NYS Office of Mental Health
14 NYCRR Part 599
Mental Health Outpatient Treatment and Rehabilitative Services*
Medicaid Billing and Fiscal Guidance
April 2023

Office of
Mental Health

This document is intended to provide guidance with respect to certain provisions of 14 NYCRR Part 599. Because this guidance document addresses only selected portions of regulations and does not include or reference the full text of the final and enforceable Part 599, it should not be relied upon as a substitute for the regulations.

*Part 599 Clinic Treatment Programs were renamed Mental Health Outpatient Treatment and Rehabilitative Services effective November 23, 2022, to more accurately capture the services as newly authorized under the Medicaid State Plan Rehabilitative Services benefit.

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Medicaid Reimbursement

Medicaid reimbursement provisions for Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) can be found in 14 NYCRR Sections 599.13 and 599.14.

Ambulatory Patient Groups (APGs)

Part 599 uses APGs as the basis for Medicaid fee-for service and Medicaid managed care[1] payments for MHOTRS. The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc. In the context of mental health services, APGs are a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes.

In an APG payment environment, payments are determined by multiplying a dollar base rate (varies by peer group) by the weight assigned for each procedure. The weight is a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. Procedure weights are the same for all MHOTRS providers regardless of peer group.

The current service weights, diagnosis weights and APG peer group base rates can be found at the OMH MHOTRS Fiscal/Billing Resources website

APG Peer Groups

For rate setting purposes, OMH has grouped all MHOTRS providers into one of eight peer groups and established a base rate for each. A provider's base rate is dependent on the peer group they are in. Providers within each peer group have a common base rate.

OMH peer groups are differentiated by location and licensing status. MHOTRS providers are distributed within peer groups as follows:

1. **Upstate Hospital –** All hospital-based MHOTRS providers in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates counties.
2. **Downstate Hospital –** All hospital-based MHOTRS providers in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland, and Westchester counties.
3. **Upstate D&TC –** All MHOTRS diagnostic and treatment centers (D&TC) in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates counties.

[1] Medicaid managed care in this guidance includes Mainstream Medicaid Managed Care Plans, Health and Recovery Plans (HARPs), HIV Special Needs Plans (HIV SNPs), and Medicaid Advantage Plus (MAP) Plans.

4. **Downstate D&TC –** All MHOTRS diagnostic and treatment centers in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland, and Westchester counties.
5. **Upstate –** All non-local governmental unit operated MHOTRS providers operating solely under an OMH operating certificate and located in the following counties are included in the upstate peer group: Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates counties.
6. **Downstate –** All non-local governmental unit operated MHOTRS providers operating solely under an OMH operating certificate and located in the following counties are included in the downstate peer group: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland, and Westchester counties.
7. **Local Governmental Unit-Operated (LGU) –** All MHOTRS providers operated by an LGU which are operating solely under an operating certificate from OMH.
8. **State-Operated –** All MHOTRS providers operated by OMH.

Federally Qualified Health Centers (FQHCs)

Part 599 MHOTRS regulations apply to FQHC MHOTRS providers licensed by OMH. However, the APG payment methodology is not applicable to FQHCs except when the FQHC has voluntarily agreed to participate in the APG reimbursement system. A decision by an FQHC to participate in the APG system will apply to all the services they deliver, not just mental health services.

Rate Codes

OMH uses several APG rate codes to differentiate between hospital, non-hospital, onsite, off-site, onsite crisis, health monitoring, peer support, integrated outpatient services (IOS), Delivery System Reform Incentive Payment (DSRIP), intensive outpatient program (IOP) and Utilization Threshold exempt services for court order/AOT/SIST. FQHCs also have separate rate codes. Providers must submit claims to Medicaid and Medicaid managed care using the appropriate rate code and procedure code(s).

Description	Non-Hospital	Hospital
Base Rate	1504	1516
Off-site Base Rate	1507	1519
Health Services/Peer Supports	1474	1588
Crisis Intervention (onsite)	1579	1576
Intensive Outpatient Program (IOP)	1042	1048
DSRIP	1106	1110
Integrated Outpatient Services (IOS)	1480	1122
IOS Off-site	1092	1094
IOS IOP Off-site	1084	1086
UT Exempt (Court Order/AOT/SIST)	1136	1140

MHOTRS FQHC Rate Codes (Non-APG)	
Description	**Rate Code**
Individual	4301
Group	4303
Off-site	4306
Group Psychotherapy - Court Mandated	4026
Off-site services (Indiv) - Court Ordered	4027
Individual Threshold Visit - Court Ordered	4028

OMH Service Rates, Weights and Procedure Codes

OMH maintains up-to-date rates, weights and procedure codes under the CPT Procedure Weight and Rate Schedule on the OMH website.

Current Procedural Terminology (CPT) codes are maintained by the American Medical Association (AMA) and Healthcare Common Procedure Coding System (HCPCS) codes are maintained by the Centers for Medicare and Medicaid Services (CMS). These procedure codes are updated annually. The codes used for mental health services could change; OMH will update these codes and weights as appropriate.

Payment Modifiers

MHOTRS providers may bill Medicaid FFS and Medicaid managed care for certain supplemental payments described below.

Off-site Services

MHOTRS may be provided at locations away from the program site, including in the community or the individual's place of residence. The need for off-site services must be documented in the individual's treatment plan. Off-site services are billed using a separate rate code that reimburses at 150% of the on-site rate. Services provided at a satellite location (i.e., a physically separate site that provides services, full or part time, on a regularly and routinely scheduled basis) are not reimbursed using the off-site rate codes. The off-site services rate codes are exempt from the utilization threshold count. Telehealth cannot be utilized during the provision of off-site services; billing for off-site services must be for in-person service delivery in the community. See Telehealth Services webpage for more details on providing services via telehealth.

The off-site rate compensates provider agencies for staff travel costs directly related to service provision. The off-site service rate must only be used when services are delivered off-site in a community location and can only be reimbursed in conjunction with a completed service claim. The off-site rate cannot be used when services are delivered at an agency licensed site or in situations when providers travel off-site but a service was not delivered.

Language other than English (LOE)

Eligible procedures provided in languages other than English may be claimed using the U4 modifier. This modifier will pay an additional 10% for each eligible service. This modifier is available for services provided both on and off-site.

