May 15, 2020

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

Update to the 4/28/20 guidance to include new Medicare allowances

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.

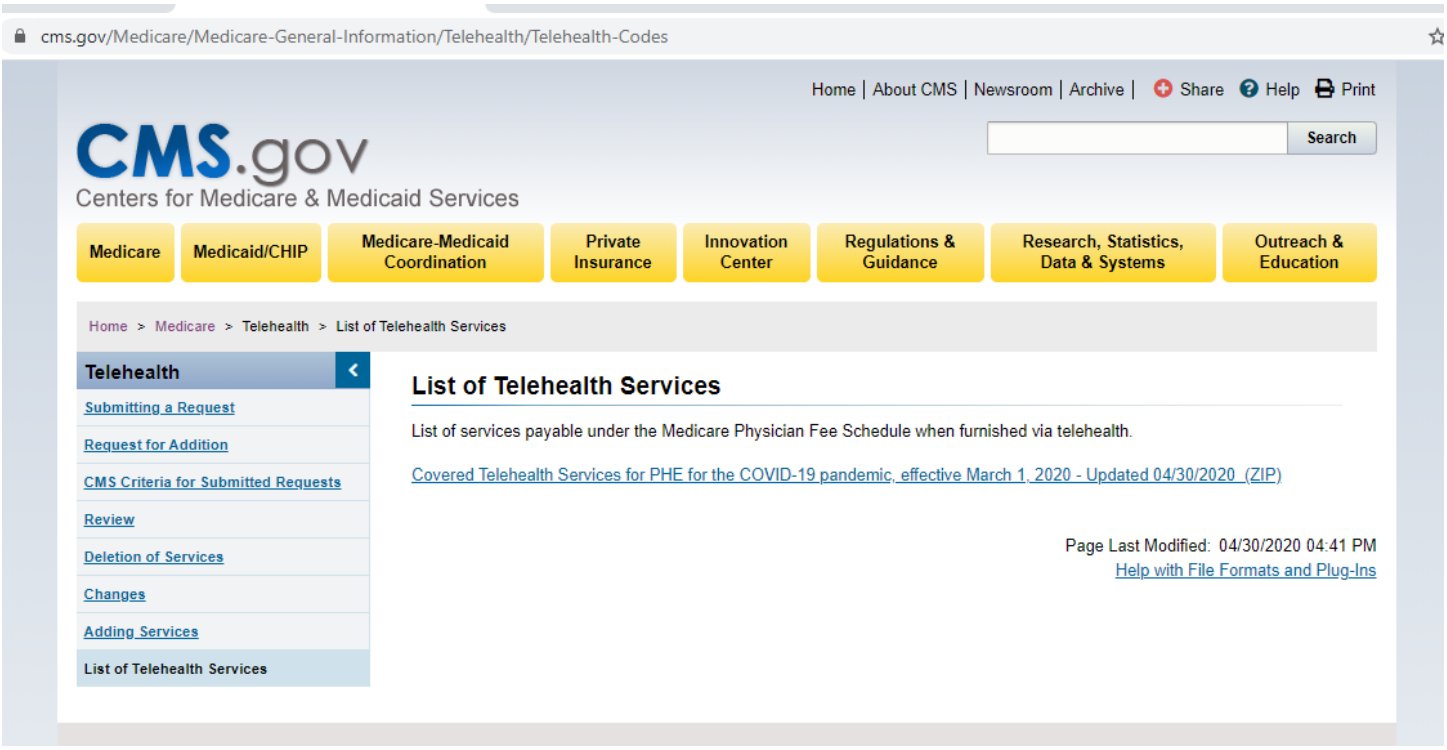
Clinic Service*	CPT Codes	Original minimum time	Temporary Time Reduction/Rounding Allowance**
Initial Assessment Diagnostic & Treatment Plan	90791	45 minutes	No MinimumTime***
Initial Assessment Diagnostic & Treatment Plan with Medical Services	90792	45 minutes	No MinimumTime***
Office Visit - New Patient	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.

The following guidance is intended to assist providers with billing 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 every telephonic procedure code allowed by Medicare and the telephonic codes may not have mandated government rates.

On April 30, 2020, CMS released updated Medicare telehealth guidance pursuant to 42 C.F.R. § 410.78(f), to add services to the Medicare telehealth services list and clarify which may be provided through audio-only technology, such as by telephone. The updated service list now includes most of the OMH Article 31 Clinic procedure codes that were used prior to the COVID-19 emergency. The full Medicare list of telehealth procedure codes can be found at the link below. Providers must adhere to the Medicare rules surrounding telehealth and telephone service provision when billing for these codes. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes



While most services are now available by telephone using the OMH clinic procedure codes, there are a couple of exceptions. Office Evaluation and Management (E&M) codes used for Psychotropic Medication Treatment and Psychiatric Assessments (99201-99205 and 99212-99215) are not to be used for services provided by telephone to Medicare clients. Instead, Medicare Telephonic E&M codes 99441-99443 must be used. When the provider crosses the claim with Medicare-required telephonic codes, the claim will be reimbursed based on the weight of the diagnosis (the same way that Mental Health clinics are paid for these services now). When claiming for a Psychiatric Assessment, the provider will also include 90833 or 90836, as applicable.

The Medicare-required telephonic E&M codes are different, but the payment providers receive from Medicaid will be the same (i.e., the higher of the full Medicare Part B coinsurance amount or the difference between the Medicare paid amount and the calculated APG payment).

Please note: CMS billing and coding requirements for Medicare reimbursement could change; 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).

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.

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

Appropriate telehealth modifiers can be found here: https://omh.ny.gov/omhweb/guidance/covid-19-telehealth-modifiers.xlsx