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Personalized Recovery Oriented Services (PROS)

Billing and Claiming Manual

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Office of Mental Health

This PROS Billing and Claiming Manual is intended to describe the Medicaid Fee-for-Service and Medicaid Managed Care billing and claiming policies and practices for PROS with Clinic Treatment (Program Code 6340) and PROS without Clinic Treatment (Program Code 7340). This manual supersedes the previous PROS Finance Handbook and any previous PROS billing, claiming, and utilization management guidance.

Note that this manual has been issued in advance of CMS approval of the proposed State Plan Amendment (23-0098) and is subject to change.

TABLE OF CONTENTS

Section 1: Background ... 5
The PROS Model of Integrated Care ... 5
Medicaid and State Aid ... 5
PROS Regulations and Guidance ... 5
Section 2: Allowability of Service ... 7
Eligibility Criteria and Admission to PROS ... 7
Program Licensure and Service Categories ... 7
Section 3: Registration Process and Requirements ... 9
Participant Registration and CAIRS ... 9
Registration System (CAIRS for PROS) ... 9
Registration Process at Admission ... 9
RRE Codes and Registration by Component ... 9
Processing Registration Requests and the Admission Date ... 10
Discharge and Disenrollment ... 10
Automatic Disenrollment ... 10
Requesting Disenrollment (for ACT, CDT, and MHOTRS Programs) ... 11
Section 4: Reimbursement Methodology and Rate Codes ... 11
PROS Components and Reimbursement Methodology ... 11
Pre-Admission Services (Rate Code 4510) ... 12
Monthly Base Rate (Rate Codes 4516, 4517, 4518) ... 12
Minimum CRS Unit Threshold for the Monthly Base Rate ... 13
Intensive Rehabilitation (IR) (Rate Code 4526) ... 13
Minimum Unit Threshold for IR Add-On ... 13
Ongoing Rehabilitation and Support (ORS) (Rate Code 4527) ... 14
Clinical Treatment (CT) (Rate Code 4525) ... 14
Group Size Ratios ... 15
Allowable Monthly Billing Combinations (PROS Components) ... 15
Article 28 Capital Add-On ... 16
Section 5: General Medicaid Billing Practices ... 17
PROS Registration & Verifying Eligibility ... 17
Units on the Claim ... 17
Billing for PROS Delivered Via Telehealth ... 17

Date of Service on Claims for PROS Services....17
Section 6: Medicaid and Medicare/Commercial Billing and Claiming....18
Medicaid Provider Enrollment....18
Medicare & Commercial Insurance Billing....18
Medicare Billing for Clinical Treatment Services....18
Medicaid Reimbursement for Medicare Crossover Claims....19
Commercial Reimbursement for PROS....19
Section 7: Contracting and Utilization Management....21
Contracting....21
Medicaid Managed Care Utilization Management Policy for PROS....21
Section 8: Additional Guidance and Technical Assistance....22
Culturally and Linguistically Competent Provider Networks (for MMCPs ONLY)....22
Medicaid Disallowances....22
Participant Financial Issues....22
Sliding Fee Scale....22
Technical Assistance....23
Appendix 1: Case Examples....24
Appendix 2: Unit Conversion Charts....26
1:1 Services....26
Group Based Services....26
Appendix 3: Cancellation forms....27
Cancellation Form for Use by ACT Teams....27
Cancellation Form for Use by CDT and MHOTRS....28

SECTION 1: BACKGROUND

THE PROS MODEL OF INTEGRATED CARE

Personalized Recovery Oriented Services (PROS) is a comprehensive team-based, site-based program model that integrates rehabilitation, treatment, and support services for adults (18+) with serious mental illness. The program is a flexible, person-centered, recovery-oriented program that serves a diverse population and fosters a supportive community. Medicaid reimbursement for PROS uses a monthly bundled rate with optional add-ons based on program licensure and service utilization.

The PROS model includes four components:

- Community Rehabilitation and Support (CRS)
- Intensive Rehabilitation (IR)
- Ongoing Rehabilitation & Support (ORS)
- Clinical Treatment (CT) (optional based on licensure)

PROS programs are licensed as PROS with Clinical Treatment or PROS without Clinical Treatment, and all must provide CRS, IR and ORS services. CRS services are reimbursed via a monthly bundled base rate claim. IR, ORS, and CT are considered add-on components, and are reimbursed via a monthly supplemental claim.

MEDICAID AND STATE AID

PROS programs receive reimbursement for services rendered through Medicaid, Medicaid Managed Care, Medicare, and Third-Party Insurer billing. Programs also receive State Aid funding from the New York State (NYS) Office of Mental Health (OMH), either through direct contract with the OMH, or via contract with their Local Governmental Unit (LGU), to reimburse for the cost of providing non-Medicaid services and/or serving uninsured individuals.

State Aid allocations and related program requirements are described fully in the Spending Plan Guidelines. These allocation amounts are rebased annually by the process defined in the Spending Plan Guidelines. The rebasing is implemented at the beginning of each program's fiscal year (July 1 for NYC providers, January 1 for non-NYC providers).

PROS REGULATIONS AND GUIDANCE

PROS Programs are subject to regulation under 14 NYCRR Part 512, which includes requirements related to eligibility, registration, recovery planning and documentation, reimbursement, and co-enrollment restrictions. The PROS Program & Operations Manual includes detailed guidance on program operations and requirements.

Providers are advised that the information included in this section is not a substitute for careful review of applicable regulations. In the event of any conflict between this document and 14 NYCRR Part 512, regulatory language takes precedence.

