

**Clinic Restructuring  
Implementation Plan  
New York State Office of Mental Health**

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### Transforming New York's Mental Health System: A Summary

New York's outpatient mental health system needs to change. It is too fragmented, overly reliant on inpatient care, and it continues to face an uncertain Federal Medicaid environment. Further, New York's own Medicaid reimbursement rules for publicly funded mental health services are overly complex. They lack appropriate incentives for rapid access, early intervention, and best practices to support recovery in adults and resiliency in children.

The New York State Office of Mental Health (OMH) has undertaken a multi-year initiative to restructure the way the State delivers and reimburses publicly supported mental health services. The goal is to develop a system of quality care that responds to the individual needs of adults and children and delivers care in appropriate settings.

Clinic restructuring represents the first phase of this transformation process. Parallel initiatives are tackling the many challenges facing support services for children, rehabilitation and support services for adults, inpatient services, and the treatment of co-occurring disorders in both mental health and substance abuse clinics.

All of these efforts include significant stakeholder participation and input. Clinic restructuring is being done with the extensive involvement of an Advisory Workgroup (Workgroup) consisting of a broadly representative range of local government officials, mental health providers, and mental health advocates (see page 25). OMH charged the Workgroup with advising the agency on ways to:

- Create a mental health system that is focused on recovery for adults and resiliency for children;
- Redefine clinic treatment services; and
- Restructure the financing of the mental health clinic treatment system.

This plan, developed by the New York State Office of Mental Health (OMH), reflects the advice and substantial efforts of the Workgroup. It describes a redesigned clinic program; a new payment system; and a multi-year implementation plan.

### Key Elements of Clinic Restructuring

This plan contains six key elements for reform:

1. **A redefined and more responsive set of clinic treatment services and greater accountability for outcomes.** Clinic is defined as a level of care with specific services. These services should enhance consumer engagement and support quality assessment and treatment. Clinic treatment should be part of a coordinated and accountable system of recovery and resiliency, which includes other Medicaid reimbursable and non-Medicaid specialty services, such as case management, day and vocational services.
2. **Redesigned Medicaid clinic rates and phase out of COPs<sup>1</sup>.** Medicaid payment rates will be based on the efficient and economical provision of services to Medicaid clients. OMH will establish peer groups for payment. Payments will be comparable for similar services delivered by similar providers across service systems. Payments will also include

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<sup>1</sup> Comprehensive Outpatient Programs (COPs).

adjustments for factors which influence the cost of providing services. **The new system will eliminate rate add-ons such as COPs.**

OMH is committed to integrating clinic restructuring with the NYS Department of Health's (DOH) new outpatient reimbursement methodology called APGs (Ambulatory Patient Groups). APGs will replace New York's current "threshold visit" methodology for reimbursement.

3. **HIPAA compliant procedure based payment systems with modifiers to reflect variations in cost.** The Federal HIPAA Administrative Simplification Act requires the use of a HIPAA compliant billing system. Billing codes for clinic services will be HIPAA compliant with modifiers to reflect differences in resources and related costs (e.g, service location, night and weekend hours, language other than English).
4. **Provisions for indigent care.** Article XVII of New York's Constitution gives the State a special responsibility to care for "persons suffering from mental disorder or defect and [for] the protection of the mental health of the inhabitants". Assuring access to outpatient clinic services is essential to meeting this objective and reducing the demand for other high cost services such as inpatient care. Currently, OMH clinics receiving COPs are required to serve all clients regardless of ability to pay. As part of restructuring, OMH will work to develop a comprehensive strategy for funding mental health outpatient services to the uninsured.
5. **Address Medicaid HMOs/State insurance plan underpayments.** Medicaid managed care, Family Health Plus and Child Health Plus plans underpay for mental health clinic services. The average managed care payment for clinic services (without COPs) is approximately one-third to one-half of actual cost. This is significant because Medicaid managed care alone (not including CHP) represents 12% of clinic visits. This percentage is expected to grow as the state expands mandatory managed care enrollment.

To ensure continued access to clinic services, OMH needs to address Medicaid managed care underpayments. Additionally, OMH and DOH need to monitor managed care plans to ensure appropriate member access to mental health services.

6. **Standards of Care.** OMH recently released standards of care for clinic treatment for adults and children.<sup>2</sup> These guidelines are a first step in articulating the basic tenets of good clinical care and accountability. While these have been longstanding expectations, they have not been consistently communicated or met. These fundamentals of care should be occurring in all clinics now as well as in our redesigned clinic of the future.

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<sup>2</sup> See Appendix 1 and 2

### Why Restructure Outpatient Services?

Over the past 50 years, New York's public mental health system evolved from one dominated by large State psychiatric hospitals serving tens of thousands to a highly dispersed system of non-profit organizations, county mental hygiene departments, and state and private hospitals. There are now more than 2,500 mental health programs in New York State. These programs provide Medicaid and non-Medicaid funded mental health outpatient, emergency, residential, community support, vocational and inpatient care services to 688,000 individuals annually.

As this change was occurring, New York, like many states, expanded Medicaid funded mental health services. Today, Medicaid pays approximately 50 percent of the more than \$5 billion annual cost of public mental health services. However, the distribution of funding for this system has not adjusted to reflect changes in our service delivery system. As a result we have a system where:

1. Outpatient services (Medicaid and non-Medicaid funded) are under funded. Services have been prevented from expanding by the State's mental health Medicaid neutrality policy (recently repealed);
2. Approximately half of the public mental health dollars finance mental health hospitalization;
3. Reimbursement for clinic services is complex and inequitable. "Short term" Medicaid initiatives like COPs<sup>3</sup> have become permanent solutions;
4. Insufficient resources are devoted to early identification and treatment. Research shows that the onset of serious mental illness occurs in early adolescence, yet identification and treatment are often delayed for years. Effective access to early identification and clinic treatment can help address this issue;
5. In some areas of the State, there is insufficient access to specialized services (e.g., case management, vocational services, children's waiver) that assist individuals in meeting life roles;
6. The financing system does not incentivize recovery/resiliency, success in school and/or employment, and other desirable outcomes;
7. Many consumers experience a system plagued by fragmentation, poor communication, poor coordination, and a lack of accountability.
8. There is poor integration between mental health/substance abuse/physical health care. As a result, individuals with emotional disturbance/mental illness often have unaddressed debilitating health conditions (e.g., obesity, diabetes);
9. There is insufficient data to demonstrate the effectiveness of service outcomes; and
10. Other systems serving children and adults (i.e., schools, criminal/juvenile justice, social services and emergency rooms) experience the effects of uncoordinated and/or limited access to mental health care.

Additionally, numerous proposed federal regulations and continuous Federal reinterpretation of previously approved state financing practices, such as COPs and the CSP add-on, puts the State, counties and providers at substantial financial risk.

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<sup>3</sup> Comprehensive Outpatient Programs (COPs). This is a Medicaid payment rate add-on for clinics and selected other outpatient providers.

### **A Recovery Vision for Clinic Restructuring**

A fundamental vision for mental health treatment systems is “resiliency and recovery” as articulated by the New Freedom Commission. Building on the historic focus of clinics solely on symptom reduction, this vision shifts to a focus on symptom reduction with a meaningful life in the community.

Clinic treatment has been the foundation of the public mental health system for over thirty years. Following deinstitutionalization, mental health clinics became a primary treatment resource and safety net for our most vulnerable populations. In many communities, the clinic remains the primary treatment resource for mental health consumers.

Historically, the role of clinics has generated a clinic culture focused on symptom stabilization and long-term treatment. However, the demands of consumers and families have changed and these practices need to change with them. Many consumers and families are now insisting on a model of care that fosters the hope of recovery and builds on the strengths of the whole person to assist them in building a meaningful life in their community.

The need for change has been widely recognized. Over the two years, the OMH and its many stakeholders have engaged in a dynamic process to redesign the role of clinic treatment. This vision builds upon the idea of a life in the community for all persons. This goal is based on the principles of recovery and resilience and strives to provide services to achieve the individual’s optimal integration in his or her community.

Clinic is defined as a distinct level of care which is integrated into a system of recovery and resiliency that includes specialty services, such as case management, vocational, and wellness services. Consumers and families have rapid access to clinic treatment when necessary and are provided with quality services that reflect our knowledge of best practices including treatments for co-occurring substance abuse disorders. These services are provided only for the length of time necessary to achieve the intended outcome for each individual.

In an effort to begin implementing this vision, OMH recently released standards of care for clinic treatment for adults and children. These guidelines are a first step in articulating the basic tenets of good clinical care and accountability. While these have been longstanding expectations, they have not been consistently communicated or met. These fundamentals should be occurring in all clinics now. They should become the building blocks for our redesigned clinic of the future.

Consistent with these standards, a re-designed clinic should provide a “clinical home” for high need adults. For those at high risk of poor outcomes, there needs to be a renewed emphasis on outreach, engagement and accountability for care. Clinics, as the locus of treatment, will need to monitor individual care to ensure that the type and extent of care is appropriate, and that individuals are encouraged to pursue life goals, including employment and school.

