



New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual For Individuals Enrolled in Mainstream Medicaid Managed Care Plans And HARPS

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Introduction

This manual outlines the claiming requirements necessary to ensure proper behavioral health claim submission with respect to Mainstream Medicaid Managed Care Plans (MMCs) and Health and Recovery Plans (HARPs). Each behavioral health service transitioning to the Medicaid managed care reimbursement model is covered in detail. This manual should be used in conjunction with the coding crosswalks of rate code to procedure code/modifier code combinations that have been prepared by OMH/OASAS for use by both Plans and providers. Both crosswalks are available as Excel files. There is one crosswalk for the existing State Plan services and another for the new Home and Community Based Services (HCBS) that will be available to many HARP members.

This billing manual does not apply to office-based practitioner billing. It applies only to behavioral health services that can be billed under Medicaid fee-for-service rate codes by OMH-licensed or OASAS-certified programs and to the HCBS services that will be delivered by OMH and OASAS “designated” providers.

Note: This manual addresses billing guidance only. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, initial and on-going treatment planning and reviews, etc. Those standards are in the regulations for each program.

Managed Care Contracting Requirements

Beginning with the start of the behavioral health transition to Medicaid managed care in each geographic area, and for the first two years (based on the regional carve-in/implementation schedule) following, managed care plans will be required to contract with providers that serve five or more of their enrolled individuals. This requirement will help ensure that individuals already receiving behavioral health services continue to receive the services they need without interruption. The specifics of this requirement are as follows:

OMH Programs: For each OMH-licensed program type, Plans must contract with providers that serve five or more of their enrollees.

OASAS Programs: Plans must contract with a provider having five or more of the Plan’s enrollees **in any combination of** Clinic, Outpatient Rehabilitation, or Opioid Treatment Programs (OTP). The Plan must contract with the provider for all of the provider’s program types. Plans must also contract with **all** OASAS-certified Opioid Treatment Programs in their service area, regardless on the number of Plan enrollees serve by that OTP.

Each Plan has already received a list of providers that meet this contracting requirement. Any OMH/OASAS provider that believes it meets the threshold requirement with a particular Plan, but who has not yet been contacted by that Plan should contact OMH at (518) 474-6911 or OASAS at PICM@oasas.ny.gov

Government Rates

New York State law currently requires that Medicaid MCOs pay the equivalent of Ambulatory Patient Group (APG) rates for OMH licensed mental health clinics. Beginning October 1, 2015 in NYC and July 1, 2016 in counties outside of NYC, Plans will be required to pay 100% of the Medicaid fee-for-

service (FFS) rate (aka, “government rates”) for selected behavioral health procedures (see list below) delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV Special Needs Plans (SNPs) when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement will remain in place for the first two years (based on the regional carve-in/implementation schedule). For the new HCBS services, the government rate is the reimbursement listed for each program on the [HCBS Fee Schedule](#).

Government rates are required for the following four categories of services:

OASAS Government Rate Services (Mainstream Managed Care, HIV-SNP, and HARP):

- OASAS Clinic
- Opiate Treatment Programs (outpatient)
- Outpatient Rehabilitation
- Part 820 – OASAS per Diem Residential Addiction Treatment Services

OMH Government Rate Services (Mainstream Managed Care, HIV-SNP, and HARP):

- Assertive Community Treatment (ACT)
- OMH Clinic (government rates are already mandated for Clinic – continue to use existing billing procedures)
- Comprehensive Psychiatric Emergency Program (CPEP), including Extended Observation Beds (Note: For CPEP EOB services, Plans are required to pay only 80% of the FFS rate, as opposed to the 100% that is required for all other government rates services. All other CPEP services must be paid at 100% of FFS)
- Continuing Day Treatment (CDT)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)

HARP-Only Home and Community Based Services (HCBS) [HCBS Services Manual](#)

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services – Peer Supports
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment (ISE)
- Ongoing Supported Employment
- Staff Transportation
- Non-Medical Patient Transportation (Note: As is already the case with medical transportation, non-medical transportation will be carved out of the Plan benefit, managed by a transportation manager based on the Plan of Care, and paid FFS directly to the transportation provider).

1115 Waiver Demonstration Programs (Mainstream Managed Care, HIV-SNP, and HARP)

- SUD Residential Treatment – Per Diem (Stabilization and Rehabilitation)
- Crisis Intervention Service
- OASAS Off-site SUD Services (practitioner must work for a clinic, APG rates will apply)
- OMH Community Mental Health Services (Other Licensed Practitioners) (practitioner must work for a clinic, APG rates will apply)

Claims

Electronic claims will be submitted using the 837i (institutional) claim form. This will allow for use of rate codes which will inform the Plans as to the type of behavioral health program submitting the claim and the service(s) being provided. Rate code will be a required input to MEDS (the Medicaid Encounter Data System) for all outpatient MH/SUD services. **Therefore the Plan must accept rate code on all behavioral health outpatient claims and pass that rate code to MEDS.** All other services will be reported to MEDS using the definitions in the MEDS manual.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing. This field is already used by Plans to report the weight of a low birth weight baby.

NYS will give Plans a complete listing of all existing providers and the rate codes they bill under, as well as the rate amounts by MMIS provider ID and locator code and/or NPI and zip+4. This list will also be posted on the OMH and OASAS websites.

Billing requirements depend on the type of service provided; however, every electronic claim submitted will require at least the following:

- Use of the 837i claim form;
- Medicaid fee-for-service rate code;
- Valid procedure code(s);
- Procedure code modifiers (as needed); and
- Units of service.

Claims Coding Crosswalks

Attached are crosswalks for HCBS and all other ambulatory behavioral health services (including 1115 demo services). Also included in the crosswalk is the per diem rate / HCPCS / modifier codes for clinic services delivered in OASAS Part 820 Residential settings. Much additional OASAS information is in tabular form near the end of this manual. These crosswalks provide a link between existing FFS rate code-based billing and the unique rate code/procedure code/modifier code combinations that will be required under Medicaid managed care. Providers will use these coding combinations to indicate to the Plan that the claim is for a behavioral health service provided by a behavioral health program, and is to be paid at the government rate. The procedure and modifier code combinations have been created such that even if rate code did not exist, the Plan would be able to differentiate between the various services and mirror the correct FFS payment amount.

Provider Assistance Including Release / Access to Plan Contract Information

As part of the state qualification process plans are required to develop and implement a comprehensive provider training and support program for network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. Training and technical assistance shall be provided to BH network providers on billing, coding, data interface, documentation requirements, and UM requirements. BH network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims. Plans will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the Plan's QM and provider profiling programs. Plans will ensure providers receive prompt resolution to their problems.

To facilitate a smooth transition from fee-for-service to plan billing it is expected that plans will reach out to and offer billing / claim submission training to newly BH providers; this should include a claims submission testing environment; and, issuance of plan contact and support information to assist programs in claim submission.

Service Combinations

Only certain combinations of HCBS and State Plan services are allowed by Medicaid within an individual's current treatment plan. The grid below shows the allowable service combinations.

HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital*	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes				Yes	
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

Note: The State will periodically be reviewing claim and encounter data annually, or upon information that there has been fraud or abuse, to determine if inappropriate HCBS and state plan service combinations were provided/allowed. In instances where such combinations are discovered, the state will make the appropriate recoveries and referrals for judicial action.

Ambulatory Behavioral Health Services

➤ **Assertive Community Treatment (ACT):**

[ACT regulations](#) ^{CA} (part 508)

[ACT program guidelines](#)

ACT services are billed once per month using one rate code for the month's services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial, or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact is defined as a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral. The attached crosswalk indicates the procedure code (H0040) and modifier combinations to be used with the ACT rate codes.

ACT Full Payment (Rate Code 4508)

Full payment requires at least 6 contacts with the recipient or collateral, or at least 4 community-based contacts and at least 6 contacts in total (combination of community and inpatient contacts), if the recipient is admitted or discharged from an inpatient setting during the month.

ACT Partial Payment (4509)

Partial payment requires at least 2 community-based contacts, or at least 1 community-based contact and at least 2 contacts in total (combination of community-based and inpatient contacts) if the recipient is admitted or discharged from an inpatient setting during the month.

ACT Inpatient Payment (4511)

If the recipient has an inpatient stay and at least 2 inpatient contacts are provided, then the claim qualifies for the inpatient payment.

➤ **Clinic (OMH-Licensed Clinic, OASAS-Certified Clinic, OASAS-Certified Opiate Treatment Clinic, and OASAS Certified Outpatient Rehabilitation):**

OMH Clinics: [OMH Clinic Regulations](#) ^{CA} (part 599)

OMH Clinics, both hospital-based and free-standing, have been billing FFS under the APG rate setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010. For non-SSI recipients enrolled in managed care, OMH Clinics have been billing Medicaid plans for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012. As of the effective date of the behavioral health managed care carve-in and the creation of the HARPs, plans will cover OMH clinic services for all enrollees and mirror the APG rates as they do now for the non-SSI population.