Providers are encouraged to maintain up-to-date copies of the regulations, and to ensure that they are accessible to relevant staff.

SECTION 2: ALLOWABILITY OF SERVICE

ELIGIBILITY CRITERIA AND ADMISSION TO PROS

The eligibility criteria for PROS, including detailed information about the recommendation for admission by a Licensed Practitioner of the Healing Arts (LPHA), is specified in Part 512.8 and in the PROS Program & Operations Manual, Part 2.

Be advised that recipient insurance status and ability to pay may not be considered when making a recommendation for admission to PROS. PROS programs must offer individuals without Medicaid a sliding fee scale.

Participation in PROS is voluntary, except when an individual is mandated through a court order (i.e., Assisted Outpatient Treatment). As part of the admission process and prior to submitting a registration request, PROS staff should discuss with the individual any co-enrollment restrictions that may impact their participation in other programs. After eligibility has been determined, PROS programs admit the individual by submitting a registration request through the Child and Adult Integrated Reporting System (CAIRS), which is described in Section 3 of this guidance.

PROGRAM LICENSURE AND SERVICE CATEGORIES

Services provided must be consistent with the terms of the provider's operating certificate (i.e., included in the list of required PROS services, or identified on the operating certificate as an "additional" service) and consistent with the regulatory definition (see Part 512.6).

While PROS services can be described in many ways, providers are advised to use the service titles as defined in regulation throughout their documentation to ensure that the meaning and intent of the service is understood by external reviewers. For example, a CRS Psychosocial Rehabilitation (PSR) group or class might be titled “Household Management Skills,” but documentation of that group should clearly indicate that the service provided was CRS PSR. As an alternative, providers are advised to develop a "crosswalk", comparing provider terminology with regulatory language. For example, if a PROS program chooses to document the “Household Management Skills” class a Basic Living Skills Training class in their documentation, the program should provide external reviewers with a crosswalk to show that Basic Living Skills Training is CRS PSR.

PROS services must be provided by a member of the program’s staff, as reflected on the provider’s staffing plan. If the program hosts or employs Student Interns who provide billable services, they must be included on the staffing plan.

PROS Services may only be provided to an individual who:

- Has been admitted to the PROS program or is in pre-admission status; or
- Is a collateral of an individual who has been admitted to the PROS program or is in pre-admission status.

Note: If services are provided to a collateral, the person receiving services must meet the regulatory definition of "collateral" and the services must be provided for the benefit of the PROS participant. See Part 512.4.

Unless an individual is registered with a PROS program, reimbursement is limited to the Pre-Admission Monthly Base Rate.

SECTION 3: REGISTRATION PROCESS AND REQUIREMENTS

PARTICIPANT REGISTRATION AND CAIRS

Medicaid rules prohibit paying more than once for duplicative services. The Participant Registration process was developed to address provider concerns regarding potential liability for retroactive recoveries. The Participant Registration process aims to prevent co-enrollment and provision of duplicative services. Please note there are instances in which the Participant Registration system and Medicaid Recipient Restriction Exception (RRE) codes will not automatically prevent enrollment in duplicative or comparable services, particularly for participants enrolled in Medicaid Managed Care. Participant Registration will restrict the individual's enrollment to a specific PROS provider and specific PROS service components but will allow enrollment in non-duplicative services. Only the PROS program in which that individual is registered will be able to bill fee-for-service Medicaid for PROS services in eMedNY.

REGISTRATION SYSTEM (CAIRS FOR PROS)

OMH utilizes CAIRS as the registration system for PROS. Providers are required to enter admissions (registration requests), 6-month follow-ups, and discharges in a timely fashion. The data entered in CAIRS is used to add, change, and remove RRE codes necessary for fee-for-service (FFS) billing and claiming.

REGISTRATION PROCESS AT ADMISSION

Admission to PROS begins when the program enters a registration request on the CAIRS PROS Admission screen. Until that registration is processed, the PROS provider will not be paid for any services other than pre-admission (and the Clinical Treatment add-on component, where applicable) for that individual. Providers are required to submit registrations and subsequent required reporting for all individuals, including those who are not Medicaid eligible or enrolled.

RRE CODES AND REGISTRATION BY COMPONENT

The registration request (CAIRS Admission Screen) is broken out by component.

The following RRE codes have been assigned to PROS:

- RRE Code 84 – PROS Base/Community Rehabilitation and Support (CRS) with Clinical Treatment
- RRE Code 85 – PROS Base/CRS without Clinical Treatment
- RRE Code 86 – Intensive Rehabilitation (IR)/Ongoing Rehabilitation Support (ORS)

The below table illustrates how the RRE Codes can be used to indicate registration in multiple components:

RRE Code Combination	Component Registration
84/86	CRS + CT + IR/ORS
85/86	CRS + IR/ORS
84 Only	CRS + CT
85 Only	CRS Only
86 Only	IR/ORS Only

Each PROS component has different restrictions related to allowable service combinations with programs outside of PROS. For example, enrollment in the Clinical Treatment component in PROS will apply the 84 RRE Code, restricting Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) programs from receiving reimbursement for duplicative clinical treatment services.

PROCESSING REGISTRATION REQUESTS AND THE ADMISSION DATE

CAIRS auto-fills the admission date field at the time the registration is entered. The admission date cannot be back dated or edited by the provider.

OMH reviews and processes registration requests and posts any notifications or comments to the provider in CAIRS. CAIRS will inform the provider if the individual has been successfully registered, with or without Medicaid, into their program.