For children, the goal is to identify childhood emotional disturbances earlier, to engage children and their families more effectively in treatment and to intervene with treatments that have been shown by science to work. Child and Family Clinic-Plus is a model for the clinic of the future. The integration of the new vision for clinic with the standards of care for children is characterized by services that are more proactive and systematic in detecting emotional disturbance and engaging children and families that have been previously under served in treatment.

Overall, the clinic of the future should be a place where the individual is provided high quality care which fosters a sense of hope in the consumer and his or her family. These programs should provide the building blocks necessary to achieve the promise of a quality life with meaningful roles for the person in his or her world. To achieve this vision, clinics must embrace the challenge and the new paradigm of service delivery.

The transition to a new clinic system will not be simple. Over the decades, the complexity of financing and regulation has grown exponentially. The services and fiscal model that follow, however, have been built upon the values and guiding principles identified by the stakeholder groups as well as the operational realities and challenges that providers face on a daily basis. These principles are summarized in Chart 1 below.

### **Chart 1: Guiding Principles for Clinic Restructuring**

- Clinic is treatment with a defined set of services, (e.g. assessment, therapy, medication, crisis services).
- Restructuring should facilitate improvements in the quality of care including:
  - Identification and engagement of clients;
  - Access to treatment services (including off-site and in the home);
  - Clinical assessments including for co-occurring disorders
  - Presumption that clinic is the “clinical home” for most clients;
  - Regular use of evidence-based and promising treatment practices; and
  - Commitment to individualized treatment planning and individual recovery
- Financial Restructuring should:
  - Pay based on the efficient and economical cost of providing quality services;
  - Phase out rate add-ons such as COPs and CSP;
  - Provide regular evaluation of prices and cost;
  - Set differential payments for procedures that reflect cost differences based on type of population, geography, staffing, venue, and service;
  - Provide sufficient funding to allow training and supervision to implement evidence-based and promising treatment practices;
  - Provide incentives for risk adjusted positive outcomes (to be developed);
  - Allow billing for multiple services in the same day; and
  - Use HIPAA compliant billing codes.
- Restructuring should promote recovery, resiliency, wellness, and family and peer support.
- Restructuring should promote staff retention and workforce development.
- Restructuring should address how future professionals (e.g., MSW and psychology interns) receive training in the delivery of clinic treatment services.
- Restructuring should address the funding of indigent care.
- Restructuring should address Medicaid managed care plans’ underpayments to providers.

### Proposed Clinic Services

To help make this vision a reality, OMH is proposing a restructured clinic system with 10 distinct clinic services (see page 9). This system should help providers, consumers, and families by funding services that improve outreach, engagement and access to care. Providers will be paid to deliver services that are offsite, during the evenings and on weekends, and in languages other than English. They will also be paid more when they provide the complex non face-to-face care coordination services that many seriously ill clients require.

For each of these services, Appendix 3 on page 36 identifies the following details:

- Services required for a clinic license;
- Draft CPT billing codes and definitions;
- Proposed minimum staff qualifications for each clinic service;
- Flexible service locations (onsite, offsite, home);
- Target populations; and
- Proposed modifiers that could affect the cost of delivering services (e.g., off-site, language, etc.)

Most of the services in Table 1 are required to be offered by all clinic providers. However, not all of the services are applicable or reasonable given workforce and target population issues. Some of the services are appropriate for a relatively small portion of clients.

**Mental Health Clinic Restructuring - Implementation Paper**

*Table 1: Clinic Service Descriptions*

	<b>Service Name</b>	<b>Service Description</b>
1	Outreach & Engagement - offsite (new or existing client)	<p>Contact to begin and enhance the engagement process with clients who are reluctant to participate in treatment services. Intent is for a peer, family advisor, or higher level service provider to meet with and help potential or current clients work through their resistance to or fear about participating in treatment. The service also includes therapeutic intervention designed to intervene early to prevent a psychiatric crisis.</p> <p>The service is initiated in response to a request from clients, staff or a family member. Services could be provided in any location but are not Medicaid reimbursable in jails, prisons or other Medicaid reimbursable locations.</p>
2	Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development (new client)	<p>Up to three face to face interviews with the consumer, and collaterals performed at the beginning of a treatment episode, to collect information resulting in a diagnosis and person centered treatment plan.</p> <p>The information collected will be used to determine admission to clinic level of treatment (or other disposition). A quality assessment must contain (but may not be limited to):</p> <ul style="list-style-type: none"> <li>• Chief complaint</li> <li>• Client’s desired outcomes and motivations</li> <li>• Individual (family) strengths and needs</li> <li>• Medical, physical history including the relationship between physical and mental health issues</li> <li>• Trauma history</li> <li>• Substance use history</li> <li>• Work or school history</li> <li>• Developmental Assessment (for children as appropriate)</li> <li>• Personal history</li> <li>• Parent/family status</li> <li>• Current medication</li> <li>• Tests and measures (as appropriate)</li> <li>• Mental health status (as appropriate)</li> <li>• Risk assessment including but not limited to health, family status, loss of children, risk to self and others, loss of housing</li> </ul> <p>1st visit can be offsite to assess the homebound status of adults. 1st visit can be offsite to assess the need to treat children offsite.</p> <p>A clinic may bill this service for unscheduled non-clients who require immediate assistance whether or not they are scheduled to come back for an additional visit.</p> <p>A clinic could also bill this service for an on-site psychiatric consultation which includes an evaluation, report or interaction between the psychiatrist and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care. (a face-to-face evaluation is required)</p>
3	Psychiatric Assessment (existing patient)	<p>An interview with a consumer, child, family, or other collateral performed by a psychiatrist (or Nurse Practitioner in Psychiatry (NPP) or Physician’s Assistant within scope of practice), which may occur at any time during the course of</p>

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*Table 1: Clinic Service Descriptions*

	<b>Service Name</b>	<b>Service Description</b>
		treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues.
4	Psychiatric Consultation	A face to face evaluation of a consumer by a psychiatrist including the preparation evaluation, report or interaction between the psychiatrist and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care. (video tele-psychiatry is acceptable )
5	Crisis Intervention	Clinical intervention with an existing client or collateral of the clinic. Crisis covered services need not be anticipated in a treatment plan and except where limited by CPT code, these services may be provided by phone or in person. The minimal service expectation is that each clinic will have the capacity (directly or by agreement) to respond with a clinician to existing clients via phone 24/7. At the clinic's option, a program may provide face-to-face crisis services 24/7. (For unscheduled non-clients who present in need of immediate assistance see note in service 2).
6	Psychotropic Medication Administration	Time spent preparing, administering, and managing the administration of psychotropic medications. (Can be billed in addition to direct billing for Risperdal Consta). Includes consumer education as necessary. Includes health status screening as appropriate.
7	Psychotropic Medication Treatment	Monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, educating and writing prescriptions. Includes health status screening as appropriate. Includes consumer education as necessary.
8	Psychotherapy	Medically necessary therapeutic communication/interaction for the purpose of alleviating symptoms or dysfunction associated with an individual's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, or encouraging personal growth or development. Such therapeutic communication/interaction should promote community integration, and may encompass interventions to facilitate readiness for and engagement of the client and family in wellness self-management, school, and employment training services, which are provided by specialized programs and service providers.  Psychotherapy may also include an option with complex care management as shown at the end of this table.
9	Developmental Testing	Administration, interpretation, and reporting of developmental testing to assist in the mental health diagnosis and treatment planning processes.
10	Psychological Testing	Psychological evaluation using standard assessment methods and instruments to assist in mental health assessment and the treatment planning processes.
This service must be billed in conjunction with another service. (Instructions	Complex Care Management <sup>4</sup>	Complex care management is not a stand alone service. It must be provided as an ancillary service to psychotherapy. It would be provided by a therapist or licensed professional. It does not include standard report writing or brief follow up calls. It is above and beyond normal care management and must be medically necessary. The need for the care coordination and the persons contacted must be documented in the treatment plan. Often it would be required to prevent a change in community status. (This may be subject to some limits to be developed).

<sup>4</sup> See discussion on page 12.

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*Table 1: Clinic Service Descriptions*

	<b>Service Name</b>	<b>Service Description</b>
to follow.)		<p>The need for complex care management can be driven by a variety of situations such as, but not limited to:</p> <ul style="list-style-type: none"> <li>• Coordination required to treat co-occurring disorders</li> <li>• Complex health status</li> <li>• Risk to self or others</li> <li>• Coordination necessary to break the cycle of multiple hospitalizations</li> <li>• Loss of home</li> <li>• Individual reluctant to engage in treatment and the clinic is not sure of the benefits of mobile treatment.</li> <li>• Children and adults with multiple other service providers in need of coordination</li> <li>• Children at risk of school failure, expulsion or lack of school placement</li> <li>• Children at risk of out of home placement</li> <li>• Changes in custody status (from the parents' or child's perspective)</li> <li>• AOT status and process</li> </ul>

### Care Coordination/Management

Care management is often critical to effective treatment. At the clinic level of care it can be handled in several ways.

