

Part 599 Mental Health Clinic Regulations

Guidance on Proposed Regulations

New York State Office of Mental Health

3-23-10

This document is not a substitute for careful review of the applicable regulations. It is meant to provide additional clarification for a number of sections of the regulations, but does not address every portion of the regulation nor repeat specific provisions of each section.

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Overview of Clinic Restructuring

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 better responds to individual needs and delivers care in appropriate settings.

The changes to the clinic program contained in the proposed Part 599 Clinic regulations reflect the work of a wide range of stakeholders. These regulations are augmented by:

- The OMH *Clinical Standards of Care* found on the OMH website at http://www.omh.state.ny.us/omhweb/clinic_restructuring/resources.html and the
- OMH *Standards of Care Anchors*, which comprise the instrument which will be used to measure performance for re-certification. These can be found on the OMH website at http://www.omh.state.ny.us/omhweb/clinic_standards/care_anchors.html

Part 599 clinic regulations define services, financing and program rules while the standards of care provide a quality of care context for these services.

Part 599 clinic regulations are designed to foster several policy objectives including:

1. Establishment of a more defined and responsive set of clinic treatment services.
2. Implementation of a redesigned Medicaid fee-for-service reimbursement system where payment is based on the efficient and economical provision of services to Medicaid clients.
3. Phase out of COPs¹ supplemental payments.
4. Institution of payments based on HIPAA compliant CPT procedure codes.
5. Provision for indigent care.

Purpose of this Guidance

Over the past several years, OMH has conducted numerous training sessions on clinic restructuring. Additionally, the OMH website provides several program and fiscal projections tools. These can be found at http://www.omh.state.ny.us/omhweb/clinic_restructuring/. Despite this, we recognize that clinic restructuring is complex and the field would benefit from an integrated guidance manual. This manual is designed to provide an overview of program and billing requirements for the various clinic services as well as guidance on how these services can be used and integrated to better meet the needs of consumers.

Supplemental Program Guidance

Supplemental guidance is also being developed to assist clinicians and others in integrating these new services into existing clinical practice. One set of supplemental guidance will be focused on

¹ Comprehensive Outpatient Programs (COPs).

clinics serving children and one set will be focused on clinics serving adults. **When completed, these documents will be posted on the OMH website**

Answers Pending

While this guidance addresses many issues related to the regulations, a few issues remain outstanding. These will be addressed as answers become available. Areas to be addressed include:

- The process for billing the physician add-on and psychiatric consultations;
- The range of non mental health medical services (other than the optional health services described in the regulations and guidance) that can be provided by Article 31 clinics; and
- The payment amount for non mental health medical services provided by Article 31 clinics.

Additionally, New York State needs federal approval for both Medicaid fee-for-service reimbursement for offsite services and the approval of treatment plans by non-physicians. These will not be available until this approval is obtained.

Who is covered by the Regulations?

Part 599 applies to all clinic treatment programs licensed by OMH. This includes clinics operating solely under a license from OMH, hospital outpatient departments, and diagnostic and treatment centers which also operate under the general auspice of the New York State Department of Health (DOH). Additionally, hospital outpatient departments and diagnostic and treatment centers must apply for an OMH clinic license if either of the following conditions is met:

- They provide more than 10,000 mental health visits annually, or
- Their mental health visits comprise over 30 percent of their total annual visits.

Consultation with the OMH Field Office is recommended to review the need for an OMH license when the volume of mental health services approaches the threshold limits.

What are the New Clinic Services?

Part 599.8 of the regulations establishes 10 required mental health clinic services that must be offered as needed at any mental health clinic licensed by the OMH. Part 599 also provides for several optional services. As they imply, the optional services are not required to be provided by clinics that are licensed by the OMH. Rather, they are meant to enhance the cadre of services that clinics can provide. If your agency has satellite site(s) in addition to the primary clinic, the optional service does not need to be available at all of the sites. While all required services do not need to be available at each satellite site, recipients **must** have access to all required services thru attendance at the main clinic site as needed.