Note on Telepsychiatry in OMH Clinics:

The Office of Mental Health has amended 14 NYCRR Part 599 (Clinic Treatment Services), effective April 30, 2015, to include a new section 599.17 which allows clinic providers to obtain approval from OMH to offer telepsychiatry services in OMH-licensed clinics. Plans are expected to reimburse at the government (APG) rate for telepsychiatry services provided by clinics that have been authorized by OMH to provide this optional service. Detailed information regarding telepsychiatry may be found on the [OMH telepsychiatry webpage](#).

OASAS TITLE 14 NYCRR PART 822 OUTPATIENT [OASAS Program Regulations](#) Clinics, Opioid, and Rehabilitation Programs: For a complete description of OASAS Outpatient and Inpatient programs please see the SUD Section of this manual.

Prior to the BH carve-in and the implementation of the HARPs, Title 14 NYCRR Part 822 OASAS clinic services (for all three types of OASAS clinics) were billed FFS (carved out) for all managed care enrollees. Those clinics bill FFS using APG rate codes for free-standing clinics and non-APG rate codes for hospital-based clinics. While, OASAS hospital-based clinics still use non-APG rate codes, but are expected to move to the APG billing system, on a retroactive basis, in the near future.

For both Freestanding and Hospital Based Programs, OASAS outpatient service reimbursement will employ government rates upon being carved into Managed Care (including HARPs). The format for billing and reimbursement in Managed Care is the same as FFS. Managed Care Plans should continue to use the same techniques they currently use to identify APG claims for OMH Clinics and adapt those techniques to identify OASAS outpatient services. For a complete list of the OASAS outpatient program rates codes, please see the SUD section of this manual. **Important!!! Just as will be the case with free-standing OASAS programs, hospitals will use APG rate codes and APG billing techniques when submitting claims to the Plans and the Plans will use the APG methodology to calculate payments. The capitation rates that were calculated for the HARPs and the BH carve-in took this change into account and are fully funded for this implementation. The State Plan Amendment that controls FFS behavioral health APGs in hospitals was just approved by CMS. Consequently, that FFS payment methodology must be mirrored in managed care.**

- **Continuing Day Treatment (CDT):**
[CDT Operational Regulations](#) (section 587.10)
[CDT Reimbursement Regulations](#) (section 588.7)

CDT services are billed on a daily basis. The rates of reimbursement are separated into 3 tiers: 1-40 hours, 41-64 hours and 65+ hours. These three tiers span across two types of visits: full-day (4 hours minimum) and half-day (2 hours minimum). Tiers are determined by totaling the number of full-day and half-day regular visits, based on their hour equivalents. As the hours accumulate throughout the month, the provider will need to move from one tier to another to bill. Each subsequent tier has a decline in payment. Providers must keep track of the number of hours of service provision in order to know what rate code (tier) should be billed. When the program hours of any single visit include more than one tier, the provider of service will be reimbursed at the tier that applies to the first hour of that visit. Each CDT service tier has a unique combination of rate code/procedure code/modifier code(s), as indicated on the attached crosswalk.

Half-Day Visit (4310, 4311, 4312) – Requires a minimum duration of two hours. To be eligible for reimbursement for a half-day visit, one or more medically necessary services must be provided and documented.

Full-Day Visit (4316, 4317, 4318) – Requires a minimum duration of four hours. To be eligible for reimbursement for a full-day visit, three or more medically necessary services must be provided and documented.

Claims for collateral, group collateral, preadmission and crisis visits are billed separately (i.e., on different claims) from the CDT regular visits using the rate codes below. The reimbursement is the equivalent to the half-day, tier 1 amount, regardless of the cumulative total of hours for CDT regular visits in that month. Collateral, group collateral, preadmission and crisis visits are excluded from the calculation of the cumulative total hours in the program for a recipient.

Collateral Visit (4325) – Clinical support services of at least 30 minutes duration of face-to-face interaction documented by the provider between one or more collaterals and/or family members of the same enrolled recipient and one therapist with or without a recipient.

Group Collateral Visit (4331) – Clinical support services of at least 60 minutes duration of face-to-face interaction documented by the provider between collaterals and/or family members of multiple recipients of the continuing day treatment provider and one therapist with or without the recipients.

Crisis Visit (4337) – Crisis intervention services are face-to-face interactions documented by the provider between a recipient and a therapist, regardless of the actual duration of the visit.

Preadmission Visit (4346) – Services of at least 60 minutes duration of face-to-face interaction documented by the provider between a recipient and a therapist.

➤ **Comprehensive Psychiatric Emergency Program (CPEP):**

[CPEP Operational Regulations](#)²⁸ (part 590)

[CPEP Reimbursement Regulations](#)²⁸ (part 591)

CPEP is claimed on a daily basis. A patient may receive one brief or one full emergency visit service in one calendar day. If a patient receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for either one crisis outreach service or one interim crisis service and either one brief or one full emergency visit per recipient, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code). Each CPEP service has a combination of rate code/procedure code/modifier code indicated on the attached crosswalk.

Brief Emergency Visit (4007) – Face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, to determine the scope of emergency service required. This interaction should include a mental health diagnostic examination. It may result in further CPEP evaluation or treatment activities on the patient's behalf or discharge from the CPEP. **Note:** Services provided in a medical/surgical emergency or clinic setting for comorbid conditions are separately reimbursed. If medical and/or nursing evaluations provided outside the CPEP are utilized by the CPEP, the CPEP may be reimbursed for a brief emergency visit only. For example – a patient is evaluated and/or treated in the emergency room (non-CPEP) for a

medical condition and subsequently transferred to the CPEP for evaluation. Both the emergency room (non-CPEP) and the CPEP may submit claims. The CPEP should utilize the evaluation completed by the emergency room and submit a claim for a brief visit.

Full Emergency Visit (4008) – A face-to-face interaction between a patient and a psychiatrist and other clinical staff as necessary to determine a recipient's current psychosocial and medical condition. It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when comprehensive psychiatric emergency program or services are completed. It may include other examinations and assessments as clinically indicated by the recipient's presenting problems. Full emergency visits should be provided to recipients whose presenting symptoms are initially determined to be serious and where the clinical staff believes commencement of treatment should begin immediately, and/or where staff is evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. No person may be involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an extended observation bed. (See extended observation beds below.)

Crisis Outreach Service (4009) – Emergency services provided outside an emergency room setting which includes clinical assessment and crisis intervention treatment. This is a per diem service and is billed on a daily basis.

Interim Crisis Service (4010) – Mental health service provided outside an emergency room setting for persons who are released from the emergency room of the comprehensive psychiatric emergency program, which includes immediate face-to-face contact with a mental health professional for purposes of facilitating a recipient's community tenure while waiting for a first post-CPEP visit with a community based mental health provider.

Extended Observation Bed (4049) - No person may be involuntarily retained in a comprehensive psychiatric emergency program for more than 24 hours unless the person is admitted to an extended observation bed. The director of the CPEP may involuntarily receive and retain in an extended observation bed any person alleged to have a mental illness which is likely to result in serious harm to the person or others and for whom immediate observation, care and treatment in the CPEP is appropriate. Retention in an extended observation bed shall not exceed 72 hours (voluntarily, or involuntarily), which shall be calculated from the time such person is initially received into the emergency room of the CPEP.

Claiming for Extended Observation Beds –

- Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
- The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
- A brief or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient's initial arrival in the CPEP.
- If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed.

➤ **Intensive Psychiatric Rehabilitation Treatment (IPRT):**

[IPRT Operational Regulations](#)^{CA} (section 587.13)

[IPRT Reimbursement Regulations](#)^{CA} (section 588.10)

Rate codes 4364 – 4368. An IPRT claim is submitted on a daily basis. The applicable rate code / procedure code / modifier codes combination is dependent on the number of hours of service in the day. The combinations are listed on the attached crosswalk. Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day.

➤ **Partial Hospitalization:**

[Partial Hospitalization Operational Regulations](#)^{CA} (section 587.12)

[Partial Hospitalization Reimbursement Regulations](#)^{CA} (section 588.9)

Regular Rate Codes 4349 – 4352, Crisis Rate Codes 4357 – 4363 - A partial hospitalization claim is submitted on a daily basis. The applicable rate code / procedure code / modifier code(s) combination is dependent on the number of hours of service a day. The combination is listed on the attached crosswalk. Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day.

Collateral Service (4353, 4354) - Clinical support services of at least 30 minutes in duration but not more than two hours of face-to-face interaction between one or more collaterals and one therapist with or without a recipient.

Group Collateral Service (4355, 4356) - Clinical support services, of at least 60 minutes in duration but not more than two hours provided to more than one recipient and/or his or her collaterals. The service does not need to include recipients and cannot include more than 12 collaterals and/or recipients in a face-to-face interaction with a therapist.

Pre-admission – Visits of one to three hours are billed using the crisis visit rate codes (4357, 4358, 4359). Visits of four hours or more are billed using partial hospitalization regular rate codes (4349, 4350, 4351, 4352). Per the coding crosswalk, the UA modifier is required on all partial hospitalization pre-admission claims.

➤ **Personalized Recovery Oriented Services (PROS):**

[PROS regulations](#)^{CA} (part 512)

[PROS Guidance](#)

A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month. Each unique procedure code / modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the pre-managed care rate code in the header of the claim. For example: if services provided during the month to an individual would have been billed under rate codes 4521, 4525, and 4532 under the old structure, those services must be submitted to the managed care plan on three claims showing the rate code in the header and the applicable procedure code / modifier code(s) combination and units of service at the line level.

- Claim 1 - Rate code 4521 in the header plus H2019U2 and 13 - 27 units at the line level
- Claim 2 - Rate code 4525 in the header plus T1015HE and 1 unit at the line level
- Claim 3 - Rate code 4532 in the header plus H2019UBU2 and 2 or 3 units at line level.

The reimbursement structure for a comprehensive PROS program consists of several elements:

- Monthly base rate;
- Intensive Rehabilitation (IR) component add-on;
- Ongoing Rehabilitation and Support (ORS) component add-on;
- Clinical treatment component add-on.
- Additional BIP elements (see below)

Community Rehabilitation and Support Services (CRS) Monthly Base Rate (4520, 4521, 4522, 4523, 4524)

The basic measure for the PROS monthly base rate is the PROS unit. PROS units are accumulated during the course of each day that the individual participates in the PROS program, and are aggregated to a monthly total to determine the PROS monthly base rate for the individual. The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation and service frequency (see table below). Daily program participation is measured in 15 minute increments, rounded down to the nearest quarter hour. In order to accumulate PROS units for a day, a PROS program must deliver a minimum of one medically necessary PROS service to an individual or collateral on that day. The maximum number of PROS units per individual per day is five. Services provided in a group format must be at least 30 minutes in duration. Services provided individually must be at least 15 minutes in duration. A minimum of two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate.

Table for the Calculation of “PROS Units” (based on “program hours” and “number of services”). This table is used on a daily basis to calculate the PROS units for the day. At the end of the month, the daily units for each day in the month are accumulated to determine the total units for the month.

Hours at Program for the Day	NUMBER OF SERVICES (for that day)		
	1 Service	2 Services	3 Services
	PROS Units	PROS Units	PROS Units
0.25	0.25	0.25	0.25
0.50	0.50	0.50	0.50
0.75	0.75	0.75	0.75
1.00	1.00	1.00	1.00
1.25	1.25	1.25	1.25
1.50	1.50	1.50	1.50
1.75	1.75	1.75	1.75
2.00	2.00	2.00	2.00
2.25	2.00	2.25	2.25
2.50	2.00	2.50	2.50
2.75	2.00	2.75	2.75
3.00	2.00	3.00	3.00
3.25	2.00	3.25	3.25
3.50	2.00	3.50	3.50
3.75	2.00	3.75	3.75
4.00	2.00	4.00	4.00
4.25	2.00	4.00	4.25
4.50	2.00	4.00	4.50
4.75	2.00	4.00	4.75
5.00 +	2.00	4.00	5.00

PROS Component Add-Ons

In addition to the monthly case payment, PROS providers are also reimbursed for three component add-ons: IR, ORS and Clinic Treatment services. Up to two component add-ons may be billed per individual, per month. **In no event will an ORS component add-on and an IR component add-on be billed in the same month for the same individual.** Component add-ons are not billed prior to the calendar month in which the individual is registered with the PROS program.

Intensive Rehabilitation - IR (4526): In order to bill the IR component add-on, an individual must have received at least six PROS units during the month, including at least one IR service. In instances where a comprehensive PROS program provides IR services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an IR-only bill. When an IR-only bill is submitted, the minimum six PROS units required may be limited to the provision of IR services.

Ongoing Rehabilitation and Support - ORS (4527): PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of 10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement. A minimum of two face-to-face contacts with the individual and/or identified collateral which include ORS services must be provided per month. A minimum contact for ORS is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days. A contact may be split between the individual and the collateral. At least one visit per month must be with the individual only. In instances where a comprehensive PROS program provides ORS services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an ORS-only bill.

Clinical Treatment (4525): In order to bill the clinical treatment add-on, a minimum of one clinical treatment service must be provided during the month. Individuals receiving clinical treatment must have, at a minimum, one face-to-face contact with a psychiatrist or nurse practitioner in psychiatry (NPP) every three months, or more frequently as clinically appropriate. Such contact during any of the first three calendar months of the individual's admission will enable billing for the month of contact, any preceding months in which the recipient has been registered with the PROS program, and the two months following the month of contact. Thereafter, each month that contains a contact with a psychiatrist or nurse practitioner in psychiatry will enable billing for that month and the next two months. The clinical treatment component may only be reimbursed in conjunction with the monthly base rate and/or the IR or ORS.

Pre-admission Program Participation (4510)

Reimbursement for individuals who are in pre-admission status is limited to two consecutive months, whether or not the individual is ultimately admitted to the program. If pre-admission program participation occurs during the month of admission, the pre-admission program participation may be included in the total number of PROS units accumulated during the calendar month, but the pre-admission rate cannot be billed.

PROS BIP (Balancing Incentives Program) Rate Codes

[PROS BIP Guidance and Information](#)

NYS pays an enhanced PROS rate (PROS BIP) to help facilitate the integration of certain populations into the community. Individuals eligible for services associated with PROS BIP enhanced payments must be identified as members of the “target population” by meeting the following eligibility criteria:

- have lived in an adult home (AH) longer than six consecutive months, or
- have lived in a nursing home (NH) longer than six consecutive months, or
- have lived in a state operated community residence (SOCR) longer than six consecutive months, or
- have lived in a state psychiatric center (PC) longer than six consecutive months, and
- have been discharged from a nursing home, adult home, or in-patient state psychiatric center into the community,
- meet all eligibility criteria for PROS admission, as defined in Part 512.7(c)(5)(i-iv)

Individuals will be considered members of the "target population" for up to 12 consecutive months following discharge to the community from one of the identified settings. For the purposes of PROS and use of BIP funds, community settings that determine eligibility may not include Congregate Treatment settings, Community Residences and Family Care. All services must be medically necessary. PROS programs can continue to provide services to these individuals beyond this period of time, but will no longer be able to bill at the increased rates.

BIP Pre-admission Service (4531)

Pre-Admission Services can be provided to individuals in the target population for a maximum of four consecutive months (vs. the two maximum consecutive months available for other “non-BIP” individuals). Pre-Admission Services provided to these individuals can also be billed at an increased “BIP payment” of \$175 (upstate) and \$191 (downstate). The BIP pre-admission rate cannot be billed in combination with billing for the existing PROS Pre-Admission payment. Additionally, the duration of months that pre-admission is billed at the BIP Pre-Admission rate cannot be consecutive with the two consecutive month maximum as currently identified in Part 512.

BIP Payments for Enhanced CRS (4532, 4533)

Rate code 4532: PROS Enhanced CRS 2 Contact – AH/NH/SOCR/PC - for two (2) or three (3) of the identified CRS services, or

Rate code 4533: PROS Enhanced CRS 4 Contact – AH/NH/SOCR/PC - for four (4) or more of the identified CRS services)

This rate code based payment is an add-on (in addition to base rate billing). CRS services eligible for the enhanced payment are as follows:

- Basic living skills
- Benefits and financial management
- Community living exploration
- Information and education regarding self help
- Wellness self-management

In order to be able to bill for the BIP enhanced CRS payment, PROS program staff must provide one or more of the identified CRS services at a community site (grocery store, bank, etc.) so that

individuals can regain functional skills and learn to manage mental health barriers. These services can be delivered on a one-to-one basis or in groups. When services are delivered using group modality, the group size cannot exceed 12 participants on a routine and regular basis, as defined in 512.7(d)(7)(i). The enhanced CRS services are to be provided in increments of no less than thirty (30) minute, face to face, and delivered on separate days.

BIP Payments for IR Services (4534)

Because it is anticipated that members of the PROS BIP population may have an increased need for IR services, a separate IR rate code (4534 - PROS Intensive Rehabilitation – AH/NH/SOCR/PC) has been established for this population for billing and audit purposes. Claims related to this IR rate code will not be counted toward a program's maximum average of 50% for IR claims submitted. In other words, the purpose of this code is to allow PROS providers to circumvent IR utilization limits for this limited population. Rate code 4534 is not to be billed during the same month as rate code 4526. Rate code 4534 acts as a temporary replacement code for 4526 for the PROS BIP population. All other PROS IR billing rules apply to rate code 4534, including the prohibition on billing IR for the same month as ORS.

