

**Clinic Frequently Asked Questions
Updated February 27, 2012**

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Clinic Services

1. Can a full group session of smoking cessation counseling in an Article 31 be legitimately billed?

Smoking Cessation Counseling (SCC) is allowed for both adults and children as a health monitoring service. SCC can be coded using 99406 (Intermediate SCC, 3 to 10 minutes – billable only as individual session) or 99407 (Intensive SCC, 3 to 10 minutes – billable as an individual or group session; using the “HQ” modifier to indicate a group SCC session, up to eight patients in a group).

Claims for SCC must include ICD-9-CM diagnosis code, 305.1 tobacco use disorder. SCC must be provided face-to-face by a physician, physician assistant, nurse

practitioner, or registered nurse. Medicaid reimbursement is available for six counseling sessions during any 12 continuous months; including any combination of individual or group counseling session. If smoking cessation counseling is part of a psychotherapy session (group or individual), the time spent on smoking cessation can be counted toward the duration of the psychotherapy session but cannot be billed as an additional smoking cessation session.

2. Is the county responsible for a crisis plan for each licensed clinic or is the expectation that the county will have a single county wide-plan?

All clinics must have crisis plans (including after-hours coverage), and those plans must be approved by the county Director of Community Services except for plans for county run clinics, which must be approved by the Office of Mental Health (OMH). The county elects whether all or some clinics will have their own crisis plan or whether all or groups of clinics will have a consolidated plan.

3. What if we already have a crisis plan in place? Do we have to have that plan re-approved?

Yes.

4. Can an intern, nonpaid family advocate or case manager not directly paid by the clinic serve as the second person for a Crisis Intervention-per diem or Crisis Intervention-complex?

The second person aiding in a crisis intervention service must be listed in the clinic's staffing plan (which would include staff under contract).

5. Are Crisis Intervention services provided by our mobile crisis team billable under Part 599?

Crisis Intervention – Brief (CPT code H2011), is Medicaid reimbursable when provided off-site (up to 6 units per client, per day). No other crisis codes will be reimbursed when provided off-site.

6. Regarding crisis plans, must the provider have a mobile capacity or can the provider rely on telephone screening and the psychiatric emergency room of their hospital?

After- hour crisis coverage must include, at a minimum, the ability to provide brief crisis intervention services by phone by a licensed clinician. During the extension of the exemption of the State Education Department [social work licensing law](#) [☞] crisis services can be provided by both non-licensed and licensed clinical staff or can be contracted

out. If contracted out, the clinic must be sure that any non-licensed crisis responders are covered by the State Education Department social work exemption.

7. How is the period of time for complex care counted? Is it five working days? Does this include Saturday, Sunday and/or holidays if the clinic is open?

Complex care may be reimbursed if the service is provided within five weekdays (e.g., Monday-Friday, Thursday-Wednesday) of a crisis or psychotherapy service. In addition, complex care may be reimbursed if provided on the same day the psychotherapy or crisis service was provided.

Please Note New Guidance: Complex Care Management must be claimed using the appropriate Health Services rate code (1474, 1477, 1588, and 1591) to avoid being counted toward an individual's Utilization Threshold.

8. The [Part 599 guidance document](#) refers to a "Clinical Services Contract" but does not define what would be expected in the content of such a contract. Presumably the secondary provider would bill Medicaid as opposed to the primary provider.

Section 599.4 (d) of the [Part 599 regulations](#) includes a definition of what a "clinical services contract" is. OMH does not specify the expected content of such a contract because of the multiple variations of circumstances and relationships that would be governed by the agreement. It should be noted however that since Part 599 does not allow a client to be enrolled in more than one mental health clinic at a time, the originating clinic would need to claim Medicaid reimbursement and make payment to the contracted clinic.

If a clinic does not offer an optional service from which a specific recipient admitted to its program could benefit, it is possible to arrange for the receipt of such services from another OMH licensed clinic via a "Clinical Services Contract." It is the expectation of OMH that this would be a time limited arrangement, which would not be used to address the ongoing service needs of an individual or group of individuals. **Please Note:** "Developmental Testing" and "Psychological Testing" are optional services that can only be provided to recipients admitted to the clinic and cannot be delivered through a clinical services contract.

A clinic can also use a "Clinical Services Contract" for after-hours crisis response. Such contract shall include, at a minimum, provisions assuring that, in the event of a crisis, the nature of the crisis and any measures taken to address such crisis are communicated to the primary clinician or other designated clinician involved in the individual's treatment at the clinic, or the individual's primary care or mental health care provider, if known, on the next business day. At the request of the local governmental unit, State-operated clinics shall consult with the local governmental unit or units in their service area in the development of such clinic's crisis response plan.

9. Did OMH stop paying for home visits for Clinic Plus?

Yes. Clinic Plus funding ended 12/31/11.

Clinic Services Modifiers

10. Our clinic program provides clinical services both in the community, often where the clients live, and onsite. The population served is formerly homeless adults with serious mental illness who are not able to, or chose not to receive services in a clinic. We are operating under the assumption that Part 599 clinic regulations do not prohibit us from continuing to provide mental health services in the community as we have done so for years. Are we correct in this assumption?

Clinics may provide services to homeless individuals and receive Medicaid reimbursement. However, once the individual is no longer homeless (see Section 1003 of the [HEARTH Act](#) [☞] for the federal definition of homeless); Medicaid will not reimburse any amount of money for any service provided off-site with the exception of select children's services (see [Part 599 guidance document](#)) and Crisis Intervention – Brief (up to 6 units) for both adults and children.

11. What are the rates for the after-hours CPT code (99051) and language other than English modifier (U4)?

These add-ons do not have rates. The language other than English modifier (U4) is paid at 10% of the eligible APG service weight. The after-hours CPT code (99051) is weighted at .0759 of the peer group base rate (ex. Downstate Article 31 with QI would receive \$11.46).

12. Can services provided to a child at a school be billed using the off-site rate code?

A service provided at a satellite location within a school is an on-site service and must be claimed using the appropriate on-site rate code.

A service provided in a school without a licensed mental health clinic satellite or a health clinic is an off-site service and should be claimed using the appropriate off-site rate code.

A service provided in a school-based health services clinic is not in any way related to OMH and cannot be billed using any of OMH's rate codes for clinics.

13. Can the after-hours procedure code (99051) be billed for emergency crisis care even if the hour isn't included in the clinic's operating certificate?

Yes. The after-hours procedure code can be billed with all three levels of Crisis Intervention services even if the hours are not listed on the agency's operating certificate.

Coding

14. With regard to pre-admission assessment visits, OMH allows up to three 90801 visits for Medicaid. However, Medicare and managed care allow only one 90801 per year. Ideally we would like a protocol that fits all payors. Would it make sense for us to code only the first visit as 90801 and the second and third visits (if they are necessary) as 90804 or 90806 (obviously the progress note would need to reflect the nature of the service)? Or must the second and third visits be coded as 90801 for Medicaid?

You may choose to code the second and third assessment services as therapy so long as therapy has been provided. However, you will not be reimbursed the rate paid for an Initial Assessment which is somewhat higher than the amount paid for a psychotherapy session. If your clinic does not have automatic crossover (all free-standing and local governmental unit (LGU) operated clinics were "opted out" of automatic crossover) between Medicare and Medicaid, another option would be to bill Medicare for the second and third assessments using the required code for Medicare and before sending the claims to Medicaid change the code to 90801 (if that is the procedure appropriately documented in the consumer's clinical record), making sure that the Medicare paid line is filled in with the paid amount. If your claims do automatically crossover the other option would be to adjust your Medicaid claim after it is adjudicated by eMedNY.

15. Can we bill for something other than an Initial Assessment if the client is not admitted?

Yes, if another procedure more accurately describes what was done during the service. However, you are limited to Medicaid payment for three procedures for adults and three visits for children if the adult or child is NOT admitted to the clinic for continuing treatment by the fourth scheduled visit.

16. Can a clinic admit a client to treatment on the same date they bill a pre-admission procedure code?

Yes, any of the available services can be provided on the admission date. There are no services that are provided solely before admittance to a clinic.

- 17. For providers with multiple clinics, does the rolling 12 months for the initial assessment procedure code apply to the provider as a whole or each individually licensed clinic? We often have clients who re-locate in between episodes.**

The rule applies to each clinic program (including all of its satellites) individually.

- 18. Can we summarize on one note and add up the time spent in that one day when dealing with a crisis or do we have to do a separate note and document the time separately for each piece of the story? It is actually the nature of a crisis to unfold and be dealt with throughout the day, not all neatly in a scheduled block of time.**

One note will suffice for a crisis intervention service provided at different times throughout the day. However, the note must document all the time spent with the recipient, especially if the time spent was NOT continuous, and be signed by all the clinicians involved.

- 19. We had a situation where we spent 15 minutes on the phone with a local case manager regarding a client's ongoing homelessness. Since the client wasn't present with the case manager or the clinician should we bill a crisis visit or something else?**

If the need for the phone call arose from a psychotherapy session or crisis session that occurred within the prior five weekdays (Monday-Friday) and the call was held at the request of the clinician then the phone call may qualify as complex care management. The call must meet the requirements for complex care management. In this case, it must focus on the coordination or development of a plan of care to address the homelessness of the client.

