April 28, 2020

Medicaid Fee-for-Service and Medicaid Managed Care Billing Guidance for OMH-Licensed Clinic Programs Regarding Emergency Response to COVID-19

Introduction

As a result of the current COVID-19 Disaster Emergency, service delivery across the system has transformed into a largely telemental health service modality. Although telemental health is a useful tool in these circumstances, it does pose challenges for Clinic programs. Additionally, providers are justifiably concerned about the fiscal health of their programs through this disaster emergency. To address these concerns, OMH is issuing guidelines for provision of services and related documentation and billing intended to afford providers sustained revenue to maintain operations, while ensuring the best possible provision of ongoing care and support.

OMH expects providers to utilize telemental health where applicable and make every effort to provide levels of service as historically provided (e.g., the intensity and frequency of service appropriate to each individual's and/or family's needs). There are however significant barriers to maintaining prior levels of contact given the nature of the disaster emergency. As such, OMH has established temporary minimum billing requirements for some clinic services to allow for more realistic billing standards during the State disaster emergency.

This document will outline Clinic program minimum billing requirements for Medicaid Fee-for-Services and Medicaid managed care for the duration of the declared disaster emergency, or until such time as supplemental guidance is issued. OMH's intent is to maintain quality services and continuity of care for program participants, as well as to support agencies in maintaining current staffing levels. Please note that guidance and recommendations are being updated frequently. Providers should regularly review OMH's Guidance Documents page for updates.

Rounding of Service Time

During the emergency period beginning 3/7/2020, OMH is relaxing current time requirements for MH Clinics to allow for billing flexibility under State regulations and to conform with American Medical Association time standards. Below is a chart of affected OMH-licensed clinic services, procedure codes, original clinic regulatory time frames and the temporary time frames that may be used during the emergency period. Clinic services not shown in the chart below remain unchanged.

Clinic Service*	CPT Codes	Original minimum time	Temporary Time Reduction/Rounding Allowance**
Initial Assessment Diagnostic & Treatment Plan	90791	45 minutes	No MinimumTime***
Initial Assessment Diagnostic & Treatment Plan with Medical Services	90792	45 minutes	No MinimumTime***
Office Visit - New Patient	99201	15 minutes	10 minutes
Office Visit - Established Patient	99212	15 minutes	10 minutes
Psychiatric Assessment - Add on with Office Visit	90833	30 minutes	16-37 minutes
Psychiatric Assessment - Add on with Office Visit	90836	45 minutes	38-52 minutes
Psychotherapy	90832	30 minutes	16-37 minutes
Psychotherapy	90834	45 minutes	38-52 minutes
Psychotherapy - Family&Client	90847	60 minutes	50 minutes
Only clinic procedures with time changes are shown. Clinic procedures not listed remain unchanged.			
****Information provided by American Medical Association 2019 CPT Professional Manual***			
*****Rule allowing a maximum of three initial assessments per episode of care remains in effect.***			

Medicare/Medicaid Crossover Claims

Previously released guidance describes how OMH has expanded telehealth to include telephone use for all clinic services provided to Medicaid fee-for-service and Medicaid managed care clients. Telehealth for Medicaid and Medicaid managed care clients requires use of the existing procedure codes with the addition of telehealth modifiers, with no reduction in payment. Medicare has a different set of billing rules, procedure codes and reimbursement amounts regarding services using telehealth and telephone. This guidance aims to alleviate OMH clinic provider confusion regarding crossover claims for dual-eligible clients.

Please note: CMS billing and coding requirements for Medicare reimbursement continue to evolve; providers should regularly check the CMS Emergency Guidance Documents page for updated information regarding the COVID-19 emergency response.

Services Provided by Medicare-enrolled Practitioners

As Medicaid is the payer of last resort, providers must seek payment from the primary insurer first, including Medicare. When a service is provided by a Medicare-enrolled practitioner, to a dual-eligible client, the claim must be submitted to Medicare first before crossing over to Medicaid. The provider must meet all Medicare requirements for claim submission, including use of the Medicare-required procedure code(s) as well as provider adherence to the Medicare rules surrounding telehealth and telephone service provision.

CMS has released guidance documents describing various types of services that may be provided virtually or by phone. The procedure codes required by CMS must be used for services provided by

telehealth to all Medicare clients (including duals). Clinics may not change the procedure code(s) before crossing over to Medicaid. When the Medicare-required telephonic codes are crossed to Medicaid, providers will be paid based on the client diagnosis code (in the same way the office evaluation and management codes pay (e.g., 99213)). Claims may not be submitted directly to Medicaid Fee-for-Service when the service is provided by a Medicare-enrolled practitioner.

Services Provided by a Practitioner Not Recognized by Medicare (e.g., LMSW, LCAT, etc.)

As per existing OMH clinic guidance, providers may bypass billing Medicare (previously known as "zero-fill") when the service has been provided by a practitioner not recognized by Medicare (e.g., LMSW, LCAT, etc.). The claims for these practitioner types may be submitted to Medicaid directly using the original Clinic APG procedure codes with the appropriate telehealth modifiers. Providers must maintain documentation on a yearly basis to prove that the service was not covered.

Please note: This guidance is intended for Medicare/Medicaid crossover claiming. OMH is requiring that claims for non-dual Medicaid fee-for-service and Medicaid managed care clients be submitted using the original Clinic APG procedure codes with the appropriate telehealth modifiers. Medicaid managed care plans may not necessarily pay for the telephonic procedure codes required by Medicare and the telephonic codes are not mandated government rates.

Questions about the information found in this memo may be sent to clinicrestructuring@omh.ny.gov