After an individual has been successfully registered in PROS, the provider will be authorized to submit claims for services rendered until:

- The individual is discharged from the PROS program,
- Another PROS program submits a subsequent registration form in CAIRS, or
- A MHOTRS, Continuing Day Treatment (CDT) or Assertive Community Treatment (ACT) provider submits a cancellation form for the individual.

DISCHARGE AND DISENROLLMENT

Discharges must be entered in CAIRS as soon as possible upon a participant's discharge from a PROS program. Programs must accurately identify the date of discharge in CAIRS as the last date on which a PROS service was provided. Failure to discharge participants in a timely manner can impact their ability to receive services elsewhere, as the RRE codes will not be removed from their Medicaid file until the discharge is entered.

AUTOMATIC DISENROLLMENT

Registration with a new PROS program will automatically disenroll the individual from the most previous PROS program in which they were enrolled, without the need to return to the former program to request disenrollment. In such instances, the effective discharge date is one day before the new program's registration date.

When a subsequent PROS admission triggers a discharge for the first PROS provider, the first PROS provider will receive notification of discharge the next day, to prevent provision of non-reimbursable services. A CAIRS discharge will be generated for individuals who have registered with another provider. The required discharge fields with this type of discharge are auto filled with "Unknown" and should be updated with the correct data by the provider.

A "Clients Receiving Services Elsewhere" link was added on the Program Notes page of CAIRS for these individuals. Please complete the discharge data at this link.

REQUESTING DISENROLLMENT (FOR ACT, CDT, AND MHOTRS PROGRAMS)

When a PROS Program fails to enter a timely discharge in CAIRS, the RRE codes will remain on the individual's Medicaid file until a disenrollment is requested or until the provider later enters the discharge. For individuals who have disengaged from PROS and wish to enroll in ACT, CDT, or MHOTRS; if the PROS program has not entered a discharge in CAIRS, the new provider should submit a PROS Cancellation Form to OMH via fax or secured email:

- Fax:
    - Attn: OMH Strategic Financial Direction
    - 518-473-8255
- Secure Email: PROSProgramBillingRelatedInquiries@omh.ny.gov

These forms can be found in the appendix to this manual.

SECTION 4: REIMBURSEMENT METHODOLOGY AND RATE CODES

The information in this section is applicable for providers billing FFS and Medicaid Managed Care Plans (MMCPs). When billing MMCPs, providers must ensure they are reporting the correct rate code, procedure code, and modifiers on the claim in accordance with the New York State Medicaid Managed Care Behavioral Health Coding Taxonomy.[1]

PROS COMPONENTS AND REIMBURSEMENT METHODOLOGY

PROS is reimbursed via a monthly bundled rate with optional add-on components. The basic measure for the PROS monthly base rate is the *PROS Service Unit*.

[1] The Medicaid Managed Care Behavioral Health Coding Taxonomy will be updated upon DOB approval of the pending PROS SPA. Until such time, providers should reference the PROS Redesign Memo for the monthly base rate coding taxonomy.

PROS Service Units are:

- A measure of the actual time spent providing direct services to PROS recipients or identified collaterals as defined in Part 512.4, and
- Generated through provision of any medically necessary PROS service, regardless of service component (CRS, IR, ORS, Clinical Treatment), and
- Equal to one unit per 15 continuous minutes of service provided in a one-to-one/individual setting, or
- Equal one unit per 30 continuous minutes of service provided in a group setting.

PROS Service Units are accumulated daily and are aggregated to a monthly total to determine the PROS monthly base rate tier that should be billed for an individual during a particular month. Related detail is provided in the section "Monthly Base Rate (Rate Codes 4516, 4517, 4518)", below.

PRE-ADMISSION SERVICES (RATE CODE 4510)

The Pre-Admission rate reimburses a PROS program for pre-admission services provided to individuals who are in pre-admission status. Individuals must receive at least one (1) PROS Service Unit in a calendar month to bill the Pre-Admission rate. The Pre-Admission rate cannot be billed for more than two consecutive months.

If PROS Pre-admission Services are provided during the month of admission, and the individual has been registered in the PROS program during that month, the aggregate total of PROS Service Units used to determine the CRS/base rate is calculated using the entire month.

There are no co-enrollment restrictions for individuals in pre-admission status.

MONTHLY BASE RATE (RATE CODES 4516, 4517, 4518)

To determine the monthly base rate, the PROS Service Units accumulated during the calendar month are aggregated and translated into one of three payment tiers, in accordance with the most recent OMH Medicaid Reimbursement Fee Schedule.

The PROS Monthly Base rate is reimbursed through three tiers:

RATE CODE	TIER	PROS UNITS
4516	1	4 – 11
4517	2	12 – 43
4518	3	44+

Reimbursement for the Monthly Base Rate is subject to the following rules:

- A minimum of four (4) PROS Service Units earned through the provision of CRS services are required to bill the monthly base rate.
    - See below for a detailed description of the four units needed to meet the minimum threshold.
- Programs may not submit a monthly base rate claim if only Complex Care Management is provided.
- A maximum of five unadjusted PROS Service Units may be counted per day (note: there is a caveat to this rule with respect to services provided outside of the PROS site, per

the bullet below).

- To recognize the higher costs associated with provision of services outside of the PROS site, PROS Service Units provided off-site will be doubled. (note: locations considered off-site *do not* include any location co-located at the same address as the PROS program) This adjustment takes place independent of the five PROS Service Unit per day maximum and may result in an individual's daily total exceeding five units (but not exceeding 10).

