NEW YORK STATE | Office of Mental Health | Office of Addiction Services and Supports

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Memorandum

To: All Article 31 and Article 32 Licensed Clinic Programs

Date: April 28, 2021

From: NYS Office of Mental Health and NYS Office of Addiction Services and Supports

RE: Submitting claims for medication management of co-occurring mental health and substance use disorders, including medication-assisted treatment for opioid use disorder

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NOTE: THIS SUPERSEDES GUIDANCE ISSUED OCTOBER 16, 2019.

Changes in the version: guidance for billing visits related to buprenorphine inductions (number 4 below) and buprenorphine maintenance (number 5 below).

In the face of the opioid overdose crisis, the NYS Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) recognize the urgent and growing need to address co-occurring mental health and substance use disorders in an integrated and person-centered manner, wherever individuals are most comfortable receiving services. This treatment often includes medication management, both for psychiatric conditions as well as medication-assisted treatments for addiction. Therefore, OMH and OASAS offer the following guidance about submitting claims for medication management services in Article 31 and/or 32 licensed clinic programs:

1. Per current regulations, the primary admission diagnosis on initial evaluation and treatment plan must be aligned with the clinic program's licensure (i.e., a mental health diagnosis for Article 31 and a substance use disorder for Article 32).

2. For individual medication visits (Psychiatric Assessments, Psychotropic Medication Treatment, Addiction Medication Management, etc.), the primary diagnosis on the claim should reflect the diagnosis primarily addressed in the visit. For example, if a patient is admitted to an Article 31 clinic for treatment of depression and has a visit with their psychiatrist to address opioid use disorder, then on the claim the primary diagnosis would be opioid use disorder and depression would be listed as an additional diagnosis. It is required that a diagnosis consistent with the licensure of the clinic be listed on each claim, but it does not have to be the primary diagnosis of the visit.

3. For long-acting injectable psychotropic medications (e.g., naltrexone or antipsychotic agents), claiming procedures depend on whether the clinic pays for the medication or

not (a and b, below), and whether the injection is given as part of another CPT coded service (c, below):

a. When the clinic does **not** pay for the medication, providers must submit the injection-only procedure code 96372 using a professional claim – 837P – (same as institutional but without a rate code), **without** a J-code;
b. When the clinic pays for the medication, the claim for the medication and the injection-only procedure 96372 is also submitted using the same 837P professional claim. The clinic must **also** include the appropriate HCPCS J-code for the medication:
    i. The J-code for long-acting injectable naltrexone is J2315 (naltrexone, depot form). Each long-acting injectable antipsychotic agent has its own J-code (e.g., J1631 for haloperidol decanoate, J2794 for risperidone microspheres, J2426 for paliperidone palmitate, etc.);
c. The CPT code 96372 (Injectable Psychotropic Medication Administration) – is an injection-only service, administered by qualified staff (Physician (MD), Psychiatric Nurse Practitioner (NPP), Registered Nurse (RN), Physician Assistant (PA), Licensed Practical Nurse (LPN)). If the injection is administered as part of an E&M CPT coded service, the CPT code 96372 should **not** be billed and only the J-code would be claimed on the 837P if the clinic pays for the drug, per above, with the appropriate E&M/HCPCS code submitted on the 837I claim form;
d. If qualified staff (MD, NPP, RN, PA) prepares, administers, manages, and monitors the injection of an intramuscular medication AND provides consumer education related to the use of the medication, spending at least 15 minutes with the client, then clinics can use HCPCS H2010 – Injectable Psychotropic Medication Administration with Monitoring and Education. When claiming H2010, the clinic cannot claim 96372 on the professional claim on the same day for the same client.
e. When administering long-acting injectable naltrexone for a substance use disorder (i.e., opioid or alcohol use disorder) in an Article 31 clinic OR a long-acting injectable antipsychotic for a thought or mood disorder (e.g., schizophrenia, bipolar disorder, etc.) in an Article 32 clinic, the claim should include the diagnosis treated by the medication. Article 31 clinics must also include the co-occurring mental health diagnosis. Likewise, Article 32 Clinics must also include the co-occurring substance use disorder diagnosis. The position of the diagnosis (i.e., primary or additional) should be determined by the content of the overall visit.

4. For any visits related to buprenorphine inductions:
    a. The claim should indicate opioid use disorder as the primary diagnosis.
    b. Article 31 clinics that do not have an integrated license may categorize buprenorphine induction visits as Psychiatric Assessments[1] and submit claims using relevant codes described in the OMH CPT Procedure Weight and Rate Schedule. A

[1] Definition: A "psychiatric assessment" is an interview with an adult or child or his or her family member or other collateral, performed by a psychiatrist or nurse practitioner in psychiatry (NPP), or physician assistant with specialized training approved by the Office. A psychiatric assessment may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues. https://omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf

minimum of 30 minutes must be spent with the client to bill for a Psychiatric Assessment.

c. Article 32 clinics, or Article 31 clinics with an integrated license to provide substance use disorder (SUD) services, may use HCPCS code H0014 (alcohol and/or drug services; ambulatory detoxification), if activities related to the induction require a discrete period of time and/or additional staff involvement above and beyond any E&M CPT coded service provided during the visit (e.g., in-office evaluation and monitoring of withdrawal symptoms by a nurse or physician).

5. For visits related to buprenorphine maintenance, claims should include opioid use disorder as a primary or additional diagnosis. In Article 31 clinics, these visits should be categorized as Psychotropic Medication Treatment Visits[2] and submit claims using relevant codes described in the OMH CPT Procedure Weight and Rate Schedule.

6. Guidance on provision, storage, administration, and billing for extended-release buprenorphine is forthcoming from OASAS.

For questions, concerns, or to report denials, please contact picm@oasas.ny.gov or OMH-Managed-Care@omh.ny.gov. For concerns specific to fee-for-service clients in OMH-licensed clinics, contact clinicrestructuring@omh.ny.gov.

CC: Managed Care Behavioral Health Medical Directors
OMH Senior Staff
OMH Licensing Directors
OMH Field Office opioid contacts
OASAS Senior Staff

[2] Definition: Psychotropic medication treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate. https://omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf