NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Policy and Medicaid Billing Guidance

for Ambulatory Patient Groups (APGs)

and

Standards for Article 16 Clinics

Provider Manual

Revision 1
July 2011

Please Note: Revision 1 contains policy clarifications and/or additions since the April 2011 Final Draft. In addition, Revision 1 provides interim billing instruction that must be followed as of service date July 1, 2011 until DOH receives State Plan Amendment approval to implement APG reimbursement methodology in OPWDD Article 16 Clinics.

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CHAPTER 1: BACKGROUND AND INTRODUCTION TO AMBULATORY PATIENT GROUPS

1.1 Purpose:

The purpose of this manual is to provide policy and Medicaid billing guidance to the Office for People With Developmental Disabilities (OPWDD) Part 679 Clinic Treatment Facilities (Article 16 Clinics) that submit New York State (NYS) Medicaid claims for reimbursement under the Ambulatory Patient Groups (APGs) payment methodology. The standards in Chapter 5 of this manual are effective July 1, 2011 and supersede in their entirety, the standards contained in the Office of Mental Retardation and Developmental Disabilities (now OPWDD) Administrative Memorandum #2005-01; *Standards for Article 16 Clinics* dated February 18, 2005.

The policy and billing guidance in this manual is specific to billing Article 16 Clinic services to the NYS Medicaid program. When Article 16 Clinics bill private/commercial insurance or Medicare, Article 16 Clinics should follow private/commercial insurance or Medicare billing and coding guidelines.

For guidance on how to bill and submit claims for NYS Department of Health (DOH) ambulatory care services provided by DOH hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers, please visit the DOH website: Ambulatory Care Payment Reform - Ambulatory Patient Groups: http://www.nyhealth.gov/health_care/medicaid/rates/apg/

1.2 Statutory Authority for New Payment Methodology:

Chapter 57 of the Laws of 2008 amended Article 2807 of the Public Health Law by adding new Section (2-a). Public Health Law 2807 (2-a) requires a new Medicaid payment methodology based on APGs that would apply to most DOH ambulatory care services provided by hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers.

The law also authorized DOH to adopt and amend rules and regulations to establish an APG payment methodology. In 2009, Article 2807 was further amended to permit the application of APG payment methodology to services provided by facilities licensed under Mental Hygiene Law, including OPWDD Article 16 Clinics.

1.3 Overview of New Payment Methodology:

DOH is involved in a multi-year agenda to reform Medicaid reimbursement and rationalize service delivery through the transition of resources from inpatient to outpatient services to support quality outpatient care and to address the problem of avoidable hospitalizations. The APG payment methodology used by DOH is based on the Enhanced Ambulatory Patient Groups (EAPG) classification system, a product of the 3M Health Information Systems, Inc. APG reimbursement is the new and more rational payment methodology for most Medicaid outpatient services and replaces the Medicaid outpatient "threshold visit" used to reimburse services provided by DOH outpatient clinic, ambulatory surgery and emergency department services, and to cover mental health services and other services carved out of Medicaid managed care for managed care enrollees.

The former six types of Article 16 Clinic visits; intake, full, brief, group, collateral and comprehensive diagnostic and evaluation visits and the corresponding rate codes will no longer exist and do not apply under APG payment methodology. The APG Medicaid payment methodology for Article 16 Clinic services will mirror the APG payment methodology used by DOH for services provided in the DOH settings identified above. By and large, the APG Medicaid payment methodology provides greater reimbursement for comparably higher intensity services and relatively less reimbursement for lower intensity services. APG payment methodology links payment to the specific array of services/procedures provided and allows for greater payment homogeneity across outpatient ambulatory service settings for comparable services.

1.4 Approved Article 16 Clinic Services & Approved Practitioners:

The APG payment methodology is applicable to approved clinical services provided by an Article 16 Clinic certified in accordance with 14 NYCRR Part 679. The approved clinical services must be delivered by an appropriately licensed/certified NY State Education Department (SED) practitioner, a person with a NY SED limited permit to practice the specific profession, an exempt person completing a NYS SED required supervised experience, an appropriately supervised student-in-training from an accredited and NY SED approved program or an authorized **qualified non-licensed staff** as defined in 14 NYCRR Part 679.

Qualified non-licensed staff may provide specific Article 16 Clinic services as indicated:

- Applied Behavioral Sciences Specialist (ABSS) – Clinic Intake and Psychology Services
- Rehabilitation Counselor – Clinic Intake and Rehabilitation Counseling Services
- Treatment Coordinator – Clinic Intake

Approved Article 16 Clinic Services	Approved Practitioners
Clinic Intake:	
Preliminary clinical interview/assessment of the potential admittee (new referral), his/her collateral, and/or the referral source for the purpose of determining the appropriateness of admission	NY SED licensed/certified Practitioner, limited permit holder, exempt person completing SED required supervised experience, student-in-training or authorized qualified non-licensed staff as indicated above
Rehabilitation/Habilitation Services:	
Occupational Therapy (OT)	Licensed Occupational Therapist or an **appropriately supervised** Certified Occupational Therapy Assistant
Physical Therapy (PT)	Licensed Physical Therapist or an **appropriately supervised** Licensed Physical Therapy Assistant
Psychology	Licensed Psychologist or an **appropriately supervised** Applied Behavioral Sciences Specialist (ABSS) as defined in 14 NYCRR Part 679
Rehabilitation Counseling	Rehabilitation Counselor as defined in 14 NYCRR Part 679
Speech and Language Pathology (SLP)	Licensed Speech and Language Pathologist
Social Work	Licensed Clinical Social Worker (LCSW) or an **appropriately supervised** Licensed Master Social Worker (LMSW)
Medical/Dental Services:	
Medicine, including medical specialties such as psychiatry & physiatry	Licensed Physician, Physician with 3-year limited license, Licensed Physician Assistant, Specialist Assistant or Nurse Practitioner
Dentistry	Licensed Dentist, Dental Hygienist or Certified Dental Assistant
Health Care Services:	
Nutrition (and Dietetics)	Certified Dietitian/Certified Nutritionist
Nursing	Registered Professional Nurse, Licensed Nurse Practitioner or an **appropriately supervised** Licensed Practical Nurse
Audiology	Licensed Audiologist
Podiatry	Licensed Podiatrist-Doctor of Podiatric Medicine (DPM)

1.5 Implementation Schedule in Article 16 Clinics:

As with services provided by DOH hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers, approval of federal financial participation by the Centers for Medicare and Medicaid Services (CMS) is required prior to implementing the APG payment methodology in Article 16 Clinics.

The APG Medicaid payment methodology will replace the regulatory based fee schedule reimbursement for services provided by Article 16 Clinics. It is anticipated that DOH will receive CMS approval to implement APG payment methodology in OPWDD Article 16 Clinics effective July 1, 2011.

1.6 Blending of APG Payment for Article 16 Clinics:

The full use of the APG reimbursement methodology for Article 16 Clinic visits will be phased-in via a multi-step blended progression. Provided that APG reimbursement methodology is effective July 1st, 2011, the phase-in progression includes two 12 month time periods, commencing with the first step July 1, 2011 through June 30, 2012 and the second step starting July 1, 2012 through June 30, 2013. The subsequent six month time period from July 1, 2013 through December 31, 2013 is the third step prior to the full implementation of APG reimbursement that will be effective beginning January 1, 2014. If APG reimbursement methodology is delayed beyond July 1, 2011, the phase-in progression time periods may need to be modified.

Time Period	Average Legacy Fee	APG Reimbursement
7/1/11 – 6/30/12 (12 months)	75%	25%
7/1/12 – 6/30/13 (12 months)	50%	50%
7/1/13 – 12/31/13 (6 months)	25%	75%
1/1/14 & going forward	0%	100%

The Medicaid payment for an Article 16 Clinic visit during the transition period will consist of a blended payment comprised of:

1. a partial operating payment determined by the Article 16 Clinic average operating payment under the pre-existing reimbursement methodology (average legacy fee), plus
2. a complementary partial operating payment calculated under the new APG reimbursement methodology, plus
3. a capital cost component, if and as appropriate.

An average legacy fee will be established for each Article 16 Clinic as follows:

1. Counts of paid visits for each Article 16 Clinic and for each visit type under the pre-existing reimbursement methodology (i.e., "full," "brief," "group," "collateral," "intake," and "diagnostic/evaluation" visit types) will be extracted from the eMedNY payment system for service dates between April 1, 2009 and March 31, 2010. OPWDD reserves the right to adjust this look-back period to accommodate instances wherein a clinic was not certified by OPWDD for the entire year.
2. Each Article 16 Clinic's total operating payment by visit type shall be determined by multiplying the count of paid visits for the visit type determined in (1) above by the operating component of its fee (i.e., full fee minus its capital cost component) in effect on the day preceding the effective date for the same visit type. OPWDD may adjust these results to prevent a clinic from incurring a decrease or an increase in Medicaid reimbursement disproportionate to that of the clinics within its peer group.
3. The total operating payments by visit type determined in (2) above will be summed and then divided by the Article 16 Clinic's total paid visits across all visit types.

