



April 13, 2020

**Program and Billing Guidance for Personalized Recovery Oriented Services Programs
Regarding Emergency Response to COVID-19**

Introduction

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

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

This document will outline PROS program expectations, changes in documentation requirements, minimum billing requirements for the duration of the declared disaster emergency or until such time supplemental guidance is issued. OMH's intent is to maintain quality services and continuity of care for program participants, as well as to support agencies in maintaining current staffing levels.

OMH previously issued [Consolidated Guidance](#) on the Use of Telephone and Two-way Video Technology by OMH-Licensed, Funded or Designated Providers and Clients Affected by the COVID-19 Pandemic (03/30/20), which expands the definition of telemental health as well as the types of staff allowed to use telemental health for delivering Medicaid-reimbursable services. Please refer to this guidance for an understanding of telemental health allowances during the COVID-19 disaster emergency (revisions to this guidance will be posted to [OMH Guidance Documents](#) page as necessary). Additionally, the Community Technical Assistance Center of New York (CTAC) has provided a webinar on [Best Practices for Telehealth](#) (03/23/20), which OMH encourages providers to review for its practical recommendations, including the safe use of various forms of technology.

New York State is in the midst of a rapidly evolving public health crisis, and guidance and recommendations are being updated frequently. Providers should regularly review [OMH's Guidance Documents page](#) for updates.



Essential Services During Disaster Emergency Period

During the disaster emergency, specific services should be prioritized and are considered essential. These services are expected to be provided, including capacity for new admissions/intakes.

Essential Services include:

- *Medication*: assessment, prescription, delivery, dispensing, injection;
- *Individual/family (or collateral) counseling/therapy*;
- *Crisis de-escalation and crisis intervention*: emotional crises (e.g., heightened symptoms of mental illness) and concrete crises (e.g., eviction, lack of food or other basic necessities, etc.) that require immediate attention and resolution;
- *Substance use services*: including harm reduction techniques and motivational interviewing, Medication Assisted Treatment, including for Tobacco Use Disorder, Alcohol Use Disorder, Opioid Use Disorder, Naloxone;
- *Dissemination of COVID-19 related information*: sharing of information from the [Center for Disease Control and Prevention](#) (CDC) and New York State [Department of Health](#) websites; and,
- *Support of emotional and physical needs*: flexible supports provided to address the needs of a vulnerable population. May include activities such as helping clients plan for food, cleaning/disinfecting living areas, and mitigating the stress of isolation. All support should ensure the recommended physical proximity and safety practices set forth by the CDC.

PROS Program Expectations:

- Programs must make a minimum of two (2) outreach efforts (telephone contacts) to every enrolled program participant each week, regardless of PROS Component enrollment. All outreach efforts must be documented.
- Continued efforts should be made for those participants you are unable to contact.
- The primary purpose of the contact is to engage the individual, assess needs and provide support. In addition, it is critical to ensure each individual has a list of important telephone numbers, local resources and a “step by step” plan for contacting appropriate stakeholders when needed.
- For individuals enrolled in Clinic Treatment, Medication Management and Clinical Counseling, services must continue to be available at least once per month.

Changes in Documentation Requirements during the Disaster Emergency Period:

For existing PROS clients during the disaster emergency period, or until such time supplemental guidance is issued:

- Individualized Recovery Plan (IRP) reviews are not required and may be postponed as needed.



- Providers may work under existing IRPs and provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency.
- The need for additional services which were not already documented in the IRP should be documented in a progress note. These services should be added to the IRP at the earliest practicable time during or after the disaster emergency.

For new PROS clients during the COVID-19 disaster emergency period, or until such time supplemental guidance is issued:

- Initial Recovery Plans and assessments may be established via telehealth capabilities (see [Consolidated Telemental Health Guidance](#) and [Admissions and Continuity of Care memo](#)).
- Specific timeframes for developing initial recovery plans are waived. Admissions should be prioritized and established in the most efficient way possible given the current disaster emergency.
- Signatures and consent on all required documentation can be obtained verbally and documented in the record.
- Assessments and initial recovery plans should be focused on the presenting immediate needs of individuals including medication management, health and safety needs and acute psychiatric symptoms. Services should commence immediately.

Utilization Review:

Providers may suspend their internal, written utilization review procedures, as required by OMH regulations, for the duration of the disaster emergency. It is OMH's expectation that this process will resume once the disaster emergency is over.

Reduction or Elimination of Minimum Billing Requirements:

For the duration of the COVID-19 disaster emergency, NYS is reducing the minimum requirements to submit claims to Medicaid FFS and Medicaid managed care. These changes will remain in effect until the end of the emergency period or until such time supplemental guidance is issued.

- All telephonic individual contacts (any service) must be a minimum of 5 minutes to count as one billable service.
- All telephonic group contacts (any service) must be a minimum of 15 minutes to count as one billable service.
- To bill Tier 1 (rate code 4520), a program must provide from one (1) to three (3) contacts in a month, or if client contact cannot be made in the month, a minimum of two (2) outreach attempts per week and documentation of such in the client record (per Program Expectations above) is sufficient to bill rate code 4520.
- To bill Tier 3 (rate code 4522), programs must provide at least a total of four (4) contacts per month.



- Pre-admission (rate code 4510) can be claimed for individuals in this status. To the best of their ability, programs must continue accepting referrals on an ongoing basis.
- All submitted claims shall use the modifier code CR (Catastrophe/Disaster related)

Please note: OMH will review claims submitted during the emergency period and may recoup any funding received that is found to be in excess of historical revenues or actual cost.

Add-On Rate Codes:

The clinic add-on (rate code 4525) can be used when Tier 1 or Tier 3 contact criteria, as outlined above, is met and one of the contacts include a clinic service.

Intensive Rehabilitation and Ongoing Rehabilitation and Support service revenue has been factored in the calculation of the revised minimum billing standard for monthly Tiers (1 and 3, as set forth above). IR (rate code 4526) and ORS (rate code 4527) may not be billed separately in conjunction with claims submitted under revised minimum billing requirements.

Implementation of these revised minimum billing requirements does not preclude PROS programs from providing and billing for PROS services to recipients as they normally would under the standards set forth in 14 NYCRR Part 512. Should services provided to a recipient meet existing standards of frequency and duration and substantiate monthly billing resulting in a higher amount of revenue (through submission of claims for CRS and applicable add-ons) than the disaster emergency methodology described above, the provider may bill as they normally would. In this instance, the CR modifier should not be used.