Please note: Complex Care Management must be claimed using the appropriate Health Services rate code (1474, 1477, 1588, 1591) to avoid being counted toward an individual's Utilization Threshold.

- 20. What is the appropriate way of updating procedures with different modifiers for Medicare/Medicaid dual eligible clients (e.g., 90806-AJ must be used for Individual Psychotherapy for Medicare and 90806-U4 (language other than English) for Medicaid). The AJ modifier means licensed clinical social worker (LCSW).**

Clinics will need to amend their claims to include the Medicaid modifiers if Medicare will not allow them to be on the claim.

- 21. When providing a psychotherapy family/collateral with recipient (90847) are we required to use two progress notes of 30 minutes each?**

No. This is one service and one note will suffice.

22. How do clinics bill for family therapy where more than one participant is a client? If you have a family session with two or more clients but also non-client family members, how will clinics code?

When there are two family members that are recipients present in one family session, the clinic will bill for only one of the recipients using the appropriate code for Family/Collateral service (90846 or 90847). Each recipient should be listed as collateral in the other recipient's treatment plan. Both files should have notes documenting the service.

23. Does an entire session need to be conducted in a language other than English (LOE) in order to qualify for the add-on U4 modifier? Some of our clients express themselves in English and Spanish during a session, depending on the subject, their emotion at the time, etc.

No. However, the need for the language other than English must be documented in the treatment plan.

24. Sometimes the medical necessity of the client determines that the composition of a family therapy session (90846 or 90847) is made up of the client and siblings, without a parent. Is this appropriate use of the code?

Yes, so long as the siblings are listed in the recipient's treatment plan.

25. Is the following scenario billable as a crisis intervention – brief? A child is in crisis. His teacher who is with him calls our agency to speak with the child's therapist. The therapist talks the teacher through how to bring the child through the crisis but does not actually speak to the child client, only the teacher.

Yes, the above scenario would be reimbursable as a crisis intervention – brief (H2011).

26. Our children's clinic program is a licensed satellite within a school. We are often involved in crises at the school where our clinician is involved with the crisis along with a non-clinic employee (e.g., teacher). Would such a situation be billable as Crisis Intervention-Complex, assuming it took at least an hour?

No. Both responders must be listed in the clinic's staffing plan. You could bill for Crisis-brief (up to 6 units). Additionally, for reimbursement of a Crisis-brief service the child in crisis must be a Medicaid recipient but does not need to be enrolled in the clinic. If the child is not a Medicaid recipient, this service may be paid by private insurance (if available) or recorded as uncompensated care.

27. Is Medication Treatment only used for complex medication evaluations or can it be used for regular brief status updates?

Medication Treatment cannot be used for regular status updates. Psychotropic medication treatment involves the in-depth management of psychopharmacologic agents with frequent serious side effects and represents a very skilled aspect of patient care. This service is not intended to refer to a brief evaluation of the patient's state or a simple dosage adjustment of long-term medication. This service requires a minimum time duration of 15 minutes with the doctor or psychiatric nurse practitioner.

28. Can clinics bill for crisis interventions made with collaterals?

Yes, so long as the crisis intervention service provided to the collateral was directly related to the stabilization of the recipient. If the collateral is the individual in crisis the clinic could provide a crisis intervention – brief (up to 6 units). This could be reimbursed by Medicaid for a Medicaid recipient, by private insurance or recorded as uncompensated care.

29. Can clinics bill for crisis interventions for meetings or telephone calls with parents when their children are in crisis?


Yes, so long as the intervention with the collateral is directly related to the stabilization of the recipient.

30. If another Medicaid provider is documented in a client's treatment plan as a necessary collateral contact, how do we bill for that contact when it occurs? Can we bill it as a regular collateral session or complex care? What if the collateral is also billing Medicaid for the contact?

If the other Medicaid provider is documented in the client's treatment plan as a collateral then you may bill Medicaid using the appropriate collateral CPT code. However, only one provider can bill for one procedure. The clinic must come to an agreement with the other Medicaid provider on which program will be billing for that service. If both providers bill that is "double-billing" and is not permitted.

31. Can you provide clarification on the content needed in the note when using Evaluation and Management (E/M) codes? What are the defining characteristics between 99201, 99202, etc. for new patients and those E/M codes for established patients since OMH specifies 30 minute minimum time durations for all the E/M codes?

OMH requires that E/M codes available for psychiatric assessment and psychiatric consultation be a minimum duration of 30 minutes. The appropriate code should be chosen based on complexity of the service as defined by the American Medical

Association (AMA). Definitions for specific codes can be found on the [AMA CPT Search website](#) .

32. Are E/M codes to be used for psychiatric consultations requested by primary care physicians?

Yes. Requests for consultation may be received from a physician or other appropriate source (e.g., physician assistant, nurse practitioner, occupational therapist, speech-language pathologist, psychologist or social worker).

33. Will E/M codes that are defined in the AMA manual as lasting a minimum duration less than 30 minutes be reimbursed by Medicaid?

No. E/M codes for psychiatric assessment and psychiatric consultation will only be reimbursed by Medicaid if the service provided was a minimum duration of 30 minutes, regardless of the AMA time durations associated with these particular codes.

34. Does the recipient need to be present during a multi-family group session?

No. The client does not need to be present. For Medicaid claiming purposes, a family represented in the group counts as one claim, irrespective of the number of family members present.

35. Regarding a Family/Collateral Psychotherapy with the Client (90847), the regulations specify that of the 60 minute minimum timeframe the client must be present for the majority of the time. After 31 minutes does the clinic have the flexibility to have either the client or collateral leave and complete the session with the remaining party?

Yes. Additionally, the recipient does not have to be present for a continuous 31 minutes so long as they are present for the majority of the time.

36. We have a clinic program for Seriously Emotionally Disturbed (SED) children. We also have an OMH waiver program. Some children are involved in both. Are 15 minute meetings between our clinic worker and the waiver worker billable as Complex Care Management?

Yes, the clinic program may bill for complex care management provided it meets the criteria for the service (tied to a therapy or crisis visit within five weekdays (e.g., Monday-Friday, Thursday-Wednesday) and is a response to complex conditions). **Please note:** Complex Care Management must be claimed using the appropriate Health Services rate code (1474, 1477, 1588, 1591) to avoid being counted toward an individual's Utilization Threshold.

The Waiver Program cannot count as a qualifying contact the meeting between their staff and the clinic staff. Please note the waiver guidance below:

Per Waiver Guidance Documents: “Contacts with providers who are also billing Medicaid are not qualifying. This includes but is not limited to staff members of outpatient clinics, Day Treatment programs, or any other mental health provider, medical providers billing Medicaid, and Day Treatment teachers. Such contacts are encouraged and should be made as indicated but are not qualifying contacts”

37. If a Medicaid primary patient received only 40 minutes of 90801 what code should the hospital bill?

If the clinician spent at least 30 minutes with the recipient an individual therapy session (90804) may be claimed.

38. If a Medicaid secondary patient received only 40 minutes of 90801 (acceptable by other payors), what code should the hospital bill when claiming coinsurance?

If the clinician spent at least 30 minutes with the recipient an individual therapy session (90804) may be claimed. If your clinic has Medicare/Medicaid dually-eligible clients and would like to be reimbursed by Medicaid, the clinic must see those clients for at least the minimum time duration for Medicaid reimbursement. If the Medicaid minimum durations are not met, you may not bill Medicaid for that service.

If the clinician did spend at least 30 minutes of time with the recipient and the payment for 90804 exceeds the value of the reimbursement from the primary payor for 90801, the provider may submit a Medicaid claim for 90804 but must include the receipts from the primary insurer.

39. If a Medicaid primary patient received only 20 minutes of 90805 what code should the clinic claim?

Medicaid will not reimburse for a Medicaid-only recipient receiving a psychiatric assessment or psychotherapy session lasting less than 30 minutes.

40. We are concerned that assigning different time values to the same code with different payors will create confusion for providers and clients. Can you give us guidance?

The [Part 599 regulations](#) describe the minimum time durations OMH requires for reimbursement by Medicaid when Medicaid is a payor.

If your clinic has Medicare/Medicaid dually-eligible clients and would like to receive Medicaid reimbursement, the clinic must see those clients for at least the minimum time duration for Medicaid reimbursement for the procedure cited on the Medicaid claim.

41. What CPT code should be used for symptom management when the clinician is not a doctor or psychiatric nurse practitioner (NPP)?

Mental health symptom management can be done as part of a psychotherapy visit with any of the listed professionals (or non-licensed staff during the licensing exemption period expiring in July 2013). Registered nurses can also provide health assessment counseling related to side effects from psychotropic medication under a psychotherapy code (i.e., 90804 or 90806).

42. What are the service and documentation requirements to bill for the participation of a psychiatrist in a service provided by a social worker?

The service would need to be medically necessary, the psychiatrist or NPP would need to spend at least 15 minutes in the session, and a separate note would need to be written by the psychiatrist or NPP.

43. When a social worker is conducting a group of six people, what would be the service and documentation requirements to bill for the participation of a psychiatrist?

To bill the physician add-on in a group setting, the group must either be run by the physician/NPP or the physician/NPP must participate in the session for at least 15 minutes. The doctor's participation must be documented separately for each individual participating in the group. The physician add-on modifier would be added to the appropriate CPT code for each individual. For group services, the physician modifier will add 20% to the APG portion of payment for each recipient participating in the group.

Interim Claiming

Please note: Interim claiming is in effect for all services provided 10/1/2010 through 12/31/2011. All services provided on or after 1/1/2012 must now be billed using the [APG rate codes](#) with the appropriate CPT codes and modifiers. Adjustments to any claims for dates of service prior to 1/1/2012 must be made using the [interim claiming methodology](#). These older claims will begin to be reprocessed by eMedNY as APG claims beginning in April 2012.

COPS-Only- Interim Claiming

44. Should clinics continue to bill for COPS-only for services provided on or after 1/1/2012?

Yes, clinics will continue to bill for COPS-only using the 4093-4098 rate codes until further notice. COPS-only claims will NOT be part of the readjudication process. These codes will be eliminated when “government rates” become effective.

45. Is it true that COPS-only and Community Support Programs (CSP) reimbursement will be paid at 100% during the entire interim billing period?

Yes, COPS-only and CSP will be paid for the entire interim billing period.

46. Once APGs are approved will COPS-only payments be reduced retroactively to 10/1/2010?

No. COPS-only payments will be eliminated prospectively. The Department of Health (DOH) is in the process of notifying the Medicaid managed care companies of their obligation to pay “equivalent” rates. OMH expects that Medicaid managed care companies will begin paying equivalent rates in April 2012. Up until that time when the Medicaid managed care companies begin paying equivalent rates clinics will continue to receive 100% of their COPS-only payments.

47. How are clinics to handle multiple claims for COPS-only payments? Are they bundled together or on separate claims?

During the interim period, you will continue to bill for COPS-only as you did prior to 10/1/10 using rate codes 4093-4098.

For services provided on or after 1/1/12 you will continue to bill COPS-only using rate codes 4093-4098.

eMedNY –Interim Claiming

48. Upon readjudication will the remittance statement show the rejected additional claims?

No.

49. If claims need to be adjusted later do the free-standing Article 31s adjust using the 1504/1510 rate codes?

Yes, if the adjustment happens after eMedNY does the initial readjudication (which OMH expects to happen in April 2012). However, if the clinic is adjusting prior to the initial readjudication the interim rate codes (4300/4600 series) must be used.

50. Do clinics have to submit multiple claims for services provided prior to 1/1/2012 in order to be paid upon readjudication?

No, but at least one claim needs to be submitted in a timely manner. This claim may need to be amended later in order to be reimbursed properly.

51. If a clinic submits multiple services on one claim do you have to make sure the higher paid service is first?

It does not matter what order the procedures are listed.

52. Will eMedNY reimburse for different rate codes on the same claim?

No.

53. Can clinic providers hold claims where they have more than one procedure a day because their software vendor is unable to put multiple procedures on one claim for interim billing? Would this be a valid 90-day reason if claims become that old?

No. Holding claims because the clinic cannot submit multiple services on a claim is not a valid 90-day reason. The clinic must submit the claim with one procedure within 90 days and amend it when their systems allow (subject to eMedNY deadlines for amendments). After this original claim is readjudicated, the clinic can submit an amendment to that claim to add the second procedure. Software issues are not valid reasons for late initial claims. If necessary, ePACES may be used in place of proprietary software to submit claims with multiple procedures.

54. How will clinics be able to tell that a claim has been successfully reprocessed?

Clinics will receive an approved remittance statement showing the claim has been paid and the amount paid.

55. Will the 835 also include detail for the legacy rates?

Yes. The legacy detail will be shown on the remittance statement.

56. If an individual psychotherapy service and a medication treatment service are provided on the same day under APGs, how will clinics report this visit on LS-3 reports and the Consolidated Fiscal Report (CFR); as one visit or two?

During the interim claiming period you will send in one claim for this particular scenario. You will bill using the crosswalk from the [interim claiming instructions](#) and place both CPT codes on the claim. You will receive payment for the appropriate rate code as well as COPS. Once the claim is readjudicated you will be reimbursed for the other service provided on that day. Even if the actual procedures on any day include scheduled procedures in the morning and an unscheduled crisis visit in the afternoon or evening, it will be reported on the CFR as one visit (i.e., one service day).

57. Our clinic needs clarification on the claiming of the following scenario: two services, 4301 and 4304 are provided on the same day. Our clinic will submit 2300 cpt4301, lx1 4301, lx2 4304 and also submit a second 2300 cpt4304 lx1 4304, lx2 4301. Will this avoid “data backlog/rebill”?

4301 and 4304 are rate codes, not CPT codes. Submit one claim with the rate code 4301 (loop 2300) and the procedure (CPT) codes (e.g. 90801, 90804) for the services associated with the 4301 rate code and the 4304 rate code (loop 2400). Submit another claim with the rate code 4304 (loop 2300) and the procedure codes (CPT) for the services associated with the 4301 rate code and the 4304 rate code (loop 2400). During readjudication, eMedNY will select only one of the two described claims for reprocessing. Putting all of the procedure codes (NOT rate codes) delivered that day on both claims (the 4301 and 4304 claims) assures that the clinic will receive full payment after readjudication for the procedures delivered that day irrespective of which of the two claims was selected for readjudication.

58. Is OMH saying that clinics should submit two procedures on two separate 2300s but use each corresponding CPT as the controlling CPT? Essentially creating two claims with different CPTs but duplicate financial impact?

Clinics will submit claims in the same manner as prior to 10/1/10. The only difference is to put all mental health clinic procedures performed in the day on every claim submitted for that day. If claiming for two procedures with two different rate codes submit two claims, each with one rate code (loop 2300) and both procedure codes(CPT)(loop 2400). Please note that according to the OMH [interim claiming guidance](#), some procedures (when provided prior to 1/1/12) are not currently reimbursable and must be held.

59. Should clinics begin submitting all billable procedure codes as of 1/1/2012? Will eMedNY auto-adjust the claims retroactively after federal approval of APGs? Also, for services that are not reimbursable until federal approval, should they be charged but not billed?

Yes. All services provided on or after 1/1/2012 must be billed using the APG rate codes and appropriate procedure codes. For services provided on or after 1/1/2012 all clinic procedures are now billable; there are no Part 599 procedures that need to be held.

However, the [interim claiming guidance](#) must continue to be followed for all services provided prior to 1/1/2012. Any off-site services or health monitoring services provided prior to 1/1/2012 must continue to be held until notification from OMH.

60. How do clinics arrange the 15% “repayment plan” in the event we end up owing money after the implementation of the APG rate codes?

This repayment will be an automatic deduction from future Medicaid payments. If the money owed is more than 15% of the first check due to you after the receivable is readjudicated, then repayments will be 15% of each subsequent check until the total is repaid. **Important:** the automatic recoupment is debited against a provider’s total Medicaid remittance, not just the subtotal for the mental health clinic. The OMH Field Offices can provide guidance to clinics in “financial distress” regarding appeals to DOH to reduce the 15% repayment plan. **Note:** repayment plans extending beyond 10 weeks do accumulate interest.

61. When the claims for 4301 and 4304 are reprocessed, will the 4301 claim pass through the APG grouper pricer and we will then be reimbursed for both procedures on that claim but the reimbursement paid on the original 4304 claim will be taken back, base plus COPS?

The first claim received by eMedNY will be the claim that is readjudicated. The second claim will be rejected. Other than that, this scenario is correct.

62. Can DOH calculate the amount a provider will need to pay back as the claims are submitted and paid before the readjudication and give the provider the option of how to pay the recoupment back?

Unfortunately the eMedNY system is not capable of this. (Of course DOH will calculate any overpayment incurred through the interim claiming process after the readjudication is completed.) OMH has provided a [revenue projection model](#) that will enable providers to calculate how much revenue they should set aside for potential recoupment.

63. Will providers be notified in advance of the amounts that will be recouped?

OMH expects that in April 2012 DOH will begin to reprocess all claims for services delivered between October 1, 2010 and December 31, 2011. OMH anticipates that this will occur on a rolling basis, commencing with two readjudicated cycles (weeks) every week. This may result in additional reimbursement for any service day or may result in a recoupment of reimbursement received for any service day. Clinics will receive the “net” adjustment after claims are readjudicated. Clinics will have an extended opportunity to amend the paid claims to account for multiple procedures and/or applicable modifiers that were not included on the “interim” claim that was readjudicated.

As providers become familiar with the tasks associated with reviewing the readjudication remittance and amending claims, as necessary, this pace may be accelerated.

64. Will ePaces automatically be updated to implement these changes?

There are no changes to be made to ePaces. It is ready for both interim and APG claiming now.


65. We understand that claims for health services must be held for services provided prior to 1/1/2012. Can we bill for other services provided on the same day as a health service or do we have to hold claims for all services provided that day and submit on one claim?

You should bill for the other services. Once the health monitoring service is reimbursable for services provided prior to 1/1/12 it will be claimed using a separate rate code which will require a separate claim. Please note that health services provided on or after 1/1/12 may be billed to Medicaid now using the appropriate health services rate code.