MINIMUM CRS UNIT THRESHOLD FOR THE MONTHLY BASE RATE

The four PROS Service Units of CRS services necessary to bill the monthly base rate may be accrued through any combination of individual and group-based services, onsite or off-site, including:

- four (4)15-minute individual services,
- four (4) 30-minute group services,
- one (1) 15-minute individual service and three (3) 30-minute group services,
- two (2) 15-minute individual services and two (2) 30-minute group services, or
- three (3) 15-minute individual services and one (1) 30-minute group service.

Note: any doubling of PROS Service Units provided off-site *does not count toward the accrual of the minimum four CRS services required to allow for billing rate codes 4516-4518.*

INTENSIVE REHABILITATION (IR) (RATE CODE 4526)

Reimbursement for the IR Add-On Component is subject to the following rules:

- The individual must have RRE Code 86 on their Medicaid file.
- The individual must have received at least six (6) PROS Service Units during the month, including at least one IR service.
- An individual must have received at least one PROS unit in-person or through audio-visual telehealth (this one unit does not need to be an IR service).
- Medicaid will reimburse the IR component add-on for up to 50% of the provider's total number of monthly base rate claims reimbursed annually.
- The IR Add-On may be billed without the Monthly Base Rate when appropriate (e.g., no CRS Services were provided). In such instances the minimum six PROS units shall be limited to the provision of IR services.

MINIMUM UNIT THRESHOLD FOR IR ADD-ON

The six PROS Service Units, including a minimum of one IR service, necessary to bill the IR component add-on may be accrued through any combination of individual and group-based services, onsite or off-site, including:

- six (6) 15-minute individual services,
- six (6) 30-minute group services,
- one (1) 15-minute individual service and five (5) 30-minute group services,

- two (2)15-minute individual services and four (4) 30-minute group services
- three (3) 15-minute individual services and three (3) 30-minute group service,
- four (4) 15-minute individual services and two (2) 30-minute group services, or
- five (5) 15-minute individual services and one (1) 30-minute group service.

ONGOING REHABILITATION AND SUPPORT (ORS) (RATE CODE 4527)

Reimbursement for the ORS Add-On Component is subject to the following rules:

- The individual must have RRE Code 86 on their Medicaid file.
- PROS programs may only bill the ORS component add-on for individuals who work in integrated competitive employment or in an integrated educational program.
- ORS services must be provided off-site or via telehealth. ORS services may not be provided onsite.
- The individual must receive a minimum of four (4) 15-minute ORS service units per month in order to bill ORS, which must occur on a minimum of two (2) separate days. At least one service per month must be with the individual only.
- The ORS Add-On may be billed without the Monthly Base Rate when appropriate (e.g., the individual is enrolled in ORS-only). The individual must receive at least 4 units of ORS in order to bill the stand-alone ORS claim.

CLINICAL TREATMENT (CT) (RATE CODE 4525)

Reimbursement for the CT Add-On Component is subject to the following rules:

- The individual must have RRE Code 84 on their Medicaid file or they must be in pre-admission status.
- At least one clinical treatment service must be provided during the month in order to receive reimbursement.
- The CT Add-On must be billed in conjunction with a Monthly Base Rate (Rate Codes 4516-4518).
- Individuals receiving Medication Management in the PROS clinic component must have, at a minimum, one contact with a psychiatrist or nurse practitioner in psychiatry every three months, or more frequently as clinically appropriate. Such contact during any of the first three calendar months of the individual's admission will enable billing for the month of contact, any preceding months in which the client has been registered with the PROS program, and the two months following the month of contact.[2] Thereafter, each month that contains a contact with a psychiatrist or nurse practitioner in psychiatry will enable billing for that month and the next two months.

Example: if an individual is seen by the physician in February, they must be seen again by the end of May in order to bill for May. That physician contact authorizes billing for June and July as

[2] For a provider's first three months of operation of a PROS program, the requirement that would have necessitated a psychiatrist visit within the first month for newly admitted clients is waived. However, the client must be seen by a psychiatrist within the first three months of enrollment.

long as the individual receives a clinic service in those months. The individual would then need to be seen again by the end of August to bill for August, September and October.

GROUP SIZE RATIOS

CRS, CT, and IR Services may be provided in group-based settings with the following participant-to-staff ratios:

Component	Participant-to-Staff Ratio	Exceptions
CRS	1:12	Groups of 13-24 are allowable if a second PROS staff person co-facilitates
CT	1:12	Groups of 13-24 are allowable if a second PROS staff person co-facilitates
IR	1:8	Groups of 9-16 are allowable for Family Psychoeducation services if a second PROS staff person co-facilitates

If group sizes exceed the ratios described above, the program may only deem units to have been accrued for up to the maximum number of allowable participants. For example, if 14 individual participants attend a CRS group facilitated by one (1) staff person, the group will only accrue units for up to 12 individuals. However, if the program added a second staff person to co-facilitate the group, all 14 individual participants could accrue units for that group.