1. **Incidental Care Management.** This is brief incidental care management which can be delegated to any clinic staff. It is funded through overhead.
  - **Example** – a call to a client about a missed visit; a call to a landlord about the client getting evicted; or a follow up call to a school.
2. **Complex Care Management Related to Therapeutic Need.** This type of care management would be provided by a therapist or licensed professional. This is above and beyond normal care management referred to in 1 above and does not include standard report writing or brief follow up calls. As with all Medicaid services, it must be medically necessary. The need for the care coordination (including the types of persons contacted) must be documented in the treatment plan. Often this level of coordination would be required to prevent a change in community status.

Therapy with complex care coordination could be **billed within five weekdays** following a face-to-face visit.

- **Example** – The need for complex care management can be driven by a variety of situations such as:
    - Coordination required to treat co-occurring disorders
    - Complex health status
    - Risk to self or others
    - Coordination necessary to break the cycle of multiple hospitalizations
    - Loss of home
    - Individual reluctant to engage in treatment and the clinic is not sure of the benefits of mobile treatment.
    - Children and adults with multiple other service providers in need of coordination
    - Children at risk of school failure, expulsion or lack of school placement
    - Children at risk of out of home placement
    - Changes in custody status (from the parents' or child's perspective)
    - AOT status and process
3. **Targeted Case Management.** The needed care management is more than incidental. The client is referred to a Comprehensive Medicaid Case Management (CMCM) program.
    - **Example** – the client is in need of longer term linking, referral and coordination to other programs such as family support, employment, physical health, housing, etc.

## **Mental Health Clinic Reimbursement – The System as Currently Constructed**

Mental health clinics serve a relatively diverse range of clients depending on their organizational and community characteristics. Funding comes from a mix of Medicaid, Medicare, Medicaid managed care, private insurance, and those self-paying.

The New York State Medicaid plan authorizes reimbursement for a set of mental health services fundable under the Medicaid Clinic state plan option. OMH has essentially two Medicaid rate methodologies for paying for licensed mental health clinics; one for free-standing clinics (Article 31 clinics) and another for mental health clinics co-licensed by the Department of Health (Article 28 clinics). The latter are located in hospitals or diagnostic and treatment centers (“D&TCs”).

Medicaid reimbursement for outpatient clinic services includes a Medicaid base fee and supplementary payments. The base fee is based on nearly 20 year old costs and estimates of appropriate productivity adjusted for several COLAs in intervening years. Base fees are promulgated in OMH’s regulations (14 NYCRR Part 588).

Additionally, there are two main supplementary payments, or add-ons:

- Comprehensive Outpatient Programs (COPs) – used to fund clinic services
- Community Support Programs (CSP) – used to fund community support programs. The amount or distribution of CSP funding will not be changed as result of this project.

Free standing (Article 31) providers in the New York City metropolitan area receive a higher base fee than providers in Upstate New York.

Rates for hospital-based clinics (Article 28) are hospital-specific. They are determined on a cost related, provider specific basis, utilizing DOH’s outpatient department methodology. They are composed of an operating component capped at \$67.50 and an uncapped capital component. OMH requires these mental health clinics to follow OMH program regulations and seek Medicaid reimbursement using the “rate codes” (service categories) outlined in OMH regulations.

OMH’s current Medicaid reimbursement strategy identifies three service categories:

- Brief visit – for individuals
- Regular visit – for individuals, collaterals, and crisis
- Group rate - for all varieties of “groups”

Both Article 31 and Article 28 clinics are required to specify which visit type was performed in both the consumer’s record and on claims for Medicaid reimbursement. On the claims for Medicaid reimbursement, these visit categories do not otherwise identify the purpose of the visit, (except crisis, collateral, and group collateral), nor the qualification of the clinician providing the service.

Article 31 providers are paid different amounts for these visit categories. Article 28 clinics are paid the same amount for each type of visit. OMH currently allows reimbursement for only one service per consumer per day, except for crisis and collateral services. Where a provider does deliver more than one service in a day to a client, OMH does allow the providers to seek reimbursement for the service with the highest fee.

***COPs and DSH***

Through the 1980s, most OMH-licensed mental health clinics also received OMH-sponsored Local Assistance. Local Assistance was distributed to counties and providers to support:

- Activities not eligible for Medicaid reimbursement;
- Medicaid-reimbursable services for individuals not eligible for Medicaid; or
- To supplement Medicaid fees or other third party payments where the county and OMH agreed the applicable Medicaid rates were inadequate to support services in the community.

Funds were allocated based on county plans submitted annually to OMH.

**COPs and DSH:** Beginning in the early 1990s, OMH replaced almost all the Local Assistance received by mental health clinics with COPs. COPs supplements are based on historic allocations of various OMH-financed Aid to Localities funds and county allocations. The current COPs reimbursement methodology was implemented in 1991 and has remained substantially unchanged apart from periodic COLAs and the conversion of additional Aid to Localities funds. Additionally, some hospital clinics had some of their Local Assistance replaced with a special allocation of Disproportionate Share Payments to Hospitals (“DSH”). Although OMH has not increased the base Medicaid rates since 2005, COPs has received several COLAs. OMH also created a new COPs category for clinics previously ineligible for COPs.

***How much Medicaid, COPs, and Local Assistance go to OMH licensed clinics?***

In 2007, clinic revenues associated with Medicaid and State aid amounted to \$526 million. This funded approximately 3.3 million units of clinic services. Sixty-nine percent of the funding went to Article 31 free standing clinics while thirty-one percent went to clinics dually licensed by the OMH and DOH as Article 31 and 28 clinics.

**Table 2: Medicaid Mental Health Clinic Visits, Reimbursement, and Local Assistance  
(Millions of Dollars, 2006-07 NYC, 2007 Rest of State)**

	Fee for Service (FFS) Units Unweighted	Base Medicaid \$ (No COPs)	Estimated '07 COPs Medicaid FFS Threshold	Medicaid \$ for Dual Eligibles (Medicare/Medicaid)	Medicare \$ for Dual Eligibles (Medicare/Medicaid)	Medicaid Managed Care Visits w/ COPs Only Payments	Estimated '07 COPs-Only Medicaid Threshold	Disproportionate Share Payments (DSH)	NYS Aid to Localities and Contract Dollars	Total
Article 31	2,291,929	\$137.7	\$116.3	\$36.0	\$7.8	291,124	\$38.6	\$0.0	\$24.5	\$360.9
Article 28	1,024,412	\$57.0	\$46.4	\$16.0	\$17.7	107,953	\$8.4	\$7.7	\$11.9	\$165.1
State Total	3,316,341	\$194.7	\$162.7	\$52.0	\$25.5	399,077	\$47.0	\$7.7	\$36.4	\$526.0

In addition to this funding, clinics received another \$49 million in Medicaid Community Support Program funding (CSP). This funding is not part of clinic restructuring and will remain in place for the foreseeable future.

Effective July 2008, OMH increased the minimum reimbursement for a clinic visit to about \$100 for NYC and its suburbs (base rate plus COPs and quality improvement supplement). The rate is proportionately less in other regions of the State.

### Why Change Clinic Reimbursement?

New York's Medicaid reimbursement methodology for clinic services needs to change. While conversion to COPs and DSH replaced 50% of Local Assistance with the Federal share of Medicaid, it had some unintended and problematic consequences.

- **COPs allocations don't reflect changes in need.** Currently, within specified limits, counties can move COPs from one provider to another. However, this is a complex and difficult process. As a result, COPs funds are rarely moved to reflect changing State and local priorities or the profile of consumers.
- **Variations in cost and productivity.** The consequence of "freezing" COPs for clinics allowed substantial variations to develop over time, in provider unit costs, staff complements and productivity.
- **Unintended use of funds.** COPs funding was originally intended to support local planning, emergency services, the uninsured and accelerated access to clinic services for those recently discharged from hospitals and Comprehensive Psychiatric Emergency Programs (CPEPs). As COPs rates climbed and base rates stayed flat, COPs transformed into funding that supports the basic cost of clinic services, unique provider programs, and other uncompensated costs.
- **De-professionalized workforce.** The current methodology pays the same rate for all individual services of the same duration irrespective of the clinician's qualifications. According to the Workgroup, this has encouraged some clinics, in the face of generally inadequate rates, to "de-professionalize" their staff complements, presumably reducing the general quality of the services they offer.
- **Failure to comply with changing Federal Medicaid rules.** Federal rules for Medicaid are in a continual state of flux and federal audits for waste, fraud and abuse are on the increase. Additionally, Medicaid payments must be for the efficient and economical provision of services.

### Proposed Reimbursement Methodology

Based on the advice of the OMH Clinic Restructuring Workgroup, OMH has developed a new procedure-based (CPT) clinic reimbursement methodology that:

- Eliminates COPs payments;
- Establishes new peer group base rates; and
- Uses CPT billing codes.

This fulfills the requirements of the Federal Administrative Simplification Act (HIPAA) and the NYS Medicaid reimbursement redesign underway at DOH (see discussion of APGs below).