This modifier is applicable when the service to the recipient or collateral is provided in a language other than English, including sign language. Translation may be provided by a staff

person fluent in the language or by a paid translator. It is expected that the individual providing language assistance services will have sufficient level of fluency to ensure effective communication. MHOTRS providers should develop a process to assess or verify the language competency of those persons who will be providing language assistance services. Resources might include local organizations, universities, or schools where the relevant languages are taught. In all instances, the confidentiality of information and respect for those served and for their culture must be maintained, especially where services are provided using translation services.

The LOE billing modifier may not be used when translation is provided by a friend or family member of the recipient. Although the use of friends or family members as interpreters is not generally recommended, it is not prohibited. The decision to do so should be reviewed for clinical appropriateness and be documented.

Provider must document the use of language assistance services and the method of providing the service in a progress note.

After-Hours

The purpose of the after-hours procedure code (99051) is to encourage providers to make services available at times that are more convenient for the individuals they serve. There does not need to be a special justification for the provision of services after hours. The procedure code is applicable when services to adults or children are provided weekdays before 8AM, weekdays 6PM or later, and all day on weekends. To qualify, weekday services must begin before 8AM or at or after 6PM. Services provided on holidays during normal business hours are not eligible for the after-hours modifier. This modifier is available for services provided both on and off-site.

Additionally, the service must be provided during the extended hours of operation listed on the MHOTRS provider operating certificate. If the provider currently has extended hours, the modifier can be claimed during these times. Providers currently without extended hours that wish to bill this code must have an approved change to their operating certificate before being able to bill for after-hours service provision.

Procedure code 99051 is reported in addition to the service procedure code. Only one 99051 will be reimbursed by Medicaid per client, per day. Currently 99051 is weighted at .0759 of the APG peer group base rate.

MD/NPP Modifiers

MHOTRS providers may claim one of the following modifiers: AF (psychiatrist), AG (physician), or SA (Nurse Practitioner) when a psychiatrist, physician practicing in lieu of a psychiatrist with approval by OMH, or psychiatric nurse practitioner spends at least 15 minutes participating in the provision of services being provided by another practitioner or when the service is provided fully by a psychiatrist, other physician, or NPP, respectively. The modifier may also be claimed for each recipient when a psychiatrist, other physician, or NPP runs a group session or participates in the group for at least 15 minutes.

The modifier will add 45% to the payment for the individual service and will add 20% to the payment for group services for each recipient participating in the group. These modifiers are available for services provided both on and off-site.

In all cases, each psychiatrist, other physician, or NPP must document separately in each individual's case record with documentation specific to the individual receiving the service. The psychiatrist, physician, or NPP who provided the service must sign their documentation.

Modifier Chart

Payment modifiers are available for eligible services as indicated on the following chart. Modifiers are available for services provided on and off-site.

Service Name	After-Hours	LOE	Psychiatrist/Physician/NPP
Complex Care Management	X	X	
Crisis Intervention – brief	X	X	
Crisis Intervention – Complex	X	X	
Crisis Intervention – Per Diem	X	X	
Peer/Family Support Services	X	X	
Developmental, Neurobehavioral Status Exam, and Psychological Testing	X	X	
Injectable Psychotropic Medication Administration with Monitoring and Education	X	X	
Psychotropic Medication Treatment	X		
Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development	X	X	X
Psychiatric Assessment – brief	X	X	
Psychiatric Assessment – extended	X	X	
Individual Psychotherapy – brief	X	X	X
Individual Psychotherapy – extended	X	X	X
Group and Multifamily/Collateral Group Psychotherapy	X	X	X
Family Therapy/Collateral without patient	X	X	X
Family Therapy/Collateral with patient	X	X	X

Please note that all services provided using Telehealth must use the applicable modifiers found at https://omh.ny.gov/omhweb/telehealth/telehealth-modifiers.xlsx.

Medicaid Utilization Thresholds

Utilization thresholds (UT) for individuals receiving MHOTRS are calculated using "countable service days" claimed to Medicaid FFS by a MHOTRS provider for each Medicaid beneficiary. These counts reset to zero each April 1 (beginning of state fiscal year). When an individual receives services in excess of the utilization threshold, payment reductions will occur.

The payment reductions linked to utilization thresholds are:

- For individuals whose age on April 1 of each state fiscal year was LESS than 21 years old, Medicaid payments for "countable" services will be reduced by 50% beginning with their 51st service day during the fiscal year. This count will reset to zero at the beginning of each SFY thereafter (April 1st).
- For individuals whose age on April 1 of each state fiscal year was 21 years old or greater, Medicaid payments for countable services will be reduced by 25% for their 31st through 50th service days during the state fiscal year. Payments for MHOTRS will be reduced by 50% beginning on their 51st service day during the fiscal year. This count will reset to zero at the beginning of each SFY thereafter.

Note:

- A "countable service day" is the accumulation of all procedures provided in one day that have been claimed to Medicaid using rate codes 1504 and 1516.
- The UT applies to MHOTRS claims that are paid in whole or in part by Medicaid on a FFS basis (i.e., Medicare/Medicaid duals, individuals with primary third-party coverage and Medicaid secondary).

Services Exempt from the Utilization Threshold Count

The following types of services are exempt from the UT count when submitted under the appropriate rate codes (listed above):

- Court Order/Assisted Outpatient Treatment (AOT)/Strict and Intensive Supervision and Treatment (SIST)/Other (as specifically approved by OMH)
- Off-site
- Health Services/Peer Supports
- Crisis Intervention
- Intensive Outpatient Program (IOP)
- Integrated Outpatient Services (IOS; OMH host)

Medicare/Medicaid Crossover Billing

For individuals with both Medicaid and Medicare coverage, Medicaid will pay the "higher of" what Medicare or Medicaid would pay for the visit. Medicaid will not pay for Medicare co-pays or deductibles for non-Medicaid covered services.

If one procedure must be billed to Medicare first, the MHOTRS program must wait to submit the claim for the rest of the procedures provided on that day until Medicare pays for the crossover procedure. If the claim is then submitted to Medicaid outside of the 90-day window for claiming but within 30 days of receipt of the adjudication by Medicare, it is considered by CMS to be an acceptable reason for delay. The claim will require the use of delay reason code 7: Third Party Processing Delay.

For MMCPs with an integrated Medicaid and Medicare product line, the provider would submit one claim with all the relevant Medicaid and Medicare information. Please refer to the Mainstream/HARP/HIV-SNP Behavioral Health Billing and Coding Manual or the Medicaid Advantage Plus Behavioral Health Billing and Coding Manual for more information on submitting MHOTRS claims for services that are covered under Medicaid and Medicare.