➤ **Transportation:**

Medically Necessary Transportation for Behavioral Health Services:

As is the current practice for services already in the managed care benefit package, medically necessary transportation for behavioral health will be a carved-out service that will be billed directly to the State on a FFS claim submitted by the transportation provider. These services must be approved by the regional transportation manager.

Note: For New York City based enrollees receiving services at an OASAS Certified Opioid program transportation (metro –card reimbursement) is accommodated through the New York City Human Resources Administration (HRA)/ PTAR system.

Non-medical Transportation (only for HARP enrollees and individuals in HIV SNPs meeting the HARP eligibility criteria and qualifying under an HCBS needs assessment):

This service is an HCBS service that will be carved-out of the HARP benefit in order to garner the benefits provided by the use of a transportation manager. It will be billed and managed in the same way as medically necessary transportation; it will be billed directly to the State on a FFS claim submitted by the transportation provider. However, mainstream plans may also provide this service on an "in lieu of" basis outside of their capitation rate (but not through the transportation manager and FFS). All other HCBS services are detailed at the end of this document. Non-medical transportation is an ad hoc, time-limited service. Examples of transportation as a non-medical service would be travel to job interviews or to a GED course. Travel to HCBS services are generally considered to be medically necessary transportation. Again, approval mechanisms and reimbursement to transportation providers is the same for both medical and non-medical transportation, except the non-medical transportation is not reimbursable outside of a HARP.

HARP Home and Community Based Services (HCBS)

HCBS services are only available to HARP enrollees who have been qualified through the assessment process and HARP eligible individuals enrolled in HIV-SNPs and assessed as HCBS eligible. A mainstream plan may provide HCBS to its enrollees as a cost effective alternative to regular OMH and OASAS licensed/certified services (on an in lieu of basis and paid by the Mainstream plan from its capitation rate). A HARP may also make these service available on an in lieu of basis to an otherwise unqualified HARP-enrolled individual, but must pay for them out of the HARP's existing capitation rate.

For the first two years (based on the regional carve-in/implementation schedule), HARPs and HIV-SNPs will be reimbursed for HCBS services on a FFS basis outside the capitation rate by submitting claims under supplemental rate codes. (These supplemental rate codes are similar in nature to the rate codes used for "kick payments".) The rate code/procedure code/modifier code combinations for all the services below are shown on the attached HCBS coding crosswalk. Note: It is anticipated that all HCBS practitioners will receive health insurance from their employer and the HCBS service rates have been constructed accordingly.

HCBS Utilization Thresholds

HCBS services will be subject to utilization caps at the recipient level that apply on a rolling basis (any 12 month period). These limits will fall into three categories:

1. Tier 1 HCBS services will be limited to \$8,000 as a group. There will also be a 25% corridor on this threshold that will allow plans to go up to \$10,000 without a disallowance.
2. There will also be an overall cap of \$16,000 on HCBS services (Tier 1 and Tier 2 combined). There will also be a 25% corridor on this threshold that will allow plans to go up to \$20,000 without a disallowance.
3. Both cap 1 and cap 2 are exclusive of crisis respite. The two crisis respite services are limited within their own individual caps (7 days per episode, 21 days per year).

If a Plan anticipates they will exceed any limit for clinical reasons they should contact the HARP medical director from either OMH or OASAS and get approval for a specific dollar increase above the \$10,000 effective limit.

See the HCBS manual for program/clinical guidance. [HCBS provider manual](#)

➤ **Psychosocial Rehabilitation (PSR):**

PSR is divided into three different types of sessions:

- **Individual, per 15 minutes**
 - Billed daily in 15 minute units with a limit of 8 units per day.
 - Individual service may be billed the same day as a PSR group session.
 - Individual service (15 minute unit billing) cannot be billed on the same day as a PSR Individual per diem.
 - May be provided on or off-site (two separate rates apply).
 - Transportation is billed separately as appropriate.
 - Maximum of 8 units (2 hours) per day.

- **Individual, per diem**
 - Billed daily with a max of 1 unit.
 - Due to the long duration of these sessions, the PSR Individual per diem service may not be billed the same day as a PSR group session
 - Individual per diem service cannot be billed the same day as PSR Individual per 15 minutes.
 - May be provided on or off-site - under a single rate code and payment amount.
 - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
 - Minimum of 3 hours.
 - **Group**
 - Billed daily in 15 minute units with a limit of 4 units per day.
 - Group sessions may be billed on the same day as a PSR individual per 15 minutes.
 - Group sessions may not be billed on the same day as a PSR Individual per diem session.
 - Service must be offered in the setting best suited for desired outcomes.
 - Maximum 4 units (1 hour) per day.
 - Payment for group sessions is broken into various levels through the use of Px modifier codes to distinguish the number of individuals present in the session (i.e., 2-3, 4-5, 6+). The rate code/procedure code/modifier code combinations are shown on the attached HCBS services coding crosswalk.
- **Community Psychiatric Support and Treatment (CPST):**
- Billed daily in 15 minute increments with a limit of 6 units (1½ hours) per day.
 - Payment for CPST services is broken into various levels through the use of Px modifier codes that indicate the type of staff providing the service (i.e., physician, psychologist, NP, RN, all other professions).
 - There are no group sessions for this service.
 - May only be provided off-site.
 - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
- **Habilitation/Residential Support Services:**
- Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day.
 - There are no group sessions for this service.
 - May be provided on or off-site.
 - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Family Support and Training (FST):**

- **FST session provided to one family**
 - Billed daily in 15 minute increments with a limit of 12 units per day.
 - FST is detailed by using modifiers that indicate whether the service was provided to the family with the recipient present or to the family without the recipient present.
 - May be provided on or off-site.
 - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

- **Group FST (consists of 2-3 families)**
 - Billed daily in 15 minute increments with a limit of 6 units (1.5 hours) per day.
 - Group sessions may be billed on the same day as an FST one family session.
 - May be provided on or off-site.
 - Payment for FST group sessions is differentiated through the use of Px modifier codes to distinguish the number of families present in the session (i.e., 2 or 3).
 - Billing is at the recipient (family level (e.g., if the group consists of the families of three recipients and, for purposes of this example, eight people are in the group, there would be only three claims submitted)).

The rate code/procedure code/modifier code combinations for both types of FST services are shown on the attached HCBS services coding crosswalk.

➤ **Short-Term Crisis Respite:**

- Billed daily with a max unit of 1 per day.
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual).
- May only be provided in facilities dedicated solely for this purpose.
- Fee includes transportation, do not bill transportation separately.
- It is anticipated that persons may also receive other HCBS services and state plan services while in this level of care.

➤ **Intensive Crisis Respite:**

- Billed daily with a max unit of 1 per day.
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual).
- May only be provided in facilities dedicated solely for this purpose.
- Fee includes transportation, do not bill transportation separately.
- Because of the high level of clinical involvement associated with this service, persons receiving intensive crisis respite may not receive any other HCBS or state plan service – with the only exception being peer supports.

➤ **Education Support Services:**

- Billed daily in 1 hour units with a max units of 2 (2 hours).
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Empowerment Services – Peer Supports (OMH):**

- Billed daily in 15 minute units with a limit of 16 units (4 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Pre-Vocational Services:**

- Billed daily in 1 hour units with a limit of 2 units (2 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Transitional Employment:**

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Intensive Supported Employment (ISE):**

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
- Modifier is used to indicate “Complex Level of Care”.

➤ **Ongoing Supported Employment:**

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

➤ **Staff Transportation:**

The staff transportation service covers the actual cost of provider staff travel to off-site service locations – and only for selected HCBS services. There is no reimbursement for “staff time” while in travel status and that time is not billable under the other HCBS rate described above. The cost of “staff time” while in travel status has been built into the rates for the programs listed above.

Staff transportation billed under the recipients Medicaid ID (CIN) and is only allowable for a single staff person for a single service. There is no travel reimbursement for additional staff persons traveling to the service location.

Staff transportation is divided into two types:

- **Per mile**
 - Billed daily in per mile units with a limit of 60 miles for a round trip.
 - 56 cents per mile (per Federal guidelines).
- **Per round trip**
 - Billed monthly using the first day of the month as date of service.
 - Each round trip counts as one unit, with a limit of 31 units per calendar month.

OMH 1115 Waiver Demonstration Programs

➤ **Crisis Intervention**

Plans may not deny coverage for Crisis Intervention. This service is billed using the APG methodology and is divided into two separate types of sessions:

- **Crisis Intervention (per hour)**
 - Billed daily in 1 hour units with a limit of 4 units (4 hours) per day.
 - Requires the participation of at least 2 staff (one can be non-licensed).
 - Provided off-site.
 - Fee includes transportation, do not bill transportation separately.
- **Crisis Intervention (per diem)**
 - Billed daily with a max unit of 1 (5+ hours).
 - Requires the participation of at least 2 staff (one can be non-licensed).
 - Provided off-site.
 - Fee includes transportation, do not bill transportation separately.