Reimbursement for an Article 16 Clinic's capital cost may vary in dollar amount among Article 16 Clinics. Under APG reimbursement methodology a clinic's capital cost is made as a separate, distinct payment added to the APG operating payment calculation using the NYS DOH standard rules with respect to which APGs and/or procedures allow for the added capital component. During the transition period, the Medicaid system will automatically connect each Article 16 Clinic average legacy fee and if applicable, the appropriate capital cost component, to the APG (procedure) service paid.

There are certain APGs and individual procedures that are listed by DOH as "no blend" under APG reimbursement methodology and therefore are not subject to the blended payment during the transition period.

The complete list of "no blend" APGs is available online at:

http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_blend.pdf

The complete list of "no blend" procedures is available online at:

http://www.nyhealth.gov/health_care/medicaid/rates/apg/docs/apg_no_blend_procedures.pdf

Effective the date of APG reimbursement, most Article 16 Clinic claims will be paid a blended payment using the following formula:

- Total Payment: [75% * Average Legacy Fee] + [25% * (APG Payment Calculation)] + Capital Cost Component, if and as appropriate.

The blended payment will vary at each step of the multi-step progression as described in the first paragraph of this section.

Effective the date of APG reimbursement, payment for Article 16 Clinic claims that represent services that are listed by DOH as "no blend" APGs or procedures will be calculated as follows:

- Total Payment: APG Payment + Capital Cost Component, if and as appropriate.

1.7 Interim Billing for Article 16 Clinics:

To be consistent with DOH recent actions OPWDD will pend implementation of the use of APG reimbursement methodology to await State Plan Amendment (SPA) approval from CMS, which is expected to be retroactive to July 1, 2011.

Claims for Article 16 Clinic services as of service date July 1, 2011 must be fully coded with all applicable CPT/CDT/HCPCS codes (including all required procedure code modifiers) and ICD-9 diagnosis codes in anticipation of the automatic reprocessing of these claims by eMedNY under the APG payment methodology back to service date July 1, 2011.

Claims for Article 16 Clinic services as of service date July 1, 2011 should be submitted using the appropriate pre-APG Article 16 Clinic rate codes (4140 – 4145, 4150 – 4155) based on the regulatory standards in place prior to July 1, 2011 until DOH receives approval from CMS to implement APG reimbursement methodology in OPWDD Article 16 Clinics.

Article 16 Clinic providers will be notified by OPWDD when SPA approval is received by DOH from CMS. Once notified, all new claim submissions to eMedNY should use the new APG rate codes appropriate to the services as described in this manual.

Further instructions on the interim claiming process and next steps will be provided once CMS approval of the SPA is obtained by DOH.

CHAPTER 2: APG GROUPING LOGIC AND USE OF MODIFIERS

2.1 APG Payment Methodology:

The APG payment methodology software consists of two distinct subsystems:

1. Grouper
   - groups and categorizes related procedures rendered during a clinic visit in a clinically relevant manner
   - based on clinical concepts that are universal in nature
   - varies little across implementations

2. Pricer
   - uses the output of the grouper to determine actual reimbursement
   - determines payment based on reimbursement concepts that may vary significantly by payor
   - customized to the implementation

Modifications were made to the APG grouper and pricer for the application of APG payment methodology to some services provided by Article 16 Clinics.

Grouper Changes

1. Addition of new Group Therapy APGs
   - OT/PT (includes group Rehabilitation Counseling)
   - SLP

2. Restructuring of Psychotherapy APGs based on recommendations of NYS Mental Hygiene agencies

Pricer Changes

1. Reduced packaging: Most Mental Hygiene series APGs will NOT package with a same-day medical visit.

2. Multiple same APG discounting: When multiple procedures group to the same Mental Hygiene APG, discounting – not consolidation, is typically employed to the APG weighted payment.

   - Nutrition, OT, PT & SLP Therapies: 25% discount
   - Psychotherapy, Mental Hygiene Assessment and Developmental & Neuropsychological Testing: 10% discount

3. Unit Based Service Intensity Weighting: Typically, the pricer ignores CPT units of service. However, for specific Mental Hygiene APGs (OT, PT, nutrition and education/collateral services) this has been modified. For these APGs, the submitted units of service act as a weight multiplier (up to an allowed limit).

4. Procedure-Specific Weighting: Typically, procedures within the same APG share the same service intensity weight (SIW). Procedure-specific weighting allows the APG category to be divided into multiple sub-weighted bands.

Payments to Article 16 Clinic providers are directly related to the actual services provided based on the person's diagnosis and the allowable Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) and/or Current Dental Terminology (CDT) codes reported on the Article 16 Clinic Medicaid claim. APG processing uses software that examines the procedure codes and any associated modifiers reported in each of a claim's service lines and assigns each line an APG code, along with other relevant values such as APG weights, packaging flags, discounting percentages, etc. For medical evaluation and management (E&M) services, the assignment of the APG is dependent on the International Classification of Diseases (ICD) Primary Diagnosis code recorded on the claim.

APG-specific weights reflect average cost for the APG visit divided by the average cost of all APG visits. Some services provided by Article 16 Clinics such as OT, PT, SLP, developmental & neuropsychological testing, psychotherapy, nutrition and education/collateral services have procedure-specific weights that vary the APG payment based on the particular CPT/HCPCS code.

Some procedure-based weights for OT, PT, nutrition and education/collateral services, including diabetes self-management services provided by a Certified Diabetes Educator, also recognize units in the APG payment. When coding a unit-based procedure, the actual total number of units provided by the approved practitioner should be reported on the claim (even if the total number of units provided is above the unit maximum for a specific CPT/HCPCS code). Please refer to Chapter 3 Section 6 Units of Service Related to Timed CPT/HCPCS Codes for additional information. The procedure-based weight and the number of units are both used in the APG payment calculation for the units based procedure.

The final weight for a given Article 16 Clinic visit is multiplied by the assigned OPWDD base rate as part of the APG calculation. A single claim can be assigned one or more APG values, each of which carries its own weight, depending on the service line procedure codes, modifiers, and in some cases, the diagnosis codes.

2.2 APG Types:

The APG grouper/pricer maps CPT/HCPCS procedure codes and ICD diagnosis codes reported on the Article 16 Clinic claim to the appropriate APGs that correspond to the services provided during the Article 16 Clinic visit. The primary types of APGs that reflect most services provided during an Article 16 Clinic visit are described below.

1. Significant Procedures: A procedure/service that constitutes the reason for the visit and dominates the time and resources expended during the Article 16 Clinic visit. (Examples: group medical nutrition therapy, physical therapy evaluation, diagnostic interview examination, psychotherapy)

2. Medical Visits: A visit during which a person receives medical treatment/examination but does not have a significant procedure performed. E&M codes are assigned to one of the medical visit APGs based on the primary diagnosis reported on the claim for the medical visit.

3. Ancillary Tests and Procedures: A test or procedure ordered by the primary physician to assist in the person's diagnosis or treatment. (Examples: immunizations, laboratory tests, etc.)

4. Incidental Procedures: An integral part of an Article 16 Clinic visit usually associated with professional services being given to the service recipient. (Example: range of motion testing)

A full list of APG types can be found at the DOH website: Ambulatory Care Payment Reform - Ambulatory Patient Groups.

http://www.nyhealth.gov/health_care/medicaid/rates/apg/

2.3 APG Classification Logic:

The APG classification logic employed for DOH ambulatory care services provided by hospital outpatient departments, emergency departments and ambulatory surgery departments, and free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers is the same classification logic that is employed for OPWDD services provided by Article 16 Clinics.

The clinic visit is described by a list of APGs that corresponds to the services provided to a person. The significant procedure or therapy (rather than diagnosis) is the initial classification variable. Procedures that are provided on an outpatient ambulatory basis, including those provided by Article 16 Clinics, are categorized as either significant procedures or ancillary services.

Clinic visits are assigned to a significant procedure APG on the basis of the CPT/HCPCS code that describes the precise significant procedure or therapy. Clinic visits that involve medical services and that do not involve a significant procedure are assigned to a medical APG based on the ICD diagnosis code.

In some cases, a clinic visit may involve a significant procedure and medical services, in which case the visit would be assigned to a significant procedure APG. The use of modifier codes may change how the significant procedure combined with the medical visit is reimbursed. Under the default APG logic, the procedure would be paid at the line level and the medical visit payment would be included (packaged) in the payment for the significant procedure. A clinic visit that neither involves medical treatment nor a significant procedure but involves the performance of an ancillary service would be assigned to an ancillary service APG.