OMH recognizes that providers bill multiple payers. Therefore, OMH sought, where possible, to use clinic services and procedures that are recognized by Medicare and other insurers. This will also minimize coverage carve outs of some clinic services by other payers. However, it is understood that not that all services or the proposed procedure codes and "modifiers" will be recognized by payers other than Medicaid.

Further, this design must be approved by DOH (NY's single state Medicaid agency) and the federal Centers for Medicare and Medicaid Services (CMS). By law, these approvals are required before these changes can be made. Therefore, the specifics of this design are subject to change. OMH will, however, make every effort to preserve the values of the design should the details have to be modified.

### ***Payment for Services***

A key objective of the new reimbursement system is to drive the objectives of clinic restructuring. For example, reimbursement should “incentivize”:

- Access to care;
- Integration of care;
- Elimination of unnecessary trips by consumers by encouraging delivery of medically necessary procedures on the same day;
- Comprehensive attention to consumers' clinical condition and needs;
- Delivery of appropriate services to individuals;
- Responsiveness to crises;
- Consumer friendly hours and service locations (nights and weekends); and
- Services provided in languages other than English.

Several elements of the new reimbursement system help to accomplish this goal:

- Providers will bill for specific clinic services;
- Many services will have “optional” payment modifiers to account for off-site services, evening and weekend hours of service, and non-English service provision;
- Payments for different procedures will reflect the relative cost of the staff required to deliver each procedure;
- Assessment and therapy services provided by psychiatrists and other physicians will be reimbursed by Medicaid through the physician fee schedule. This will be paid in addition to the regular Medicaid reimbursement for the appropriate underlying service.
  - For example, if in the course of a psychotherapy service delivered by a social worker a psychiatrist steps in for 15 minutes to discuss unexpected symptoms, the clinic will be reimbursed for the full duration of the visit with the social worker AND be reimbursed for the psychiatrist off the physician fee schedule;
- Crisis services will be reimbursed for their duration, either face-to-face or by telephone, subject to a limit to be developed; and
- Providers will be reimbursed for more than one service provided to an individual consumer in a day (subject to certain limits to be determined).
  - This should reduce the inconvenience to consumers for visits on successive days necessitated by the rigidity of the current reimbursement rules. It should also increase provider efficiency and reduce the number of missed visits.

### ***APGs***

Different incentives are embedded in various reimbursement methodologies. Our current threshold system pays a flat price for every visit. This methodology encourages providers to do

the least during a visit and serve the least ill clients. Paying for every service that is included during a visit encourages providers to provide the most services possible. A compromise approach that attempts to remove the disincentive to serve persons with higher needs while not encouraging the over provision of services are Ambulatory Patient Groups (APGs). Under this methodology, providers report every procedure delivered but the methodology automatically groups and discounts services where efficiencies should reduce costs.

The NYS Department of Health (DOH) is in the process of replacing the current “threshold visit” methodology with APGs. OMH is committed to integrating clinic restructuring with this system.

During the development of behavioral health APGs, OMH and DOH will determine the “weight” (relative resource use) for each psychiatric procedure (the services in Table 1) relative to a “standard” weight. The APG system will multiply each procedure’s weight by a “base rate” to determine the actual reimbursement for a particular procedure or group of procedures delivered to a particular consumer.

Providers in a particular “peer” group have common base rates. The weights for each procedure or groups of procedures will be identical, irrespective of the “peer group” of the provider.

APGs are designed to capture the administrative efficiencies associated with providing more than one service to the same consumer in a day. Administrative necessities such as consumer sign in, record keeping, etc. may represent a significant percentage of the time for an individual medical procedure (e.g., blood drawing) but need not be duplicated when a patient receives more than one procedure at the same time.

In psychiatric clinics, the costs of sign-in, record keeping, etc. represent a very small percent of time for almost any procedure, since most procedures are measured by duration extending beyond 15 minutes. Therefore, OMH anticipates little or no discounting in the APGs for psychiatric clinics.

Importantly, providers will not, on a day-to-day basis, need to be concerned about the procedure groupings in each APGs. Medicaid claims will simply list out all the procedures delivered to a consumer during a visit. The 3M APG grouper will be integrated with the state’s EmedNY billing’s system and will calculate the appropriate reimbursement. (Providers can also purchase access to this grouper from 3M).

### ***Payment Features***

In contrast to the current threshold payment system, the restructured system will reimburse providers for the actual services delivered. After transition, all providers in the same peer group, delivering the same services will be paid the identical amount.

Ultimately, rate setting will be impacted by how much money is available and the expectations of the volume of services for each new clinic service. Table 2 on page 14 provides a summary of 2007 Medicaid-related and state aid funding for clinics. These funds, once adjusted for 2008 changes and prospective 2009 state budget changes, represent the approximate pool of available dollars for clinic restructuring. However, the amount of funding available for rebasing mental health clinic Medicaid rates will not be known until after the 2009-10 state budget is passed.

Some portion of these funds may need to be used to help address underpayments to clinics by Medicaid managed care plans as well as the costs of indigent care. Some funds may also be

reserved to help individual providers transition to APGs. The final distribution to these funding pools will not be clear until the New York State 2009-10 budget is passed.

Additionally, OMH is exploring prospective “pay-for-performance” options. The initial measures are likely to be very basic and will be refined over time. At first, OMH will only track provider performance against these measures. In succeeding years, OMH will distribute a portion of increased funds for clinics based on a provider’s performance.

### ***Phase-in/Transition***

The restructured reimbursement system will not commence before January 2010. Several key tasks remain before OMH and DOH can proceed. These include developing regulations and obtaining approval from State and Federal agencies.

The current reimbursement plans project a four-year phase-in. In the initial year, providers will be paid 75% of the amount they would, on average, have received under the current Medicaid system and 25% of what they are calculated to receive under the new system. In the second year, they will receive 50% of their “old” payment, and 50% of the new payment. In the third year, their payments will be 25% “old” and 75% “new”. In the fourth year, the COPs add-ons will entirely disappear and 100% of the new system will be in place.

OMH hopes to minimize the administrative complexity of transition. During and after the transition, providers will generally need to submit one claim for each visit capturing all procedures. An additional claim will need to be submitted for each service billed off the physician fee schedule. The Medicaid system will automatically attach each provider’s old payment to the APG (procedure) service paid. The old payment will decline each year as the APG payment increases.

OMH and DOH reserve the right to adjust the old and new payment amounts throughout the phase-in process should the new volume generate payments significantly in excess of the base-level Medicaid disbursements.

OMH and DOH have not yet determined how to assure that clinics will receive the full payment for services to individuals enrolled in Medicaid managed care.

Prospectively, there will be some type of indigent care pool of funds available to offset the costs of services to individuals without any third party coverage. All payments from the pool will be based on unreimbursed costs up to the newly established Medicaid rates, not providers’ costs. OMH will be developing policy and procedures regarding consumers’ eligibility for uncompensated care and the standards for sliding fee schedules.

The key elements of reimbursement are summarized below.

### ***Key Elements of Reimbursement:***

- **CPT/HCPC Codes:** Clinic services identified in Table 1 will be billed using CPT/HCPC codes that reflect time spent (visit duration), service location, and practitioner qualifications. (see appendix 3 on page 36).
- **Non Face-to-Face Activities:** Providers will be able to bill for non face-to-face time spent coordinating care for complex cases. Time spent must be medically necessary and documented in the consumer’s chart. (Some limits will be established).

- **Multiple Same Day Services:** Providers will be allowed to seek reimbursement for multiple, medically necessary services on the same day to reduce the need for consumers to make multiple trips for complementary services, and minimize missed appointments. (Some limits will be established.)
- **Physician Billing<sup>5</sup>:** For some services, providers (or providers and physicians if they are contractors) will submit two claims for reimbursement for services provided by physicians. Where applicable, the physician component will be billed using the physician fee schedule. The provider will simultaneously claim the underlying “facility” charge for the duration a doctor was present or the medically necessary duration of time another clinician acting within their “scope of practice” was present. These provisions will apply to video telepsychiatric services.
- **APGs (“Ambulatory Patient Groups”):** The NYS Department of Health (DOH) is implementing a new outpatient reimbursement methodology called APGs. This will replace its current “threshold visit” methodology for hospital outpatient department (OPD) and diagnostic and treatment center (D&TC) reimbursement. APGs use CPT procedure codes. Individual procedures and APGs are weighted based on diagnosis and other factors that affect resource use. OMH is committed to using APGs as the basis of its final reimbursement recommendations. OMH will be working with DOH and the Office of Alcoholism and Substance Abuse Services to develop appropriate APG procedure groupings and modifiers.
- **Base Rates:** The APG system establishes weights for each APG. Reimbursement is based on the weight of the APG multiplied by a base rate for a class of providers (peer group). Conceptually, a class of providers could be all mental health clinics in the State, clinics in each OMH region, clinics serving mostly children, etc.
- **“Weights”:** OMH expects to establish “weights” for all procedures based on the *minimum qualifications* for staff permitted under OMH regulations to deliver a particular procedure. Apart from the weights for services expected to be delivered by physicians, OMH plans to establish different weights for services expected to be delivered by:
  - Psychologists;
  - Nurse Practitioners/Physicians’ Assistants;
  - LCSWs/LMSWs/RNs/psychoanalysts/other licensed counselors; and
  - Peers/family advocates/approved others.
- **Offsite Payments:** Offsite services are restricted to services for children up to and including age 18 and for persons determined to be homebound. Homebound individuals include people who have a physical and/or mental illness that prevents them from leaving their residence. The first initial assessment visits can be used to determine if an adult is eligible for homebound off-site services. A billing code modifier will be used to track off-site service locations. Additionally, outreach and engagement services will also be done offsite and are not subject to the homebound limitations.
- **Other Payment Adjustments:** OMH will adjust payments through either procedure codes, procedure code modifiers, or multiple procedures for:

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<sup>5</sup> Includes psychiatric nurse practitioner.

