

# Part I: Mental Health Clinic Billing 101

June 23, 2015

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**The Community Technical Assistance Center**  
EFFICIENT PRACTICES. EFFECTIVE CARE.

# Agenda

- Introduction
- Claim Submission
- Recent updates to Part 599 regulations and guidance document
- Reimbursement increases
- Medicaid Managed Care and APG “government” rates
- Revisions to OMH Clinic Webpage
- Questions?



# Poll Question

What is your role in your agency?

- A. Director/Administrator
- B. Reimbursement Supervisor
- C. Billing Staff
- D. Clinician
- E. Other



# The problem with denials

- Medicaid data shows that a surprising number of denials are never adjusted and ultimately paid.
  - That's money the clinic earned but left on the table.
- Providers should review their remittance statements and correct claim denials as soon as possible (timely filing rules apply).  
[https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information for All Providers-General Billing.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information%20for%20All%20Providers-General%20Billing.pdf)
- Better yet, make sure the claim is accurate before being sent to eMedNY.
  - The following slides should help...



# How to ensure a clean claim

- Check the eligibility of the client EVERY time a service is provided.
- Claims must include the following information:
  - The client’s Medicaid ID (CIN);
  - The NPI of the clinic as the billing provider;
  - The NPI of the attending clinician or the OMH unlicensed provider ID (02249154).
    - If the attending clinician is not enrolled in Medicaid (e.g., non-licensed), the referring field **must** include the NPI of a Medicaid enrolled provider.
  - The designated mental illness diagnosis (or “diagnosis deferred” for pre-admission visits).
  - The location of the service, as identified by the location’s “zip+4”, NOT by its historic Medicaid locator code. Do NOT enter the location’s historic locator code on the claim



# Maximizing Reimbursement

- There are a few things to keep in mind when trying to maximize reimbursement:
  - All same rate coded procedures provided to an individual on the same day must be transmitted to Medicaid on one claim. This includes procedures provided by different clinicians. If same rate coded procedures provided to one individual on the same day are submitted as separate claims, only one of the claims will be paid.
- If you find that your clinic has submitted multiple claims for the same individual, on the same day, using the same rate code, you must adjust the paid claim to include the service that was not paid.



# Maximizing Reimbursement

- Psychiatric Assessments (30 or 45 minutes)
  - In order to be paid correctly for the amount of time spent with the client, clinics must use the combination of E&M code (e.g., 99213) and psychotherapy procedure code add-on (90833 or 90836).
  - OMH defines psychotherapy as “any type of interpersonal counseling and/or care coordination including but not limited to evidence based treatments that has as its aims support and/or assistance through engaging in a focused discussion about patients’ problems and possible solutions”.



# Maximizing Reimbursement

- Psychotropic Medication Injections
  - Injectable Psychotropic Medication Administration with Monitoring and Education (H2010) is billed using the 837i claim form (min. of 15 minutes).
  - However, the injection-only (administration) procedure (96372, no time minimum) must be submitted to Medicaid using a professional claim – 837p – (same as institutional but without a rate code). The clinic will receive \$13.23 for the injection. There are no modifiers available.
  - If the injection-only code 96372 is submitted on an 837i claim it will package with other services provided on the day and will not pay. Check your billing system to make sure that this code is being billed using the correct claim form.
  - Note: The injection-only CPT code 96372 is not considered a mental health carve-out service. This code should not be billed to Medicaid FFS for managed care individuals. It is possible that the managed care plan may pay for this but it is not mandated.





# Maximizing Reimbursement

- Utilization Threshold (UT) is a count that only applies to certain rate codes: 1504, 1510, 1516, 1522.
  - Countable service days do NOT include days in which only crisis services (on and off-site), health monitoring services, health physicals, psychotropic medication treatment, complex care management or children's off-site services were provided (so long as the claim is submitted using the appropriate rate codes for those services).
  - If a psychotropic medication treatment and/or complex care management are the only services provided on a day, providers should use the appropriate health services rate code (1474,1477,1588, 1591) to avoid having the visit count toward the utilization threshold for that individual.
  - There are also a few new UT-exempt rate codes that we will talk about later...