National Provider Identifier (NPI) Affiliation

MHOTRS providers, hospitals and other facilities that bill Medicaid FFS and Medicaid managed care are required to maintain an up-to-date roster of Attending Providers (practitioners). The NPIs of all practitioners providing Medicaid reimbursable services in the MHOTRS program must be affiliated with the clinic in the eMedNY system. Claims containing NPIs of licensed practitioners not affiliated with the facility will result in a denial of payment. Practitioners may be affiliated with more than one program or provider. To enter affiliated practitioner information, visit the eMedNY NPI affiliation page.

Additionally, there is a batch Facilities Practitioner's NPI Reporting (FPR) submission method, which was developed to accommodate facilities that have a large quantity of affiliations to record with NYS Medicaid.

For more information, please refer to the Facilities Practitioner's NPI Reporting Guidance on the eMedNY website.

Attending/Referring Practitioners

An attending practitioner NPI is required on all claims, except when all procedures included on the claim are provided by a non-licensed practitioner, where permitted by Part 599. The NPI of a practitioner performing one of the procedures is entered as the attending provider on the claim. If the attending provider reported on the claim is enrolled in NYS Medicaid, the referring field may be left blank as the attending will be considered the referring provider.

Licensed Master Social Workers, Creative Arts Therapists, and Psychoanalysts cannot currently enroll in NYS Medicaid. When they or a non-licensed practitioner are the attending provider reported on the claim, a Medicaid-enrolled referring provider must be added to the claim in the referring provider field. As appropriate, report the NPI of the Medicaid enrolled physician or NPP who signed the treatment plan or the NPI of the Medicaid enrolled individual who supervises the attending provider. Using the agency's NPI in the referring field is not appropriate and will result in overpayment liability.

Referring providers do not need to be formally affiliated with the MHOTRS provider in eMedNY. However, referring providers must be enrolled Medicaid providers on the date of service. Attending and referring providers may be enrolled with Medicaid as either billing providers, or as Ordering/Prescribing/ Referring/Attending (OPRA) providers. Claims with a non-enrolled attending or referring provider will be denied.

Claims for Services Provided by Non-Licensed Practitioners

When claiming for services provided by a non-licensed practitioner (including students), the OMH unlicensed practitioner ID (02249154) is the ONLY attending practitioner information that should be put on the claim. Use the ID in place of the NPI and leave all other information fields–name, license, etc., blank. Again, where the non-licensed practitioner ID is used in the attending field, the claim MUST also include the NPI of a Medicaid enrolled practitioner in the referring field. Failure to include a referring provider will result in overpayment liability.

Claims for Services Provided by Medical Residents in Teaching Hospitals

NYS Medicaid follows the Medicare requirements for teaching hospitals. Medicaid guidance with respect to these requirements can be found in the June 2009 NYS Medicaid Update.

CMS Guidelines for Teaching Physicians, Interns and Residents also contains information with respect to this topic.

Claims for Services Provided by Students

Students may perform clinical work in an OMH-licensed MHOTRS program. They must be enrolled in a New York State Education Department (NYSED) approved program leading to a license allowed to provide services in an OMH-licensed MHOTRS program. A plan for the use of students and student supervision must be included as part of the MHOTRS provider's OMH-approved staffing plan. Appropriate procedures performed by students working in this capacity are reimbursable by Medicaid.

Billing Medicaid for Multiple Procedures on the Same Day

Please note the following information does not apply to services provided to individuals enrolled in a MHOTRS Based IOP. Please refer to the MHOTRS-Based Intensive Outpatient Program Guidance for more information on that program.

In order to reduce the need for the client to make multiple visits for complementary services, MHOTRS programs may submit claims to Medicaid FFS and Medicaid managed care for up to three services per client, per day, not including crisis services. However, of those three services, there is a maximum of two Psychiatric or two Health services allowed per day. Psychotropic Medication Treatment, Injectable Psychotropic Medication Administration with Monitoring and Education and Complex Care Management services may be counted as either health services or psychiatric services (distinguished by using either the base rate codes or the health services rate codes). This flexibility will allow for these services to be provided on the same day with any other types of services, up to the three per day limit. Injectable Psychotropic Medication (injection only) is billed using the 837-P professional claim and may be counted as either a psychiatric or health service.

When multiple procedure codes are included on the same rate coded claim, the MHOTRS program will receive 100% reimbursement for the APG procedure with the highest APG weight and a 10% discount will be applied to each additional procedure with a lower APG weight. This rule does not apply to multiple services submitted on an IOS rate coded claim, which are not subject to discounting.

All mental health procedures provided to an individual on the same day and claimed using the same rate code must be submitted to eMedNY or Medicaid Managed Care on the same claim. Currently there is only room for one practitioner ID on the attending line of the claim. There is currently no NYS requirement regarding which NPI should be placed on a claim when the claim contains multiple procedures. The MHOTRS provider must include an NPI belonging 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 medical record.

Billing Multiple Procedures for Individuals Covered by Medicaid/Private Insurance

Medicaid regulations at 18 NYCRR Section 540.6(e) require a provider to pursue any available commercial insurance prior to submitting a claim to Medicaid. This means that providers must investigate and pursue reimbursement from available commercial insurance but are not required

to contract with all available commercial insurers. Additional information can also be found in the DOH Medicaid Update February 2008 Vol. 24, No. 2, Office of Medicaid Management.

Medicaid pays the lower of either:

- the Medicaid rate minus the insurance payment, or
- the patient responsibility amount.

When a provider contracts with a commercial insurance payer, the Medicaid program 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 payer, 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.

Where multiple services are provided on the same day, the patient responsibility depends upon whether a provider is under contract with a private insurer and the rules of the MHOTRS provider contract.

- If the MHOTRS provider contract with the insurer requires that the patient only be billed for co-pays and deductibles regardless of the number of procedures provided in a day, the patient responsibility amount will be limited to the co-pays and deductibles. This is true even if the third-party insurer only paid for one procedure.
- For any procedure covered by Medicaid, but not fully covered by a recipient's primary insurance plan, Medicaid will pay for the patient responsibility for the uncompensated procedure(s) up to the Medicaid rate. The total patient responsibility must be associated on the claim with the procedure(s) it pertains to. This works for ePACES as well. The user must fill out a line level claim response.

Information regarding ePACES may be found on the eMedNY ePACES website.