Taken together, these services will help consumers, families and providers by improving engagement and access to care. Additionally, the optional health and wellness services will help clinics improve the integration of mental and physical health services.

If a clinic does not have the capacity to provide optional services, there may be specific instances where a recipient could receive such services from another licensed clinic via a Clinical Services Contract. In general, however, this arrangement is not meant to address ongoing service needs of an individual or group of individuals. Health Physicals and Health Monitoring, for example, would be better addressed through a referral and follow up with a community medical provider. This arrangement would promote community integration for the recipient and provide them with access to a broader range of ongoing medical services. Similarly, a need for Psychotropic Medication Administration for children should ideally prompt the clinic program, as the individual’s clinical home, to consider means of delivering this service in order to enhance service integration and be responsive to the needs of the child and family.

Psychiatric Consultation could provide valuable input into the diagnosis or treatment of individuals by qualified practitioners with specialized expertise, but would not be an ongoing service. It should also be noted that Developmental Testing and Psychological Testing are optional services that can only be provided to recipients enrolled in the clinic.

Required and Optional Clinic Services	
<p>Required</p> <ol style="list-style-type: none"> 1. Complex care management 2. Crisis intervention 3. Initial assessment 4. Outreach 5. Psychiatric assessment 6. Psychotherapy - individual 7. Psychotherapy - family/collateral 8. Psychotherapy - group 9. Psychotropic medication administration - injectable (for clinics serving adults) 10. Psychotropic medication treatment 	<p>Optional</p> <ol style="list-style-type: none"> 1. Developmental testing 2. Health monitoring 3. Health Physicals 4. Psychiatric consultation 5. Psychological testing 6. Psychotropic medication administration – injectable (for clinics serving children)

Service Definitions and Guidance

The following provides the definition of each clinic service as well as some brief guidance on how the services should be interpreted.

Required Services

1. Complex Care Management

Definition: Complex care management is an ancillary service to psychotherapy or crisis intervention services. It may be provided by a clinician in person or by telephone. It may be provided with or without the client present. Complex Care is a clinical level service which is required as a follow up to psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions.

Guidance: Complex care management is not a standalone service. It must be provided as an ancillary service to psychotherapy or crisis services and must take place within 5 working days of either service.

The need for the Complex Care and the persons contacted must be documented in the treatment plan and/or the progress note.

While Complex Care must be provided by a therapist or licensed medical professional it is not necessary that the same therapist or licensed medical professional that delivered the therapy or crisis service provide the complex care. However, if Complex Care is performed by a different therapist, the activities must be coordinated with the treating therapist and documented in the clients progress note.

The need for complex care management can be driven by a variety of situations such as, but not limited to:

- 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
- 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

2. Crisis Intervention

Definition: Crisis intervention is activities, including medication and verbal therapy, designed to address acute distress and associated behaviors when the individual's condition requires immediate attention.

Guidance: A crisis is an unplanned event that requires a rapid response and/or an issue that is so severe you would delay another appointment. Crisis covered services need not be anticipated in a treatment plan.

OMH is not intending for each clinic to become community wide mobile crisis teams. However, all clinics will need 24 hour a day/7 day per week availability of crisis services. Every clinic must have its plan for providing crisis services and after hours coverage approved by the local governmental unit or the Commissioner.

The clinic plan must demonstrate the ability to accommodate crisis intakes and walk-ins during normal business hours. The after-hours crisis response plan must provide for contact with a licensed professional by recipients and their collaterals who need assistance. The primary clinician must be informed the next business day of information from the clinician providing after hours services. Additionally, the clinic must demonstrate after hours contact is explained to all recipients and significant others where appropriate during the intake process.

After hours services may be provided in person or by phone. They may be provided directly by the clinic or pursuant to a Clinical Services Contract. Contracting allows clinics to pool resources in ways that make sense in each community. If this is done, the contract must include a process for transmitting information about an after-hours call to the appropriate clinic by the next business day.

Providers will be given 6 months from the effective date of Part 599 to have their crisis plan approved and implemented.