➤ **OMH Community Mental Health Services (Other Licensed Practitioners):**

These services must be provided by a behavioral health practitioner licensed in the State of New York to prescribe, diagnose and/or treat individuals with mental illness who practices under the auspice of an agency licensed by the Office of Mental Health (pursuant to 14NYCRR Part 599).

- Claims submitted using OMH clinic off-site rate codes
- Use the applicable procedure code (same code as used for onsite)
- All services require prior authorization and must be in accordance with medical necessity criteria.
- Allowable practitioners are as follows:

- Licensed Psychiatrist or Advanced Nurse Practitioner,
- Licensed Psychologist,
- Licensed Psychoanalyst,
- Licensed Social worker (LMSW, LCSW),
- Licensed Marriage & Family Therapist, and
- Licensed Mental Health Counselor
- Unlicensed Professionals may provide this service if supervised by an LMSW, LCSW, LMHC, PsyD, PhD or MDs within a licensed agency. Unlicensed professionals must have either a Bachelor's degree in an appropriate subject area (such as nursing, social work, psychology, etc.) or appropriate state training and certification (such as a peer certification).
- Services may be provided in any setting permissible under State practice law, but must be outside of the OMH licensed clinic.
- Services provided while a person is a resident of an IMD, such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not separately reimbursable.

New York State Office of Alcoholism and Substance Abuse Services (OASAS) – Substance Use Disorder (SUD) Services and Billing

Manual Purpose:

There are two main purposes of the SUD section of the New York State Behavioral Health service and billing manual is to provide:

One: Provide descriptive information regarding the full scope of Substance Use Disorder (SUD) services available in New York State as authorized by the New York State Medicaid State Plan (SPA)/1115 waiver;

and,

Two: Provide the specific Qualified Mainstream Plans (QMPs); and, Qualified Health and Recovery Plans (HARPS) coding for: Title 14 NYCRR Part 822 outpatient clinic, outpatient rehabilitation, and opioid programs; and, Part 820 SUD addiction treatment services in a residential setting. These services are newly incorporated into the benefit package; and, for the first 24 months of integration into the benefit package are paid at the prescribed government rates. As such, this manual provides the statewide / standardized required codes; and, associated payment amounts for all /any QMP or HARP enrollees.

Note: The Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services are already incorporated into the benefit package. Providers of such services should speak with the enrollee's plan regarding the plan coding; contract; and reimbursement policies.

All Substance Use Disorder treatment programs in New York State are certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) pursuant to Article 32 of the New York State Mental Hygiene law and the associated / applicable State regulations. All New York State authorized SUD SPA services are delivered in the least restrictive setting based on an individual risk and needs assessment

Background – SUD Services and Medicaid Managed Care:

Previously, the New York State Medicaid Managed care benefit package included only: Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services. As such, when these services are delivered to plan enrollees the service is reimbursed by the plan; at the negotiated / contracted rate and not billed to Medicaid Fee-For-Services (FFS).

Title 14 NYCRR OASAS Part 822 Certified Outpatient Clinic; Outpatient Rehabilitation; and Opioid Programs have not been included in the benefit package and were billable through Medicaid fee-for-service and reimbursed at the government / Ambulatory patient group (APG) rate.

New York is now integrating the full complement of SUD services into the Qualified Mainstream Plans (QMPs); and, Qualified Health and Recovery Plans (HARPS) benefit packages. The integration of SUD services, in particular 14 NYCRR OASAS Part 822 OASAS Certified outpatient

clinic and opioid programs, is new to the New York State Medicaid managed care system. Therefore, the State has opted to utilize this manual to provide plans and providers with a brief overview of all the SUD services; and, the related coding for the services that are being newly incorporated into the capitated benefit package.

The SUD section of the Billing Manual for OMH / OASAS Behavioral Health Services is comprised of the following Sub- Sections and parts.

Sub - Section One: SPA service and associated OASAS Certified program / setting:

Part A: General Service Overview to orient the reader to the general scope and settings of SUD services within the New York State Medicaid system.

Part B: General Provider Qualifications for all SUD and Addiction Services provides a description of the types of services providers delivering services within an OASAS certified Program. Please note: When offering a contract to an OMH or OASAS licensed or certified programs the Plan / Contractor may not separately credential individual staff members in their capacity as employees of these programs and must contract for the full range of services offered under their license.

Part C: LOCADTR – NYS **Level of Care for Alcohol and Drug Treatment Referral** (LOCADTR) is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR is **required** within New York State for prior authorization and concurrent review decisions for all Medicaid patient utilization management

Sub - Section Two: Reimbursement for SUD and Addiction Services:

This section:

- Provides information regarding the associated Medicaid fee schedule/ reimbursement for the specific services; coding; and, what modality / OASAS certified program delivers such services.
- Identifies SUD and addiction service limitations
- Coding and Medicaid Fee-for- Service Table

Sub - Section Three: Listing of OASAS Certified Programs

Listing of OASAS certified programs that deliver the authorized SPA / 1115 demonstration services; the applicable authorizing New York State program regulation; and, where appropriate a cross walk to ASAM levels of care.

Section One - Part A:

General Overview SPA /1115 service and associated OASAS Certified program / setting:

New York State SUD services include an array of participant-centered crisis, inpatient, residential and outpatient services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for managing substance use disorder symptoms, and behaviors.

SUD services are provided by programs that are OASAS certified pursuant to applicable program specific sections of Title 14 NYCRR (Part 822; Part 818, Part 820 and Part 816). Additionally, programs are subject to shared title 14 NYCRR Part 800 regulatory staffing definitions for: Clinical staff; medical director; medical staff; and, Qualified Health Professionals Appendix B.

This subsection offers a brief overview on the primary SUD service settings:

- Outpatient(including: clinic; opioid; outpatient rehabilitation);
- SUD Services in a Residential Setting; and,
- Inpatient (including: detoxification and inpatient rehabilitation);

1. Outpatient services

Setting:

OASAS Certified Title 14 NYCRR Part 822 Outpatient Clinic; Opioid and; Rehabilitation Programs. The setting will be determined by the goal which is identified to be achieved in the individual's written treatment plan and may include OASAS outpatient settings Certified by Title 14 NYCRR Part 822 (clinic, opioid; and, outpatient rehabilitation). The 1115 give OASAS demonstration authority to provide any clinic service outside of the clinic. For example peer services may be provided within the community, in the individual's home or at another OASAS certified program such as a detox.

Clinical Indications:

Outpatient clinic settings and services are indicated for individuals whose severity of illness warrants this level of treatment, or when an individual steps-down from a higher level of care based on an individualized assessment, LOCADTR and treatment plan. Medication-assisted therapies should be utilized when a client has an established substance use disorder that has been shown through sufficient research to respond to the specific medication. This includes methadone, buprenorphine and naltrexone for opiate use disorder where tolerance and withdrawal criteria are met and naltrexone and acamprosate (Campral) for alcohol use disorder when clinically indicated.

Services:

Outpatient services include participant-centered services consistent with the individual's assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders. These services are designed to help individuals achieve and maintain recovery from SUDs. Services should address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Outpatient

services are delivered on an individual, family or group basis in a wide variety of settings including site-based facility, in the community or in the individual's place of residence.

- Medication assisted treatments should be available to the patient in the most appropriate treatment setting. OASAS certified Part 822 clinics may provide as clinically appropriate: medication management (routine complex); and addiction medication induction services. Like other services delivered in the Part 822 OASAS certified clinic, reimbursement for such services is claimed on the 837 I from using the appropriate OASAS APG clinic rate codes; and the HCPCS /CPT codes indicated on Table two.
- The plans shall include medications for the treatment of SUD in the Contractor's formulary, including drugs for the treatment of SUD and/or opioid dependency, as indicated by Official Compendia. The Contractor shall not cover these drugs solely through a medical exception process. The Contractor's formulary shall include at least one formulation of buprenorphine and buprenorphine/naloxone. The Contractor's clinical criteria shall include lengths of therapy with oral buprenorphine appropriate for Enrollees transitioning from long-acting opioids, or who are pregnant or breast feeding, consistent with the U.S. Department of Health and Human Services Center for Substance Abuse Treatment's "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Substance Abuse and Mental Health Services Administration." Naloxone is available in vials and prefilled syringes and auto-injector. Naloxone vials/prefilled syringes or the auto-injector shall be covered by the Contractor as a medical and pharmacy benefit. Additionally, extended-release naltrexone injectable (Vivitrol®) shall be covered by the Contractor as a medical and pharmacy benefit.
- Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals with a moderate to severe dependence condition or for whom there is substantial risk of relapse.
- Outpatient rehabilitation services may be warranted when the client has significant functional impairment and an inadequate social support system to provide the emotional and social support necessary for recovery, physical health care needs or substantial deficits in functional skills.
- Physical Health Services appropriate to the setting may be delivered within an OASAS Certified Part 822 Clinic; Opioid Treatment or Outpatient rehabilitation programs. Such services would be claimed on the 837 I form; utilize the OASAS medical visit APG rate codes for the particular peer group (see table One); and, the appropriate CPT (including e/m); HCPCS; and modifier codes (see table two). As with other services delivered in the OASAS Part 822 certified setting payment would be at the government rate and processed through 3m grouper or its exact replica.