Clinic visits that involve any significant procedures or therapies are assigned to one or more significant procedure APGs. If there are no significant procedures present and there is a medical service (generally an E&M CPT code is reported), the service is assigned to a medical visit APG. If there is neither a significant procedure nor a medical visit code, but there are ancillary test(s) or procedure(s) present, then the service is assigned one or more ancillary APGs. If there is no significant procedure CPT code, medical visit (E&M CPT) code or ancillary code, the claim is considered an error.

The complete APG logic is included in the 3M Health Information Systems Definitions manual which is available through 3M's Definitions Manual Website at:

http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Products/Definition_Manuals/

The EAPG grouper logic recognizes a list of significant procedures with which medical visits do not package. Medical visits do not package with: the more significant ancillaries; dental procedures; physical, speech and occupational therapy; and psychotherapy services. When certain significant procedures are performed on the same day as a medical visit, no packaging would occur and payments would be received by the provider for both the medical visit and significant procedure at the line level.

For a complete list of "significant procedures with which medical visits do not package," please visit the DOH website: Ambulatory Care Payment Reform - Ambulatory Patient Groups.

http://www.nyhealth.gov/health_care/medicaid/rates/apg/

2.4 Grouping Elements of the APG Payment System:

The DOH *Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual* describes the methods used by the APG system for grouping different services provided into a single payment unit: ancillary packaging, significant procedure consolidation or bundling; and multiple significant procedure and ancillary discounting.

Medical visits do not package with higher intensity significant ancillary procedures (e.g., mammograms, MRIs, CAT scans, etc.) and will pay separately at the line level. Similarly, medical visits do not package with dental procedures; physical, speech and occupational therapy; and counseling services. When provided on the same date as an E&M visit, these services will pay at the line level.

Multiple same APG discounting (rather than consolidation) which applies to most dental services (e.g., APG 352 Periodontics) also includes occupational therapy (APG 270), physical therapy (APG 271), speech therapy (APG 272) and Mental Hygiene APGs (APG 323 & 324).

For a complete description of the grouping methods used by the APG system and the list of APGs that will discount rather than consolidate when combined with other same or similar APGs, please refer to the DOH APG manual.

Services provided by Article 16 Clinics are most often subject to significant procedure consolidation or bundling and multiple significant procedures and ancillary discounting.

1. Significant procedure consolidation or bundling

    - CPT codes that group to the same APG are typically consolidated

2. Multiple significant procedure and ancillary discounting

    - If two CPT codes group to different APGs, 100% payment is made for higher cost APG & second procedure is discounted as follows:

        1. Nutrition, OT, PT and SLP Therapies: 25% discount
        2. Psychotherapy, Mental Hygiene Assessment and Developmental & Neuropsychological Testing: 10% discount

    - May also be applied when two CPT codes group to the same APG (as an alternative to consolidation)

2.5 Use of Modifier Codes in APGs:

Modifier codes can be put on a Medicaid claim to report or indicate that a service or procedure has been altered by some specific circumstance but not changed the service or procedure definition or code.

The APG system recognizes several billing modifier codes described in the DOH *Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual*. For direction regarding the use of these billing modifier codes, please refer to the DOH APG manual.

The APG system also recognizes modifier codes for use with the following Article 16 Clinic services:

1. Rehabilitation Counseling

    - License-level Modifier HN (Bachelors Level)
    - License-level Modifier HO (Masters Level)

> Note: One of the two license-level modifiers above MUST be used when Article 16 Clinic rehabilitation counseling services are claimed for APG Medicaid reimbursement. Providers must report the appropriate license-level modifier based on the educational degree of the rehabilitation counselor providing services. These license level modifiers are used ONLY with claims for rehabilitation counseling services that include the following seven CPT codes:

- 97003
- 97004
- 97530
- 97532
- 97535
- 97537
- 97150

2. Speech and Language Pathology

> Note: The GN therapy modifier MUST be used to identify those Article 16 Clinic SLP treatment plan services that are recorded using Physical Medicine and Rehabilitation CPT Codes and are claimed for APG Medicaid reimbursement. It is not necessary to use the GN modifier for other Article 16 Clinic SLP treatment plan services or for Article 16 SLP evaluation and/or testing services that fall outside of APG 270 or 271.

> Note Regarding Other Therapy Modifiers: Based on the Department of Health and Human Services Centers for Medicare and Medicaid Services, most Medicare claims for OT, PT and SPL therapy services require the use of therapy modifiers as follows: GO for OT, GP for PT and GN for SLP. Article 16 Clinic providers may choose to use these therapy modifiers. However, only therapy modifier GN is required for use with Article 16 Clinic SPL treatment plan therapy services as described in the note above when submitted for reimbursement under the NYS Medicaid Program.

Article 16 Clinic providers must submit one claim for each clinic visit as defined in this Chapter that includes all approved services provided by all approved practitioners during the Article 16 Clinic visit. Services provided during an Article 16 Clinic visit are reported using valid and allowable CPT/HCPCS and/or CDT codes.

3.1 Use of APG Rate Codes:

The following are the new APG grouper rate codes effective as of the date of implementation of APG payment methodology for Article 16 Clinic services:

1. Free-Standing Article 16 Clinic On-site Services 1546

2. Free-Standing Article 16 Clinic Off-site Services 1549

3. Hospital Article 16 Off-site Services 1537

Article 16 Clinic providers are required to use the new rate codes for all Article 16 Clinic Medicaid claims with service dates on and after the effective date of APG payment methodology implementation.

There are separate rate codes for on-site and off-site Article 16 Clinic services to comply with federal reporting requirements.

To select the proper rate code to use on a claim, the provider must know if the services were provided at an Article 16 Clinic certified location (on-site, i.e., main or satellite location) or away from an Article 16 Clinic certified location (off-site).

- If the Article 16 Clinic annual physician (re) assessment of need for the continuation of on-going treatment is conducted face-to-face; the service must be reported using the Article 16 Clinic on-site rate code or the Article 16 Clinic off-site rate code depending on where the service was provided.

Rate codes associated with the former six types of approved Article 16 Clinic visits, including on-site and off-site codes for each type of visit; intake, full, brief, group, collateral and comprehensive diagnostic and evaluation visits, will no longer be valid for dates of service on or after the date of APG payment methodology implementation.

> *Reminder:* Only approved services listed on the Article 16 Clinic Operating Certificate may be claimed for reimbursement, except for medical services that are provided by the Article 16 Clinic medical director up to ½ of the assigned FTE.

3.2 Services Not Paid Under APGs:

Services not paid based upon the APG classification and reimbursement system are described in DOH 10 NYCRR 86-9.10 Exclusions from payment.

3.3 Importance of Accurate Claim Coding:

To ensure appropriate reimbursement under the new APG payment methodology, all Article 16 Clinic APG Medicaid claims must include:

1. Date of service
   - Date of service on claim must correspond to (be the same as) date of service in treatment record/file
   - If an assessment/evaluation service, (including developmental & neuropsychological testing) is conducted over more than one day, the date of service for claiming purposes is the last day face-to-face service is provided.

2. Appropriate Article 16 Clinic rate code
   - There are separate rate codes for on-site Article 16 Clinic and off-site Article 16 Clinic visits to comply with federal reporting requirements.
   - To select the proper rate code to use on a claim, the provider must know if the services were provided at an Article 16 Clinic certified location (on-site, i.e., main or satellite location) or away from a certified location (off-site).

3. Accurate ICD primary diagnosis code(s)*
   - Use Health Insurance Portability and Accountability Act (HIPAA) compliant ICD diagnosis codes
   - Diagnosis code on the claim should reflect condition treated at the Article 16 Clinic visit (i.e., the primary reason for the service)
   - It may be appropriate to use codes that classify factors influencing health status and/or that describe contact with the Article 16 Clinic when circumstances other than a disease or injury are the reason for a clinical encounter or are recorded as problems or factors that influence services.

* Primary diagnosis code describes the condition, problem or other reason for the services provided during the Article 16 Clinic visit.

4. Valid allowable CPT/HCPCS codes reflecting services provided
   - Use allowable CPT/HCPCS Procedure Codes

     1. HCPCS Level I: American Medical Association (AMA) Current Procedural (CPT) code set
     2. HCPCS Level II: "Alphanumeric" codes established by Centers for Medicare and Medicaid Services (CMS) for other special purposes
     3. CDT Codes: Current Dental Terminology codes for dental procedures

   - If multiple procedures (services) are provided, multiple codes should be reported on the Article 16 Clinic claim.

   - CPT/HCPCS and/or CDT Codes reported on the Article 16 Clinic claim MUST be consistent with the scope of practice, certification, profession and/or training of the approved practitioner.