3. Initial Mental Health Assessment, (new client)

Definition: Face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic program, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient.

Guidance: This service requires that a health screening be done or documented in the recipient's record. Health screening documentation may be provided by the recipient or obtained from other sources such as the recipient's primary care physician, where

appropriate. Health information should be reviewed by a Psychiatrist, NPP, or other health care professional.

Up to three face-to-face pre-admission assessments sessions with the consumer/collaterals may be performed at the beginning of a treatment episode, to collect information resulting in a diagnosis and person centered treatment plan. (For more information on the combination of assessment/collateral procedures that are reimbursable by Medicaid fee-for-service see text on page 27 relating to pre-admission assessments).

Assessment 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):

- Chief complaint
- Client's desired outcomes and motivations
- Individual (family) strengths and needs
- Medical, physical history including the relationship between physical and mental health issues
- Trauma history
- Substance use history
- Work or school history
- Developmental Assessment (for children as appropriate)
- Personal history
- Parent/family status
- Current medication
- Tests and measures (as appropriate)
- Mental health status (as appropriate)
- Cultural and language needs
- Risk assessment including but not limited to risk to self and others and other risk factors as appropriate.

The 1st pre-admission assessment visit can be offsite to assess the homebound status of adults. See page 24 for additional information on offsite services.

4. Outreach (new or existing client) – Required once Federal approval is received

Definition: Face-to-face services with a recipient, or, in the case of a child, a recipient and/or family member for the purpose of beginning or enhancing the engagement process, or reengaging with individuals who are reluctant to participate in services, or to promote early intervention to prevent a psychiatric crisis.

Guidance: Outreach is not a therapeutic service. It is intended to begin and enhance the engagement process with clients who are reluctant to participate in treatment services. The intent is for a peer, family advisor, or other service provider to meet with and help potential or current clients work through their resistance to or fear about participating in treatment.

This service is required for people enrolled in a clinic when the clinic is concerned that a recipient has stopped coming and he or she is at risk to themselves or others. This service may also be provided at the clinic's discretion to un-enrolled individuals in response to a request from community members or a family member. The name of the referring entity and the individual referred would need to be documented.

Outreach services must be provided offsite.

Note: Medicaid fee-for-service reimbursement for offsite services is dependent upon federal approval and will not be available until this approval is obtained.

5. Psychiatric Assessment

Definition: An interview with a consumer, child, family, or other collateral performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office, which may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues. It may also include on-site psychiatric consultation which includes an evaluation, report or interaction between a psychiatrist or nurse practitioner in psychiatry or physician assistant with specialized training approved by the Office and a referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

Guidance: This assessment may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues.

6. Psychotherapy (Service 6,7,8)

Definition: Psychotherapy is therapeutic communication and 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, encouraging personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones.

Guidance: Psychotherapy 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 result in the identification of a need for complex care management.

There are three types of psychotherapy sessions allowed in OMH licensed clinics:

- Individual
- Family/Collateral Psychotherapy
- Group Psychotherapy

Under New York State law, psychotherapy must be provided by a licensed therapist after 6/1/10 unless legislation allowing for an extension of the current waiver is in place. See page 16 of this guidance for more information on staffing requirements and staffing waivers.

9. Psychotropic Medication Administration – Injectable (for clinics serving adults)

Definition: Injectable psychotropic medication administration is the process of preparing, administering, and managing the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

Guidance: This service includes consumer education as necessary and health status screening as appropriate. It must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 48.

This service is optional for clinics serving only children.

10. Psychotropic Medication Treatment

Definition: Psychotropic medication treatment is monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate.

Guidance: This service must be provided by MD or NPP. It may also be provided by a Physician Assistant with specialized training approved by OMH.

Optional Services

1. Developmental Testing

Definition: Developmental testing is the administration, interpretation, and reporting of screening instruments for children or adolescents to assist in the determination of the individual's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes.

Guidance: Developmental testing may only be offered to individuals enrolled in the clinic.