2. SUD services in a residential setting

Setting:

OASAS Certified Residential Treatment programs Residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential setting certified by OASAS under Title 14 NYCRR Part 820 and designed to help beneficiaries achieve changes in their SUD behaviors

Services:

Include participant-centered residential services consistent with the beneficiary's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and behaviors.

Clinical Indications:

These services are designed to help beneficiaries achieve changes in their SUD behaviors within a safe and supportive setting when the individual lacks a safe and supportive residential option in the community. Services should address the beneficiary's major lifestyle, interpersonal, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUDs; (3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and (4) Medication assisted treatment when medically necessary.

3. Inpatient services include:

Crisis or Detoxification Setting

Crisis or detoxification services are provided in hospital or community based inpatient setting that is certified by OASAS under Title 14 NYCRR Part 816.

Services:

Crisis or detoxification services are medically directed with 24 hour medical staff monitoring including vital sign monitoring, medication to manage withdrawal and other medical intervention required to stabilize the individual. Crisis SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) Medication assisted treatment as medically necessary, and linkage to the next level of SUD care.

Inpatient Setting

These services are delivered in inpatient settings certified by OASAS under Title 14 NYCRR Part 818.

Services:

Inpatient services are participant-centered services consistent with the beneficiary's assessed treatment needs, with a rehabilitative and recovery focus designed to stabilize acute SUD, medical and psychiatric needs within a structured setting with 24 hour medical oversight. Inpatient SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill

development for coping with and managing symptoms and behaviors associated with SUDs; (3) counseling to address a beneficiary's major lifestyle, attitudinal, and behavioral problems; and (4) Medication assisted treatment when medically necessary.

Section One – Part B:

Provider Qualifications for all SUD and Addiction Services

When offering a contract to an OMH or OASAS licensed or certified programs the Plan / Contractor must contract for the full range of services offered under the program's license / certification and MAY NOT may not separately credential individual staff members in their capacity as employees of these programs and

Within an OASAS Certified Program services are provided by licensed; certified; and unlicensed professional staff, who are at least 18 years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved program guidelines and certifications. Licensed practitioners are licensed by the New York State Department of Education and include, but are not limited to licensed master social worker (LMSW), licensed clinical social worker (LCSW), licensed mental health counselor (LMHC), licensed marriage and family therapists (LMFTs), licensed psychoanalysts; registered nurses (RNs); licensed practical nurses; nurse practitioners (NPs); medical doctors (MD and DO) and psychologists. Any staff who is unlicensed and providing addiction services must be credentialed by OASAS as a credentialed alcoholism and substance abuse counselor (CASAC); a credentialed alcoholism and substance abuse counselor – trainee (CASAC-T); or be under the supervision of a qualified health professional (QHP). State regulations require supervision of CASAC-T and non-credentialed counselors by QHP meeting the supervisory standards established by OASAS. A QHP includes the following professionals who are currently registered with their respective New York board or OASAS: CASAC; LMSW; LCSW; NP; occupational therapist (OT); physician; physician assistance; RN; psychologist; rehabilitation counselor certified by the Commission of Rehabilitation Counselor Certification; a therapeutic recreation specialist who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience; a family therapist currently accredited by the American Association for Marriage and Family Therapy; a licensed mental health practitioner registered as such by the New York State Education Department (Title VIII, Article 1630; a counselor certified by and currently registered as such with the National Board of Certified Counselors. The QHP provides clinical/administrative oversight and supervision of non-credentialed staff.

Section One – Part C:

[NYS - LOCADTR - Level of Care for Alcohol and Drug Treatment Referral](#)

LOCADTR Summary Overview

LOCADTR is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR is REQUIRED within New York State for all patient placement.

Level of care determinations are made through an individualized assessment of risks, resources, community support services and other clinical considerations through an interview process and the decision logic within the LOCADTR tool. It is based on the following risk and resource questions and associated decision trees.

LOCADTR – Who may complete / Staffing

A licensed practitioner or unlicensed counselor or assessor under the supervision of a QHP may complete the assessment. However, interpretation of the information must be within the assessor's scope of practice. Consultation with the interdisciplinary team is required whenever the individual completing the assessment is functioning outside of his or her scope of practice and expertise.

LOCADTR Outline – Risk and Resources when assessing placement

Risk:

1. Does the person have significant medical condition(s) that need to be managed in an inpatient rehab setting for SUD treatment to be effective?
2. Does the person have significant psychiatric disorders(s) that need to be managed in an inpatient rehab setting for SUD treatment to be effective?
3. Does the person use in hazardous situations, in amounts or frequencies that are likely to imminently cause severe physical or emotional harm to self or others?
4. Do all of the following apply (please check all that apply)?
 - i. Is medication-assisted treatment (MAT) available in the community?
 - ii. Is the person willing to utilize it on an outpatient-basis?
 - iii. Is the person expected to stabilize on medication on outpatient basis?
5. Does the person have one of the following?
Interpersonal and personal skills deficits indicated by (please check all that apply):
 - i. an inability to establish and maintain stable employment;
 - ii. an inability to establish and maintain stable relationships;
 - iii. persistent disregard for social norms, rules and/or obligations.

For example, a history of repeated arrests or involvement in the criminal justice system.

6. Does the person have a history of predatory behavior that may create harm to others in a congregate setting?
7. Does the person have a psychiatric condition that requires 24-hour care in a secured environment?
8. Does the patient have strong cravings and/or urges to use OR medical or psychiatric conditions that require stabilization with medical oversight within a residential setting?

Resource:

1. Is the person adequately performing responsibilities in their work, social and family roles?
2. Does the person have strong self-efficacy/confidence that he/she can pursue recovery goals outside of an inpatient setting?
3. Is the person connected to social/family network supportive of recovery goals?
4. Had the person demonstrated a therapeutic alliance with at least one professional helper in the past?
5. Can the person be managed in an outpatient setting with additional recovery supports (e.g., Case Management, Certified Paraprofessional?)

Additional Housing Questions:

6. Can the person manage triggers for substance use in their environment?
7. Does the person have stable access to food and shelter?
8. Is the person able to meet recovery goals in an independent living environment with supports?

Specific Outpatient SUD and Addiction Services

Section Two: Reimbursement for SUD and Addiction Services

A. General SUD and Addiction Services Requirements and Limitations

General Service Requirements

All state plan SUD services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from an identified SUD diagnosis.

Services are subject to prior approval, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license[s] and applicable State law, to promote the maximum reduction of symptoms and/or restoration of the beneficiary to his/her best age-appropriate functional level according to an individualized treatment plan

Services Delivered in Accordance with Signed Treatment Plan

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and be based on the beneficiary's condition and the standards of practice for the provision of rehabilitative services.

The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount, and duration of services.

The treatment plan must be signed by the licensed practitioner or physician responsible for developing the plan with the beneficiary (or authorized representative) also signing to note concurrence with the treatment plan. The development of the treatment plan should address barriers and issues that have contributed to the need for SUD treatment.

The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the beneficiary, family, and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals consistent with all relevant State and federal privacy requirements.

A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services. A new assessment should be conducted when medically necessary.

Service Documentation

Providers must maintain medical records that include a copy of the treatment plan, the name of the beneficiary, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary, are not eligible for Medicaid reimbursement.

Additionally, OASAS Certified programs are required to maintain service documentation in accordance with [applicable state regulations](#), including but not limited to the relevant section of Title 14 NYCRR as applicable to the specific program certification type.

Non Covered Services

Services provided at a work site must not be job task oriented and must be directly related to treatment of a beneficiary's behavioral health needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered.

Services cannot be provided in an IMD with more than 16 beds. Room and board is excluded from addiction services rates. [State] residential placement under New York State LOCADTR may require prior approval and reviews on an ongoing basis as determined necessary by the State Medicaid agency or its designee to document compliance with the placement standards.

Medicaid will not reimburse for 12-step programs run by peers. A unit of service is defined according to the HCPCS approved code set per the national correct coding initiative unless otherwise specified for licensed practitioners to utilize the CPT code set. No more than one per diem rate may be billed a day for residential SUD programs, however bills may be submitted for allowable medical procedures in accordance with CPT approved coder set per the national correct coding initiative.