66. Prior to restructuring, clinics would bill an individual psychotherapy session and a collateral session using two separate claims. During the interim claiming phase how should this family session be claimed?

If the total duration is one consecutive hour with the individual present for at least 31 minutes (majority of the session) clinics can bill rate code 4301 (Full) with CPT code 90847 as well as bill rate code 4304 (Collateral) with CPT code 90847. Clinics will be paid for both claims during the interim billing phase. eMedNY will readjudicate the first claim received and a recoupment will be required on the payment received for the second claim.

67. Do clinics have 90 days to initially submit a claim and two years to amend claims? During the interim claiming period will clinics be held to the 90-day rule for those services which have a currently active rate code such as 4301? What about the CPT codes that do not crosswalk to a current rate code?

Clinics are required to submit claims within 90 days from the date of service for all services provided during the interim period that crosswalk to a current rate code ([see interim claiming instructions](#) for crosswalk). If a service is provided that does not crosswalk to a current rate code clinics can hold that claim until OMH informs clinics that the service may be billed. In this case clinics will have a valid exception to the [90-day rule](#) .

68. Can you please advise if we are to include all axis I diagnosis codes on a claim?

Yes. Principal diagnosis is required on all claims and encounters except claims for religious non-medical claims (bill types 4XX and 5XX) and hospital other (bill types 14X). “Other diagnosis” is required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develops subsequently during the patient’s treatment.

Modifiers – Interim Claiming

69. Are clinics NOT to use the after-hours modifier during the interim claiming phase? Even though the interim claiming instructions from OMH states to utilize modifiers? Do clinics use the Children’s Evenings and Weekends rate code (4099) instead of the after-hours CPT code (99051)?

For services provided prior to 1/1/2012, clinics may continue to use the 4099 rate code for children’s evenings and weekends. In addition, clinics will place the after-hours modifier (99051) on the service claim for adults and children as appropriate. The add-on will be paid when claims are readjudicated under APGs. Please keep in mind that 4099 claims will not be readjudicated and the reimbursement will be taken back when the clinic voids their 4099 claim or OMH “zeroes-out” the 4099 rate code. It is imperative that clinics who are appropriately submitting 4099 claims now also include the after-hours CPT code (99051) on the appropriate 4300 or 4600 series claim. Clinics that have not included the modifier on 4300 or 4600 claims will have the opportunity to amend the APG claims during readjudication.

70. If two services are provided after-hours do both claims get the after-hours modifier (99051) plus two Children's Evenings and Weekends (4099) claims as well?

Yes. However, after readjudication the eMedNY system will reject the 4099 claims and only reimburse for one of the after-hours modifiers. Part 599 allows for only one after-hours modifier per client, per day.

71. Does the Children's Evenings and Weekends rate code (4099) now apply to adults as well as children?

No. Clinics that provide after-hours services to adults will add the after-hours modifier (99051) to their claims as appropriate.

72. Is the U5 modifier for school-based services used or Group sessions only, or does it apply to individual sessions as well?

The U5 modifier only applies to school-based group sessions.

Office of the Medicaid Inspector General (OMIG) – Interim Claiming

73. Has DOH or OMIG given its opinion on potential liability of providers when submitting duplicate claims?

Yes. The [interim claiming guidance](#) was established with DOH and they are identical to what was required for Diagnostic and Treatment Centers (D&TCs) licensed by DOH until DOH received federal approval for APGs.

74. OMIG is now reviewing financial statement for amounts owed to Medicaid. As of January 2011 it is illegal to hold any overpayments (Patient Protection and Affordable Care Act (PPACA)). Clearly if we are getting our full COPS payments in 2010 we will have overpayments. Will OMH notify OMIG so that clinics will not be held liable for these overpayments?

Until the readjudication of claims, providers will not be held liable for over or underpayments due to the need for federal State Plan approvals.

On December 6, 2010 a [letter co-signed by OMH and DOH](#) was sent to the OMIG which in part temporarily waives the 90 day claims submission requirement and gives clinics 3 months from the date of federal Medicaid State Plan approval to adjust all claims and make any corrections as appropriate. The letter also requests that OMIG allow a time-limited moratorium on Article 31 clinic audits and disallowances.

Please note: When submitting claims more than 90 days from date of service during the period the waiver is in effect, clinics must enter **reason code 3** (Authorized Delays - Delays previously approved). In addition, you should keep a copy of the attached letter in your files.

Services – Interim Claiming

75. Are multiple services per day required now, regardless of APG rate code or legacy rate?

No. As of October 1, 2010 clinics have the option to provide multiple services per day, subject to the limits in Part 599 and explained in the [guidance](#) and these FAQs. However, clinics will need to follow the [interim claiming instructions](#) for all services provided between 10/1/2010 and 12/31/2011.

76. What is the “hold claims status” associated with the health services? Are clinics not to provide these services at this time?

For health services provided prior to 1/1/2012, claims must continue to be held. OMH plans to retroactively pay for both health services and off-site services at the same time that the readjudication process begins. More information on this issue will be available shortly.

Please note: To provide any of the Optional Services, including Health Monitoring and Health Physicals, the clinic must first add the optional services to the operating certificate via the [Mental Health Provider Data Exchange \(MHPD\)](#).

77. The September 17th [OMH Interim Claiming Instructions](#) states that “all Medicaid fee-for-services claims for the off-site children’s and off-site crisis services must be held and submitted after the Centers for Medicare and Medicaid Service (CMS) approves the SPA”. It was our understanding that the State was going to provide state aid dollars to pay for off-site children’s services and off-site crisis services. If that is still true, how should providers bill for these services?

OMH is committed to reimbursement for off-site children’s services and off-site crisis services using state-only dollars. This does not require CMS approval. Clinics must hold these claims for eligible services provided prior to 1/1/12 but for services provided on or after 1/1/12 the services may be billed now using the appropriate [rate code](#). More information will be sent to clinics shortly.

Licensing

78. Please explain the Continuous Quality Improvement (CQI) add-on.

The CQI initiative focuses on improving the quality of psychotropic prescribing practices for individuals with serious mental health problems. It provides incentive through an add-on for claims submitted by participating providers. The project focuses on two high-priority quality issues identified by a scientific advisory committee of nationally respected experts: psychotropic polypharmacy and antipsychotics associated with cardio-metabolic risks. OMH's vision for this initiative is that agency leadership, clinicians, and consumers join together to promote thorough and thoughtful decisions about medications in order to assist consumers in realizing their recovery goals.

79. How does a clinic become eligible for the Quality Improvement add-on?

The CQI initiative is now open to all clinics licensed solely under Article 31 and to D&TCs with a clinic license. Participation requires the completion of a project application form, participation in a training session, and registration for the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) access. Information can be found on the [PSYCKES website](#), including contact information for project coordinators in your region.

80. If a clinic plans to have an employment unit on the same floor as a clinic with separate entrances and separate waiting rooms, do we still have to request approval regarding shared space? Please note that while the entrances and waiting rooms would be separate, the copier, mailboxes and fax machine would be in the clinic main office. Would this be a problem?

You do not need to request approval as long as the space being used by the employment program is not part of the licensed clinical space. In addition, it is allowable to share non-clinical space (such as the main office which houses the copier, mailboxes and fax). The clinic must follow confidentiality rules with regard to non-clinic staff. Requests for shared space must be sent to your OMH Field Office for approval.

81. If a clinic provides a collateral service and an individual service on the same day can all the information go into one note?

If both services were provided by the same clinician, then yes, both services can be on one note. However, they must be documented as separate procedures. If the services were delivered by two or more clinicians then they must be documented using separate notes.

82. If shared space has existed for the last 40 years, does a request still need to be submitted to OMH?

The clinic should contact their OMH field office and request an updated approval under Part 599.

83. We have New York State Office of Alcoholism and Substance Abuse (OASAS) and OMH licensed clinics within our agency. Can we co-facilitate a co-occurring group within one of our offices without violating shared space rules?

No. Section 599.12 (Premises) of the [Part 599 clinic regulations](#) allows for sharing of program and non-program space. However, sharing space does not mean the co-facilitation of sessions, the waiving of confidentiality rules or billing using the same rate codes. The sharing of program space requires approval from your OMH field office; the sharing of non-program space does not.

84. Will a staffing request be granted to allow a Physician's Assistant (PA) to provide therapy services? If so, how does a clinic submit the request?

Under the [social work licensing law](#) [☞] exemption (extended to July 1, 2013) a physician's assistant can provide therapy services. However, after the expiration of the extension OMH will review staffing approval requests on a case-by-case basis. Staffing requests must be sent to your OMH field office for review.

85. Can a physician's assistant provide Injectable Psychotropic Medication Administration or Medication Treatment?

A PA can perform Injectable Psychotropic Medication Administration. In order for a PA to perform Medication Treatment services the clinic must submit a staffing request to their OMH field office for approval. This request must include the PA's qualifications, job description and supervision arrangements. Staffing requests must be submitted to your OMH field office and are approved on a case-by-case basis.

86. How long are Article 31 clinics required to maintain records, documentation and clinic notes for recipients following their discharge?