   - Clinical file documentation must be sufficient to support the descriptive terms and guidelines associated with the CPT/HCPCS and/or CDT Codes reported on the Article 16 Clinic claim.

5. Identification of approved practitioner (service provider)
   - NY SED licensed/certified practitioner – NPI # of practitioner (including OTAs & PTAs)
   - ABSS, SED limited permit holder & student-in-training – NPI # of supervising licensed practitioner
   - Rehabilitation Counseling & Intake service by qualified non-licensed staff – "Bypass" Code 02249136

3.4 Basic Unit of Service Under APGs:

- An Article 16 Clinic visit is defined as a **unit of service** under APG reimbursement methodology.

- Reimbursement for approved services provided during an Article 16 Clinic visit is based on **face-to-face service, including observation associated with the face-to-face service** as defined by allowable CPT/HCPCS or CDT codes.

- *Pre and post delivery services/encounter time* is **not** billable time and is defined as the time spent by the approved practitioner before and/or after the face-to-face service/encounter performing the following tasks:

    1. Reviewing records and tests
    2. Arranging for additional services
    3. Communicating with other professionals or service providers in any manner, such as in person, through written reports or telephone or electronic contact
    4. Communicating with the person, the collateral, or others through written reports or telephone contact
    5. Documenting the face-to-face service/encounter in the clinical record

- An Article 16 clinic visit is defined as all approved clinical services that share a common date of service and includes reimbursement for all the approved clinical services provided for a person, his/her collateral or potential admittee on the common date of service by practitioners of the healing arts and/or other authorized parties pursuant to this Part **except as noted below**:

    1. If a diagnostic and evaluation service **(including developmental & neuropsychological testing)** is conducted over more than one day, the date of service for claiming purposes is the last day the service is provided.

    2. If an on-site clinic visit is provided and claimed for reimbursement on the same day as an off-site clinic visit, **reimbursement for each visit is considered a separate unit of service**.

- The Article 16 Clinic **annual service authorization level** is the maximum number of **units of service** (~~generally~~ all services connected to **a single date of service and a single rate code, except as noted above**) per calendar year an Article 16 Clinic can receive reimbursement from NYS Medicaid.

3.5 Use of Visit Rate Codes:

All services and procedures provided during an Article 16 Clinic visit to a person with the same date of service and the same rate code must be billed together on one claim. If two claims are submitted for the same person with the same rate code, same date of service, and same provider (Article 16 Clinic), only the first claim submitted will result in payment. The second claim will be denied.

If a person returns to the Article 16 Clinic for multiple visits that correspond to the same rate code on the same date of service, all the procedures must be billed on one claim with the appropriate APG rate code. If the Article 16 Clinic provider attempts to submit multiple APG claims for that rate code for the same recipient/same date of service, only one claim will be paid. All others will be denied as duplicative claims.

3.6 Units of Service Related to Timed CPT/HCPCS Codes:

Generally, the APG reimbursement system does not recognize units of service related to timed CPT/HCPCS codes. However, effective January 1, 2010, multiple units of service may be claimed for a limited group of occupational and physical therapy procedures. Additional unit-based procedures that may also be claimed as multiple units are nutrition services and patient education/collateral services; including diabetes self management training that is rendered by a Certified Diabetes Educator.

When calculating the number of units to record on the Article 16 Clinic claim, do NOT include the time the service recipient spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the approved practitioner's *pre and post delivery services/encounter time as defined in Chapter 3 Section 4*.

Providers should not code multiple lines on a single claim with the same CPT/HCPCS code to signify the provision of multiple units of a single procedure/service. Providers should include the CPT/HCPCS code on one line along with the number of units of the service provided on that same line.

Providers should record all of the number of units for all services provided even if the number of units provided is above the respective unit maximum for a given CPT/HCPCS code. (Please see Article 16 Clinic Mental Hygiene Crosswalk)

There are service/procedure specific billing limitations (unit limits) for some CPT/HCPCS codes. For a complete list of unit-based procedures and their respective unit maximums, please visit the DOH website: Ambulatory Care Payment Reform - Ambulatory Patient Groups.

http://www.nyhealth.gov/health_care/medicaid/rates/apg/

4.1 Mental Hygiene APG Service Categories: Article 16 Clinic Allowable CPT/HCPCS Codes:

Article 16 Clinics utilize Mental Hygiene APG categories to record long term therapies such as OT, PT, SLP; rehabilitation counseling; behavioral health services such as psychology, social work & pharmacological management (by appropriate medical practitioners) and nutrition (and dietetics) and education/collateral services.

Article 16 Clinic programs must record the appropriate and allowable CPT/HCPCS and/or CDT codes associated with the standard APG categories for other approved Article 16 clinic services such as audiology, dentistry, nursing, podiatry and medicine, including medical specialties such as psychiatry and physiatry services. Reimbursement for these approved Article 16 Clinic services follows standard APG logic.

The Mental Hygiene APG categories and the corresponding allowable CPT/HCPCS codes listed below are for the purpose of billing Article 16 Clinic services to the NYS Medicaid program. Article 16 Clinics should use the allowable CPT/HCPCS codes listed for billing approved Article 16 Clinic services to the NYS Medicaid program. When billing private/commercial insurance or Medicare, Article 16 Clinic programs should use appropriate codes as directed by private/commercial insurance or Medicare billing and coding guidelines.

APG CATEGORY	CPT/HCPCS CODES	APG CATEGORY	CPT/HCPCS CODES
118 Nutrition Therapy	97802, 97803, 97804, G0270, G0271	270 Occupational Therapy (Rehabilitation Counseling may only use 97003, 97004, 97532, 97535, 97537)	97003, 97004, 97532 - 97537, 97542
271 Physical Therapy (Rehabilitation Counseling may only use 97530)	97001, 97002, 97010 – 97039, 97110 – 97124, 97140, 97530, 97545, 97546, 97750, 97755, 97760 – 97762, 97799	272 Speech Language Pathology	92506, S9152, 92507, 92526, 92597, 92605 - 92610, 92626, 92630, 92633, 92640
274 Physical Therapy Group (includes OT & Rehabilitation Counseling Group)	97150	275 Speech Therapy Group	92508
310 Developmental & Neuropsychological Testing	96101, 96102, 96105, 96110, 96111, 96116, 96118, 96119, 96125	315 Individual Brief Psychotherapy	90804, 90805, 90810, 90811
316 Individual Comprehensive Psychotherapy	90806, 90807, 90808, 90809, 90812, 90813, 90814, 90815, 90819, 90845	317 Family Psychotherapy	90846, 90847
318 Group Psychotherapy	90849, 90853, 90857	323 Mental Hygiene Assessment	90801, 90802
324 Brief Assessment (Clinic Intake may be provided by Treatment Coordinator)	T1023	426 Psychotropic Medication Management & Drug Monitoring	M0064, 90862
428 Education – Individual & Collateral &/or Diabetes Self Management Training (DSMT)	98960, G0108	429 Education - Group & Group Collateral &/or Diabetes Self Management (DSMT)	98961, 98962, G0109

4.2 Mental Hygiene APG Service Categories: Article 16 Clinic Billing Guidance:

- 118 Nutrition Therapy

1. Article 16 Clinic dietetic/nutrition services MUST be provided by a NY SED certified dietitian/nutritionist; in addition, the person may also be a registered dietitian (RD).

2. Article 16 Clinic dietetic/nutrition services include assessment/reassessment of the nutritional status of a person with an illness and/or diet-related condition to identify if the person is at risk for major nutrition related health problems and to determine if nutrition services are clinically indicated.

3. Nutritional assessment/reassessment includes the establishment of nutrition diagnoses and treatment goals that result in the development of specialized interventions that may involve patient or appropriate collateral education, self-management training, nutritional counseling/therapy and/or recommendations of dietary adjustments/ interventions that lead to better health outcomes and improved quality of life.

4. Ongoing Article 16 Clinic dietetic/nutritional services are provided ONLY for clinical signs/symptoms related to Type 1 and Type 2 diabetes, renal disease, gastro-intestinal disorders, cardio-vascular disease, obesity, anorexia and/or bulimia.

5. If dietetic/nutrition services are provided to a person who resides in an OPWDD certified residence and/or family care home, the services that may be provided are those dietetic/nutrition services that can not be safely addressed by the nutrition and/or nursing staff assigned to the person's OPWDD certified residence and/or family care home, within the scope of his/her NYS licensure, training and/or competence.

6. A unit of service for nutrition services must be the full time indicated per unit by the allowable CPT/HCPCS code (e.g. 15 minutes for CPT code 97802 must be a full face-to-face 15 minutes). Do NOT include the time the service recipient spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the approved practitioner's *pre and post delivery services/encounter time as defined in Chapter 3 Section 4*.