ALLOWABLE MONTHLY BILLING COMBINATIONS (PROS COMPONENTS)

The following combinations of PROS Components/ Rate Codes are possible:

- Pre-Admission Screening Services only (4510)
- Monthly Base Rate Only (4516, 4517, or 4518)
- Monthly Base Rate (4516, 4517, or 4518) + CT Add-On (4525)
- Monthly Base Rate (4516, 4517, or 4518) + CT Add-On (4525) + IR Add-On (4526)
- Monthly Base Rate (4516, 4517, or 4518) + CT Add-On (4525) + ORS Add-On (4527)
- Monthly Base Rate (4516, 4517, or 4518) + IR Add-On (4526)
- Monthly Base Rate (4516, 4517, or 4518) + ORS Add-On (4527)
- IR Add-On Only (4526)
- ORS Add-On Only (4527)

The minimum service time and service type associated with each possible billing combination is summarized in the table below:

Billing Combination	Minimum PROS Service Units Required	CRS Service Units Required	IR Service Units Required	ORS Service Units Required	Clinic Treatment Service Units Required
Monthly Base Rate Only	4	4	0	0	0
Monthly Base Rate + IR	6	4	1	0	0
Monthly Base Rate + ORS	8	4	0	4	0
Monthly Base Rate + Clinic	5	4	0	0	1
Monthly Base Rate + IR + Clinic	6	4	1	0	1
Monthly Base Rate + ORS + Clinic	9	4	0	4	1
IR only	6	0	6	0	0
ORS only	4	0	0	4	0

REMINDER: *Doubling of off-site service units DOES NOT count toward minimum standards.*

ARTICLE 28 CAPITAL ADD-ON

Hospital-based providers may receive an add-on to their monthly base rate that reflects their capital costs. PROS programs operated by providers pursuant to Article 28 of the Public Health Law, shall be added an allowance for the cost of capital, this will be determined by the application of the principles of cost-finding for the Medicare program. Allowable capital expenditures shall not include costs specifically excluded pursuant to Section 2807-c of the Public Health Law.

The capital payment per service month for a provider's PROS licensed outpatient mental health programs shall be determined by dividing all allowable capital costs of the provider's PROS programs, after deducting any exclusions, by the annual number of service months for all enrollees of the PROS program.

SECTION 5: GENERAL MEDICAID BILLING PRACTICES

PROS REGISTRATION & VERIFYING ELIGIBILITY

All PROS providers must have the capability for verifying Medicaid eligibility and checking the registration status of enrolled individuals. Providers of Medicaid-reimbursed services are expected to verify an individual's Medicaid eligibility at every visit to ensure there are no payment issues. The verification of a registered individual's Medicaid eligibility will indicate the type of registration and will provide advance warning to other providers that their bills may be denied if they serve the individual. Information regarding this can be found on the eMedNY website.

If an individual does not have Medicaid coverage at the time of registration, but coverage is later opened, the PROS provider should email the PROS Program Billing Related Inquiries mailbox to request that the account be reviewed for potential RRE code backdating. The request can be approved or rejected based on Medicaid Billing Regulations. If approved, this would enable the PROS program to capture reimbursement for up to 90 days prior to the individual's Medicaid enrollment.

UNITS ON THE CLAIM

PROS providers are required to report the number of units on Medicaid FFS and Managed Care claims to support the State's monitoring of service utilization.

BILLING FOR PROS DELIVERED VIA TELEHEALTH

PROS providers approved to deliver telehealth services in accordance with Part 596 and the OMH Telehealth Services Guidance for Providers, must report the telehealth modifiers when submitting claims in addition to the rate code, procedure code, and modifiers for the service. Given PROS services are billed as a monthly bundle rate and one claim may cover multiple contacts, it is appropriate for providers to add the telehealth modifier if there is any telehealth service provided during the month. In addition, the provider can bill two different telehealth modifiers on the same claim if two different telehealth modalities (i.e., audio-only or audio-visual) were utilized when providing PROS services during that month.

DATE OF SERVICE ON CLAIMS FOR PROS SERVICES

For Medicaid FFS and Managed Care, the date of service on any claim must be the last day of the month, as that date represents all days of the month, except in a recipient's month of discharge. When a recipient is discharged mid-month, the date of service on the claim is the date of discharge. The end date of the RRE code should be equivalent to the discharge date.

SECTION 6: MEDICAID AND MEDICARE/COMMERCIAL BILLING AND CLAIMING

MEDICAID PROVIDER ENROLLMENT

Providers must be enrolled in Medicaid with the correct Category of Services (COS) to be reimbursed. For more information, please see the eMedNY Provider Enrollment page.

MEDICARE & COMMERCIAL INSURANCE BILLING

Medicaid regulations at 18 NYCRR Section 540.6(e) require a provider to pursue any available third-party insurance[3], such as Medicare and commercial insurance prior to submitting a claim to Medicaid. This means that providers must investigate and pursue reimbursement from available Medicare and commercial insurance but are not required to contract with all available Medicare and commercial insurers. Additional information can also be found in the DOH Medicaid Update February 2008 Vol. 24, No. 2, Office of Medicaid Management.

MEDICARE BILLING FOR CLINICAL TREATMENT SERVICES

Medicare reimbursement will not be available for the majority of services provided in a PROS program as Medicare pays for only certain licensed practitioners, as listed in the CMS Medicare and Mental Health Coverage manual, to provide certain specialized services (e.g., medication management, counseling, individual psychotherapy, or evaluation and monitoring).

Services provided in the CRS, IR and ORS components of PROS programs are not eligible for Medicare reimbursement. Services provided in the clinical treatment component may be Medicare reimbursable, therefore Medicare reimbursement must be pursued.

PROS programs that are licensed to offer Clinical Treatment must apply to become a Medicare provider as well as any Medicare-enrollable practitioners in the PROS program must enroll. The Medicare application process generally takes between three and six months to complete. Approval is retroactive to the date of application. PROS programs will have 12 months from the date of licensure to obtain approval for Medicare billing.