Records must be retained for a minimum period of six years from the date of the last service in an episode of care. The record retention requirements contained in the Part 599 regulations pertain to what is necessary to meet OMH's licensing and monitoring requirements. There may be legal or other ramifications that a provider may wish to consider in determining what time period is appropriate.

87. What are the standards for determining a satellite location?

A location where scheduled services are provided on a regular and routine basis (full or part time), is considered a satellite location. In determining the regular and routine nature of services at a given site, the Office of Mental Health takes into consideration the volume of services, the number of recipients receiving services, the number of staff assigned, the range of services provided, and whether the site will be utilized on a permanent or temporary basis.

88. Does OMH license Article 28 school-based health centers? It seems that the school-based health centers have less stringent rules and their reimbursement and time durations are different.

OMH has no role in licensing Article 28 school-based health centers. School-based health centers are required to be licensed for their mental health services only when their mental health services exceed 30% of their visit volume or 10,000 visits. The clinical needs of clients served by school-based health centers are generally less intensive and less complex. At a local level it is very important to coordinate and develop service agreements among the school mental health and health providers to eliminate duplication and maximize the effective use of resources.

89. If an agency doesn't provide services to children do the staff members still need to go through the child abuse registry?

All clinic staff with the potential for regular and substantial contact with children in performance of their duties must submit to clearance by the New York Statewide Central Register of Child Abuse and Maltreatment. Clinic staff members who have not been screened by the New York Statewide Central Register of Child Abuse and Maltreatment cannot perform duties requiring contact with children unless there is another staff member present.

Medicaid Billing

90. Where can we find the APG rate codes?

[OMH clinic rate codes](#)

91. Is there a way to appeal legacy rates if an organization previously had a large number of off-site services during the period you are using to determine the legacy payment?

Yes. If the legacy rate has been calculated incorrectly, OMH will correct it. **Note:** eliminating off-site visits from the blend rate calculation will not likely have a positive impact on the blend rate calculation. The blend rate correlates with the average “weight” of historic visits (excluding visits that include Medicare and third party reimbursement). If they are eliminated from the calculation, brief visits and group visits will represent a greater percentage of “countable” visits and the blend rate will decline.

92. Will clinics be paid for more than one blend service per day for the same client (e.g., Group and Individual)?

The legacy portion of the blend payment is based on the historical provider specific Medicaid payment. It is adjusted to reflect the historical volume of multiple claim visits for each provider. Payment for blend procedures will consist of a legacy payment and an APG payment. Reimbursement for blend procedures will be based on a mix of APG payment (based on coded procedures, payment modifiers, and base rate) and a provider specific legacy/blend amount. While it is allowable to provide more than one blend service (ex. Group and Individual) per day, only one provider specific legacy/blend amount will be paid per visit. To encourage some multiple procedures on a service day, some procedures are being paid at the full APG value (subject to the 10% discount) when accompanying a “blended” procedure.

93. With regard to Utilization Threshold requirements: For one claim with multiple services with the same date of service should we count each service or count the service that will pay the greater rate as we have done in the past? An example would be a patient sees the MD in the morning and then sees their therapist later in the same day (not crisis).

With the implementation of APGs, utilization threshold counts are visit based; each visit counts toward the Utilization Threshold once.

94. Will providers be reimbursed for more than one add-on per procedure? Are there any restrictions?

Yes, providers may be reimbursed for more than one add-on per procedure. There are some restrictions; for example, only one after-hours add-on may be claimed per client, per day. The [Part 599 guidance document](#) gives more detail.

95. Will Clinic Plus screenings continue to be reimbursed by state aid?

No. A Request for Proposal (RFP) was issued in 2011 for grant-funded performance-based screening. Starting January 1, 2011 there is a small subset of former Clinic Plus providers who won the grant and are now providing screening.

96. How do we get NPI numbers for students?

Students cannot receive NPI numbers. Students and non-licensed staff will continue to bill Medicaid using the OMH MMIS non-licensed practitioner ID: 02249154.

97. If a doctor provides consultation outside of the mental health clinic how will that clinic be reimbursed? Does the doctor actually have to enroll the patient in the mental health clinic? Does the medical clinic submit the claim?

A psychiatric consultation is provided at the request of another physician (outside of the clinic) requesting advice regarding evaluation and/or management of a specific problem. The request for the consultation and the reason for it must be recorded in the patient's medical record; and a written report must be prepared on the findings and provided to the referring practitioner. The consultation may be provided off-site but will not be reimbursed by Medicaid. The Article 31 clinic must claim using one of the following CPT codes for reimbursement - 99201-99205 (New Patient) or 99212-99215 (Established Patient). The recipient is not enrolled in the clinic.

98. Does Crisis Intervention – Brief (H2011) have to be 15 continuous minutes? Or can the service be provided for a total of 15 minutes over several phone calls in the same day?

Crisis Intervention – Brief has a minimum time duration of 15 minutes but it does not have to be 15 continuous minutes. The progress note must document the time spent with the recipient.

99. Is there a limit to the number of brief crisis procedures (H2011) that may be billed for the same client on the same day?

Crisis Intervention – Brief has a limit of six (15 minute) units per client, per day for Medicaid.

100. If a client was required to have Complex Care Management in several psychotherapy sessions should the treatment plan be revised to include Complex Care Management?

This is not a requirement. Complex Care Management is not a routine service. It is a clinical level service which is required as a follow up to a psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions. Complex Care Management was designed to coordinate care provided subsequent to a psychotherapy or crisis visit. It is designed to address immediate mental health issues or factors that are impacting on the individual's health or community status. The need for Complex Care Management must be documented in the progress note for the service where the need was determined.

Please note: Complex Care Management must be claimed using the appropriate Health Services rate code (1474, 1477, 1588, 1591) to avoid being counted toward an individual's Utilization Threshold.

101. Is there a minimum length of time that the parent/guardian must be in the room during a 60 minute family therapy session (90847)? The Part 599 regulations state that the client must be in the room for the majority of the time but what about the parent?

No. The service requires that the client be present for at least 31 minutes. There is no requirement for how long the collateral is in the room.

102. If a psychiatrist uses CPT codes 90805 or 90807 for an existing Medication Treatment-only patient, will DOH and OMH think that a psychiatric assessment was conducted? There are clients who have been on medication and stable for some time and are not seen for just 15 minutes.

When delivered within an OMH licensed mental health clinic, 90805 and 90807 are to be used for Psychiatric Assessments only. If Medication Treatment is the service provided, the clinic must code 90862. Medication Treatment must be a minimum duration of 15 minutes, not a maximum duration of 15 minutes. For more information see the [Part 599 guidance document](#).

103. How do clinics code the claims of clients that see two different practitioners on the same day?

All procedures using the same rate code and provided to the same individual in a day MUST be billed using one claim. Currently the claim form allows for only one professional's license. There is currently no New York State requirement regarding which NPI should be placed on a claim when the claim contains multiple procedures.

The clinic must include an NPI that belongs to one of the practitioners who performed one or more of the procedures being claimed. The NPI must match a practitioner who performed a procedure in the case file. General advice is to enter the practitioner ID for the highest weighted service.

Please note: The NPIs of all practitioners providing Medicaid reimbursable services in the clinic must be affiliated with the clinic in the eMedNY system. Practitioners may be affiliated with more than one clinic.

104. Will putting only one practitioner NPI on a claim lead to the assumption that only one practitioner provided services, which in turn will cause compliance issues from an OMIG perspective?

No. Providers must be sure to list the clinicians providing each service in the progress notes.

105. If the practitioner NPI number is used on bills submitted with other providers' services occurring on the same day, is the listed provider responsible in any way for claims made against the other providers?

The 837i claim form only has room for one NPI number. Clinics need to document internally which provider delivered which service in case any questions arise related to the claim.

106. Is Case Management within the clinic reimbursable?

No. Case Management is no longer reimbursable when delivered by an Article 31 clinic.


107. How does a Federally Qualified Health Center (FQHC) “opt out” of APG billing?

FQHCs cannot opt out of the Part 599 clinic program regulations or the required services. However, FQHCs have the option of opting out of the APG payment methodology on an annual basis. The FQHC has to “opt out” of APGs for all of its ambulatory services, not just mental health clinic services. The FQHC has to notify both DOH and OMH of its intent.

108. Please give a brief explanation about the change in Utilization Threshold.

Please see the [Part 599 guidance document](#) for information about Utilization Threshold.

109. There may be situations where a clinic will need to cross-over/bill Medicare for some providers and not others. What if the claim does not reach Medicaid within the 90-day timeframe for submitting claims?

All procedures provided to an individual on the same day must be sent to Medicaid on one claim. This includes procedures provided by different clinicians. If one procedure must be billed to Medicare first, then the clinic must wait to bill the rest of the procedures provided on that day until Medicare pays for the cross-over procedure. If the claim is submitted to Medicaid outside of the 90 day window, it is considered by CMS to be an acceptable reason for delay. The provider has 30 days after receipt of Medicare's remittance/determination to file the claim with Medicaid. Use reason code 7 - Third Party Processing Delay. [90-day rule](#) 

110. How will providers be notified of their legacy (blend) rate?

Providers were notified of their legacy rate by mail. In addition, all provider legacy rates are posted on the [Medicaid Reimbursement Rates](#) page of the OMH website.