Reimbursement for Collaborative Documentation/Concurrent Record Keeping

For Medicaid and Medicaid managed care, the time spent on concurrent documentation is a reimbursable part of a procedure if it is a component of the therapeutic encounter. This activity may or may not be reimbursable by other third-party payers.

Service-Specific Medicaid Billing Requirements

Several MHOTRS have specific Medicaid billing limitations. Please note that where services have a minimum duration, the duration of services must be documented.

Providers may bill for services consistent with applicable AMA and CMS coding guidelines for service duration ranges. Where there is no duration range defined within those guidelines, the minimum duration cited in this guidance and OMH regulations must be followed.

Assessments

There are two types of assessments – Initial Assessments and Psychiatric Assessments.

Initial Assessment – No more than three initial assessment procedures will be reimbursed. The only exception to this rule is when there has been more than 365 days since the client's most recent Medicaid reimbursed visit to the MHOTRS program.

Procedure codes for Initial Assessment:

- 90791 – Psychiatric diagnostic evaluation
- 90792 – Psychiatric diagnostic evaluation with medical services

Note: Regardless of the code chosen, if a psychiatrist, other physician, or NPP provides or participates in the service for at least 15 minutes, the appropriate modifier must be added to the claim line for the 45% increase in reimbursement.

Psychiatric Assessment – May be performed for admitted individuals where medically necessary without limitations. Psychiatric Assessments may also be provided to determine whether an individual should be admitted to the MHOTRS program and will count toward the pre-admission service limit of three visits (see below).

MHOTRS programs bill for 30-minute or 45-minute Psychiatric Assessments using either an office Evaluation & Management (E&M) code alone, or where psychotherapy services are also provided for the required minimum time, by using and office Evaluation & Management (E&M) code on one claim line AND 90833 (16-37 minutes) or 90836 (38-52 minutes) on the second claim line. If 90833 or 90836 add-on is used, psychotherapy services must be documented in the record along with Psychiatric Assessment. Where the add-on is used, the provider should select the appropriate E&M code based on the level of medical decision making (MDM). See https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

E&M codes may be used without 90833 or 90836 if the psychiatrist provides straight medical evaluation and management without psychotherapy, or where psychotherapy services were provided, but not for the required minimum time in order to bill the add-on. Where E&M codes are used without the add-on, providers may select the appropriate E&M coding as follows:

1. Based on level of medical decision making (MDM). Providers billing based on MDM should document each element of their analysis even though the APG procedure weights and reimbursement do not differ based on the provider's selection; or
2. Based on time within the ranges established in the table below titled, "APG Codes, Procedure Codes and Service Time". Providers may only bill based on time if more than 50% of the time during the encounter is spent on psychotherapy, counseling, or care coordination activities.

For purposes of determining the appropriate billing codes for Psychiatric Assessments, note that OMH defines psychotherapy to mean a therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to develop or restore age-appropriate developmental milestones.

Medicaid reimbursement amounts for E&M codes vary by diagnosis.

MHOTRS programs may use psychiatric assessments for buprenorphine or long-acting naltrexone inductions for individuals with co-occurring opioid use disorder.

E&M codes for Psychiatric Assessments:

- 99202-99205 (New Patient)
  - 99202 (15-29 minutes)
  - 99203 (30-44 minutes)
  - 99204 (45-59 minutes)
  - 99205 (60-74 minutes)
- 99212-99215 (Established Patient)
  - 99212 (10-19 minutes)
  - 99213 (20-29 minutes)
  - 99214 (30-39 minutes)
  - 99215 (40-54 minutes)

Psychotherapy Add-on Procedure Codes:

- 90833 (16-37 minutes)
- 90836 (38-52 minutes)

Complex Care Management

This service must be provided within 14-calendar days following a psychotherapy service, psychotropic medication treatment service or crisis intervention service. Complex Care Management can be provided by telehealth, including audio-only/telephonic, or in-person. If a combination of psychotherapy, psychotropic medication treatment, or crisis services occurs on the same day, Medicaid will only reimburse for up to four units of complex care within 14-calendar days following the provision of these services.

Complex Care Management is billable in full 5-minute units, with a four unit maximum (20 minutes). Each full 5-minute unit may be provided on a separate day (within the 14-calendar day limit), with a maximum of four, full 5-minute units associated with each eligible MHOTRS visit. This service does not include standard report writing or routine follow-up calls. It is not routine care management and must be medically necessary.

Procedure code for Complex Care Management:

- 90882 (5 minutes)

Crisis Services

Crisis Intervention services consist of three reimbursable levels of service.

1. *Crisis Intervention – Brief* may be provided in person or by telehealth. For services of at least 15 minutes in duration, one unit of service may be billed. For each additional service increment of at least 15 minutes, an additional unit of service may be billed, up to a maximum of six units per day.
2. *Crisis Intervention – Complex* requires a minimum of one hour of in-person or by telehealth contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. Certified Peer Specialists, Credentialed Family Peer Advocates, and Credentialed Youth Peer Advocates, or paraprofessional staff may substitute for one clinician. MHOTRS providers may be reimbursed for Crisis

Intervention – Complex services provided to individuals who have not engaged in services for a period of up to two years.
3. *Crisis Intervention – Per Diem* requires three hours or more of in-person or by telehealth contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. Certified Peer Specialists, Credentialed Family Peer Advocates, and Credentialed Youth Peer Advocates or paraprofessional staff may substitute for one clinician. MHOTRS providers may be reimbursed for Crisis Intervention- Per Diem services provided to individuals who have not engaged in services for a period of up to two years.

Note: Crisis Intervention – Brief can be reimbursed for individuals regardless of whether they have previously received services from the MHOTRS provider. Crisis Intervention – Complex and Per Diem are reimbursable only for those individuals that have been seen by the program within the previous two years.

Procedure codes for Crisis Intervention:

- H2011 (15 minutes)
- S9484 (60 minutes)
- S9485 (per diem)

Health Monitoring

Health Monitoring services for people receiving MHOTRS are considered ancillary to mental health services.

Health Monitoring groups require documented in-person or by telehealth service with a minimum of two individuals and a maximum of 12 individuals for services of a minimum of either 30 or 60 minutes, or in the case of Smoking Cessation Counseling, a minimum of 10 minutes.

Individual and group Health Monitoring services must be claimed using the appropriate Health Services rate code and will be excluded from the utilization threshold count. Medicaid reimbursement amounts for Health Monitoring E&M codes do not vary by diagnosis.