Court Ordered Services

Assessments and testing for individuals not in the custody of the penal system (e.g., not involuntarily residing in prison or jail overnight or detained awaiting trial) are Medicaid eligible, including any laboratory tests and urine tests. Drug court diversion treatment programs are eligible for Medicaid funding. Medicaid eligible individuals who are in the penal system and admitted to medical institutions such as SUD residential treatment programs are eligible for Medicaid funding for eligible medical institution expenditures. Laboratory procedures that the practitioner refers to an outside laboratory must be billed by the laboratory to the Medicaid MCO

B. Service Reimbursement and Coding for SUD services

Overview

Service reimbursement (negotiated versus government rates) and coding varies (application of government mandated codes / claim for submission requirements) will vary by service type / OASAS certification. This section will detail:

- which services / OASAS certified programs are paid via government rates and any applicable coding requirements;
- which service may be reimbursed via a negotiated rate between the plan and the provider; and any applicable coding. When services are reimbursed via a negotiated rate, it is suggested that the prevailing Medicaid FFS rate service is used as an initial starting point for rate negotiations.

Inpatient Providers:

The Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services are already incorporated into the benefit package. Part 820 treatment services are new for the Medicaid managed care benefit package

Providers of Part 816 and Part 818 services should speak with the plan regarding the plan coding, contract, and reimbursement policies. Part 820 programs are reimbursed at the government rate. However, please note that at a minimum, plans must include providers as indicated below to meet minimum network requirements.

Service	OASAS Regulation / Certification Authority	Negotiated or Government Rate
Crisis	Title 14 NYCRR Part 816 Medically Managed Withdrawal	Negotiated
	Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Out Observation Days	Negotiated
	Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/One Observation Days	Negotiated
	Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Two Observation Days	Negotiated
	Title 14 NYCRR Part 816 Medically Supervised Outpatient Withdrawal (MSOW). Note: While this is not an inpatient service it is a crisis service that has been previously included in the benefit package and is not subject to government rates.	Negotiated
	Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW)	Negotiated
Inpatient Rehabilitation	Title 14 NYCRR Part 818 Inpatient Rehabilitation	Negotiated
	Title 14 NYCRR Part 818 Inpatient Rehabilitation - State Operated (ATC)	Negotiated
Residential Treatment	Title 14 NYCRR Part 820 Residential Programs	Government Rate 24 months See rate table below

For claims submitted by Title 14 NYCRR Part 820 Residential Programs the following: rate codes should be used in the claim header; the following CPT / HCPCS codes should be used at the line level; and the plan should assign the indicated specialty code:

Title 14 NYCRR Part 820 Residential Program Type	Rate Code	CPT / HCPCS Code
Stabilization	1144 (treatment services)	H2036 and modifiers: TG; and, HF. May also submit E/M claims for ancillary withdrawal services.
Rehabilitation	1145 (treatment services)	H2036 and HF modifier
Reintegration	1146 (treatment services)	H2034 and HF modifier
Note: The HF modifier is requested to be added on all OASAS claims types including, but not limited to residential addiction treatment services. The modifier does not impact pricing but will support data collection. Plans should not deny a claim for failure to include the HF modifier.		

For claims submitted by Title 14 NYCRR Part 820 Residential Programs the following rate will apply:

Title 14 NYCRR Part 820 Residential Program Type	Upstate Payment	Downstate Payment
Stabilization	\$151.53	\$165.27
Rehabilitation	\$142.01	\$163.56
Reintegration	TBD	TBD
Upstate Includes:	All counties not listed in the Downstate Peer Group	
Downstate Includes:	Five counties comprising New York City (Bronx, Kings, New York, Queens, and Richmond counties), and the counties of Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, and Westchester.	

Outpatient Providers

Reimbursement:

For first 24 months of inclusion in the benefit package Government Rates to: Title 14 NYCRR Part 822 OASAS Certified Outpatient: Clinic (including intensive outpatient); Opioid; and, Outpatient Rehabilitation Programs. Beginning with the mainstream/HARP implementation start date, for services delivered by an OASAS certified Title 14 NYCRR Part 822 program, plans will be required to pay the Medicaid fee-for-service (FFS) "government rates" for the first two years (based on the regional carve-in/implementation schedule). For current OASAS-certified programs, the "government rate" is the reimbursement currently paid by Medicaid fee-for-service for each service (e.g. assessments; groups; individual; medication management) and refers specifically to the Ambulatory Patient Group Rates (APGs) for Freestanding and Hospital Based OASAS Certified Clinic (including intensive outpatient); Opioid; and, Outpatient Rehabilitation Programs.

Coding:

Plans will process provider claims through the New York State APG 3M grouper or an exact replica to ensure government rates are rendered to OASAS Certified Title 14 NYCRR Part 822 programs (hospital or Freestanding). The following pages include further claim component detail and requirements.

837i Coding Claims Submissions Requirements for all OASAS Certified Clinic, Opioid, and Outpatient Rehabilitation:

Claim Component	Description	Notes
Claim Form	837i	Required format; plans must accept
Rate Code	Value code "24"; Assigned four digit rate code in header	See table one below: The Rate Codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 I claim
CPT / HCPCS Codes	Line level CPT / HCPCS procedure code(s). HCPCS codes are utilized by OASAS certified programs when service rendered by non-licensed professionals e.g. CASACS.	See table two below: the CPT / HCPCS codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 I claim
ICD 10	Programs should utilize the appropriate ICD 10 coding.	For the transitional implementation week spanning Sept. 2015 and Oct. 2015 OTP programs should follow the ICD 10 coding information provided by the NYS DOH . Specifically, the FAQ which speaks to claims that span October 1, 2015 must be coded as ICD-10 for all dates of service - even if the episode started before October 1, 2015.
Procedure Modifiers	CPT / HCPCS specific modifier and HF modifier for all services delivered in a Title 14 NYCRR Part 822 OASAS Certified Outpatient Program (clinic and opioid). The HF modifier should be attached to each coded (Line level) service on the claim.	KP Modifier: Opioid Program only The KP modifier must be included KP with the date service CPT / HCPCS coding line associated with first medication administration service (H0020) delivered during a service week. The program will also include the HF modifier. The modifier codes are entered by the program on the 837 I claim Note the program should code the HF modifier to allow for data collection; however, plans should not deny claims for failure to include.
Service delivery date.	Corresponds to date service delivered and associated CPT / HCPCS coding	The dates are entered by the program on the 837i claim

Claim Component	Description	Notes
Service Units	where applicable	The codes are entered by the program on the 837i claim
OASAS CASAC ID / Number:	ID number 02249145.	In those instances where a practitioner does not have an NPI, e.g. a CASAC, the equivalent DOH-approved NPI 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).

Additional Claim Submission Requirements for Opioid Treatment (OTP) Programs
See also end note at bottom of page.

Note: Historically OTPS claims were submitted with a visit-based claim that utilizes the four digit weekly OTP APG rate code in the claim header. This single claim contains all visit dates and services delivered during the service week, including the first Medication Administration service delivered during the service week. This claim secured payment for the services delivered during the entire week, including the first Medication Administration service reimbursement and enhanced 1st day Medication Administration payment. This claim separately identified each visit date (defined as the calendar date) and services delivered to the patient on the specific visit date. The program submitted the claim using:

- The four digit visit rate code 1564 in the claim header. With the episode week defined as Monday-Sunday.
- Line level visit date(s)
- The first Medication Administration H0020 with Modifier KP on the first occurrence of this service being provided.
- Line level appropriate HCPCS or CPT code for the delivered service(s) associated with the specific visit date including any additional Medication Administration services provided during that week. Additional Medication Administration services provided during the week may not be coded with a KP modifier.
- OTP programs must be reimbursed for additional cost Buprenorphine.

Within a managed care claiming structure the OTP programs may either:

- A) Immediately convert to daily process /claiming. Submitting a single visit claim for each date of service, or
- B) Continue to submit a single visit claim that codes all services delivered during the service week on the single visit claim. It is expected that over time the OTP programs will transition to submitting a single visit claims for each date of services.

In either scenario the programs utilize:

- the 837i;
- the OTP APG rate code for their peer group in the headers;
- the appropriate CPT /HCPCS / Modifier codes (including KP modifier for the first medication administration visit and the HF modifier for all line level procedure coding);
- the claim is processed by the plan through the 3M grouper or its exact replica; and

- OTP programs must be reimbursed for additional cost Buprenorphine.