- Complex visits;
  - Visits conducted in a language other than English;
  - Visits delivered outside of normal business hours; and
  - Visits provided in non-licensed locations – subject to some restrictions.
- **Overhead:** The rate for all procedure codes will include reimbursement for such overhead activities as general care management, clinical supervision, record-keeping, billing, training, general agency administration, etc.

**Students/Internships/Supervised Services:** OMH is reviewing the workforce development, cost, reimbursement, and clinical supervisory implications of the use of students as clinicians in clinics. As part of their overall staff recruitment and development plans, many clinics have entered into agreements with educational institutions whereby the clinic provides student field placements for clinical training and supervision. Under the new clinic model, clients at a clinic should generally expect to receive services provided by professional level mental health staff, which may necessitate changes to these agreements to ensure that professional staff supervises these sessions. These arrangements will need to be described in a clinic's OMH approved staffing plan and in the clinic's policies dealing with students (see discussion on page 23).

Rules and requirements for student supervision and billing for visits done by students have not yet been established.

- **“Rebasing”:** OMH's proposed reimbursement design has more variables that impact total Medicaid expenditures than the current reimbursement methodology. Initial base rates and weights will be best estimates regarding staff distribution, productivity, etc. Should actual reimbursement patterns be different than anticipated, it will have unintended consequences. OMH will, therefore, “rebase” periodically.
- **Performance/Outcomes.** As the restructured clinic program is implemented, OMH will examine possible criteria to implement a “pay-for-performance” system that can be administered as adjustments to Medicaid payments.
- **Transition/Phase-in.** OMH expects that providers will transition from the current reimbursement system to the new reimbursement system over four years (as described above). During the transition, providers will submit only one claim for each procedure (except for physician services) but will be paid a combination of the old reimbursement system and the new system. (see discussion on page 18).

OMH anticipates that the new system will continue to supplement clients who are dually eligible for Medicaid and Medicare by paying the difference between what Medicare paid, and the higher of the Medicare approved amount or Medicaid rate.

## Uncompensated Care

Addressing indigent/uncompensated care is a critical aspect of restructuring. OMH is committed to developing a pool of funds to pay for indigent/uncompensated care. Distributions from the pool will be based on a methodology similar to that used by DOH in hospital-based clinics and Diagnostic and Treatment Centers. Some key elements of the current DOH D&TC system include:

1. Indigent Care is defined as services to the uninsured.

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2. Payments are based on actual units of service provided to the uninsured valued at the applicable Medicaid rate for the service, less expected client payments.
3. Payments to providers are made on a progressive coverage scale.
4. Provider eligibility for payments requires compliance with the terms of the Patient Financial Aid law. Compliance involves:
  - a. Client eligibility based on 300% of the FPL (currently \$10,400 per-person plus \$3,400 per additional person);
  - b. Sliding scale discount schedule as defined in the Law;
  - c. Clear client communication practices (including language requirements); and
  - d. Compliance with terms regarding collection agency referrals and treatment of billings for services retroactively covered by Medicaid.
5. Provider reporting on audited cost reports require uninsured units of service by type of service, valued at the Medicaid rate, less actual payments from clients.

### **Medicaid HMOs/State Insurance Plan Underpayments**

Medicaid managed care, Family Health Plus and Child Health Plus plans underpay for mental health clinic services. The average managed care plan payment for clinic services (without COPs) is approximately one-third to one-half of actual cost. This is significant because Medicaid managed care alone represents 12% of clinic visits. This percentage is expected to grow as the State expands mandatory managed care enrollment. To ensure continued access to clinic services, OMH needs to address Medicaid managed care plan underpayments. Additionally, OMH and DOH need to monitor managed care plans to ensure appropriate member access to mental health services.

## **Licensing Revision and Standards**

OMH currently licenses clinic treatment programs to provide a range of services pursuant to existing regulations, Parts 587 and 588 of Title XIV. These regulations were publicly reviewed and subsequently adopted as part of New York State's federally approved State Medicaid Plan. In order to implement the new array of clinic services and the billing and rate codes which link to these new services, OMH needs to adopt revised clinic regulations.

OMH is currently starting the internal process of converting the recommendations of the Restructuring Workgroup into draft revised clinic regulations. As mentioned, these revised regulations will need to be approved by the DOH and the federal government as part of New York's State Medicaid Plan before they become operational.

OMH oversees the Prior Approval Review Process (PAR)(Part 551 of Title XIV) which requires the Commissioner's approval of new licensed programs or significant changes to the operation of existing licensed programs. Since existing clinics will not change licensing categories when the new clinic regulations become effective, they will not need to be reviewed under the PAR process. However, the revised clinic regulations will contain a "transition" section, and depending upon what is eventually included in that section, clinics may be asked to submit current information or plans for future operation when the new regulations become effective.

## **Program Leadership, Supervision and Standards**

Under the new clinic model, programs will be reimbursed in a manner which better reflects the costs of providing services, as discussed elsewhere in this paper. Included in these rates are overhead costs for staffing and non-staff expenses for the day-to-day operation of the clinic. As a governmentally licensed program, the new model will establish programmatic expectations in regulatory standards and guidelines that will look very different than a program of outpatient services operated by a private practice model. Staff costs for these quality of care, staff training, and interdisciplinary team activities will be reimbursed, for the most part, in overhead, resulting in a model for the delivery of clinic services that meets people's mental health needs with higher quality services.

### ***Clinic Director***

The legal entity (county, hospital, not-for-profit) responsible for the clinic will be required to designate a highly qualified and experienced individual to function as the clinic director who will oversee the clinic's administrative and clinical operation. One of the most important duties of the director is to assemble and maintain qualified, experienced, licensed and skilled staff members able to meet the unique service needs of the clinic's client base. The resultant staffing plan must be approved by the clinic agency's governing body as well as by the Office of Mental Health. The new model will rely heavily on a professional staffing approach to improve quality.

### ***Psychiatrist***

Psychiatrists (or psychiatric nurse practitioners) are senior clinical staff whose role in achieving effective treatment outcomes must be recognized in a transformed clinic. There is widespread consensus that the role of psychiatrists must be made more meaningful for the client and the psychiatrists. OMH proposes to shift to a model where:

1. Psychiatrists (or psychiatric nurse practitioners) participate in treatment when appropriate and develop/approve treatment plans for clients who are being prescribed psychotropic medications and/or have significant co-morbid health issues.
2. Other licensed practitioners develop/approve treatment plans for other clients.

Regulations will address requirements regarding the establishment of provider quality controls (including which clinicians may approve treatment plans).

### ***Supervision***

The clinical supervisory relationships within the clinic need to be explicit as clinical supervision is key to monitoring and improving services. Responsibility for clinical oversight must be lodged in a qualified and experienced clinician. This individual is usually the clinic's director but, depending on the size of the clinic and the credentials of the director, may rest with a clinical or medical director. Many larger clinics have clinical directors, medical directors and administrative directors who report to the clinic's director. Whatever organization is utilized, it is crucial that the lines of clinical supervision are clear and that the clinic has adopted internal procedures to ensure that clinical supervision is effectively carried out.

### ***Role of Students in OMH Licensed Clinic Treatment***

Clinic treatment programs licensed by the Office of Mental Health are a significant field placement site for students in clinical training programs. This function strengthens the clinic's connection with local universities, creates and energizes a learning community within the program and is an effective tool to aid in the recruitment of new full-time clinic staff. In the interest of delivering the highest possible care to the individuals served by the clinic, the following parameters should apply to clinic field placement and reimbursement for students:

- A written agreement should exist between the clinic and the State Education Department (SED) accredited higher education institution. The agreement should include provisions regarding :
  - a. The selection of students. All students should be enrolled and in good standing in a graduate degree program in a field leading to one of the mental health disciplines approved to provide clinic services, and should possess any permits or approvals required by SED to participate.
  - b. Supervision of the student. In assigning students to clients, each supervisor should carefully assess the student's skill and experience. Only licensed professionals on staff at the clinic should supervise students.
- Clients of the clinic should be informed of the student's status and agree to be seen by the student before services are initiated.
- The supervision of students at a clinic should be clearly defined and included as part of the OMH approved clinical supervision plan and the clinic's staffing plan.
- Progress notes completed at the end of each session should be signed by the student and countersigned by the licensed professional designated as the clinical supervisor.