- 270 Occupational Therapy; 271 Physical Therapy & 274 Physical Therapy Group

  1. Article 16 Clinic OT/PT services MUST require the skills of, and be provided by a NY SED licensed/certified OT, PT, OTA or PTA, a person holding an appropriate NY SED limited permit or an appropriately supervised student-in-training.

  2. A qualified and approved OT/PT practitioner, including an OTA or PTA, may utilize a specific CPT code from APG 270, 271 or 274 to provide clinically indicated services within their scope of practice &/or competence even if the CPT code is mapped to an APG that reflects a "different discipline".

  3. Article 16 Clinic OT/PT services must be services as defined in the current NYS Medicaid Program *Rehabilitation Services Policy Guidelines*:

     - Evaluation: Assessment of a person's physical and functional status to determine if OT/PT services are medically necessary and clinically indicated, gather baseline data that includes objective findings, and establish a treatment plan with reasonable and attainable goals within a defined period of time. All evaluations are administered or conducted with appropriate and relevant assessments or protocols using objective measures and/or tools. An evaluation is required prior to implementing a treatment plan.

     - Reevaluation: An assessment to evaluate progress or to modify or redirect therapy services when there are new clinical findings, a rapid change in status, or failure to respond to the therapeutic interventions.

     - Restorative Services: Diagnostic evaluation and therapeutic intervention designed to improve, develop, correct or rehabilitate physical conditions that have been lost, impaired, or reduced as result of acute or chronic medical conditions, congenital abnormalities, or injuries.

     - Long Term Therapy Services: Services that due to the person's unique physical, cognitive or psychological status, are necessary to prevent deterioration and sustain functioning, provide interventions that enable a person with chronic and/or progressive disability to be as independent as possible, and/or provide treatment interventions that result in demonstrated clinical progression, but not necessarily at a rate that is comparable to restorative care/treatment.

  4. When calculating units for OT/PT services based on "Timed Code Treatment Minutes" (constraining minutes), do NOT include the time the service recipient spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the approved practitioner's *pre and post delivery services/encounter time as defined in Chapter 3 Section 4*.

  5. When determining the number of units to bill for OT/PT services Article 16 Clinic providers must use the guidelines for timed CPT codes found in the current CMS Local Coverage Determination (LCD) for Outpatient Physical and Occupational Therapy Services.

  6. When the total timed treatment minutes for the OT/PT service is less than 8 minutes, the OT/PT service does not meet the threshold for billing.

➢ Rehabilitation Counseling

1. Article 16 Clinic rehabilitation counseling is defined as services to assist individuals with developmental disabilities to maximize their vocational/employment potential and independence through appropriate pursuits; to become or remain productive and/or self-sufficient; to obtain and maintain employment. Rehabilitation counseling involves face-to-face interaction with the service recipient and the rehabilitation counselor for the purpose of:

    - Assessment and follow-up reassessment of person's vocational/employment strengths and abilities; obstacles and limitations
    - Service/activity design and actual hands-on training in use of equipment at a job site
    - Problem solving/counseling involving personal, environmental, and societal issues
    - Job modification and/or obtaining and training in the use of assistive devices
    - Skill development assistance necessary to obtain and/or to maintain employment

2. Rehabilitation Counseling may ONLY use the following seven CPT codes from APG 270, APG 271 and APG 274 to record services:

97003	97004	97150 (Group)
97530	97532	
97535	97537	

3. Based on 14 NYCRR Part 679, a rehabilitation counselor is someone who has:

    - a master's degree in rehabilitation counseling from an accredited institution of higher education whose program includes supervised clinical experience in a vocational setting of at least six months; or
    - a bachelor's degree in a human services discipline from an accredited institution of higher learning and three years supervised experience in providing rehabilitation services in a vocational setting

4. Article 16 Clinic rehabilitation counseling services claimed for APG Medicaid reimbursement MUST include license-level modifier on the claim that indicates the educational level of the rehabilitation counselor.

    - HN-Bachelors
    - HO-Masters

5. A unit of service for rehabilitation counseling services must be the full time indicated per unit by the allowable CPT code (e.g. 15 minutes for CPT code 97535 must be a full face-to-face 15 minutes). Do NOT include the time the service recipient spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the approved practitioner's *pre and post delivery services/encounter time as defined in Chapter 3 Section 4*.

- 272 Speech Language Pathology & 275 Speech Language Pathology Group

    1. Article 16 Clinic SLP services must be provided by a NY SED licensed speech language pathologist or a person who is exempt from licensure for professional practice that is completed as part of the NYS SED required supervised experience in a speech language pathology clinical fellowship year (CFY) plan.

    2. A NY SED licensed speech language pathologist or an exempt person completing his/her CFY plan may utilize a specific allowable CPT/HCPCS code from APG 270 (OT) or APG 310 (Developmental & Neuropsychological Testing) to record services appropriate to his/her scope of practice &/or competence even though the CPT/HCPCS code is mapped to an APG that reflects a "different discipline".

    3. Article 16 Clinic SLP services that are recorded using Physical Medicine and Rehabilitation CPT Codes and claimed for APG Medicaid reimbursement MUST include therapy modifier GN on the claim to identify the services as Article 16 Clinic SLP treatment plan services. It is not necessary to use the GN modifier for other Article 16 Clinic SLP treatment plan services or for Article 16 SLP evaluations and/or testing.

    4. Swallowing Evaluation and Dysphagia Treatment – Swallowing assessment and rehabilitation are highly specialized services that must be provided by a skilled professional therapist who has specific education, experience and demonstrated competencies. Competencies include, but are not limited to: identifying abnormal upper aero-digestive tract structure and function; conducting oral, pharyngeal, laryngeal and respiratory function examination as it relates to the functional assessment of swallowing; recommending methods of oral intake and risk precautions; and developing a treatment plan employing appropriate compensations and therapy techniques.

    5. A skilled professional therapist as referenced above refers to a licensed speech-language pathologist, occupational therapist, physician, or non physician practitioner, such as a nurse practitioner, who is licensed, certified, or otherwise authorized by NYS to perform swallowing evaluation and dysphagia treatment services.

- 310 Developmental & Neuropsychological Testing

1. Each CPT code in this APG has a unit maximum of one (1). Practitioners should record the total number of units for a given CPT code based on the CPT description and/or guidelines even if the total number of units provided is above the unit maximum of one.

2. Developmental & neuropsychological testing is divided into multiple sub-weighted bands of procedure-specific weights that vary based on the CPT descriptions, the test content, the length of time involved in the administration of the test and the allowed practitioners who may administer the test.

3. All testing CPT codes MUST involve face-to-face service/interview with the service recipient and may also include face-to-face service/interview with an appropriate informant as defined by testing protocol.

4. In addition to NYS licensed psychologists and physicians, appropriately qualified and/or supervised health care professionals within the scope of his/her NYS licensure and/or training may provide some testing services.

5. An applied behavioral sciences specialist (ABSS) is *someone having a master's degree in a clinical and/or treatment field of psychology from an accredited institution, who has training in assessment techniques and behavioral program development and who functions under the supervision of a licensed psychologist.*

6. An ABSS is considered an appropriately qualified and/or supervised health care professional to provide testing services based on the scope of his/her training for those CPT codes indicated in the chart below.

CPT Code	Type of Test	NY SED Licensed/Certified Practitioner/14 NYCRR Part 679 Authorized Professional; Examples of Tests associated with CPT code
96101	Psychological Testing	Code used ONLY by Licensed Psychologist, Physician (including Psychiatrist) or LCSW; e.g. MMPI, Rorschach, WAIS, ADOS, ADI-R
96102	Psychological Testing	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. MMPI, WAIS, ADOS, ADI-R
96105	Assessment of Aphasia	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. Boston Diagnostic Aphasia Examination
96110	Developmental Testing, Limited	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. Developmental Screening Test II, Early Language Milestone Screen
96111	Developmental Testing, Extended	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. Adaptive Behavior Assessment System or Vineland Adaptive Behavior Scales
96116	Neurobehavioral Status Exam	Code used ONLY by Licensed Psychologist or Physician (including Psychiatrist); e.g. Neurobehavioral Cognitive Status Examination (NCSE)
96118	Neuropsychological Testing	Code used ONLY by Licensed Psychologist or Physician (and Psychiatrist); e.g. Halstead-Reitan Neuropsychological Battery, D-KEFS, NEPSY
96119	Neuropsychological Testing	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. Halstead-Reitan Neuropsychological Battery, D-KEFS, NEPSY
96125	Cognitive Performance Testing	Code may be used by appropriately qualified and/or supervised health care professional to report services within the scope of his/her NYS licensure and/or training; e.g. Ross Information Processing Assessment

- 315 Individual Brief Psychotherapy; 316 Individual Comprehensive Psychotherapy; 317 Family Psychotherapy & 318 Group Psychotherapy

1. Psychotherapy is defined as the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the person who is receiving psychotherapy and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

2. The following NY SED licensed/certified practitioner &/or authorized professional under 14 NYCRR Part 679 within the scope of his/her training may provide psychotherapy in an Article 16 Clinic:
   - Psychiatrist (MD/DO)
   - Licensed Psychologist
   - Licensed Clinical Social Worker
   - Psychiatric Nurse Practitioner

   And an appropriately supervised:
   - Physician Assistant
   - Licensed Master Social Worker
   - Applied Behavioral Sciences Specialist (ABSS) as defined in 14 NYCRR Part 679

3. Providers should select the appropriate psychotherapy CPT code to report based on the type of psychotherapy (insight oriented, behavior modifying and/or supportive versus interactive), the length of the face-to-face time spent providing psychotherapy and whether medical E&M services are also provided on the same date of service as the psychotherapy.