2. Health monitoring

Definition: Health monitoring is the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), and smoking status. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

Guidance: This service must be provided by a physician, nurse or other medical professional acting within scope of practice.

3. Health physicals

Definition: Health physical is the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures.

Guidance: This service must be provided by a physician, Nurse Practitioner or other medical professional acting within scope of practice.

4. Psychiatric consultation

Definition: Psychiatric consultation is a face-to-face evaluation, including video tele-psychiatry, of a consumer by a psychiatrist or nurse practitioner in psychiatry, including the preparation, evaluation, report or interaction between the psychiatrist or nurse practitioner in psychiatry and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

Guidance: This service is intended to support primary care doctors in their treatment of individuals with mental illness. Consultation services can support:

- The treatment of mental illness in primary care settings; or
- The transition from clinic based mental health care to primary care mental health treatment.

A written report must be provided by the consulting physician or nurse practitioner to the referring physician.

5. Psychological Testing

Definition: Psychological testing is a psychological evaluation using standard assessment methods and instruments to assist in mental health assessment and the treatment planning processes.

Guidance: Psychological testing must be provided by a licensed doctor of psychology and may only be provided to individuals enrolled in the clinic.

6. Psychotropic Medication Administration – Injectable (for clinics serving children only)

Definition: Injectable psychotropic medication administration is the process of preparing, administering, and managing the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

Guidance: This service includes consumer education as necessary and health status screening as appropriate.

Regulatory Requirements

This section summarizes several of the provisions found in the Part 599 regulations.

Organization and Administration

All clinics licensed by OMH are required to have policies and procedures for:

1. Age appropriate health monitoring including screening for smoking, blood pressure, weight, developmental status
2. Initial and ongoing assessments and plans to address identified areas of elevated risk;
3. Screening for abuse or dependence on alcohol or other substances
4. Obtaining records from prior episodes of treatment and communicating with collaterals
5. Addressing consumer engagement and retention in treatment
6. Admission and discharge from the program. Admission policies should include mechanism for
 - Screening individuals at the time of referral
 - Providing initial assessment within 5 business days for those:
 - Referred from inpatient, forensic, or emergency settings;
 - Screened as high risk; or
 - Determined to be in urgent need by the County Director of Community Services.
7. Ensuring that all recipients are receiving appropriate services and are being served at an appropriate level of care. Clinics must ensure that a utilization review is performed, at a minimum, on a random 25 percent sample of recipients.

Reference: 599.6

Premises

The regulations contain several requirements for clinic facilities. The major change included in these regulations is the provision for shared space. The regulations allow a clinic to share space (both treatment space and non-treatment space) with other programs, pursuant to a plan approved by OMH. For example, a clinic may wish to share space with a substance abuse or medical program. Plans would need to be submitted to the OMH Field Office for review and approval. Among other things, clinics would need to show that the shared use is compatible with the operation of the clinic; respects recipient privacy/confidentiality, and won't interfere with clinic operations.

Reference: 599.12

Staffing Requirements

In 2002, New York State adopted a “scope of practice law” that established four new mental health practitioners and required a license to provide psychotherapy. This law also contains a waiver for programs licensed, operated and funded by the Office of Mental Health. The waiver expires June 2010. Given New York State law, Part 599 established licensing requirements for most services provided in OMH licensed mental health clinics. With the exception of outreach, all services must be delivered by licensed staff starting June 1, 2010.

Staffs authorized to work in OMH licensed clinics after June 1, 2010 include the following:

- Psychiatrist
- Physician (MD)
- Licensed Master Social Worker (LMSW)
- Licensed Clinical Social Worker (LCSW)
- Psychologist²
- Registered Nurse /Licensed Practical Nurse
- Psychiatric Nurse Practitioner NPP
- Licensed Creative Arts Therapists (LCAT)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Mental Health Counselors (LMHC)
- Licensed Psychoanalyst
- Licensed Psychologist
- Physician Assistant- physical health procedures only
- Permitted staff
- Students within approved SED programs
- Qualified non-licensed staff including qualified peer advocates and family advisors

For a crosswalk of services and allowable staffing see the table on page 48.