Table One: OASAS Outpatient Rate Codes

<p>OASAS Rate Codes Outpatient Providers will input the rate code in the header of the claim as a value code. This is done in the value code field by first typing in "24" and following that immediately with the appropriate four digit rate code. This is the standard mechanism currently used in Medicaid FFS billing. Rate Codes: Once the claim is received the plan will utilize the rate code for MEDS reporting. Rate codes are assigned based upon Certification / Program type and setting (hospital vs freestanding)</p>	
Code Table	Rate Code (Same as APG rate code)
Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient	
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program	1528
Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program	1561
Part 822 Hospital (Art 28 and Art 32) Opiate Tx Program	1567
Medical Services	
Part 822 Hospital (Art 28/ 32) Chemical Dependence Outpatient Program	1552
Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program	1558
Part 822 Hospital (Art 28/32) Opiate Tx Program	1555
Title 14 NYCRR Part 822 Community / Freestanding	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program	1540
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1573
Part 822 Community (Art 32 only) Opiate Tx Program	1564
Medical Services	
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program	1468
Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program	1570
Part 822 Community (Art 28/32) Opiate Tx Program	1471

Table Two: Outpatient CPT / HCPCS Coding

For the first two years (based on the regional carve-in/implementation schedule) plans are required to utilize the CPT / HCPCS codes in Table Two below. When available both CPT and HCPCS codes are provided to support services delivery via different practitioner types / accommodate scope of practice coding requirements. In addition to the CPT / HCPCS codes, **all line level service coding for SUD services must also include the “HF” modifier. Note the program should code the HF modifier to allow for data collection, however plans should not deny claims for failure to include.**

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); and, the HF modifier on each service line					
APG	OASAS Service Category Description	CPT Codes <input checked="" type="checkbox"/>	CPT Code Description	HCPCS Codes <input checked="" type="checkbox"/>	HCPCS description
315	Psychiatric Assessment with Counseling – Brief (30 minute min)	E&M Code Plus 90833	Psychiatric Assessment with Counseling-30 minutes Select E&M Code from Range: 99201-99205, 99211-99215 PLUS Add-on Code 90833	N/A	
316	Psychiatric Assessment with Counseling (45-50 minute min)	E&M Code Plus 90836	Psychiatric Assessment with Counseling-45-50 minutes Select E&M Code from Range: 99201-99205, 99211-99215 PLUS Add-On Code 90836	N/A	
315	Individual Therapy – Brief 25 minute minimum	90832	Alcohol/Substance Interview (Individual Brief 25 minutes minimum)	G0396	Alcohol/Substance assessment and brief intervention
316	Individual Therapy – Normative 45 minute minimum	90834	Alcohol/Substance Interview (Individual Normative 45 minutes minimum)	G0397	Alcohol/Substance assessment and brief intervention
317	Family/Collateral Therapy w/o patient 30 minute minimum	90846	Family/Couple Counseling (30 minute minimum) w/o patient	T1006	Alcohol/Substance services family / couple counseling

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); and, the HF modifier on each service line					
APG	OASAS Service Category Description	CPT Codes <input checked="" type="checkbox"/>	CPT Code Description	HCPCS Codes <input checked="" type="checkbox"/>	HCPCS description
318	Group Therapy 60 minute minimum	90853	Alcohol &/or Drug Services (group counseling by a clinician)	H0005	Alcohol/Substance; group counseling by a clinician
318	Group Therapy 60 minute minimum	90849	Multiple Family Group (adolescent patients) (60-90 minutes)	N/A	
322	Medication Administration & Observation No minimum time		N/A	H0033	Oral Medication, direct observation
322	Medication Administration & Observation No minimum time		N/A	H0020	Alcohol / drug services methadone admin
323	Assessment – Normative 30 minute minimum		N/A	H0001	Alcohol / drug assessment
323	Assessment – Extended 75 minute minimum	90791	Behavioral Health Screening – Admission Eligibility (75 minute minimum)	H0002	Behavioral health screening to determine admission eligibility
324	Assessment – Brief 15 minute minimum		N/A	T1023	Determine appropriateness of individual for participation in a program
324	Screening 15 minute minimum		N/A	H0049	Alcohol &/or Drug Screening
324	Brief Intervention 15 minute minimum		N/A	H0050	Alcohol &/or Drug Services, Brief Intervention – 15 min service
324	Brief Treatment 15 minute minimum		N/A	H0004	Alcohol &/or Drug Services, Brief Treatment – 15 min service
426	Addiction Medication Induction/ Withdrawal Management 30 minute minimum		N/A	H0014	Alcohol &/or Drug Services, Ambulatory Detox
426	Medication Management & Monitoring – Routine 10 minute minimum	99201- 99205 99211- 99215	New Patient Existing Patient	N/A	

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); and, the HF modifier on each service line					
APG	OASAS Service Category Description	CPT Codes <input checked="" type="checkbox"/>	CPT Code Description	HCPCS Codes <input checked="" type="checkbox"/>	HCPCS description
426	Medication Management & Monitoring – Complex 30 minute minimum	E&M Code	Medication Management-Complex (15 minute minimum) Select E&M Code from Range: 99201-99205, 99211-99215	N/A	
451	Smoking Cessation Treatment 3 to 10 minutes		N/A	99406	Behavior change Smoking prevention intervention counseling
451	Smoking Cessation Treatment >10 minutes		N/A	99407	Behavior change Smoking prevention non-counseling
490	Complex Care Coordination 45 minute minimum	90882	Environmental Manipulation – Complex Care Coordination	N/A	
490	Peer Counseling 30 minute minimum		N/A	H0038	Self-Help/Peer Services-per 15 minutes
327	Intensive Outpatient Program 9hrs/week at 3hrs/day		N/A	S9480	Intensive Outpatient Program
328	Outpatient Rehabilitation 2-4 Hour Duration		N/A	H2001	Rehab program per ½ day
328	Outpatient Rehabilitation 4 Hours and Above Duration		N/A	H2036	Alcohol / drug program per diem
840-843 Physical Health – New/Existing Patient – Select CPT Code from Range:					
New:		Existing:		Select Diagnosis: <input checked="" type="checkbox"/>	
<input type="checkbox"/> 99201	<input type="checkbox"/> 99204	<input type="checkbox"/> 99211	<input type="checkbox"/> 99214		
<input type="checkbox"/> 99202	<input type="checkbox"/> 99205	<input type="checkbox"/> 99212	<input type="checkbox"/> 99215		
<input type="checkbox"/> 99203	<input type="checkbox"/> 99213				
840	Physical Health – Opioid Dependence		<input type="checkbox"/>	Evaluation & Management – No Counseling	
841	Physical Health – Cocaine Dependence		<input type="checkbox"/>	Evaluation & Management – No Counseling	

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); and, the HF modifier on each service line					
APG	OASAS Service Category Description	CPT Codes <input checked="" type="checkbox"/>	CPT Code Description	HCPCS Codes <input checked="" type="checkbox"/>	HCPCS description
842	Physical Health – Alcohol Dependence		<input type="checkbox"/>		Evaluation & Management – No Counseling
843	Physical Health – Other CD		<input type="checkbox"/>		Evaluation & Management – No Counseling
840-843	Physical Exam – New/Existing Patient – Select CPT Code from Range:				
	New:	Existing:		Select Diagnosis: <input checked="" type="checkbox"/>	
	<input type="checkbox"/> 99382	<input type="checkbox"/> 99385	<input type="checkbox"/> 99392		<input type="checkbox"/> 99395
	<input type="checkbox"/> 99383	<input type="checkbox"/> 99386	<input type="checkbox"/> 99393		<input type="checkbox"/> 99396
	<input type="checkbox"/> 99384	<input type="checkbox"/> 99387	<input type="checkbox"/> 99394		<input type="checkbox"/> 99397
840	Physical Exam – Opioid Dependence		<input type="checkbox"/>		Physical Exam – New/Established Patient
841	Physical Exam – Cocaine Dependence		<input type="checkbox"/>		Physical Exam – New/Established Patient
842	Physical Exam – Alcohol Dependence		<input type="checkbox"/>		Physical Exam – New/Established Patient
843	Physical Exam – Other CD		<input type="checkbox"/>		Physical Exam – New/Established Patient

Section Three

Below is a list of OASAS certified programs that deliver the authorized SPA services; the applicable authorizing New York State program regulation; and where appropriate, a crosswalk to ASAM levels of care.

OASAS Program Type	New York State Regulation	ASAM
Outpatient		
Outpatient Clinic	Title 14 NYCRR Part 822	Level I
Outpatient Day Rehabilitation	Title 14 NYCRR Part 822	Level II.5
Intensive Outpatient	Title 14 NYCRR Part 822	Level II.I
Opioid Treatment Programs	Title 14 NYCRR Part 822	Level I
Medically Supervised Outpatient Withdrawal	Title 14 NYCRR Part 822	Level I-D
Clinical Services in a Residential Setting		
Stabilization Services in a Residential Setting	Title 14 NYCRR Part 820	Level III.5
Rehabilitation Services in a Residential Setting	Title 14 NYCRR Part 820	Level III.3
Reintegration in a Residential Setting.	Title 14 NYCRR Part 820	Level III.1
Inpatient		
Medically Managed Inpatient Detoxification	Title 14 NYCRR Part 816	Level IV-D
Medically Supervised Inpatient Detoxification	Title 14 NYCRR Part 816	Level III.7-D
Inpatient Treatment and Residential Rehabilitation for Youth	Title 14 NYCRR Part 818	Level III.7