4. Psychotherapy with medical E&M services CPT codes 90805, 90807, 90809, 90811, 90813 & 90815

   - These services MUST be provided by a Nurse Practitioner (NP), a Physician (MD/DO), including a psychiatrist or an appropriately supervised Physician Assistant (PA) and MUST include a medical services (E&M) component.

5. Psychoanalysis CPT code 90845

   - Psychoanalysis employs the use of specialized techniques. It is a different therapeutic modality than psychotherapy. The physician or other healthcare professional using this technique must be trained by an accredited program of psychoanalysis.

   - Psychoanalysis is defined in 8405(1)(a) of the Education Law as the observation, description, evaluation, and interpretation of dynamic unconscious mental processes that contribute to the formation of personality and behavior in order to identify and resolve unconscious psychic problems which affect interpersonal relationships and emotional development, to facilitate changes in personality and behavior through the use of verbal and nonverbal cognitive and emotional communication, and to develop adaptive functioning.

6. Based on the current CMS Local Coverage Determination (LCD) for Outpatient Psychiatry and Psychology Services, family psychotherapy CPT codes 90846 & 90847 and group psychotherapy CPT codes 90853 & 90857 are typically, but are not required to be, 45-60 minutes in duration. Family psychotherapy CPT codes 90846 & 90847 may include services provided to appropriate collateral as defined in Part 679.99 (f).

7. Multiple-family group psychotherapy CPT code 90849 represents a multiple-family group service that is usually directed to the effects of the primary service recipient's condition on the family and the purpose of the service is to support the affected family members. The primary service recipient (the person with a developmental disability) must receive services from (must be admitted to) the Article 16 Clinic. However, this does not mean that the primary service recipient must be present when the family member(s) is/are receiving the group service.

- 323 Mental Hygiene Assessment

    1. CPT codes 90801 & 90802 are reported for a clinical diagnostic or evaluative interview that includes history, mental status and disposition. Information may be obtained from members of the patient's family, educational and/or employment setting; and other relevant health information sources to complete a family, social and/or psychiatric history, to conduct a mental status evaluation, to establish an initial psychiatric diagnosis and treatment plan and/or to evaluate the person's ability and/or capacity to respond to treatment.

    2. CPT codes 90801 & 90802 MUST be conducted by a Psychiatrist, a Licensed Psychologist, a Licensed Clinical Social Worker (LCSW), or an appropriately supervised Licensed Master Social Worker (LMSW) or an appropriately supervised applied behavioral sciences specialist (ABSS) as defined in 14 NYCRR Part 679.

    3. CPT code 90802 Interactive psychiatric diagnostic or evaluative interview using play equipment, physical devices, language interpreter, or other mechanisms of communication is reported evaluating children and also adults who do not have the ability to interact through ordinary verbal communication, including some people with developmental disabilities. The clinical record documentation must indicate that the person being evaluated does not have the ability to interact through normal communicative channels.

    4. CPT codes 90801 & 90802 MUST involve face-to-face service/interview with the service recipient and may also include face-to-face service/interview with an appropriate informant and/or referral source.

    5. The service is not generally repeated for the same person for the same reason unless there is clinical justification to do so; clinical record documentation MUST support and justify the reason to provide this service more than once to the same person.

- 324 Brief Assessment (Clinic Intake)

    1. A NY SED licensed/certified practitioner, a Part 679 authorized professional, or staff functioning as an Article 16 treatment coordinator as defined in 14 NYCRR Part 679 may provide a clinic intake.

    2. An Article 16 Clinic treatment coordinator is the single professional or otherwise qualified (i.e., holding at least a baccalaureate degree or a license as a registered nurse) clinic staff member designated for each person receiving clinic services to coordinate the provision of all treatments, activities, experiences, or therapies as prescribed through the clinic's admission process and by the treating professionals in the person's treatment plans.

    3. HCPCS code T1023 is used to claim a clinic intake defined as a preliminary face-to-face clinical interview/assessment of the potential admittee (new referral), his/her collateral, and/or the referral source conducted by a licensed professional and/or other authorized party pursuant to this Part 679 for the purpose of determining the appropriateness of admission to the Article 16 Clinic.

    4. A clinic intake may include the gathering of information, including relevant documentation of clinical diagnoses, personal demographics, insurance information, establishment of financial resources/benefits, completion of related clinic program paperwork, and the scope and type of services currently received by the person outside of the Article 16 Clinic to ensure coordination and non-duplication of services.

    5. A clinic intake is not "repeated" or claimed (billed) to "update" information for the admitted person's clinical record.

    6. A clinic intake may NOT be necessary for a person to receive Article 16 Clinic services if the person is known to the clinic program and if there is appropriate and sufficient documentation of the person's established developmental disability.

- 426 Psychotropic Medication Management

    1. Pharmacologic management CPT code 90862 includes prescription, use, and review of medication, monitoring the effect of the medication, and adjusting the dosage. It also involves relevant interval history, focused mental status evaluation, assessment of treatment response & ongoing treatment formulation; any psychotherapy provided is minimal and is usually supportive in nature.

    2. Brief office visit for monitoring or changing drug prescriptions, HCPCS code M0064, is used for the lesser level of drug monitoring, such as simple dosage adjustment. Time spent is generally less than 10 minutes.

    3. CPT code 90862 and/or HCPCS code M0064 MUST be provided by a Physician (MD/DO), including a psychiatrist; a Nurse Practitioner (NP); or an appropriately supervised Physician Assistant (PA).

    4. If pharmacologic management and psychotherapy with an E&M (90805, 90807, 90809, 90811, 90813 or 90815) are provided on the same date of service, the pharmacological management is included in the E&M services and 90862 may NOT be billed separately for the date of service.

- 428 Education – Individual & 429 Education – Group

1. CPT codes 98960, 98961 & 98962 include education services provided to individuals or groups; i.e., to the primary service recipient or a group of primary service recipients, and/or to a person's collateral or a group of collateral, using a standardized curriculum and/or generally accepted community standards of professional practice.

2. Collateral may only be:

   - A member of the family, defined as biological/adoptive family, guardian, foster care parent, or family care provider; or

   - A non-related party, who has a long-term care-giving relationship with the admitted person with developmental disabilities, provided they are not being paid to provide clinical or direct care-giving services to that person.

3. The primary service recipient (the person with a developmental disability) must also receive services from (must be admitted to) the Article 16 Clinic if collateral services are provided.

4. The service is provided to address the need for the primary service recipient to self manage their illness and/or to address the need for the collateral of the primary service recipient to understand the primary service recipient's developmental disability, to be supportive of the primary service recipient and/or to reinforce or to carry out treatment.

5. The collateral must be identified in the treatment plan of the primary service recipient. (The training service must be linked to a therapeutic outcome for the primary service recipient.)

6. Services that involve collateral training must be documented in the primary service recipient file as an individual or group collateral service, based on the persons receiving the training services.

7. HCPCS codes G0108 & G0109 are used to record Diabetes Self-Management Training (DSMT). DSMT MUST be provided to individuals and/or groups of individuals with a new diagnosis of diabetes or a change in diagnosis that requires additional training in diabetic care.

8. DSMT must be provided by a NYS licensed, registered, or certified professional as allowed by DOH, who is also a Certified Diabetes Educator (CDE).

9. A unit of service for education services must be the full time indicated per unit by the CPT/HCPCS code (e.g. 30 minutes for CPT code 90896 must be a full face-to-face 30 minutes). Do NOT include the time the service recipient spends getting ready to begin, resting, or toileting, or the approved practitioner's ***pre and post delivery services/encounter time as defined in Chapter 3 Section 4***.

CHAPTER 5: STANDARDS FOR ARTICLE 16 CLINICS (Effective for services delivered on or after July 1, 2011)

Title 18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, "the provider agrees…to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date of care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and such records and information, upon request, to…the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health." It should be noted that there are other entities with rights to audit Medicaid clinic claims, including OPWDD.

In addition, 18 NYCRR, Section 517.3(b)(2) states that "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later."