### ***Staffing Credentials***

Another factor that impacts clinical staffing and supervision as well as an individual's professional development is the need to accommodate standards set by the State Education Department and discipline-specific credentialing bodies. Clinic standards need to ensure that the frequency and mode of clinical supervision at a licensed clinic counts toward an individual staff member's progress in achieving higher levels of a credential or professional license.

In setting minimum staffing requirements and clinical supervisory expectations in standards, OMH acknowledges staffing shortages among professionals in some disciplines and will provide some flexibility in compliance. Program guidelines are planned which will provide clinics with additional information and give examples of alternative methods of compliance. At the same time, OMH is cognizant of the statewide nature of these staffing and supervision issues and will work with other agencies to solve or ameliorate them.

### ***Quality Improvement***

In addition to staffing and clinical supervision, clinic directors under the new model will be expected to oversee quality improvement procedures. The following tasks will take place at very different levels of complexity given the differences in size and settings within which a clinic operates:

- Basic quality management functions such as checking credentials, doing background checks, and verifying the currency of professional licenses;
- Carrying out risk management practices which may range from the establishment of criteria to increase the monitoring and supports for some clients, to guidelines for responding to crisis situations or incidents, or to the legal and fiscal implications of documentation practices;
- Collecting and analyzing outcome data necessitated for quality improvement, performance based reimbursement, and billing; and
- Ensuring that mechanisms are in place to monitor compliance with external standards such as those established by OMH for licensure and reimbursement purposes, and by accrediting agencies such as JCAHO or CARF.

## Mental Health Clinic Restructuring Workgroup

### Committee Chairs

**Workgroup Chair** - Kristin Riley and Dawn Lannon, New York State Office of Mental Health

**Finance Committee Chair** – Glenn Gravino, CCSI Consultant

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#### Conference of Local Mental Hygiene Directors

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## **Appendix 1: Mental Health Clinic Standards of Care for Adults- Interpretive Guidelines<sup>6</sup>**

Clinical standards of care are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State.

We provide the following description of clinical standards for adult outpatient licensed clinics at this time as a result of recent reviews of care that revealed that too often these standards, which we believe to be fundamental to good care and a longstanding expectation of clinic services, may not be explicitly understood, regularly considered or consistently met. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

### **I. Client care**

#### **A. Evaluation**

By the time the client arrives for initial evaluation, a single clinician should be designated as responsible for ensuring that a comprehensive evaluation is completed in a timely manner. With the client's permission, the clinician should pursue information from other available sources, particularly family members, significant others and current and past providers of services. The evaluation should include:

- A thorough exploration of current concerns, goals and symptoms
- A review of mental health history including past successes and difficulties, prior interaction with mental health care professionals and past treatments, including medications, adherence and preferences
- Current or past use, abuse or dependence on alcohol or other substances
- A thorough understanding of the client's social circumstances, support network, and ongoing life-stressors, including family issues, housing stability and past traumas
- An initial risk assessment, including risk to self and others
- Medical history and treatments

#### **B. Care plan**

Every client is required to have a comprehensive care plan, developed in a timely manner and signed by all clinicians participating in the person's care and by the supervising psychiatrist.

The care plan should be:

- Recovery oriented, including a focus on work and/or education
- Responsive to the client and family cultural and linguistic needs
- Person centered in that the goals are developed with the recipient of service and fashioned to meet the aims and preferences of the client

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<sup>6</sup> Taken from Appendix E of the New York State/New York City Mental Health-Criminal Justice Panel Report and Recommendations June 2008.

- Updated according to the client's needs and regulatory requirements

### **C. Ongoing care**

#### **1. Attending to the Consumer and Family**

Consistent with the mission of a clinic is the need to be available and accountable to its clients and their families. This includes flexibility in time and place of appointments, after hours responsiveness and shared decision making. A clinic may directly provide care, make referrals and collaborate with other providers, including the client's primary care physician.

#### **2. A Primary clinician**

A primary clinician should be identified for each clinic client in a timely manner.

#### **3. Patient safety and security**

The primary clinician should ensure that appropriate and ongoing safety assessments are completed. These would include assessments of risk to self and others as well as making contact with other providers, community agencies and supports, family members and significant others, and past treatment providers when appropriate.

#### **4. Engagement and retention in care**

A primary goal for clinic services is client engagement and retention in care in order to assist the person in achieving his or her goals. The frequency and nature of client contacts with members of the treatment team should be commensurate with the severity of problems and the prescribed treatment plan. Diagnosis and treatment of a co-occurring substance use disorder, when present, is a best practice and will enable clients to remain in care (See Appendix on Co-Occurring Disorders). The identified primary clinician should be responsible for ensuring that the appropriate level of engagement is occurring at all times.

#### **5. Attention to co-occurring disorders**

Clients in mental health clinics commonly show the presence of a co-occurring medical and/or substance use disorder (including alcohol, drugs and tobacco). The treatment of a co-occurring disorder whether at the mental health clinic, in a chemical dependency program or in primary medical care, is essential to consumer well being and recovery and should be a primary clinical administrative goal for the clinic.

#### **6. Communication with families**

Families or significant others should be contacted as soon as possible, with proper consent, when an individual is beginning treatment, and should subsequently be involved as partners in the development and implementation of the plan of care; families or significant others should also have all information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

#### **7. Disengagement from treatment**

When clients refuse or discontinue participation in all or part of the agreed-upon care plan, all members of the treatment team as well as collaborating providers and agencies should be made aware, especially the treating psychiatrist and/or clinical supervisor, and should conduct a review of the client's history, previous assessments of risk to self or others and render an opinion as to any aggravating or mitigating factors related to risk, with the clinician taking appropriate actions

for the timely re- engagement of the client, including assertive outreach commensurate with the degree of assessed risk.

### **II. Clinical administration**

#### **A. Caseloads**

The clinic supervisor or director should be responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of assigned clients permits the appropriate delivery of services.

#### **B. Supervision**

Clinic leadership should provide regular guidance and oversight for staff (especially new staff), with attention to ongoing care as well as emerging client problems or crises.

#### **C. Integration and information sharing**

When clients receive services from more than one clinic or agency, efforts will be made to ensure that all involved treatment providers have a shared understanding of the client's goals and progress, and that the respective intervention plans are integrated, complementary and reflected in the client's records. Current State law allows clinicians from OMH-licensed or operated facilities or providers under contract with OMH or DOHMH to speak specifically about the care of a client they are treating as a best practice and when clinical circumstances warrant, and without consent of the client. Furthermore, current state law also permits these mental health providers to share relevant clinical information, without consent, when a client is referred for services to another mental health provider of a facility that is licensed, operated or contracted by OMH or DOHMH.

#### **D. Communication**

Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services, within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals, when there is evidence of emerging instability and during periods of crisis.

### **Guidelines for sequential screening of risk for violence**

Safety, both of individual clients and of the public, is a fundamental aspect of psychiatric treatment. Accordingly, the assessment and management of the risk for violence is an essential component of clinical care. For most clients, it can quickly be established that the risk of violence is low and, in the absence of a possible change in their level of risk, additional assessment is not needed. However, when indications of elevated risk are present, more detailed assessment is required. The process of risk assessment involves the identification of risk factors present, followed by an assessment of the significance of each factor and consideration of how these factors together indicate a certain level of risk.

The following stepwise evaluation is recommended:

- Universal violence risk screening for all clients as part of the intake process,
- Targeted violence risk assessment when screening indicates increased risk,
- Violence risk-focused treatment when indicated, and
- Reassessment when the client's clinical, legal or contextual status changes.

Although the emphasis of this appendix is on the assessment of the potential for violence by individuals under psychiatric care, it is important to note that-notwithstanding public perceptions of the dangerousness of persons with mental illnesses-they are actually more likely to be the victims of violent crime than the perpetrators. The relationship between violence and mental illness is complex and strongly correlated with additional variables besides the presence of mental illness alone, such as a history of prior violence or the influence of co-occurring substance use.

### **I. Risk assessment framework**

#### **A. Universal risk screening**

The routine evaluation of all new clients requires the assessment of risk. All clients should be asked directly whether they have ever fought with or hurt another person and whether they have recently thought about hurting another person. In addition, there are critical events (e.g. past hospitalizations and arrests) that raise the possibility of past violence. As with any clinical assessment, some information may be provided directly by the client. Whenever possible, collateral sources should be included in the assessment process for additional information or corroboration. Collateral sources include family members, friends, or other significant close contacts and sources of support, as well as prior treatment records.

Recommended areas for screening include determining if there is any history of:

- Physical or sexual aggression towards other people
- Deliberate self-injury
- Emergency room visits or hospitalization related to threatening or violent behavior
- Arrest or orders of protection related to the client's threatening or violent behavior
- Current or recent thoughts or behaviors that others have interpreted as threatening

Additional screening areas, in cases where a higher index of suspicion is warranted regarding a predisposition to aggression, include a history of:

- Problems with controlling anger
- Expulsion from school related to violent behavior
- Workplace or domestic violence

#### **B. Targeted risk assessment of clients with histories of violence or recent ideation**

Should screening yield a history of violent behavior or recent ideation, a more in-depth analysis of the risk of future violence is derived by obtaining the details of violent behavior or ideation and by identifying factors that increase the level of a client's acuity or protective factors that mitigate risk.