111. Insurance payment rules are different depending upon whether or not a clinic is a participating provider. If we are not a participating provider we can get the full Medicaid rate. Does this continue to be the case?

Yes. When a provider contracts with a commercial payor, Medicaid pays the difference between the commercial insurance payment amount and the commercial insurance patient coverage amount. Essentially, Medicaid pays the commercial insurance co-payment, deductible and/or co-insurance.

When a provider does not contract with a commercial insurance payor, Medicaid pays the patient responsibility. In this case this is the difference between the commercial insurance payment amount and the provider's usual and customary charge, up to the Medicaid rate.

112. Will Medicaid pay for a client to attend two group psychotherapy sessions in a day?

Medicaid will pay for a psychotherapy multiple-family group session (90849) and group psychotherapy (90853) provided on the same day. No other combination of group sessions will be reimbursed by Medicaid when provided on the same day.

113. Will Medicaid pay for an individual and group session in the same day?

Yes. However appropriateness is based on medical necessity.

114. It would be very helpful if you could give us the expectations in the specific loops and segments of the 837i if we are to combine two procedures and two rate codes on the same day.

The 837i allows for only one rate code per claim. Therefore if two rate codes are to be reported for the same date of service, two claims must be submitted, one for each rate code. The procedure codes are submitted one per line. If multiple procedure codes are being reported for a single rate code then there will be multiple lines. If you are reporting two procedure codes you will have two lines, three procedure codes three lines. Please refer to the 837i companion guide on the [eMedNY website](#). Go to the HIPAADESK tab and clinic eMedNY Companion Guides on the left menu.

Medicaid Managed Care and COPS-Only

115. Should clinics continue to bill for COPS-only for services provided on or after 1/1/2012?

Yes, clinics will continue to bill for COPS-only using the 4093-4098 rate codes until further notice.

116. Can we cross the services to Medicaid if the managed care companies deny them as non-covered services until the new contracts go into effect?

No, you cannot bill Medicaid Fee-For-Service for a Medicaid Managed Care client (with the exception that designated SED clinics can continue to claim Medicaid fee-for-service reimbursement for children enrolled in Medicaid managed care who the clinic evaluates as having a serious emotional disturbance (SED). The only payor for persons enrolled in managed care will be the managed care company.

Clinics can continue to bill COPS-only until further notice. COPS-only will expire when the equivalent rates go into effect.

117. What do we do when the services are retroactively changed? For instance if a doctor's E/M service is currently billable as a regular session and the managed care approves this CPT procedure, but in the new world it would not get a legacy rate, should we bill the COPS-only service?

eMedNY will not change payments for COPS-only claims retroactively. OMH will send an advisory to all clinics well in advance of the elimination of COPS-only

118. Can an OMH clinic with managed care contracts bill a managed care patient's substance abuse benefit if the clinic is treating the patient for a secondary substance abuse disorder?

This answer depends on the clinic's contract with the managed care company.

119. Will the CPT codes be grandfathered into our contracts with insurance providers or do we have to amend the contracts?

No, CPT codes will not be grandfathered into clinic contracts. In fact, while Medicaid managed care companies must provide access to the full range of services detailed in the Part 599 clinic regulations, these companies do not have to purchase every procedure from every clinic. Clinics will need to negotiate with their Medicaid managed care companies on the services that will be reimbursed.

120. Will providers use the new CPT codes for Medicaid managed care? Do we have to bill the same way we do for Medicaid fee-for-service (FFS) (e.g., multiple procedures on the same day, modifiers)?

Yes, Medicaid managed care companies will use the same CPT codes; however the answer to the second part of your question depends on whether the companies use the APG grouper. OMH expects the Medicaid managed care companies will use the APG grouper but we do not yet know for sure.

121. Do agencies need to renegotiate contracts with Medicaid managed care companies to qualify for the equivalent rates or will the equivalent rates be paid automatically to the agencies?

Equivalent rates will be mandated by NYS so clinics will not need to negotiate reimbursement rates. However, the contract between the clinic and the Medicaid managed care company will need to detail the clinic services the insurer will reimburse.

122. Are Family Health Plus (FHP) and Child Health Plus (CHP) considered Medicaid managed care and if so allowable for COPS-only claims?

Services provided to FHP and CHP recipients are not eligible for COPS-only. FHP and CHP are not Medicaid managed care and the claims will deny if submitted.

123. Should clinics bill Medicaid managed care for any OMH-approved CPT code and if the claim is rejected bill directly to Medicaid for reimbursement?

No. Clinics should bill Medicaid managed care as they did prior to 10/1/2010. Do not send claims to eMedNY for services provided to a recipient that does not have Medicaid

fee-for-service coverage, with the exception that designated SED clinics can continue to claim Medicaid fee-for-service reimbursement for children enrolled in Medicaid managed care who the clinic evaluates as having a serious emotional disturbance (SED).

124. Will Medicaid managed care companies reimburse for multiple services in a day? Should we wait for approval before we provide services in this way? Will Medicaid managed care companies be required at some point to reimburse for multiple services?

It is our expectation that most Medicaid managed care companies will use APGs to comply with state law which requires the payment of equivalent rates. We are not clear at this time whether or not Medicaid managed care companies will be required to reimburse for multiple services in a day. Clinics will receive guidance on this issue shortly.

Medicaid / Medicare Crossovers

125. If the CPT code billed to Medicare is different from the approved OMH CPT code (e.g., billing an E/M code for Medication Treatment) do we need to change the CPT code to 90862 before submission to Medicaid?

Yes. In addition, you will need to indicate the amount received by Medicare on the Medicaid claim as you would for any other crossover claim.

126. If a Crisis procedure is billed to another payor such as Medicare under a different CPT code identified by OMH, how will the claims be billed to Medicaid (e.g., Medicare does not pay for CPT codes H2011, S9484 or S9485)?

Clinics will need to add the appropriate CPT codes to the Medicaid claim and apply any revenue received from Medicare (or any other third party payor).

127. How will codes such as Injectable Psychotropic Medication Administration with Education and Monitoring (H2010) be reconciled when the CPT/HCPCS code is not valid for Medicare payors? In the event that this is a dually-eligible beneficiary, what do we do when our visits are automatically forwarded from Medicare to Medicaid?

If you are an Article 31 free-standing clinic your claims will not automatically cross-over. Clinics will need to use the appropriate CPT codes when sending their claims to Medicaid. If your clinic claims do automatically cross-over (e.g., most hospitals), the clinic will need to amend the Medicaid claim after receiving the remittance resulting from the automatic cross-over to get the correct reimbursement from Medicaid.

128. How will Medicaid pay for dually-eligible Medicaid / Medicare homebound adult recipients?

Medicaid will not reimburse for off-site services with the exception of select children's services and Crisis Intervention – brief (up to 6 units) for both adults and children.

129. In our Article 28 clinic we have always sent a Medicare/Medicaid crossover claim to Medicare with the Medicaid rate code. This triggers the claim to pay the “higher of” up to the Medicaid rate. For our Article 31, the claim does not cross-over and we send the claim to Medicaid ourselves, again with the appropriate rate code. Will this be any different when billing with the new rate codes?

No. However, to receive Medicaid payment the procedure delivered by the clinic must meet the Part 599 Medicaid billing standards and minimum time durations.

130. When clinics bill Medicare primary, will the non-covered services like Crisis crossover for Medicaid to pay as long as the CPT code is on the claim?

Clinics will need to use the appropriate CPT codes when sending their claims to Medicaid. If your clinic's claims do not automatically crossover (which is the case for Article 31 free-standing clinics) then the Medicaid claim should include all the appropriate procedures including those not claimed to Medicare (for those services that are not reimbursed by Medicare). If your clinic's Medicare/Medicaid claims automatically cross-over, the clinic will need to amend the claim to get reimbursed for the non-Medicare covered service and to receive the appropriate reimbursement from Medicaid.

131. Should clinics bill Medicare or third party even though we know the claim will not be paid?

Yes. A denial of service is required with the exception of Medicaid claims for services that are eligible to be “zero-filled”. For more information on zero-fill see page 12, question #19 of the [837i Supplemental Companion Guide](#) [☞].

After implementation of 5010, Zero-fill will still be allowed but it will be handled differently. [5010 Zero-fill Instructions](#) [☞] are in this presentation beginning on page 20. If you are in need of technical assistance, contact information is at the end of the presentation.

Staffing

132. In my clinic, the Director is an LCSW-R as are all the coordinators and supervisors. My Associate Executive Director, who really oversees all the Program Directors (including the Clinic Director), is a Masters in Counseling and a Credentialed Alcoholism and Substance Abuse Counselor (CASAC). Can she continue to supervise the Clinic Director?

If the supervision is administrative in nature then yes, the Associate Executive Director can continue to supervise all of the Program Directors. If the supervision is clinical in nature then after the July 2013 expiration of the scope of practice exemption, the Associate Executive Director will no longer be able to supervise the Program Directors.

133. Can a clinic hire a CASAC and be reimbursed if the CASAC is used to provide substance abuse services to patients with secondary substance abuse disorders?