5.1 Clinic Visits

Article 16 Clinics may receive reimbursement for a clinic visit defined as a unit of service under APG reimbursement methodology (see Chapter 3 Section 4 for additional information).

- Reimbursement for approved services provided during an Article 16 Clinic visit is based on face-to-face service, including observation associated with the face-to-face service as defined by allowable CPT/HCPCS or CDT codes.

- Face-to-face service/encounter time does NOT include the time the person or party spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the authorized party's pre and post delivery services/encounter time as described below.

- Pre and post delivery services/encounter time is the time spent by the authorized party before and/or after a face-to-face service/encounter performing the following tasks:
  1. Reviewing records and tests
  2. Arranging for additional services
  3. Communicating with other professionals or service providers in any manner, such as in person, through written reports or telephone or electronic contact
  4. Communicating with the person, the collateral, or others through written reports or telephone contact
  5. Documenting the face-to-face service/encounter in the clinical record

- If an authorized party begins to provide a face-to-face service/encounter to an individual and the individual refuses to stay, becomes disruptive or a piece of equipment fails, etc., thus preventing the completion of the service delivery, the ACTUAL time spent providing the face-to-face service/encounter can be claimed for reimbursement as long as the service provided meets the definition of an Article 16 Clinic visit. These situations should be clearly documented in the clinical record to prevent claiming disallowances.

- An Article Clinic visit must be delivered by an appropriately licensed/certified NY SED practitioner, a person with a NY SED limited permit to practice the specific profession, an exempt person completing a NYS SED required supervised experience, an appropriately supervised student-in-training from an accredited and NY SED approved program, or an authorized qualified non-licensed staff as defined in 14 NYCRR Part 679.

5.2 Clinic Service Documentation:

Medicaid reimbursement rules require the inclusion of sufficient, supporting documentation in the person's clinical record to support the services delivered and claimed for reimbursement. Service documentation elements included in the person's clinical record are:

- The individual's name
- The individual's Medicaid number (CIN)
- Treatment notes (progress notes) that describe the face-to-face service/encounter, i.e. what happened during the treatment session; the tasks, activities and/or procedures performed that are associated with the person's clinic treatment plan, and the progress, result and/or the person's response to the clinic service, and includes:
  1. The service date. (month/date/year)
  2. The location of service delivery. (e.g. Maple Avenue IRA)
  3. The duration of the face-to-face service/encounter. (OPWDD best practice is to document the time the service started and the time the service ended.)
  4. The full signature and title of the clinic staff providing the clinic service. (Full countersignature and title must be provided if required by NY SED)
  5. The date the note was written or documented in the record/file. (Medicaid rules require that the note must be contemporaneous to the service provision.)

5.3 Clinic Treatment Plans:

All clinic treatment plans are based on a current and written individualized, clinical examination, assessment and/or evaluation and are individually tailored to the person's needs. The duration of the clinic treatment plan is one year unless otherwise indicted or changed by the clinic medical director. The clinic medical director or designee reviews and approves (signs) all treatment plans at least annually, by the end of the calendar month in which the clinic treatment plan is effective, or when there are changes to the elements of the treatment plan. The clinic treatment plan contains the following elements:

- The treatment diagnosis as related to the primary reason the service is provided.
- The person's developmental disability and other documented diagnoses (medical and/or psychiatric) that may relate to or demonstrate the person's need for the service.
- Identification of the therapy, therapies or specific type or modality of therapeutic intervention (e.g. physical therapy – gait training) that will be used to address the person's need(s).
- The treatment goals; functional and time framed.
- The frequency of service delivery. If frequency is stated as a range, the range must only be written to include a plus 1 type order, i.e., 1-2 or 2-3 times per week or per month.
- The location of the service delivery if the service delivery is in an OPWDD-certified residence. The treatment plan must identify the specific clinic service and provide justification for the delivery of the clinic service in the residence.

5.4 Clinic Treatment Reviews:

Clinic treatment reviews incorporate ~~a~~ review of the frequency of the clinic service(s) the goals the treatment plan is intended to achieve; whether treatment goals have been met, and/or whether new goals need to be established. Clinic treatment goals should be established that incorporate expected achievements within specified time periods.

- The clinic treatment outcomes and/or the course of clinic treatment are reviewed according to the following schedule:
  1. as specified by the treating physician or dentist for medical, including medical specialties, or dental treatment; and
  2. at least every six months by the end of the calendar month in which the clinic treatment review occurs by the treating clinic practitioner or the clinic treatment coordinator, in consultation with the person receiving services and/or as appropriate, his/her collateral for all other Article 16 Clinic treatment plan services
- The review of clinic treatment outcomes and/or the course of clinic treatment should be specific rather than general; quantifiable, if appropriate; and directly related to the person's clinic treatment plan.
- Documentation must indicate that the clinic treatment outcomes and/or the course of clinic treatment have been reviewed, and whether clinic treatment is to continue, be changed (next steps) or be discontinued.

5.5 Annual Physician (Re) assessment:

The clinic medical director or designee (physician) assesses all individuals annually as to the continuing need to be served by the clinic.

- The annual physician (re) assessment includes the review of the individual's treatment and evaluative and clinical/medical information.
- The review should take account of the clinic service provided, the frequency at which it is provided, the length of time it has been provided, the therapies or modalities employed in treatment, the intended treatment goals, and the clinical appropriateness of the treatment goals in relation to the individual's diagnosis (es), cognitive functioning, physical abilities and the provision of other clinical services to the person.
- The clinic medical director or designee (physician) may choose to include a face-to-face encounter to obtain needed additional and/or substantive information about the person.
- Documentation must indicate the date of the (re) assessment, the signature of the physician, the physician's recommendations regarding continuing treatment and briefly, the rationale involved in the determination.
- The annual physician reassessment must be completed and dated no later than 31 days after a full calendar year has elapsed since the date of the last completed physician reassessment. For example: If the physician's reassessment is dated June 15, 2011, the date of the reassessment in 2012 must be on or before July 16, 2012.

5.6 Clinic Nursing Services

Article 16 Clinic nursing services consist of professional services that require the skill or direction of a registered nurse (RN) to perform.

- An RN and a licensed practical nurse (LPN) may only provide services within his/her respective scope of practice & competence as defined by NY SED.
- An LPN may only provide Article 16 Clinic nursing services under the direction of an RN, licensed physician, dentist, physician assistant and/or nurse practitioner directly employed by the Article 16 Clinic.
- Any treatment generally considered first aid; collection of a laboratory specimen (including phlebotomy), or routine medication administration is not a reimbursable Article 16 Clinic nursing service.
- Nursing services required by Administrative Memorandum #2003-01, *Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities*, are not reimbursable Article 16 Clinic nursing services.

5.7 Clinic Quality Assurance Plan:

The clinic quality assurance plan includes a planned and systematic process for monitoring and assessing the quality and appropriateness of treatment, the clinical performance of staff, a means to resolve identified problems to improve treatment, and the opportunity to incorporate input of consumers, collateral, referral sources and other pertinent parties. The quality assurance process should:

- Specify written operational procedures and the staff responsible for quality assurance activities that include both program and individual service evaluation.
- Include individual service evaluation that is representative of the population being served by the clinic and the type of services being provided to that population.
- Define methods for the identification and selection of clinical and administrative problems to be reviewed.
- Establish review criteria in accordance with current standards of professional community practice.
- Document findings, trends, recommendations, and actions taken to resolve problem areas.
- Demonstrate timely implementation of necessary corrective actions.
- Provide for periodic assessment or re-assessment of the corrective actions taken.

5.8 Coordination of Clinic Treatment Plans:

The clinic treatment coordinator has primary coordination responsibility for all services, therapies and/or treatment provided to a person by the Article 16 Clinic. The clinic treatment coordinator forwards written treatment plan recommendations to the person's Medicaid Service Coordinator or other coordinator outside of the clinic program, and as appropriate, to other caregivers and referral sources. Written recommendations must be forwarded when the treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of treatment are completed; and whenever the clinic treatment plan is significantly changed.

- To avoid the duplication of clinical services, treatment plans must attempt to incorporate all of the person's other individualized written plans of services required by law or regulation. All plans should be generally consistent (i.e. not in conflict) and not duplicate the same clinical service or modality (e.g. gait training) from multiple sources. Other plans can include: the Individualized Services Plan (ISP), the Individualized Education Program (IEP), the Individual Program Plan (IPP), and clinic treatment plans for services delivered by other clinics. Identification of an Article 16 Clinic service on other individualized plans of service is not a billing requirement for the Article 16 Clinic provider.

    1. If the person is enrolled in the OPWDD Home and Community Based Services (HCBS) waiver or is receiving only Medicaid Service Coordination (MSC), the clinic treatment coordinator should request that the Medicaid Service Coordinator provide a copy of the person's current ISP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.

    2. If the person is a resident of an OPWDD Intermediate Care Facility (ICF), the clinic treatment coordinator should request that the ICF administrator provide a copy of the person's IPP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.

        - Each OPWDD certified ICF/DD is fiscally responsible for the costs of certain long term therapies provided to a person who resides at the ICF/DD regardless of the location where the service is received (e.g., Article 16 Clinic services provided at the main site, certified satellite site, or ICF; Article 28 Clinic services provided at the main clinic site, certified extension or part-time clinic site). This provision applies to various long term therapies: dietetics and nutrition, nursing services (excluding medical services provided by a nurse practitioner), occupational therapy, physical therapy, psychologist services, rehabilitation counseling, social work, and speech and language pathology services.

- This provision does NOT apply to medical services (including medical services provided by a nurse practitioner and medical specialty services such as psychiatry). Separate time-limited billing of up to three consecutive months per calendar year is allowed for certain services (i.e., dietetics and nutrition, nursing, occupational therapy, physical therapy, speech and language pathology and psychologist services) in response to an acute illness, accident, or post-hospitalization health need.

3. If an OPWDD provider operates both a clinic certified pursuant to Article 16 of Mental Hygiene Law, and a clinic certified pursuant to Article 28 of Public Health Law, the clinic treatment plans for any person who is being served by both clinics are expected to be coordinated.

4. If a person is enrolled in an OPWDD day treatment program, the clinic treatment coordinator must ensure compliance with regulation 690.3(a)(5)(v) that prohibits reimbursement of Article 16 Clinic services other than in the four specified clinical service areas of audiology, special medical, routine medical and dentistry when an individual also receives an OPWDD certified collocated day treatment service (a.k.a., partial day treatment) on the same day. A certified day treatment program that is located on the same site as an OPWDD certified day training or sheltered program is considered to be a collocated day treatment service.

❖ Treatment plans should be coordinated with clinical services delivered by other providers, including other clinics.

1. If different clinic services are being provided to a person by two or more Article 16 Clinics (e.g. clinic "A" is providing psychology services to the person while clinic "B" is providing occupational therapy to the same person), the clinical record and the clinic treatment plan for each clinic must include documentation that clearly indicates what service is being provided by each Article 16 Clinic.

2. If a particular clinic service (e.g. psychology) is being provided to a person by one Article 16 Clinic, that service must not also be provided to the same person by another Article 16 Clinic, unless there is a compelling clinical justification to do so (e.g. the person needs a specific treatment service that is only offered by a therapist from another clinic). The clinical record and the clinic treatment plan for each clinic must include documentation that the service is being provided by another Article 16 Clinic, and include the clinical justification for the provision of the same service by two different clinics.

3. If a person residing in an ICF receives Article 16 Clinic services (because the specific clinical service is not included in the reimbursement rate for the ICF or because the agency operating the ICF purchases the clinical service directly from the Article 16 Clinic), the clinic treatment coordinator should provide a copy of the person's clinic treatment plan to the ICF administrator when the clinic treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of clinic treatment are completed; and whenever the clinic treatment plan is significantly changed.

5.9 Clinic Administration:

❖ The clinic administrator of an Article 16 Clinic must be directly employed by the agency that holds the Article 16 Clinic operating certificate.

❖ The clinic administrator, the medical director, and/or the medical director designee of an Article 16 Clinic must not have interests that could materially affect his/her objective judgment when making decisions about the provision of Article 16 Clinic services.

CHAPTER 6: Contract Clinician Organizations:

Clinical services provided by contract clinicians or contract clinician organizations for an Article 16 Clinic are subject to control and oversight by the agency holding the Article 16 operating certificate. All referrals and recommendations for Article 16 Clinic services must be reviewed and approved by the clinic medical director or other designated physician/dentist. Oversight of contract clinicians or contract clinician organizations should be documented by the agency that holds the operating certificate for the Article 16 Clinic.

- Contract clinicians or contract clinician organizations should not be the only mechanism used by an Article 16 clinic to obtain the services of clinicians.

- The agency which holds the operating certificate must describe in its clinic program policy and procedure manual or similar document, the plan to provide oversight of services delivered by contract clinicians or contract clinician organizations. The plan must specify how staff directly employed by the agency which holds the operating certificate will oversee the development of all clinic treatment plans and updates to the treatment plans.

- The agency which holds the operating certificate must document the oversight of contract clinicians or contract clinician organizations through monitoring reports that detail the type, frequency and location of clinical services provided, the review of "sign-in" and "sign-out" logs for clinicians, and visits to actual service delivery locations. Staff directly employed by the agency that holds the operating certificate must conduct the monitoring reports and reviews.

- The agency which holds the operating certificate must retain the final authority to decide what services will be delivered to each person, and the amount, frequency and length of time the services will be provided, and may not delegate final decision-making responsibility for such decisions.

- The agency which holds the operating certificate must retain the authority to adopt and enforce policies governing services delivered by the clinic, or by any party or organization hired or under contract to provide services.

- The agency which holds the operating certificate must retain access to and right of control of all books, records and supporting documents in connection with the operation of the clinic, and may not transfer ownership of, or relinquish control of such books, records and supporting documents except as otherwise required by law.

- The agency which holds the operating certificate must retain the authority to incur debts or liabilities and enter into contracts, and may not allow another party or organization to incur debts or liabilities or enter into contracts on their behalf.

- The agency which holds the operating certificate must not allow any part of an organization that is providing services on their behalf as an independent contractor, to do any marketing or advertising for or on behalf of the clinic program.

GLOSSARY OF TERMS

Allowed APG Weight – The relative resource utilization for a given ambulatory patient group (APG) after adjustment for bundling, packaging, and discounting.

Ambulatory Patient Group (APG) – A defined group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of diagnoses from the latest International Classification of Diseases (ICD) and Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes. APGs are defined under the 3M Health Information Systems, Inc. grouping logic outlined in the APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M.

APG Relative Weight – A numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs.

Ancillary Services – Those laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment.

APG Software System – The New York State-specific version of the APG computer software developed and published by Minnesota Mining and Manufacturing Corporation (3M) to process HCPCS/CPT and ICD code information in order to assign patient visits, at the procedure code level, to the appropriate APG category and apply appropriate bundling, packaging, and discounting logic to assign the appropriate final APG weight and associated reimbursement. Each time the software is updated, 3M will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software, can perform the computations by accessing the APG definitions manual, which is available on the 3M web site.

Base Rate – The numeric value that shall be multiplied by the allowed APG weight for a given APG or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

Case Mix Index (CMI) – The actual or estimated average final APG weight for a defined group of APG visits.

Coding Improvement Factor – A numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system.

Consolidation/Bundling – The process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit.

Current Dental Terminology (CDT) – A code set with descriptive terms developed and updated by the American Dental Association (ADA) for reporting dental services and procedures.

Current Procedural Terminology (CPT) – The systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT is maintained by the American Medical Association and the HCPCS is maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

Discounting – The reduction in APG payment that results when additional procedures do not consolidate. Additional occurrences of the same ancillary APG within a single visit or episode will also discount.

Evaluation and Management (E&M) Services – Services and/or consultations provided by an appropriately authorized medical practitioner, i.e., physician, nurse practitioner or an appropriately supervised physician assistant.

Final APG Weight – The allowed APG weight for a given visit as expressed in the applicable APG software, and as adjusted by applicable consolidation, packaging and discounting and other applicable adjustments.

Grouper/Pricer – The New York State-specific Grouper software development by 3M, with modifications for payable APGs made to support the New York State Medicaid Program.

Healthcare Common Procedure Coding System (HCPCS) – A numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

International Classification of Diseases (ICD) – A comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually. Providers should utilize the ICD version that is currently approved by CMS for use in HIPAA compliance.

Medical Visit APG – An APG representing a visit during which a person received medical treatment but did not have a significant procedure preformed.

Modifier Code – A code that can be put on a Medicaid claim to report or indicate that a service or procedure has been altered by some specific circumstance but not changed the service or procedure definition or code. Modifier codes enable health care professionals to effectively respond to payment policy requirements established by other entities.

No Blend APG – An APG that has its entire payment calculated under the APG reimbursement methodology without regard to the historical average operating payment (average legacy fee) per visit for the provider.

Packaging – Those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software.

Peer Group – A group of providers or services that share a common APG base rate.

Procedure Based APG Weight – a numeric value that reflects the relative expected average resource utilization (cost) for a specific procedure. In the APG payment methodology, a procedure-based weight overrides the APG weight.

Significant Procedure APG – An APG incorporating a medical procedure that constitutes the primary reason for the visit in terms of time and resources expended.

Visit – A unit of service consisting of all the APG services performed for a person that are coded on the same claim and share a common date of service and rate code.