Additionally, if a professional is eligible to enroll in Medicare, they must be enrolled, and Medicare claims must be submitted as appropriate. For recipients with dual (Medicare and Medicaid) coverage, if the service is covered by Medicare but the practitioner is not a Medicare eligible professional, the Provider Agency may submit a claim directly to Medicaid (FFS or Managed Care) as outlined in the Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees guidance. Provider Agencies *may not* submit claims to Medicaid if denied by, rejected by, or not submitted to Medicare solely due to the eligible professional not being enrolled.

[3] Third party coverage is considered as part of an individual's ability to pay. Participants must make their third-party coverage available for covered services. Third party payers include but are not limited to: the New York Essential Plan, Medicare, Veterans Affairs (VA) Health Care, employer-sponsored health insurance (commercial insurance), and health insurance purchased through the New York State of Health (NYSOH).

MEDICAID REIMBURSEMENT FOR MEDICARE CROSSOVER CLAIMS

Because PROS is paid via a monthly bundled rate, line level information is not required for PROS claims. For claims involving Medicare, providers should report the total Medicare paid amount and patient responsibility amounts (deductible, co-pay and coinsurance) for the entire month at the header level. FFS or MMCPs will add the deductible, co-pay and coinsurance amounts entered and pay the total.

On the Medicaid claim, you will see the language “The Medicare paid amount and patient responsibility amounts (deductible and coinsurance) are reported in Loop 2320 on the 837I claim format”. This is reference to the fact that, while Medicare reimburses at the service level, when crossing over a claim for a dually covered recipient to Medicaid, the pertinent Medicare payment information is entered at the header level because the Medicaid claim is paid via a monthly bundled rate. Entry of procedure codes specific to the Medicare reimbursed services is unnecessary.

Programs will be given 12 months from date of licensure to obtain Medicare approval, begin billing and credit Medicaid for any Medicare payments received. Medicaid can be credited simply by filing an adjustment claim which contains the Medicare approved and paid information. For the Medicare application please see the CMS website. For assistance with the Medicare application process, please contact the CMS Regional Office.

Should a PROS program not begin billing Medicare within the 12-month window, the following two actions will be taken:

- The Medicaid system will disallow any further billing on the Clinic Treatment rate code; and
- On the assumption that at least one bill per quarter would have been paid by Medicare, one-third of the Medicaid payments for the Clinical Treatment add-on for Medicare-eligible individuals will be recovered.

Note: If a recipient is enrolled in an integrated product that consists of a Medicare Advantage Plan (Part C) and a Medicaid managed care plan operated by the same corporation (also known as Integrated Benefits for Dually Eligible Program), crossing over the claim is not necessary. The provider only needs to submit one claim to the MCO on the institutional form for BH services.

COMMERCIAL REIMBURSEMENT FOR PROS

Pursuant to new provisions in the Insurance Law enacted in the 2024-2025 Budget, for NYS regulated insurance policies or contracts issued, renewed, or amended on or after January 1, 2025, commercial health insurance payers are required to reimburse for in-network PROS services at the Medicaid rate. The State will be issuing more guidance about this requirement.

The above provision applies to both individuals who have commercial coverage only and those who have both commercial and Medicaid dual coverage. However, this rate mandate does not change the crossover process for those with dual coverage. Medicaid is always the payer of last

resort providers must pursue reimbursement from the commercial payers, and cross over the claims to Medicaid for balance billing.

SECTION 7: CONTRACTING AND UTILIZATION MANAGEMENT

CONTRACTING

New PROS providers who have or will be issued an OMH Operating Certificate, should begin to engage with MMCPs as soon as possible prior to delivering services to managed care enrollees. If the PROS agency knows which county/ies they are going to serve, it is recommended they review the MCO Plan Matrix at Matrix | MCTAC (ctacny.org). The Matrix will help to identify each Plan that serves the agency's county/ies and get the appropriate Plan contact information to begin the contracting process. (Note: The PROS agency will need to set up a free MCTAC account to access the Plan Matrix.)

If the OMH Operating Certificate has not been issued yet, it is recommended the agency include the OMH conditional approval letter in the materials being sent to the MMCP which may help to begin the contracting process sooner. The MMCP/Provider may be able to establish Single Case Agreements to be able to serve enrollees until the contract is finalized. Plans may decide to reimburse the agency on an out of network basis or by backdating the agreement, which is ultimately executed, but they are not legally required to do so except in some specific cases (e.g. the patient is not able to get an in-network appointment within certain timeframes). If PROS providers are experiencing difficulties engaging with the MMCPs, please reach out to OMH-Managed-Care@omh.ny.gov for assistance with connecting to the MMCP.

MEDICAID MANAGED CARE UTILIZATION MANAGEMENT POLICY FOR PROS

MMCPs are required to comply with the utilization management guidelines outlined in the Guidelines for Medicaid Managed Care Organizations regarding UM for PROS which align with the Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services (issued 11/25/19). The guidance MMCPs must follow includes but is not limited to:

1. Prior authorization for PROS is not allowed; and
2. Concurrent authorizations are no longer required for PROS but may be done based on utilization management criteria described in the UM Triggers and Care Management by the MCO section.