E&M codes used for Health Monitoring:

- 99401-99404 (Individual)
  - 99401 (15 minutes)
  - 99402 (30 minutes)
  - 99403 (45 minutes)
  - 99404 (60 minutes)
- 99411-99412 (Group)
  - 99411 (30 minutes)
  - 99412 (60 minutes)

Smoking Cessation Counseling (SCC) is reimbursed for both adults and children as a health monitoring service. SCC must be provided by a physician, physician assistant, nurse practitioner, or registered nurse. If SCC 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 cession session. SCC must be claimed with diagnosis code, 305.1 – tobacco use disorder.

Other clinic staff may provide treatment for Tobacco Use Disorder as a part of individual or group clinical treatment billed as a psychotherapy service, using codes 90832, 90834, 90846, 90847, 90849, 90853. If treatment for Tobacco Use Disorder is part of a psychotherapy session (group or individual), the time spent on treatment for Tobacco Use Disorder can be counted toward the duration of the psychotherapy session; programs can claim a longer psychotherapy session because of time spent on tobacco use disorder. An additional SCC treatment can be provided by physicians, physician assistants, nurse practitioners, or registered nurses and billed for on the same day as the psychotherapy service (so long as the time spent is separate and discreet from the psychotherapy). If SCC is billed using the appropriate Health Service rate code, the payment will not be discounted as an additional procedure provided on the same day.

Psychiatrists and nurse practitioners may also provide treatment for Tobacco Use Disorder as part of a psychiatric assessment or psychotropic medication treatment service, using the appropriate psychiatric evaluation and management (E&M) billing codes.

E&M codes used for SCC:

- 99406 (Intermediate- 3-10 minutes)
- 99407 (Intensive- greater than 10 minutes) – This code may be used for individual and group sessions. Groups may include up to eight individuals. Claims for group sessions must include the HQ modifier on the SCC service line.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Practitioners must complete an OASAS-approved SBIRT training of at least four hours in order to bill for these services. For information, see [DOH Medicaid Update June 2011 Volume 27, Number 8](). Codes used for SBIRT:

- H0049 (Alcohol and/or drug screening)
- H0050 (Alcohol and/or drug service, brief intervention, per 15 minutes)

Health Physicals

Physical exams delivered at a MHOTRS program for people receiving mental health services are considered ancillary to mental health services.

No more than one health physical may be claimed in one year. Health physicals will be claimed using the appropriate health services rate code and will be excluded from the utilization threshold count. Medicaid reimbursement amounts for E&M codes vary by diagnosis.

E&M codes for Health Physicals (codes are age-specific):

- 99382-99387 (New Patient)
- 99392-99397 (Established Patient)

Injectable Psychotropic Medication Administration

MHOTRS providers must submit 837-P professional claims (without a rate code) using the appropriate J-code for the drug (if the provider paid for the drug) and CPT code 96372 for the injection. Medicaid will pay for the acquisition cost of the drug (if applicable) and for the injection. No modifiers are available.

Injectable Medication Administration with Monitoring and Education

This service has a 15-minute minimum and cannot be provided by LPN staff. Claims are submitted using HCPCS code H2010. When claiming H2010, providers cannot claim 96372 using a professional claim on the same day for the same individual.

Additional Information on Injectable Medication Administration

For long-acting injectable psychotropic medications (e.g., naltrexone or antipsychotic agents), claiming procedures depend on whether the program pays for the medication or not, and whether the injection is given as part of another CPT coded service:

a. When the clinic does not pay for the medication, the program must submit the injection procedure code using a professional claim – 837P – (same as institutional but without a rate code), without a J-code.
b. When the program pays for the medication, the claim for the medication and the injection procedure is also submitted using the same 837P professional claim. The clinic must also include the appropriate J-code for the medication.
c. If the injection is administered as part of a E&M CPT coded service, the CPT code 96372 should not be billed and only the J-code would be claimed on the 837P if the clinic pays for the drug, per above, with the appropriate other E&M/HCPCS code submitted on the 837I claim form.

Peer Support Services

Youth, Family, Adult, and Older Adult Peer Support Services (herein referred to as Peer Support Services) may be provided to individuals, family or other collaterals, or groups of individuals not to exceed 12 individuals. For service duration of at least 15 minutes, one unit of service may be billed. For each additional service increment of at least 15 minutes, an additional unit of service can be billed, up to 12 units per day, or three hours maximum. Multiple units of Peer Support Services can be provided consecutively or at different times of the day. Peer support services will be claimed using the appropriate health services/peer supports rate code and will be excluded from the utilization threshold count. Procedure Codes for Peer Support Services:

- H0038 (individual 15 minutes)
- H0038 with HQ modifier (group 15 minutes)

Pre-Admission Services

OMH allows reimbursement for three pre-admission procedures for adults and three pre-admission visits for children to evaluate if a recipient is appropriate for admission to the MHOTRS program. Part 599 does not mandate three pre-admission sessions. Any available MHOTRS, excluding Testing services, may be provided during pre-admission status. Peer/Family Support Services will not count toward the three service/visit limit as this service has no pre-admission reimbursement limit.

Psychiatric Consultation

For this service, the referring physician cannot be employed by the MHOTRS program providing the consultation.

Consultations are claimed using the appropriate office visit evaluation and management codes, determined in the same manner as Psychiatric Assessment services, see above. Providers may also include Psychotherapy add-on code 90833 (16-37 minutes) or 90836 (38-52 minutes) on the second claim line where psychotherapy services are also provided for the required

minimum time. Where the add-on is used, the provider should select the appropriate E&M code based on the level of medical decision making (MDM). See https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

If 90833 or 90836 add on is used, psychotherapy service must be documented in the record along with consultation. Psychiatric Consultation services are diagnostic and therapeutic services including an evaluation of a beneficiary who is not currently enrolled in the practitioner's program when the service is provided. Psychiatric Consultation is not a professional consultation between two health care professionals, but rather direct services provided to a beneficiary for purposes of diagnosis, integration of treatment, and continuity of care.

A consultation must meet the following conditions for reimbursement:

- The consultation must be performed at the request of another physician 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 individual's medical record; and
- A written report must be prepared on the findings and provided to the referring practitioner.