Licensing Waiver: The Governor has proposed a four year extension of the licensing waiver. **If approved, this waiver would allow programs licensed and funded by OMH to continue employing both licensed and non-licensed staff.** Should the legislature provide continued waiver authority, OMH plans a multi-year transition to the licensing requirements required by Part 599. Clinic staffing requirements will be phased in as follows.

- By the end of transition year 1, all services billed to the uncompensated care pool (except outreach) must be provided by appropriately licensed staff.
- By the end of transition year 3 all clinic services (except outreach) must be provided by appropriately licensed staff.

Additional information on scope of practice issues can be found on the website of the New York State Education Department, Office of the Professions <http://www.op.nysed.gov/prof/>.

Staffing Waiver Authority: Separate from the legislative licensing waiver, Part 599 allows the Commissioner to approve other qualified staff to perform clinic services as appropriate. For example, the Commissioner could approve the:

² Under New York State law, unlicensed psychologist may be employed by a federal, state, county or municipal agency or other political subdivision. In all other cases, psychologists working for OMH licensed clinics must be licensed.

- Substitution of a another physician for a psychiatrist
- Use of a Physician Assistant for mental health care.

Reference: 599.9

Documentation

Consumer records are not only an adjunct to good clinical care; they are a fundamental and integral part of care. The following components are required elements of the clinical case record:

- consumer identifying information and history;
- preadmission screening notes, as appropriate;
- admission note;
- diagnosis;
- assessment of the consumer's goals regarding psychiatric, physical, social, and/or psychiatric rehabilitation needs;
- reports of all mental and physical diagnostic exams, mental health assessments, screenings, tests, and consultations, including risk assessments, wellness screenings, and evaluative reports concerning co-occurring developmental, medical, substance use or educational issues performed by the program;
- the consumer's treatment plan;
- dated progress notes which relate to goals and objectives of treatment;
- dated progress notes which relate to significant events and/or untoward incidents;
- periodic treatment plan reviews;
- dated and signed records of all medications prescribed;
- discharge plan, if applicable;
- referrals to other programs and services;
- consent forms;
- record of contacts with collaterals; and
- discharge summary, if applicable.

Treatment Plans

The treatment plan should be a dynamic document that accurately reflects the current strengths and needs of the recipient. The treatment plan should be revised during periods of emerging stress/crisis or when significant positive changes occur. It should be regarded as a roadmap for the clinician, to ensure that the most relevant issues are consistently addressed in the treatment sessions.

The treatment/care plan is:

- Required for every recipient;
- Developed with the recipient;

- Responsive to cultural and linguistic needs;
- Referenced in the progress notes;
- Developed in a timely manner;
- Signed by all clinician's participating in the person's care.

The periodic review of the treatment plan shall include the following:

- An assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan;
- Adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; and
- Determination of continued homebound status, where appropriate.

Reference: 599.10

Treatment plan approvals

Treatment plans and treatment plan updates must include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. Their participation should be documented by signing the treatment plan. Treatment plans must also include the signature of one of the following:

- For recipients receiving services reimbursed by Medicaid fee-for-service - **only signed by a psychiatrist or other physician.** Otherwise;
- For recipients who do not receive psychotropic medication - a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, or licensed clinical social worker.
- For recipients for whom the program prescribes psychotropic medication - a psychiatrist, physician or nurse practitioner in psychiatry.

Reference: 599.10

Treatment plan timeframes:

Treatment planning should be an ongoing process and not a moment in time activity. However, certain regulatory standards must be met for treatment plans.

- Treatment plans must be completed no later than 30 days after admission. However, this requirement can be modified for services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Insurance Department.

Essentially, if the managed care/third party payer has a different time standard or requirement for completing the treatment plan than that would be the controlling requirement. If they do not, the individual would be subject to the 30 day standard.

- Treatment plans must be reviewed and updated as necessary based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. This must be done no less frequently than every 90 days, or the next scheduled service, whichever shall be later..