# Maximizing Reimbursement

- Payment Modifiers - If you are providing services that are eligible for a modifier, make sure you use them!
  - Language other than English (U4) – code on each applicable line, modifier pays 10% bump for that service.
  - After-hours (Procedure code 99051) – service beginning before 8 a.m. or beginning after 6 p.m. and all day on weekends. Weighted at .0759 of the APG peer group base rate. Only one 99051 is allowed per claim.
  - Physician add-on (AF (psychiatrist), AG (Physician) or SA (Nurse Practitioner)) will provide 45% bump for individual service, 20% for every individual in a group. Must either provide the entire service or be in the session for at least 15 min. (E&M codes are not eligible as they are already priced for a doctor)



# Recent Clinic Updates

- Complex Care Management (CPT 90882) (effective Oct. 1, 2014)
- 5% payment increase for 30 & 45 min. psychotherapy services (CPTs 90832/90834) when provided to a child (effect. Jan. 1, 2015)
- Change to the definition of a 45 min. psychotherapy service (CPT 90834) (effect. Jan. 1, 2015)
- Base rate increases (effect. Jan. 1, 2015)
- 20-minute visit allowed (effect. Jan. 1, 2015)
- Utilization threshold exemption for court-mandated services (effect. Jan. 1, 2015)



# Complex Care Management (90882)

- Psychotropic Medication Treatment has been added as a service that is eligible to generate CCM services (this is in addition to the Psychotherapy and Crisis services that already generate CCM eligibility).
- The time frame for the provision of CCM has been extended to 14 calendar days post any eligible service. This is a change from 5 working days post eligible service.
- **CCM is now billed in “five full minutes” units, with a units maximum of four (up to 20 full minutes). This is a change from one, 15-minute unit.**
- Each full five minute unit may be provided on a separate day (within the 14 day post limit), with a maximum of four full five minute units associated with each eligible clinic visit.
- The weight for CCM has been lowered from .2896 to .0965 per unit (cut by two-thirds, since the duration of the billing unit has been cut by two-thirds).
- Provider billing changes
  - Providers must indicate the number of “five full minute” units provided per day, up to the four unit max (20 minutes) in the 14 days post any eligible service.
  - If the CCM service is fully completed over the course of one day (up to 4 units) all units will be billed using one claim, on one claim line.
  - If units occur over the span of the 14-day limit, separate claims must be submitted depending on the date of service those units of CCM were provided.



# Complex Care Management (90882)

- What the data shows since the CCM unit change:
  - There has been a rise in number of recipients receiving this service.
  - While there was an increase in recipients it appears that some providers are still billing this as 1 unit, even for services longer than 5 minutes.
  - Check your billing system to make sure the change has been made to accept 1-4 units of CCM and that your billers are coding the correct number of units.



# Payment Increase for Individual Psychotherapy for Children

- The reimbursement for the 30 minute and 45 minute individual sessions (CPT codes 90832 and 90834), when provided to a child, has been increased effective January 1, 2015.
- This increase of 5% is available when these services are provided to a child up to age 19.
- Providers will continue to bill as usual, no changes required.
- For the 30 minute visit, reimbursement rose to about \$90 upstate, \$99 downstate and \$126 for LGU. For the 45 minute visit, reimbursement rose to \$121, \$131, and \$168 respectively.
- The base rate increase is on top of the numbers shown here.



# Greater Flexibility in the use of the 45 min Psychotherapy visit (client and collateral)

- Definition change to the 45-minute individual psychotherapy service (CPT 90834)
- Previously CPT 90834 was billed when an individual received face-to-face psychotherapy for 45+ minutes. Collaterals may or may not have been present and the client had to be present the entire time.
- The new definition allows for 30 minutes to be spent with the individual (with or without the collateral) and the remaining 15 minutes to be spent with the collateral (with or without the individual).
- Documentation must show the split in time between the individual or collateral.
- There is no change to the claim.