Psychotherapy

Psychotherapy consists of the following types of reimbursable services:

- *Individual-brief* is provided in-person or by telehealth with the individual with a documented duration of 30 minutes
- *Individual-extended* is provided in-person or by telehealth with the individual with a documented duration of 45 minutes
- Where clinically appropriate and consistent with applicable AMA coding guidelines for service duration ranges for psychotherapy codes, Individual-brief and extended may be billed for shorter service durations than those specified above.
- Note: there is a 5% payment increase for 30- and 45-minute psychotherapy services (CPT codes 90832/90834) when provided to a child up to, and including, the age of 18.

Brief and extended psychotherapy may be billed when more than half of the minimum service duration is spent providing services to the individual and the remainder of the minimum service duration is spent providing services to a collateral. Documentation must include the split in time between the individual and collateral. No change in billing is required.

- *Family/Collateral with the individual* is provided in-person or by telehealth with a documented duration of 50 minutes. The individual must be present for the majority of the time. It is not required that the family/collateral be present for the entire session.
- *Family/Collateral without the individual* is provided in-person or by telehealth with a documented duration of 30 minutes. The individual may also be present for some or all of the time. Where clinically appropriate and consistent with applicable AMA coding guidelines for service duration ranges for psychotherapy codes, Family/Collateral may be billed without the individual for shorter service durations than those specified here.

- *Multi-Individual Group* is provided in-person or by telehealth with a minimum of two individuals and a maximum of 12 individuals for a documented duration of 60 minutes. For services lasting at least 40 minutes but less than 60 minutes, reimbursement will be reduced by 30 percent. Providers will indicate this reduced time by using the U5 modifier on the service line of the claim.
- *Multi-Family/Collateral Group* is provided in-person or by telehealth with a minimum of two multi-family/collateral units and a maximum of eight multi-family/collateral units in the group, with a maximum total number in any group not to exceed 16 individuals, for a documented duration of 60 minutes. For services lasting at least 40 minutes but less than 60 minutes, reimbursement will be reduced by 30 percent. Providers will indicate this reduced time by using the U5 modifier on the service line of the claim.

Procedure codes for Psychotherapy:

- 90832 (*16-37 minutes*) – Individual Brief
- *90834 (38-52 minutes)* - Individual-extended
- *90846 (26-49 minutes)* - Family/Collateral without the individual
- *90847 (50 minutes)* - Family/Collateral with the individual
- *90849 (60 minutes)* - Multi-Individual Group
- *90853 (60 minutes)* - Multi-Family/Collateral Group

Psychotropic Medication Treatment

This service must be a minimum of 15 minutes to be reimbursed by Medicaid. This service cannot be reimbursed by Medicaid if a psychiatric assessment or psychiatric consultation was provided for the same individual on the same day. In those cases, only the appropriate psychiatric assessment or psychiatric consultation code should be claimed on that day. The pharmacologic management is included as part of the evaluation and management service by definition.

MHOTR Programs can use psychotropic medication treatment visits to provide maintenance treatment for co-occurring opioid use disorder with buprenorphine or long-acting naltrexone. These visit types may also be used to treat other co-occurring substance use disorders, such as alcohol use disorder and tobacco use disorder.

Psychotropic Medication Treatment services may be claimed using either the Health Services rate codes or the Base rate codes (e.g., 1504/1516).

Procedure codes for Psychotropic Medication Treatment:

- 99202-99205 (New Patient)
  - 99202 (15-29 minutes)
  - 99203 (30-44 minutes)
  - 99204 (45-59 minutes)
  - 99205 (60-74 minutes)
- 99212-99215 (Established Patient)
  - 99212 (10-19 minutes)
  - 99213 (20-29 minutes)
  - 99214 (30-39 minutes)
  - 99215 (40-54 minutes)

Testing Services – including Developmental Testing, Neurobehavioral Status Examination, and Psychological Testing

Testing services are reimbursed only for individuals admitted to the MHOTRS program. Testing services must be provided either in-person or through audio-visual telehealth with the individual. Audio-only is not acceptable. There is no limit to the number of medically necessary testing services that may be provided over one or multiple sessions. The reimbursement includes the expected cost of testing, including scoring and report writing.

Procedure codes for Testing Services:

- Developmental Testing – limited: 96110
- Developmental Testing - First Hour: 96112
- Developmental Testing - Additional 30 min.: 96113
- Psychological Testing Evaluation - First Hour: 96130
- Psychological Testing Evaluation - Additional Hour: 96131
- Psychological Test Admin and Scoring - First 30 Min: 96136
- Psychological Test Admin and Scoring - Additional 30 Min: 96137
- Psychological Testing - Neurobehavioral Status Examination First Hour: 96116
- Psychological Testing - Neurobehavioral Status Examination Additional Hour: 96121

Submitting Claims to Medicaid

All Medicaid and Medicaid managed care claims require the submission of the appropriate CPT or HCPCS code for the procedure provided and the appropriate rate code (with the exception of Injectable Psychotropic Medication Administration which is submitted using the 837-P claim form). Additionally, all claims submitted to Medicaid and Medicaid managed care plans (MMCPs) must include, at a minimum:

- The Medicaid client identification number (CIN) of the individual.
- The National Provider Identification (NPI) of the MHOTRS provider billing agency.
- The NPI of a Medicaid-enrolled clinician as the referring practitioner.
- The NPI of the attending clinician or the Department of Health-approved alternative for unlicensed clinicians (02249154). If the attending clinician is not enrolled in Medicaid (e.g., unlicensed), the referring field must include the NPI of a Medicaid-enrolled provider.
- The designated mental illness diagnosis. For pre-admission visits, the code for "diagnosis-deferred" may be entered on the claim, where appropriate.
- The location of the service, specifically the licensed location where the service was provided or the clinician's regularly assigned licensed location for an off-site procedure. The location will be identified by the "zip+4", not by its historic Medicaid locator code. Do not enter the location's historic locator code on the claim.

Safety Net

The Safety Net consists of state and federal funding provided to offset a portion of losses due to uncompensated care experienced by most Diagnostic and Treatment Centers (D&TCs) licensed by the New York State Department of Health (DOH), MHOTRS programs licensed by OMH that are not affiliated with hospitals or directly operated by OMH, and MHOTRS programs operated

by some D&TCs not eligible to participate in DOH's uncompensated care funding program, which is separate from the OMH Safety Net.

Payments from the Safety Net are made in accordance with payment rules established by the OMH and DOH. Periodic partial payments from the Safety Net will be made by the Department of Health. To participate, agencies must submit annual data for each of their MHOTRS locations using the OMH-4, an OMH form included the Consolidated Fiscal Report (CFR). MHOTRS programs that fail to submit the OMH-4 will be excluded from the pool. The Safety Net uses data collected from the CFR OMH-4 from two-years prior.

The percentage of uncompensated care paid by the Safety Net is dependent on the total funds available and the total value of allowable uncompensated care visits. To be eligible for an allocation of funds from the pool, MHOTRS programs must demonstrate that a minimum of three percent of total visits during the applicable period were uncompensated. Federally Qualified Health Centers (FQHC) MHOTRS programs must demonstrate that a minimum of five percent of total visits during the applicable period were uncompensated.

All MHOTRS programs qualifying for a distribution from the Safety Net must undertake reasonable efforts to obtain or maintain financial support from other community and public funding sources and attempt to collect payments for services from third-party insurance payers, governmental payers, and self-paying individuals. This is subject to audit. OMH anticipates that visits can be counted toward uncompensated care volume if they meet the following conditions:

1. Self-pay, including partial-pay or no-pay visits (does not include partial payment associated with co-pays or deductibles).
2. Required or optional services provided but not covered under a program's agreement with an insurer. The service must be provided by a practitioner qualified to deliver the service under State regulations.
3. Unreimbursed MHOTRS program visits/procedures appropriately provided to an insured individual by a program staff member not approved for payment by a third-party payer (Commercial/Medicare) under contract with the MHOTRS program. The provider must document that the program received a denial of payment.
4. Unreimbursed MHOTRS program visits/procedures appropriately provided to an insured individual by a program staff member when the procedure is not reimbursed by a third-party payer not in contract with the program. Only visits for which the program received a written denial of payment from the insurer or a written attestation from the individual/insured that the insurer made no payment will be considered uncompensated. This documentation must be retained by the program and will be subject to an audit by the NYS Office of the Medicaid Inspector General (OMIG) or other party empowered to conduct such audits.

Visits ***will not*** be counted if they meet the following conditions:

1. Visits paid in whole or part by MMC or a third-party payer.
2. Visits not authorized (considered not medically necessary) by an insurer/managed care plan.
3. Visits provided to a recipient who has coverage from a third-party payer not in contract with the program when an insurer does reimburse the insured for the visit, irrespective of the amount of the reimbursement.

4. Visits delivered by persons unqualified to deliver the services under NYS regulations.
5. Services provided to individuals served in forensic settings.

Safety Net Calculation Methods

MHOTRS Providers (non-FQHC)

All eligible MHOTRS programs (non-FQHC) will receive a uniform rate add-on. This add-on will be calculated by dividing the total distribution available for MHOTRS programs by the sum of the total number of uninsured visits and Medicaid fee-for-service visits reported on the certified cost report for all eligible MHOTRS programs. Any visit in which Medicaid is not the only payer shall not be included in the Medicaid visit count. If the amount of eligible uncompensated care visits in the Safety Net calculation exceeds the funding available, payments to providers are proportionately reduced.

MHOTRS programs (non-FQHC) may be excluded from the Safety Net if they generate net profits from the program in excess of 15% of total revenue and report total net assets in excess of two times their total annual operating budget. OMH analyzes information from the Consolidated Fiscal Report (CFR) to determine a provider's eligibility in the Safety Net for a given year. More detail on this eligibility standard can be found in 14 NYCRR 599.15(k).

FQHC MHOTRS Programs

Each eligible FQHC MHOTRS program will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

Percentage of Eligible Uninsured Visits to Total Visits							
Upstate				**Downstate**			
Low (at least)	High (less than)	Amount	Tier	Low (at least)	High (less than)	Amount	Tier
0%	5%	$0	0	0%	5%	$0	0
5%	10%	$15	1	5%	15%	$32	1
10%	15%	$25	2	15%	20%	$42	2
15%	20%	$36	3	20%	25%	$53	3
20%	25%	$48	4	25%	35%	$65	4
25% or more		$61	5	35% or more		$78	5

Safety Net payments for FQHC MHOTRS programs will be calculated by multiplying each facility's rate add-on by the number of Medicaid visits reported in the base year certified cost report. **Per CMS requirements, Medicaid visits include Medicaid FFS visits only.**

The Safety Net rate adjustment total payment for each eligible FQHC MHOTRS program, which is determined based on the tier system, will be scaled based on the ratio of the total amount that was allocated for payment, using the tier system, to the total statewide safety net funds available for distribution to all eligible FQHC MHOTRS programs. If the amount of eligible uncompensated care visits in the Safety Net calculation exceeds the funding available, payments to providers are proportionately reduced.

New Providers without Cost/Visit Experience

New Providers with less than two full years of cost experience may qualify for inclusion in the distribution. To participate, providers must meet the eligibility criteria, be eligible to receive a Medicaid rate, and must submit a request to the Department of Health to participate in the distribution. The annual distribution for a new provider will not exceed $100,000.

Additional information: Department of Health Safety Net

Resources

OMH Fiscal and Claim Submission Resources:

OMH maintains several fiscal and claiming guidance documents on the MHOTRS fiscal webpage, including current Medicaid rates, APG weights and revenue calculator.

APG Codes, Procedure Codes and Service Time

Detailed information on APGs can be found on the NYS Department of Health APG webpage

Procedure codes are maintained by the American Medical Association and the Centers for Medicare and Medicaid Services.

- CPT coding information can be found on the AMA website
- HCPCS coding information can be found on the CMS website

Regarding service time minimum durations, providers may bill for services consistent with applicable AMA and CMS coding guidelines for service duration ranges, unless otherwise noted below. Where there is no duration range defined within those guidelines, the minimum duration cited in this guidance and OMH regulations must be followed.

Procedure Code	Part 599: Service Title	AMA CPT Title	OMH *Recommended* Minimum Service Duration (unless noted as required)	Time range allowed if AMA Duration Standard is listed below.
90791	Initial Assessment	Psychiatric diagnostic evaluation.	45 minute minimum required	
90792	Initial Assessment with Medical Services	Psychiatric diagnostic evaluation with medical services.	45 minute minimum required	
99202	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	15-29 minutes

99202	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	15-29 minutes	15-29 minutes
99203	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	30-44 minutes
99203	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	30-44 minutes	30-44 minutes
99204	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	45-59 minutes
99204	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	45-59 minutes	45-59 minutes
99205	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	60-74 minutes

99205	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	60-74 minutes	60-74 minutes
99212	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	10-19 minutes
99212	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	10-19 minutes	10-19 minutes
99213	Psychotropic Medication Treatment)	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	20-29 minutes
99213	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	20-29 minutes	20-29 minutes

99214	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	30-39 minutes
99214	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	30-39 minutes	30-39 minutes
99215	Psychotropic Medication Treatment	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	If billing based on complexity, at least 15 minutes minimum required	40-54 minutes
99215	Psychiatric Assessment/Psychiatric Consultation (+ Psychotherapy add-on when applicable)	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	40-54 minutes	40-54 minutes
90833	Psychotherapy ADD ON- this code may be added to an E&M code if the provider has documented the required duration of actual psychotherapy services during the E&M visit.	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service.	30 minutes recommended but AMA time range is allowed	16-37 minutes
90836	Psychotherapy ADD ON- this code may be added to an E&M code if the provider has documented the required duration of actual psychotherapy services during the E&M visit.	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service.	45 minutes recommended but AMA time range is allowed	38-52 minutes
H2011	Crisis Intervention - 15 minutes	Crisis intervention service, per 15 minutes.	15 minute minimum required	
S9484	Crisis Intervention - complex	Crisis intervention mental health services, per hour.	60 -180 minutes	

S9485	Crisis Intervention - per diem	Crisis intervention mental health services, per diem.	> 180 minutes required	
H2010	Injectable Med Admin with Monitoring & Education	Comprehensive medication services, per 15 minutes.	15 minute minimum required	
96372	Injection Only	Therapeutic, prophylactic, or diagnostic injection.	N/A	
Q3014	Telehealth Facility Fee*	Telehealth originating site facility fee.	N/A	
90832	Psychotherapy - Individual - 16-37 minutes	Psychotherapy, 30 minutes with patient.	30 minutes recommended but AMA time range is allowed	16-37 minutes
90834	Psychotherapy - Individual - 38-52 minutes	Psychotherapy, 45 minutes with patient.	45 minutes recommended but AMA time range is allowed	38-52 minutes
90846	Psychotherapy - Family - 30 minutes	Family psychotherapy (without the patient present), 50 minutes	30 minutes recommended but AMA time range is allowed	26-50 minutes
90847	Psychotherapy – Family & Client - 50 minutes	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	50 minute minimum required. Use 90846 if less than 50 min.	
90849	Psychotherapy - Family Group - 60 minutes	Multiple-family group psychotherapy	60 minutes recommended but for service durations between 40-59 minutes, U5 modifier must be used to reduce payment by 30%. Service duration less than 40 min is not reimbursable.	

90853	Psychotherapy - Group - 60 minutes	Group psychotherapy (other than of a multiple-family group)	60 minutes recommended but for service durations between 40-59 minutes, U5 modifier must be used to reduce payment by 30%. Service duration less than 40 min is not reimbursable.	
H0038	Peer and Family Peer Recovery Support Services - 15 minutes	Self-help/peer services, per 15 minutes.	15 minute minimum required	
H0038-HQ	Peer and Family Peer Recovery Support Services, Group - 15 minutes	Self-help/peer services, per 15 minutes.	15 minute minimum required	
96110	Developmental Testing - limited	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.	N/A	
96112	Developmental Testing - First Hour	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report: first hour	60 minute minimum required	
96113	Developmental Testing - Additional 30 min.	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report: each additional 30 minutes.	30 minute minimum required	
96130	Psychological Testing Evaluation - First Hour	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregivers(s), when performed: first hour	60 minute minimum required	

96131	Psychological Testing Evaluation - Additional Hour	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregivers(s), when performed: each additional hour.	60 minute minimum required	
96136	Psychological Test Admin and Scoring - First 30 Min	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.	30 minute minimum required	
96137	Psychological Test Admin and Scoring - Additional 30 Min	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes.	30 minute minimum required	
96116	Psychological Testing - Neurobehavioral Status Examination First Hour	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing report; first hour.	60 minute minimum required	
96121	Psychological Testing - Neurobehavioral Status Examination Additional Hour	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing report; each additional hour.	60 minute minimum required	
90882	Complex Care Management - 5 mins	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	5 minute minimum required	
99382	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years).	N/A	

99383	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years).	N/A	
99384	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years).	N/A	
99385	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.	N/A	
99386	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.	N/A	
99387	Health Physicals - New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.	N/A	
99392	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years).	N/A	

99393	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years).	N/A	
99394	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years).	N/A	
99395	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.	N/A	
99396	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.	N/A	
99397	Health Physicals - Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.	N/A	
99401	Health Monitoring - 15 mins	Preventative medicine counseling and/or risk factor reduction interventions(s) provided to an individual (separate procedure): approximately 15 minutes.	15 minute minimum required	
99402	Health Monitoring - 30 mins	Preventative medicine counseling and/or risk factor reduction interventions(s) provided to an individual (separate procedure): approximately 30 minutes.	30 minute minimum required	
99403	Health Monitoring - 45 mins	Preventative medicine counseling and/or risk factor reduction interventions(s) provided to an individual (separate procedure): approximately 45 minutes.	45 minute minimum required	

99404	Health Monitoring - 60 mins	Preventative medicine counseling and/or risk factor reduction interventions(s) provided to an individual (separate procedure): approximately 60 minutes.	60 minute minimum required	
99411	Health Monitoring Group - 30 mins	Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.	30 minute minimum required	
99412	Health Monitoring Group - 60 mins	Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.	60 minute minimum required	
99406	Smoking Cessation Treatment - 3-10 mins; requires Dx code 305.1	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.	3-10 minutes required	
99407	Smoking Cessation Treatment - >10 mins; requires Dx code 305.1 10 minutes	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.	> 10 minutes required	
99407-HQ	Smoking Cessation Treatment (Group) - >10 mins; requires Dx code 305.1 (req HQ modifier)	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.	> 10 minutes required	
H0049	Alcohol and/or Drug Screening	Alcohol and/or drug screening.	N/A	
H0050	Alcohol and/or Drug, brief intervention, per 15 mins 15 minutes	Alcohol and/or drug services, brief intervention, per 15 minutes.	15 minute minimum required	

Contacts

- OMH Medicaid Fee-for-Service Reimbursement and Billing Assistance: medicaidffsbillinghelp@omh.ny.gov
- OMH Medicaid Managed Care Assistance: OMH-Managed-Care@omh.ny.gov
- eMedNY: 1-800-343-9000 and the eMedNY contacts webpage