SECTION 8: ADDITIONAL GUIDANCE AND TECHNICAL ASSISTANCE

CULTURALLY AND LINGUISTICALLY COMPETENT PROVIDER NETWORKS (FOR MMCPS ONLY)

Pursuant to Sections 15.10 and 15.11 of the *Medicaid Managed Care Model Contract* and Section 15.3 of the *Medicaid Advantage Plus (MAP) Model Contract*, MMCPs must maintain a culturally competent provider network capable of delivering services to all enrollees including those with limited English proficiency. Information on the NYS approved cultural competence training offered by the United States Department of Health and Human Services (HHS) can be found in *Cultural Competency Training for Participating Providers*. MMCPs must arrange for language assistance services and adequately reimburse PROS programs for language assistance services when network providers cannot meet an enrollee's language needs. MMCPs are also responsible for informing PROS programs how to access and be adequately reimbursed for language assistance services for enrollees with limited English proficiency.

MEDICAID DISALLOWANCES

PROS providers are advised to be aware of circumstances under which disallowances have previously occurred and to take steps to avoid vulnerability of future audit adjustments. Listed below are common reasons for Medicaid disallowances:

- Missing case records;
- Missing service plans;
- Missing progress notes;
- Missing required signatures on services plans;
- No indication of services provided;
- Untimely completion or review of service plans; and
- Improper rate codes used.

As of the date of this manual, the NYS Office of the Medicaid Inspector General (OMIG) has not yet issued an audit protocol for PROS. OMH encourages PROS providers to regularly check the OMIG Audit Protocol website for any updates.

PARTICIPANT FINANCIAL ISSUES

The PROS program is approved as a Medicaid program under the Rehabilitation option. Both Federal and State Medicaid rules require that all individuals receiving services from a Medicaid program be liable for the cost of those services, regardless of whether the individuals are eligible for Medicaid. In actual practice this requirement means that all participants in a PROS program are liable for the full cost of the services received.

SLIDING FEE SCALE

Medicare, Medicaid and NYS statutes recognize that many individuals receiving public health services do not have the ability to pay the full cost of the services they receive. The "ability to pay" concept has developed over the years as a rational approach to the patient liability problem.

Ability to pay, simply stated, means an individual's income and assets are matched against a reasonable and rational fee schedule and charts are assessed accordingly. Typically, a sliding fee schedule is developed which sets a base level for income and assets. A percentage of poverty level is often used to determine the base level. Individuals whose income and assets are under this base level are not charged for services based on their ability to pay. The sliding fee schedule will set incrementally larger fees to be charged to the individual based on where their income falls on a predetermined chart of income and asset levels in excess of the base level. Usually, the fee derived is charged per service received. However, as most individuals receiving mental health services have set monthly incomes, sliding fee schedules commonly set monthly maximum charges. Monthly maximums ensure that no matter how many services an individual requires in a month, they will not be charged in excess of the amount they can afford.

A sliding fee schedule that is documented and enforced will meet the requirements of the Medicaid program. For PROS programs that are part of agencies that already participate in the Medicaid program, it is suggested that the sliding fee schedule already used by the agency also be used for PROS. Those PROS programs that are new to Medicaid and have no experience with sliding fee schedules should contact their local government unit (LGU, or county) for guidance.

TECHNICAL ASSISTANCE

If you have questions or need technical assistance related to PROS Billing and Claiming, please contact the appropriate mailbox from the list below:

- For Medicaid enrollment questions, including Category of Service, NPI, or MMIS, please refer to the eMedNY Provider Enrollment site, or contact the eMedNY help desk at 1-800-343-9000.
- For assistance with licensure, including address updates please contact: certification@omh.ny.gov
- For assistance with FFS Billing and Claiming, please contact: MedicaidFFSBillingHelp@omh.ny.gov
- For assistance with RRE Codes, please contact: PROSProgramBillingRelatedInquiries@omh.ny.gov
- For assistance with Medicaid Managed Care Billing, Claiming, and/or Utilization Management, please contact: OMH-Managed-Care@omh.ny.gov
- For assistance with commercial billing or reimbursement for PROS services, please contact: commercial-billing@omh.ny.gov
- For assistance with program operations, please contact: PROS@omh.ny.gov.

APPENDIX 1: CASE EXAMPLES

The below examples are intended to illustrate the billing rules outlined in Section 4. The monthly totals are based on 4.5 weeks in a month.

- ***Example 1*** – *CRS onsite and IR off-site:* An individual attends four (4) 30-minute *onsite* CRS groups per week (18) 30-minute groups over the course of the month and receives one (1) 45-minute 1:1 IR service off-site, in their home.
  - Their *total units* for the month would equal 24 (18 CRS + 6 IR off-site).
  - The program would bill for a Tier 2 monthly base rate plus the IR add-on.
- ***Example 2*** – *No Bill:* An individual attends one (1) 15-minute onsite CRS session and three (3) 30-minute onsite IR groups.
  - Their *total units* for the month would equal four (4).
  - The program *would not bill*, as this individual did not meet the minimum threshold for either the monthly base rate *or* IR add-on.[4]
- ***Example 3*** – *IR only, off-site:* An individual receives weekly 30-minute 1:1 IR sessions off-site in various community locations (five sessions over the course of the month).
  - Their *total units* for the month would equal 20.
  - The program would bill for the IR add-on *only*, as the individual did not meet the minimum threshold for the monthly base rate.
- ***Example 4*** – *ORS only, telehealth:* An individual receives weekly 15-minute 1:1 ORS sessions via telehealth (4 total over the course of the month).
  - Their *total units* for the month would equal 4.
  - The program would bill for the ORS add-on only, as the individual did not meet the minimum threshold for the monthly base rate.[5]
- ***Example 5*** – *ORS only, off-site:* An individual receives two (2) 30-minute 1:1 ORS sessions off-site over the course of the month.
  - Their *total units* for the month would equal 8.
  - The program would bill the ORS add-on only, as the individual did not meet the minimum threshold for the monthly base rate.
- ***Example 6*** – *CT, CRS, and IR onsite:* An individual receives weekly 1:1 45-minute onsite Clinical Treatment[6] sessions (five sessions per month), attends five (5) 30-minute onsite CRS groups per week (22 group sessions per month), and attends one (1) onsite 60-minute IR group per week (5 groups per month).
  - Their *total units* for the month would equal 47 (15 CT, 22 CRS, and 10 IR).
  - The program would bill for a Tier 3 monthly base rate, the CT add-on, and the IR add-on.
- ***Example 7*** – *CRS, IR, and ORS, onsite and telehealth:* An individual receives weekly 15-minute ORS sessions via telehealth (five sessions over the course of the month), attends one weekly 30-minute onsite CRS group (five groups over the course of the month) and attends one weekly 30-minute onsite IR group (four sessions over the course of the month).
  - Their *total units* for the month would equal 14 (5 ORS, 5 CRS, and 4 IR)