Yes. However, staff not licensed by the NYS Education Department (including CASACs) will not be allowed to provide clinic services after the July 2013 expiration of the NYSED exemption of the [social work licensing law](#) [☐]. Also, the services provided by the CASAC must be an OMH-approved service as outlined in the [Part 599 Clinic Regulations](#).

134. Can a security guard that is an employee of the county be counted as a second staff person in a Complex or Per Diem Crisis service?

No. The second staff person involved in a Crisis Intervention – Complex or Crisis Intervention – Per Diem must be listed in the clinic's staffing plan.

135. Can psychology students in a program leading toward a license and post-doctorate psychologist interns provide psychological testing under proper supervision?

Yes.

136. In the regulations, eligible practitioners for the review of health screenings are listed as nurse practitioner, psychiatrist or other healthcare professional. What does "other healthcare professional" mean?

"Other healthcare professional" refers to professionals qualified to assess and interpret the health screening information within their scope of practice and competency (e.g., a physician's assistant or registered nurse).

137. Will students be allowed to provide clinic treatment services?

Yes. Students in a NYS Education Department (NYSED) approved program leading to a license are able to provide clinic treatment services under supervision as required by law and regulation. A plan for the use of students must be included as part of the clinics OMH approved staffing plan. Private payors are not required to reimburse for services provided by students.

138. Where are the provisions of the Social Work Licensing Act of 2002 found?

[Title VIII Article 154 – Social Work](#) [☞] in the New York State Education Law

Please note: There is currently an exemption in place for all state operated, licensed or funded programs for the Social Work “scope of practice” provision until July 1, 2013.

139. What are the key provisions of the 2002 statute defining the scope of practice for social workers?

Under the statute, the LCSW is legally responsible for the Licensed Master Social Worker (LMSW). The LMSW is limited in the scope of practice and cannot provide diagnosis, treatment planning or psychotherapy without direct supervision from the LCSW.

140. Will masters-level social workers be grandfathered into the social work licensing law?

No. However, an individual with a Master of Social Work (MSW) degree training to become an LMSW will be considered a student if he is in a NYS Education Department (NYSED) approved program leading to a license. A plan for the use of students must be included as part of the clinics OMH approved staffing plan.

141. How does an LMSW become an LCSW?

The provisions of the New York State Education Law require that the LCSW applicant must demonstrate:

- 12 semester hours of clinical social work (content acceptable to NYSED)
- 3 years post-MSW supervised experience in diagnosis, psychotherapy and assessment-based treatment planning.
- Experience is defined as three years of full-time (20 client hours per week) or part-time (10 client hours per week) within no more than six years; under acceptable supervision defined in regulation.
- Supervision must be with an LCSW, licensed psychologist, or physician (psychiatrist) in a legal setting such as an OMH licensed clinic, Partial Hospitalization program or with a private practice/group.

142. What will happen to non-licensed psychologists after the July 1, 2013 expiration of the social work licensing law exemption?

Non-licensed psychologists can continue to be employed as part of the clinical staff if they meet one of the following two criteria:

- The individual holds a Limited Permit which signifies that the NYS Education (NYSED) has determined that they have met all requirements for licensure except those relating to the final examination, and that pending licensure Limited Permit holders are functioning under proper supervision as outlined in NYSED law governing each of the professions.
- The individual meets the qualifications for the Psychology exemption under the Psychology Law Article 153. This exemption states that Masters-level psychologists under the supervision of a PhD are exempt if their practice is in the employ of a federal, state, county or municipal agency.

143. Is there any consideration for how to bill for services provided licensed mental health counselors (LMHC)?


Medicaid reimburses for clinic services provided by licensed mental health counselors in the same manner as it reimburses for services provided by other licensed mental health practitioners.

Testing Services – Developmental and Psychological

144. What are the time durations for Developmental and Psychological testing?

Clinics cannot submit more than one developmental and/or psychological testing claim per day regardless of the number of tests performed in that day. Additionally, clinics may only submit one claim for a specific test regardless of the time spent and whether the test is completed in one or more days. However, additional distinct tests on different days may be reimbursed if medically necessary. If more than two units of testing services are provided to an individual it will trigger an alert for OMH to look at those claims. Providers will need to be sure that they have all their documentation to back up the need for more than two units. OMH may make changes to this rule as necessary once usage data becomes available.

145. Where do I find the specifics of testing?

The AMA provides definitions in their CPT code manual which gives examples of the types of tests clinics may provide for each code. Clinics can also look-up specific codes using the [AMA search website](#) .

CPT Code	Description	Examples
96101	Psychological testing	Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, Minnesota Multiphasic Personality Inventory (MMPI), Rorschach, Wechsler Adult Intelligence Scale (WAIS)
96110	Developmental testing, limited with interpretation and report	Developmental Screening Test II, Early Language Milestone Screen
96111	Developmental testing, extended with interpretation and report	Assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments
96118	Neuropsychological testing	Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, Wisconsin Card Sorting Test
96116	Neurobehavioral status exam	Clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities

146. Some of our clinics have previously provided psychological testing to medical clinics and coded these testing services with the current CPT codes (96101, 96116, and 96118) and were paid by Medicaid. Now it seems that the only patients that can be billed for such services are those enrolled in the mental health clinic. Is this correct?

Yes, you are correct. Clinics will only be reimbursed for testing services provided to recipients enrolled in the clinic.

147. The regs say psychological testing sessions have to be face-to-face. Yet examples in the regs include tests that are completed by the client in a self-report methodology then scored and reviewed with the client with recommendations. The regs reference as an example the MMPI, the most respected, most valid and most used test in America. In fact more than half the tests used by clinical psychologists are self-report tests. Another is the Beck Depression Inventory, also very highly valid and highly used. If you allow the MMPI to be used as per your regs what about tests that are administered in a similar manner?

The Beck Depression Inventory (BDI) is not considered a psychological test in that it does not require a licensed psychologist to administer or score it. Both of these functions may be carried out by paraprofessionals. The interpretation of the final score requires a professional with clinical training and experience, which need not be a psychologist. Social workers regularly administer, score and interpret the BDI during the course of the initial assessment or therapy sessions.

Self-report tests may be administered as part of the psychological testing service, but psychological testing does not consist solely of handing a pencil and paper to a client in a waiting room. In order for a self-reported test to be a billable service there must also be face-to-face time spent between the client and the psychologist. The rate paid for this service takes into account the time the psychologist may need to spend preparing, scoring and analyzing the tests as well as writing reports.

148. CPT codes for psychological testing indicate that the service must be one hour including the conducting of the test, interpreting the test and report writing. Do the Part 599 regulations require that the length of service for psychological testing be face-to-face for the entire time?

No. Clinics will be paid per test which includes the time it takes to administer, interpret and report some of which will take place without the client present. Clinics may only bill for one test per day although multiple tests provided over different days may be billed.

149. Can more than one testing session be billed in one day? For instance, if two hours of testing is completed can this be billed?

No, only one code per test, per day will be reimbursed by Medicaid.

150. Can two different CPT codes be billed if one test is an Intelligence Quotient (IQ) test and the other is a personality test such as the Rorschach?

According to the CPT code descriptions put forth by the American Medical Association, the same CPT code (96101) should be used for both the Rorschach and tests of intellectual abilities, such as the WAIS. Therefore, if two tests are administered in a day

that fall into the same CPT code you will only be reimbursed for that code once per client, per day.

151. Can a session shorter than one hour be billed? For instance there is a test for Attention Deficit Hyperactivity Disorder (ADHD) that only takes 20 minutes face-to-face time. Can this be billed or will it need to be combined with other tests to make a full hour?

Clinics will be reimbursed by Medicaid for the test regardless of time spent.

152. Can you have several days of testing and bill for each day or are we limited to one charge for all tests no matter how many days it takes?


Clinics cannot submit more than one developmental and/or psychological testing claim per day regardless of the number of tests performed in that day. Additionally, clinics may only submit one claim for a specific test regardless of the time spent and whether the test is completed in one or more days. However, additional distinct tests on different days may be reimbursed if medically necessary.

153. What is the difference between Developmental Testing – limited and extended?

The developmental testing procedures should be differentiated based upon the amount of time it takes the clinician to administer, interpret, provide feedback and make recommendations to the child and his/her family.

- Developmental Testing – limited (96110)
 - Utilizing a brief (15 minutes) standardized screening tool.
 - Limited to observation and inquiry regarding achievement of developmental milestones.
 - The expectation is that the tool is one that is completed by a parent/guardian/significant other and reviewed by the practitioner.
- Developmental Testing – extended (96111)
 - Involves the administration, interpretation and reporting of a standardized developmental assessment tool by the practitioner.

154. What staff is eligible to provide developmental testing?

Clinicians with the competence to provide the testing services are eligible. However, non-licensed staff will not be allowed to provide clinic services after the July 2013 expiration of the NYSED exemption of the [social work licensing law](#) .

155. If testing is optional and can only be provided to recipients enrolled in the clinic, does that mean that a recipient needing psychological testing cannot be referred to another clinic if their clinic does not provide that service?

That is correct. However, you can refer the recipient to a private provider.

Treatment Plans

156. Do the actual names of the psychiatric medications need to be listed on the treatment plan? They are currently listed in the assessments and in the psychiatrist notes.

No.

157. Part 599 states that the treatment plan is due within 30 days of admission but standards of care states “or prior to the 4th visit”. If we admit someone and then they don’t show (despite outreach efforts) for 30+ days and then finally arrive can the treatment plan be done on the day 31 or should the case be closed and reopened or should a treatment plan be completed without any of their input other than information that was collected during the intake?

The Part 599 regulations state that, “Treatment plans shall be completed not later than 30 days after admission”. The initial treatment plan must be signed-off by the psychiatrist within 30 days of admission regardless of whether the client shows up for an appointment within that time frame. The Standards of Care will be amended to conform to the Part 599 regulations.

158. For a child client, should the treatment plan be reviewed in the next scheduled session with the collateral/caregiver?

For children, there is an expectation that the parent/caregiver will be an integral part of the treatment planning process. Assuming the question reflects a situation in which the child is seen alone for a session at which time the treatment plan is due, and the parents come in at a later date, then yes, the treatment plan should be reviewed together with the parents as soon as they come in. The parents should be given the opportunity to have input into and modify the plan at that time if necessary. However, this meeting at a later date with the parents is not considered the “next provided service” for which a treatment plan may be signed outside of the 90-day timeframe.

159. If we have a psychiatrist that only works on Monday and Thursday and the client is seen on Friday, is it okay for the psychiatrist to sign the treatment plan the next time they are at work?

If the treatment plan is signed by the psychiatrist within the 90 day timeframe then it is fine to have the psychiatrist sign-off on a later date. However, if the treatment plan is updated during the “next provided service”, say on the 95th day, then the plan MUST be signed by the psychiatrist on that day. The deadline for updating the treatment plan and signage (if not within the 90-day timeframe) is the “next provided service” date.

160. What if the treating psychiatrist is not scheduled to work on the “next provided service” date?

Then the treatment plan should be completed before the 90 days. The “next provided service” after the 90 day timeframe is the deadline. The “next provided service” stipulation was to give flexibility, but in your scenario it will not work.

161. With regard to treatment planning, a patient may only need to be seen two to three times per year under the definition of medical necessity. Will two to three treatment plans per year on this patient be enough for OMH?

OMH does not have a requirement that there must be four treatment plan reviews per year. Our regulations require that a treatment plan review be completed every 90 days or next provided service. We do not want clinics to bring in their clients for appointments just to sign the treatment plan.

162. If a quarterly treatment plan review is written later than 90 days (because the client comes to the program after the 90 day due date) is the next (future) treatment plan review due 180 days from the original date or 90 days from the new date?

The next treatment plan review is due 90 days from the date the psychiatrist signs the current treatment plan review whether it is earlier or later than the 90 days.

163. Does Medicaid reimbursement depend on the client's signature on the treatment plan? Can the treatment plan be written and signed by staff without the client present (or on the phone)?

Medicaid reimbursement requires the doctor's signature. The treatment plan should be developed in collaboration with the recipient and collaterals.

164. Is a psychiatric resident allowed to sign the treatment plan?

Treatment plans must be signed by the psychiatrist or another OMH-approved physician. Licensed residents who are moonlighting and have OMH approval to substitute for a psychiatrist may sign treatment plans. OMH and DOH are developing guidance on billing Medicaid for Residents in teaching hospital affiliated programs.

165. When does the 90-day clock begin? Is it when the final signature is in place? When the psychiatrist signature is in place?

The 90-day clock begins on the day the psychiatrist signs the treatment plan.

166. What if the other payor (primary) has no requirement for treatment plan reviews?

Then the clinic must follow the regulations for Medicaid recipients.

167. If a third party payor (that is primary) requires treatment plan updates only every 6 months, does that prevail?

Yes.

168. Please provide further clarification on the limit of three initial assessments within 365 days.

No more than three initial assessments are reimbursed by Medicaid unless at least 365 days have transpired from the last provided service.

Uncompensated Care

169. Under the Part 599 regulations we will be reimbursed by Medicaid for certain crisis and complex care phone calls. Both services are required. In order to count a service in the Uncompensated Care Pool we will need to show due diligence to collect. I cannot find any conclusion to this other than that we will need to start billing patients for phone services in order to count them in the pool. Am I correct in the assumption?

Yes. Clinics will need to bill for these services as they would for any other service. If the recipient is uninsured they could be billed based on sliding scale. The visit can then be counted toward the clinic's uncompensated care visit volume. If a self-pay payment is received that amount must also be reflected in the CFR OMH-4.

170. If payments from the uncompensated care pool are on a two-year lag, does this mean that any marginal increase of new uncompensated care visits we provide starting January 1, 2012 above the previous baseline will not be reimbursed until 2014?

Correct.

171. Are FQHCs eligible for the uncompensated care pool?

FQHCs are not eligible for the pool.

172. Once eligibility for the pool funds has been determined, what is the process for payment and what is the time period for payment?

Currently the Department of Health disperses funds from the D&TC uncompensated care pool on a monthly basis.

173. If a clinic is not eligible for the pool in a given year, could the clinic be eligible the following year?

Yes. The clinic must continue to submit data via the CFR OMH-4. The clinic would be eligible for any period for which the clinic volume for uncompensated care meets the 5% requirement.

174. What if the OMH-4 requires information we do not track?

There are [four categories of visit scenarios](#) that are eligible for the count towards uncompensated care visit volume. If your clinic cannot track and verify the required information, the clinic should not claim those visits towards uncompensated care visit volume.


175. If the clinic does not meet the 5% threshold for uncompensated care pool eligibility, does the data still need to be submitted through the CFR OMH-4?

Yes. The data must be submitted regardless of whether the clinic meets the 5% threshold for inclusion in the pool.

176. Why does the OMIG have the authority to audit the uncompensated care pool?

The pool will be comprised of both state and federal dollars. The federal dollars are Medicaid Disproportionate Share dollars (DSH), and therefore auditable by OMIG.

177. If a clinic is not a Medicare provider, will a denial still be required?

Clinic providers must be enrolled in Medicare prior to applying for enrollment as a New York State Medicaid Provider. See [eMedNY General Policy guidelines](#) .

178. Where can I find more information on the uncompensated care pool?

See [Uncompensated Care](#).

179. Once a client's financial status is determined is there any guideline as to how long this status is valid assuming the client doesn't voluntarily submit information to change the status?

OMH does not have a standard. Some providers use one year. OMH recommends that you consult with your attorney.

180. If the proper rules were followed to get an authorization but the insurer did not respond properly or timely would the service be uncompensated?

No.

181. Can a clinic count a visit as uncompensated care for an out-of-network clinician even when the clinic has other clinicians in the network, but whose caseloads are full?

Yes. But the clinician must be assigned based on the routine process for assigning clinicians to caseloads.

182. Does a denial for "no prior authorization" count as uncompensated care?

No. All reasonable efforts must be made to collect revenue from other sources. Failure to comply with third party billing rules is not sufficient.


183. Can a clinic include claims if the client's insurance is cancelled?


Yes. If the client is not insured by any source, the visit can be counted.

184. Are jail services eligible for the pool?

No.

185. Should a clinic bill Medicare or third party even though you know the claim will not be paid?

Yes. A denial of service is required every time unless these services are eligible to be “zero-filled”. For more information on zero-fill see page 12, question #19 of the [837i Supplemental Companion Guide](#) .

After implementation of 5010, zero-fill will still be allowed but it will be handled differently. The presentation, “5010 and D.O Implementation Highlights”, includes [5010 Zero-fill Instructions](#)  beginning on page 20. If you are in need of technical assistance, contact information is at the end of the presentation.

186. If a recipient is self-pay and the clinic receives a payment of \$15 according to our sliding fee schedule would this visit be counted towards our uncompensated care volume?

Yes. The visit is counted as uncompensated care volume and the \$15 received would be indicated on the self-pay revenue line of the survey.

187. When submitting data for self-pay revenues, should clinics use the amount billed to the client or the amount collected from the client?

Revenue earned from the client for a date of service within the submission period must be reported where indicated whether the revenue was received or not. Providers will follow their Generally Accepted Accounting Principles (GAAP) process for writing-off uncollectibles.

188. Can we count services provided to individual with high deductible insurance or Medicaid spend-down?

During the time an individual is on spend-down or is paying a deductible they are considered uninsured. These services can be counted as uncompensated care as long as no other insurance payment of any amount was received for these services. The individual will need to be billed according to your process for billing spend-down clients. These services and revenue will be recorded as “self-pay” on the uncompensated care survey.

189. Are non-covered group services treated as one unit or are they weighted?

At this time, there is no weighting within the uncompensated care pool. The services provided must be a service that is reimbursable by Medicaid.

190. If a self-pay client pays in full can we still count the visit as part of our uncompensated care volume?

Yes. The self-pay visit is counted but the revenue received must be entered on the self-pay line.

191. Where can a clinic confirm the type of filing schedule the facility is on (Calendar or Fiscal)?

The filing schedule is based on the location of the provider headquarters. If the clinic is in one of the five boroughs, the filing period is July to June. If not, the filing period is calendar year. To verify, call the CFR Unit at (518) 473-3572

192. When a clinic writes off bad debt from a prior year where does it go on the CFR?

See the General Instructions section of the [CFR Manual](#) (Section 8).