# 20 Minute Psychotherapy Session

- New rule now allows reimbursement for a 20 minute psychotherapy visit under Px code 90832.
  - Providers must use the U5 modifier to effect a 30% reduction in payment from that of the 30 minute visit.
- This change was made using feedback from providers and stakeholders; it allows for reimbursement for a brief visit when a client arrives late to the appointment or did not stay for the entire 30 minutes.





# Utilization Threshold Exemption

- To ensure that providers receive the full reimbursement for mandated services, OMH has amended the Part 599 regulations to allow a utilization threshold exemption in specific cases:
  - Use of the newly developed UT exemption rate codes applies only when a specific level of additional services exceeding the UT is required pursuant to one of the following:
    - Court Order
    - Assisted Outpatient Treatment(AOT)
    - Strict and Intensive Supervision and Treatment (SIST)
    - Other (as specifically approved by OMH)
- The rate codes below are only to be used for the circumstances specified above and will be subject to audit:
  - 1136 – Free-standing Article 31 Clinic (equivalent to 1504)
  - 1138 – Free-standing Article 31 Clinic (equivalent to 1510)
  - 1140 – Hospital-based Article 31 Clinic (equivalent to 1516)
  - 1142 – Hospital-based Article 31 Clinic (equivalent to 1522)



# APG Peer Group Base Rate Increases

- Increases were approved to help equalize the ratio of payment to cost between regions, resulting in the following:
  - Downstate free-standing clinics +3.3%
  - Upstate free-standing clinics +1.0%
  - LGU (county) clinics +1.0%



# Medicaid Managed Care Plans and APG (“government”) Rates

- NYS statute mandates that Medicaid Managed Care (MMC) plans’ mental health clinic reimbursement “shall be in the form of fees...which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology”. The fees are referred to as “government rates.”
- If your clinic is not receiving the APG “government” rate for services provided in your OMH-licensed MH clinic you must contact the Health Dept. at: [managedcarecomplaint@health.state.ny.us](mailto:managedcarecomplaint@health.state.ny.us) . Include a summary of the problem and the contact information of the plan rep. DOH will contact the plan.



# OMH Clinic Webpage

- The OMH Clinic webpage was recently updated with:
  - Newly adopted Part 599 Clinic regulations
  - New Part 599 guidance document
  - Provider-specific APG peer group base rates
  - New CPT Procedure Weight and Rate Schedule

[http://www.omh.ny.gov/omhweb/clinic\\_restructuring/](http://www.omh.ny.gov/omhweb/clinic_restructuring/)



# Questions/Concerns



For further discussion, questions and answers, please join us during our Consultation Webinar on Friday from 12-1pm.

Please submit your questions ahead of time to [ctac.info@nyu.edu](mailto:ctac.info@nyu.edu) with the subject line 'MH Clinic Billing 101'



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# Upcoming Webinars in this Series:

## **Billing 101: Consultation Webinar (Office Hours)**

- **Friday, June 26th 12:00pm-1:00pm**
- **Presenters: Gwen Diamond**, Reimbursement Policy and Implementation, New York State Office of Mental Health & **David Wawrzynek**, Chief Financial Officer, Spectrum Human Services

## **Part II: Dealing with Claims Denials**

- **Tuesday, July 7th 12:00pm-1:00pm**
- **Presenter: Rita Guido**, Outreach Supervisor, Computer Sciences Corporation

## **Claims Denials: Consultation Webinar (Office Hours)**

- **Friday, July 10th 12:00pm-1:00pm**
- **Presenters: Rita Guido**, Outreach Supervisor, Computer Sciences Corporation & **David Wawrzynek**, Chief Financial Officer, Spectrum Human Services



# Thank you for participating with us today!



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