario #3

Sara is referred for treatment by a family member after several years of heroin, benzodiazepine, and alcohol use. She has never been in substance abuse treatment although she has two prior psychiatric hospitalizations. Sara agrees to enter methadone treatment. The first two weeks of treatment are focused on getting her stabilized on methadone, developing a preliminary plan of care, beginning the bio-psycho-social assessment, and coordinating care for Sara's psychiatric condition in order to address her benzo use.

A single episode claim, submitted on Sunday using the appropriate APG rate code e.g. 1531 Hospital Episode Code; the discrete visit date; and the HCPCS / CPT that corresponds to the discrete visit date.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week One Assessment Extended CODE H0002 Medication Management Complex CODE 90862 Medication Administration CODE H0020	Medication Administration CODE H0020	Medication Administration CODE H0020 Individual Brief 25 mins) CODE G0396	Medication Administration CODE H0020	Medication Administration CODE H0020 Medication Management Routine CODE H0034	Medication Administration CODE H0020
Week Two Medication Administration CODE H0020 Group CODE H0005	Medication Administration CODE H0020 Individual Normative CODE G0397	Medication Administration CODE H0020	Medication Administration CODE H0020 Brief Treatment (tox positive for heroin & benzo) CODE H0050	Medication Administration CODE H0020 Complex Care Coordination CODE 90882	Medication Administration CODE H0020

END OF SCENARIOS

General Medicaid Billing

Traditional Claim Components

Under APGs providers will continue to use many previous Medicaid claim components: Medicaid service claims and documentations for individuals who have been admitted to a clinic program shall include, at a minimum:

Component	Description
Patient Medicaid ID:	The Medicaid identification number of the recipient,
Diagnosis Code	The designated chemical dependence diagnosis
HCPCS / CPT Code	The procedure code or codes corresponding to the procedure or procedures provided,
Program NPI	The Program National Provider Identifier (NPI)
Attending Practitioner NPI as appropriate of the attending clinician.	NPI of a clinic, hospital, or other facility is not accepted as an Attending Provider NPI. The claim must include the practitioner specific NPI. In those instances where a practitioner does not have an NPI, e.g. a CASAC, the equivalent DOH-approved alternative should be used in its place. For OASAS programs, this number is the OASAS unlicensed practitioner number: ID number 02249145. This number should be used when services are delivered by an appropriate program staff person who does not / cannot get an NPI number, e.g. a CASAC For more NPI information please go to: http://www.emedny.org/hipaa/NPI/index.html
Service Location –ZIP plus	Specifically, the licensed location where the service was provided or the regular assigned licensed location from which the program staff person departed for an "outreach and engagement procedure. The location of service as indicated by the appropriate Zip plus four address that is on file with the Medicaid billing system.
Revenue Code and Bill Type	http://www.emedny.org/hipaa/Crosswalk/Rate%20Code.xls
Cross Over Claims	837 COB Tutorials for example of balancing: http://www.emedny.org/hipaa/FAQs/837_COB_Tutorial_2.html or http://www.emedny.org/hipaa/FAQs/837_COB_Tutorial_1.html
Medically Necessary	All claimed Medicaid services must be medically necessary
Face to Face	All claimed service must be for a documented face to face encounter. The exception is complex care.
Appropriate Practitioner	All services must be delivered by the appropriate practitioner as articulated in this guidance document, OASAS regulation, and where appropriate as dictated by the practitioner license or certification
Service Documentation	The provider must also document in the individual's service record compliance with the OASAS regulatory requirements associated with any procedure code being billed. OASAS Regulation may be found at: http://www.oasas.state.ny.us/regs/index.cfm
Date and Duration	Reflects the date the service was provided and the time spent on the individual service. Duration can be identified by: total minutes; start / end times; and, or both.

Regulatory Compliance

- OASAS Regulation and Clinical Guidelines:

To qualify as a Medicaid billable service, the occasion of service must at a minimum meet the standards;

- established in this guideline manual;
- reflected in OASAS Part 822 regulation;
- reflected in Department of Health Medicaid Regulation 505.27; and,
- additional regulation cites as necessary.

- General Medicaid Billing Regulation and Guidelines:

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

HIPPA:

NYS Department of Health HIPAA site, provides information on HIPAA billing.
http://www.health.state.ny.us/nysdoh/hipaa/hipaa.htm

eMedny:

Main link to eMedNY This website is provided as a service for providers and the general public, as part of the offerings of the electronic Medicaid system of New York State.
http://www.emedny.org/new/index.html

ePaces Manual:

Link to the on line ePaces manual.
https://www.emedny.org/HIPAA/SupportDocs/ePACES/ePACES_Help.pdf

Edit and Error Knowledge Base:

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

http://www.emedny.org/HIPAA/Edit_Error/KnowledgeBase.html

Medicaid Eligibility Verification:

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

http://www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Provider_Manual/1_0/mevs_manual.html:

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

http://www.health.state.ny.us/health_care/medicaid/program/update/main.htm

Section Seven: APG Pricing

Phase-In from threshold to APG Prices: Non Hospital Based Clinic Programs

- APG reimbursement for non hospital based OASAS certified outpatient programs will be phased-in over a four phase period – with the conversion to APG prices completed upon entry into Phase four.
- Each phase will consist of 12 months, counted from the initial OASAS Program initial effective date.
- In the initial phase of blending, reimbursement for services delivered on each individual visit date payment will be based on 25% of the full amount that the APG methodology would calculate for the delivered service (based on coded procedures and diagnoses) plus a single accommodation that reflects 75% of the provider-specific Medicaid payment amount called the Legacy amount.
- The existing payment / legacy amount used for blending purposes will be based on the provider's on file per visit Medicaid reimbursement amount immediately preceding implementation
- NOTE: The *billing conversion* from threshold rate codes to APG codes will not however be phased. Upon APG the activation date all the Medicaid claiming system will no longer accept the previous threshold rate codes, Medicaid claims for dates of service after the APG activation date must be submitted to Medicaid using APG coding as discussed in the section of this manual titled "Medicaid Claim Submission Under APGS

The APG Blend Calculation for Freestanding Programs:

The APG portion of the blend will increase in each phase according to the following schedule.

Freestanding Programs will begin APGs pricing with the Phase One percentages, and will start with the 75%/25% reimbursement blend

	Current Threshold Legacy Payment	APG Payment
Phase 1	75%	25% of the full APG Payment
Phase 2	50%	50% of the full APG Payment
Phase 3	25%	75% of the Full APG payment
Phase 4	0	100% of the full APG Payment

For example in Phase One if a patient received an individual service at a non hospital (art 32 only) operated program the payment would be constructed by:

75% of the providers pre- apg Medicaid payment	+	+ 25% of the full APG payment for that service	=	APG payment for a single service

Discounting:

In those instances where more than when more than one procedure/service applies to a visit, the highest value procedure shall be paid at its full fee value. Payments for additional procedures related to the visit will be discounted by 10 percent; with the discount applied to the APG payment portion of the claim.

Phase-In from threshold to APG Prices: Hospital Based Clinic Programs

- Hospital will enter APGs in XX/XX/XXXX and will begin at Phase XXX . Note the final hospital implementation start date is under review. Once that date is set the start phase will be indentified.
- In the initial phase of blending, reimbursement for each individual visit will be based on XX% of the full amount that the APG methodology would calculate for the visit (based on coded procedures and diagnoses) and XX % of the provider-specific Medicaid payment amount called the Legacy amount.
- The existing payment / legacy amount used for blending purposes will be based on the provider's on file per visit Medicaid reimbursement amount immediately preceding implementation.
- NOTE ONE: The *billing conversion* from threshold rate codes to APG codes will not however be phased. Upon APG the activation date all the Medicaid claiming system will no longer accept the previous threshold rate codes, Medicaid claims for dates of service after the APG activation date must be submitted to Medicaid using APG coding as discussed in the section of this manual titled "Medicaid Claim Submission Under APGS"

The APG Blend Calculation:

The APG portion of the blend will increase in each phase according to the following schedule.

Hospital Programs will begin APGs pricing with the Phase XX percentages, and will start with the XX%/ XX% blend

	Current Threshold Legacy Payment	APG Payment
Phase 2	50%	50% of the full APG Payment
Phase 3 Effective xx/xx/xxxx	25%	75% of the Full APG payment
Phase 4	0	100% of the full APG Payment

For example in Phase Two if a patient received an individual service at a non hospital (art 32 only) operated program the payment would be constructed by:

50% of the providers pre- apg Medicaid payment	+	50% of the full APG payment for that service	=	APG payment for a single service

Discounting:

In those instances where more than when more than one procedure/service applies to a visit, the highest value procedure shall be paid at its full fee value. Payments for additional procedures related to the visit will be discounted by 10 percent; with the discount applied to the APG payment portion of the claim

Section Eight: Online Revenue Calculator

The following tools are available on line to assists providers project APG revenue.

- Online: CPT Procedure Weight and Rate Schedule

  This schedule gives the current base weight, peer group base rates, an updated list of APG/CPT services, definitions and weights. The schedule also includes payment amounts for the CPT coded services based on current peer group rates and procedure weights.

  Insert website address

- APG Revenue Calculator:

  This tool enables users to calculate the projected revenue for CPT procedures based on current service weights and peer group base rates.

  APG Revenue Calculator Instructions (PDF) -
  http://www.oasas.state.ny.us/admin/hcf/APG/documents/RevCalc-Instructions.pdf

  Freestanding Program APG Revenue Calculator (Microsoft Excel) –
  http://www.oasas.state.ny.us/admin/hcf/APG/documents/RevCalc-Freestanding.xls

  Hospital Based Program APG Revenue Calculator (Microsoft Excel) -
  http://www.oasas.state.ny.us/admin/hcf/APG/documents/RevCalc-Hospital.xls

APPENXIX ONE

Under Development HOLD FOR SAMPLE ENCOUNTER FORM

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