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[4] To bill for the IR add-on *only*, the individual must have received at least six (6) units of IR.

[5] Reimbursement requires a minimum of four units of ongoing rehabilitation and support per month, which must occur on a minimum of two separate days. At least one service per month must be with the individual only.

[6] In order to receive reimbursement, the individual must receive a minimum of one (1) Clinical Treatment service must be provided during the month. The clinical treatment component may only be reimbursed in conjunction with the monthly base rate.

    - The program would bill for a Tier 2 monthly base rate and *either* the IR add-on *or* the ORS add-on. Note that because the IR and ORS add-ons cannot be claimed in the same month for the same individual, the program needs to choose which add-on to bill. All units count toward the base rate regardless.
- ***Example 8*** – *CRS on-site and off-site:* An individual receives 3 hours of 1:1 CRS in their home for the purposes of assessing skill performance and environmental barriers related to their goal (24 units). They also engage in two (2) 30-minute onsite CRS groups per week (9 groups per month) and one (1) bi-weekly 1:1 15-minute CRS service (two sessions per month).
    - Their *total units* for the month would equal 21 (10 CRS off-site, 11 CRS on-site). Note that because off-site units are capped at 10 per day, the 3-hour (24 unit) 1:1 off-site session will only count as 10 units.
    - The program would bill for a Tier 2 monthly base rate.

APPENDIX 2: UNIT CONVERSION CHARTS

1:1 SERVICES

The below chart is intended to illustrate how many units would be accrued for a single session or service provided 1:1, onsite or off-site.

Time	Onsite	Offsite
0-14 minutes	0	0
15-29 minutes	1	2
30-44 minutes	2	4
45-59 minutes	3	6
60-74 minutes	4	8
75 minutes +	5	10

GROUP BASED SERVICES

The below chart is intended to illustrate how many units would be accrued for a single group-based session or service provided onsite or off-site.

Time	Onsite	Offsite
0-29 minutes	0	0
30-59 minutes	1	2
60-89 minutes	2	4
90-119 minutes	3	6
120-149 minutes	4	8
150 minutes +	5	10

APPENDIX 3: CANCELLATION FORMS

CANCELLATION FORM FOR USE BY ACT TEAMS

Cancellation Form from Personalized Recovery Oriented Services (PROS)

For use by Assertive Community Treatment (ACT) Teams

Date: ___/___/___

Recipient Information	Provider Information
Name:	Full Name:
Date of Birth:	Address:
Sex: M or F	Provider ID:
Social Security Number:	Locator Code:
Medicaid # (CIN):	

Cancellation of PROS Registration – Select One Option

☐ **To attend ACT**

By selecting this option, I agree to no longer receive services from a PROS Program.

I understand I will be able to re-register with this program at any time. I understand that in order to cancel my registration in the PROS program and in order to assure that Medicaid is appropriately billed, the New York State Office of mental Health may share my registration information with other Mental Health Medicaid providers.

ACT Staff	**Recipient**
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Date:
Telephone Number:	
Date:	

Please maintain copy of this cancellation form in the recipient’s case record.

CANCELLATION FORM FOR USE BY CDT AND MHOTRS

Cancellation Form from Personalized Recovery Oriented Services (PROS)

For use by Continuing Day Treatment (CDT) programs and Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRS) Programs

Date: ___/___/___

Recipient Information	Provider Information
Name:	Full Name:
Date of Birth:	Address:
Sex: M or F	Provider ID:
Social Security Number:	Locator Code:
Medicaid # (CIN):	

Cancellation of PROS Registration – Select One Option

☐ **To attend CDT:** By selecting this option I agree to no longer receive Community Rehabilitation and Support (CRS) or Clinical Treatment services from a PROS program. I understand I am still able to receive Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS) services through PROS.

☐ **To attend MHOTRS (Article 31):** By selecting this option I agree to no longer receive Clinical Treatment services from a PROS program. I understand I am still able to attend a PROS for CRS and/or IR/ORS services.

I understand that in order to cancel my registration in the PROS program and in order to assure that Medicaid is appropriately billed, the New York State Office of mental Health may share my registration information with other Mental Health Medicaid providers.

CDT/MHOTRS Staff	**Recipient**
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Date:
Telephone Number:	
Date:	

Please maintain copy of this cancellation form in the recipient’s case record.