*Ultimately, clinical judgment is necessary in assessing how various symptoms and factors are related to violent behavior. A thorough review of the following areas can be used to guide clinical judgment:*

- Details regarding the history of violence or violent ideation, including severity, context, and use of weapons.
  - Presence of factors associated with incidents of aggression including:
    - Interpersonal conflict, unstable relationships, poor social support
    - Employment or financial problems
    - Substance use, whether due to active intoxication, withdrawal, or craving
    - Psychiatric conditions or active symptoms, including those related to personality disorder
    - Treatment noncompliance or lack of insight
    - Criminal behavior
    - Ongoing access to weapons
- If there is a history of violent ideation, but not violence per se, is/are there:
  - A plan and available means for acting on the ideation
  - Steps taken in furtherance of the plan
  - Factors that inhibited acting on the ideation
- Presence of protective factors, including:
  - Outside monitoring (court, AOT)
  - Mental health outreach teams (e.g., ACT teams)
  - Treatment efficacy and compliance
  - Stable social support, work, and/or housing

### Application of assessment findings to risk-focused treatment

It is not necessarily the total number of risk factors present that indicates a heightened risk. A single, severe factor may in and of itself indicate substantial risk concerns. Similarly, protective factors may significantly mitigate risk. After factors have been identified as related to past violence, consideration must be given to how relevant these factors remain in the present or foreseeable future. Risk assessment assists in the characterization of acuity and identification of areas of need; when risk has been identified, actions to address that risk must be reflected in the initial treatment plan.

### Ongoing treatment plans should:

- Reflect interventions taken to manage identified risk factors
- Include efforts to actively engage the client and involve available supports
- Take into account prior treatment successes and failures
- Monitor the improvement or worsening of significant risk factors to guide any necessary change in management

When a client already in treatment misses an appointment or drops out of treatment, a review of the violence risk assessment may help guide the clinician's response. A client with active symptoms, a history of violence, and numerous risk factors for violence requires a greater degree of outreach and engagement. It must be emphasized that no guideline can include every possibility; therefore treatment decisions remain in the domain of clinical judgment, as applied on an individual basis to each particular combination of circumstances and needs. Potential multidisciplinary interventions include:

- Identification and monitoring of warning signs indicative of imminent or increasing risk

- Evaluation of medication regimen and consideration of additional treatment modalities
- Involvement of family, social services, case management, or other supports
- Consideration of social stressors
- Increased monitoring, including increased frequency of clinical contact
- or consideration of AOT
- Increased level of care, including hospitalization

### **D. Reassessment**

There are specific junctures in treatment when reassessment of violence risk, following the framework described above, should take place. If a client becomes more symptomatic, or if treatment appears to be failing, reassessment should occur. When considering a client for hospital discharge, an assessment of risk factors for violence and whether risk factors for aggression have been addressed adequately is necessary. Similarly, prior to other changes in client status such as changes in level of hospital restriction or confinement, termination of clinic care, or discontinuation of an AOT order, reassessment of violence risk is indicated.

With any framework for assessment, there remains the possibility that clinicians may encounter cases where the level of risk remains unclear, or where the management of identified risk factors is complex and difficult. In such cases, adequate supervision and/or consultation for assistance with either further assessment or management recommendations is indicated.

## **II. Actuarial tools**

The methods by which violence risk is assessed have been classified as either clinical or actuarial. Despite improved accuracy over unstructured clinical risk assessment, actuarial tools have important limitations. Past violence is the most significant factor in predicting future violence; actuarial tools will often not identify the risk of individuals who have yet to engage in serious violence. Also, actuarial tools are typically developed on a specific target population; the general clinic population is sufficiently diverse that there is no one particular actuarial tool that has been validated for use with a general clinic population.

The importance of proper training in the use and limitations of any given actuarial tool prior to implementation must be emphasized. These tools should not be approached as simple rating scales. Without an adequate understanding of their application, actuarial tools have the potential to misguide the estimation of risk.

Rather than adding any one particular actuarial tool as a required component in the standard of care for risk assessment in the general client population at this time, we recommend the sequential screening of risk for violence outlined here. However, depending on the specific circumstances, actuarial tools, administered by clinicians versed in their administration and interpretation can enhance the accuracy of the risk assessment.

## **Appendix 2: Standards of Care for Children, Adolescents, and their Families**

Clinical standards of care provide context to the Office of Mental Health regulations that define appropriate access to services and quality of care for children and adolescents treated in Clinics licensed by the New York State Office of Mental Health. These standards should be incorporated by all Clinic programs serving children, adolescents and their families as the basic operating framework within which care is provided.

### **I. ENGAGEMENT, ASSESSMENT AND TREATMENT**

#### **A. Engagement**

Engagement of the child or adolescent and their family in treatment is the first step in offering family-driven care and is a crucial element for treatment success. The process of building this connection starts with the first contact, whether by phone or in person. There are a variety of ways that engagement can occur, including the use of Parent Advisors and/or staff that have particular skill in building initial rapport with children and families; the development and dissemination of fact sheets, pamphlets and brochures; through follow-up and confirmation telephone calls used to motivate and engage families; and ensuring that the Clinic maintains cultural relevance within the community that it serves. A variety of approaches to family engagement should be used throughout the assessment and treatment process to maintain involvement and promote successful outcomes for the family.

#### **B. Assessment**

All clients shall have a single clinician designated to ensure that an assessment is completed in a timely manner. The assessment process should begin with the child or adolescent and his/her family or guardian in the child is in foster care. Clinicians should be respectful of who the family invites to be part of the assessment process (distant relatives and close friends, in some cultures, for instance, may provide comfort, for example). Additional sources of information, such as school personnel, current and previous therapists, medical providers, and social service and juvenile justice personnel should be sought to help define the concern(s) that brings the child into the clinic for treatment as well as the child and family's strengths. The assessment should include:

- A thorough mental status evaluation, including interview or interactive session with the child or adolescent, as appropriate. Individual clinical judgment will guide whether or not the child or adolescent should be interviewed alone and/or in the company of his/her parents. Parents or guardians should be interviewed, unless there is a strong clinical or legal reason to exclude their input.
- A review of developmental, mental health, and educational history and symptoms, including prior treatments, medications, and response to treatment.
- An assessment of the family, social circumstances, school performance, peer interactions, social networks. Current and previous life-stressors should be assessed.

- Past medical history and treatment should be obtained. Information from the current medical provider should be sought.
- Family history, including mental illness in family members and particular life circumstances or stressors likely to impact the child or adolescent.
- An initial risk assessment, including the child's risk to self and others.
- A comprehensive diagnostic evaluation using the five axes of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) classification.

### **C. Care Plan (Treatment Plan)**

Every child and adolescent admitted for treatment is required to have a comprehensive treatment plan that is developed in a timely manner, driven by the needs and strengths of the child and their family (demonstrated with the appropriate signature on the document) and signed by all clinicians participating in the plan and the supervising physician. The treatment plan should be:

- Clear about the needs, strengths, hopes and expectations of the child or adolescent.
- Specific in regard to the treatments to be employed in the attempt to reach those goals.
- Identify how others in the child's life, including teachers, friends, community resources will be involved in treatment and/or consulted with regarding treatment results.
- Responsive to the child or adolescent's unique developmental needs.
- Responsive to the family's social, cultural, and linguistic needs.
- Developed and written with the child (as appropriate) and parents or guardians.
- Updated according to the child or adolescent's needs, progress, and regulatory requirements

### **D. Ongoing Care (Treatment)**

#### ***1. Primary Clinician (Therapist)***

A primary clinician (therapist) should be established in a timely manner for each child or adolescent treated in the clinic. This person must be available to family members on a regular basis, in a culturally respectful manner.

#### ***2. Continued Engagement in Treatment***

It is the primary clinician's responsibility to ensure that each child and his/her family remain engaged in treatment and are making progress that is consistent with the treatment plan and with the family's expectation of outcomes. Clinicians should feel free to openly discuss issues of motivation and adapt the treatment plan accordingly. Clinicians should be well versed in local Family Support resources and readily refer families.

#### ***3. Youth and Family-Driven Care***

Clinicians should listen carefully to discover what youth and their families hope to achieve from treatment and this should be reflected in the treatment plan. Ideally, treatment planning is a collaborative process among a young person, parent, clinician, and other supports, as determined by the family. The mental health treatment goals should be realistic and relevant. Young people and their families should be encouraged to ask questions about treatment goals or to share concerns with what they feel is not working.

### ***4. Collaboration within the child's community***

Active collaboration with others involved with a child or a family can be an important aspect of treatment. Clinics shall develop a plan for each child to assure continuity and integration of care within the mental health system and with other systems of care. A clinician should be familiar with various care systems and the personnel who are serving the child and/or family. For instance, if a particular youngster routinely gets into trouble in school, the clinician should obtain a release from the parent or guardian to be able to speak with the child's school social worker, teacher, or principal. This will ensure that the clinician is obtaining accurate and relevant information and is able to fully understand the scope of the presenting problem. This will allow the clinician, family and teacher to devise treatment solutions that meet the child's unique needs in a timely and respectful manner.

Additionally, this will allow the clinician to recommend and refer the child to complementary community based treatment services, to maximize therapeutic gains for the child. Using our example, the clinician might choose to advocate for additional services for the child by making a referral to a case management service provider while simultaneously referring the child's parents to a parental support group.

### ***5. Client & Family Safety***

Many children and adolescents are referred to clinic treatment because they have engaged in high risk behaviors that pose some danger to themselves or others. Other youth come to the attention of clinic providers because their statements or behaviors suggest they have considered or might engage in high risk behaviors. Therefore the issues of "risk" and "risk assessment" are necessary parts of the assessment and are ongoing aspects of the clinician's role during treatment. Parents should be instructed in how to make appropriate risk assessments of the child or adolescent's statements or behaviors and appropriate steps to take if safety continues to be a concern.

The primary therapist should ensure that appropriate and ongoing assessments of progress in treatment are made, a part of which will include safety assessments as noted above. If there is concern about imminent danger to self or others, appropriate and timely contacts with parents and/or other care givers or agencies is important. All attempts must be made to ensure the safety of the child or adolescent and others. Children and adolescents who are the focus of treatment and their families should have information necessary to contact treatment providers for both routine follow-up and immediate access during periods of crisis.

### ***6. Lack of Progress in the Treatment Process.***

It can be scary and upsetting for parents when they first bring a child to a mental health clinic for evaluation or treatment, but most do so with the intention to work as a member of the team to help their child make meaningful progress. In some situations, life circumstances or personal challenges are too great, and treatment goals are not reached.

When children, adolescents, or parents do not progress in treatment or do not actively participate in the treatment process this should be addressed in therapy and by members of the treatment

team, and collaborating providers and agencies should be notified. A review of the child or adolescent's history, treatment progress, and assessment of risk to self or others should be made. The treatment plan should be re-evaluated to find different approaches that might be more successful. For particularly challenging situations, clinics should consider expert consultation through contract or by utilizing telepsychiatry. Attempts to re-engage the child, adolescent, parents should be made whenever feasible.

In very rare instances in which parental action or inaction rises to the level of medical neglect, appropriate contacts with social service agencies may be needed to ensure access to treatment if there is a lack of capacity or willingness of the parent or caregiver to engage in or to follow through with treatment recommendations. Of course, mandated reporter protocol should always be observed.

### **II. CLINICAL ADMINISTRATION**

**A. Caseloads:** The clinic supervisor or director is responsible for ensuring that complex, time-intensive cases are evenly distributed and considered for more experienced clinicians, and that the number of clients assigned to a clinician permits appropriate delivery of services.

**B. Supervision:** Clinic leadership should provide regular clinical guidance and oversight for staff, particularly new staff, with attention to ongoing treatment needs as well as emerging problems or crises the child or adolescent (or family) may have.

**C. Integration:** When children or adolescents receive multiple services, the Clinic is responsible for ensuring that all of the adults and services involved have a shared understanding of the youth's treatment goals and progress. The Clinician should also be committed to ensuring that any and all plans for the family are integrated and complementary. This should be reflected in the clinical record.

**D. Communication:** Complex care requires that case managers and clinicians from multiple disciplines provide concurrent services within one agency or among multiple agencies. It is imperative that these individuals have ready access to one another and share appropriate information at regular intervals, and when there is evidence of emerging instability and during periods of crisis. While receiving appropriate consent from parents or guardians is good practice and usually advised, mental health providers are authorized under both State and Federal law to share clinical or identifying information with other treating mental health providers, without consent.

## Mental Health Clinic Restructuring - Implementation Paper

### Appendix 3: Draft Clinic Services Billing Codes and Rules - (Information in this chart is not final and is subject to change)

	Service Name	Proposed CPT Codes	CPT Description	Provider Qualifications	Comment	Face to Face or Phone	Required Optional	Allowable Clients	Anticipated Modifiers
1	Outreach & Engagement	H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Skilled peer advocate or Parent Advisor as the minimal qualification.		FTF	Required	Identified Client and Collaterals	None
2	Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development	90801 90802*	Psychiatric diagnostic interview examination	MD/NPP, LMSW, LCSW, Licensed Psychologist, RN, Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), and Licensed Creative Arts Therapist (LCAT), Licensed Psychoanalysts	Up to three assessments can be billed at a higher rate. Must be a minimum of 45 minutes  MD/NPP would bill this CPT code under the physician fee schedule.  *A billing modifier is still required with this CPT code in order to receive the higher rate.	FTF	Required	Identified Client and Collaterals	Language  Evenings and Weekends  Offsite
3	Psychiatric Assessment (established patient)	90805 90811*	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, minimum of 30 minutes face-to-face with the patient; with medical evaluation and management services	MD/NPP	*A billing modifier is still required with this CPT code in order to receive the higher rate.	FTF	Required	Identified Client and Collaterals	Language  Evenings and Weekends
		90807 90813*	Individual psychotherapy, insight oriented behavior modifying and/or supportive, in an office or outpatient facility, minimum of 45 minute face-to-face with the patient; with medical evaluation and management services.		An enhanced payment related to the use of the PSYCKES health self assessment tool will likely be developed.				
4	Psychiatric Consultation	99241-99245	Office consultation of various lengths and meeting the requirements of the various CPT codes.	MD/NPP	MD/NPP will bill these CPT codes under the physician fee schedule. The fee is fixed regardless of the length of visit.  Note: These codes pay for a doctor's time to see another doctor's patient.	FTF	Required	Identified Client and Collaterals	Language  Evenings and Weekends
5	Crisis Intervention	H2011	Crisis Intervention Service, per 15 minutes	MD/NPP, Physician's Assistant with a mental health specialty, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts	H2011 - For one person by telephone or in person- Minimum of 15 minutes generates reimbursement for 1 hour. Available in multiple increments per episode. 15 minutes additional service after each hour generates reimbursement for additional hour; to a maximum of 2 hours.	Both	Required	Identified Client and Collaterals	Language
		S9484	Crisis intervention mental health services, per hour						
		S9485	Crisis intervention, mental health services, per diem (existing)						

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	Service Name	Proposed CPT Codes	CPT Description	Provider Qualifications	Comment	Face to Face or Phone	Required Optional	Allowable Clients	Anticipated Modifiers
					<p>S9484. 15 minutes up to four hours (face-to-face); requires two or more clinicians for a majority of duration of visit. (Skilled peer advocate or Parent Advisor may substitute for one clinician)</p> <p>S9485. More than 4 hours (face-to-face); requires two or more clinicians for a majority of duration of visit. (Skilled peer advocate or Parent Advisor may substitute for one clinician)</p> <p>These codes are used for office, off-site and in-home visits – no modifier is required</p>				
6	Psychotropic Medication Administration	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	MD/NPP/RN/LPN/PA (with a mental health specialty)		FTF	Required for Clinic Servicing Adults. Optional for clinic serving only Children	Identified Client	Language Evenings and Weekends
7	Psychotropic Medication Treatment	90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy  No time limit	MD/NPP/PA	An enhanced payment related to the use of the PSYCKES health self assessment tool will likely be developed.	FTF	Required	Identified Client and Collaterals	Language Evenings and Weekends
8	Psychotherapy	90804 90810*	Psychotherapy - Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility.  Minimum of 30 minutes	MD/NPP, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts	MD/NPP will bill this rate code under the physician fee schedule.	FTF	Required	Identified Client and Collaterals	Off-Site In-Home Language Evenings and Weekends
	90806 90812*	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility.  Minimum of 45 minutes	*A billing modifier is still required with this CPT code in order to receive the higher rate.						
	90846	Family therapy/collateral w/o patient (30 minutes) (Family includes current definition of collaterals.)	<b>Times for 90846-90853</b>						

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	Service Name	Proposed CPT Codes	CPT Description	Provider Qualifications	Comment	Face to Face or Phone	Required Optional	Allowable Clients	Anticipated Modifiers
		90847	Family therapy/collateral w/patient (60 minutes) (Family includes current definition of collaterals.)		are established by OMH				
		90849	Multiple-family/collateral group psychotherapy (60 minutes)						
		90853	Group psychotherapy (other than of a multiple-family group) (clients only) (60 minutes)						
9	Developmental Testing	96110	Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report (1 hour)	LPHA		FTF	Optional	Identified Client and Collaterals	Language Evenings and Weekends
		96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report (More than 1.5 hours)	LPHA					
10	Psychological Testing - various	96101 96116 96118 96119 96120 96125	Psychological testing of various types and meeting the requirements of the various CPT codes	MD/Licensed Psychologist		FTF	Optional	Identified Client and Collaterals	Language Evenings and Weekends
	Complex Care Management	90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	Licensed Psychologist, LMSW LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts	Must be ancillary to psychotherapy or crisis.	Both	Required	Identified Client and Collaterals	