However, this requirement can be modified for services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Insurance Department.

Essentially, if the managed care/third party payer has a different time standard or requirement for updating treatment plans than that would be the controlling requirement. Otherwise the OMH regulatory standard will apply.

Reference: 599.10

Progress Notes

A progress note needs to accompany the provision of any procedure. The progress note should document:

- The date of service,
- The duration of service,
- Participants,
- The goals and objectives that were addressed,
- Progress since last appointment,
- Interventions that were discussed/provided, and

A progress note is required to be completed for each billable procedure. Progress notes of this nature should be maintained in accordance with the standards established by HIPAA.

Reference: 599.10

County Role

Part 599 establishes several significant roles for the county Director of Community Services (DCS), consistent with DCS responsibilities and authority under Article 41 of New York State Mental Hygiene Law. These include the following:

- Review and approve crisis plans. All clinics must have crisis plans (including after hours coverage) approved by the county Director of Community Services. After hours services may be provided directly by the clinic or pursuant to a Clinical Services Contract. After hours crisis coverage must include, at a minimum, the ability to provide brief crisis intervention services by a licensed clinician. Providers will be given 6 months from the effective date of Part 599 to have their crisis plan approved and implemented.
- Determine individuals in urgent need of clinic care. The county director can require a clinic to provide an Initial Assessment to the individual within 5 business days.
- Require, review and approve provider transition plans describing the level and type of services not funded by Medical Assistance that will be provided in the community. This plan must describe the level of services to be maintained during the transition, consistent with the level of funding available. **The clinic's ability to receive the COPS component of the legacy payment is contingent upon the provider's compliance with such plan.**
- Designate children's specialty clinic programs. This designation allows the clinic to bill Medicaid fee-for-service for children enrolled in Medicaid managed care. The child must be diagnosed as Seriously Emotionally Disturbed.

Reference: 599.5, 599.6, 599.8, 599.13

Medicaid Fee-for-Service Reimbursement

Reference 599.13 and 599.14

APGs

New York State is switching its outpatient fee-for-service payment methodology from threshold payments to Ambulatory Patient Groups (APGs). The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc. In the context of mental health services, APGs mean a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes.

In an APG payment environment, payments are determined by multiplying a dollar base rate (varies by peer group) by the weight for each procedure. The weight is a numeric value that reflects the relative expected resource utilization for each procedure as compared to the expected resource utilization for all other procedures. Procedure weights are the same for all outpatient clinic providers regardless of peer group. They are also the same for the same procedure irrespective of the licensure of the clinic delivering the reimbursable procedure.

The most up-to date mental health service weights and proposed base rates can be found at the OMH website at

http://www.omh.state.ny.us/omhweb/clinic_restructuring/cpt_proc_weight_rate_sched.xls

Peer Groups

For rate setting purposes, OMH has grouped all licensed mental health clinics into one of seven peer groups and established a base rate for each. A provider's base rate is dependent on the peer group they are in. Providers within each peer group have a common base rate. OMH Peer groups include:

1. Upstate hospital-operated clinics
2. Downstate hospital-operated clinics
3. Upstate Diagnostic and Treatment Centers (D&TC) operated clinics
4. Downstate D&TC operated clinics
5. Upstate free-standing clinics
6. Downstate free-standing clinics
7. Free-standing mental health clinics operated by Local Governmental Units

OMH peer groups are differentiated by location and licensing status. Clinics are distributed within peer groups as follows:

1. Upstate hospital – All hospital-based mental health clinics in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson,

Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates counties.

2. Downstate hospital– All hospital-based mental health clinics in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties.
3. Upstate D&TC – All diagnostic and treatment centers in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates counties.
4. Downstate D&TC – All diagnostic and treatment centers in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties.
5. Upstate clinics: All non-Local Governmental Unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the upstate peer group: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates counties.
6. Downstate: All non-Local Governmental Unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the downstate peer group: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties.
7. Local Governmental Unit-Operated: All mental health clinics operated by a local governmental unit which are operating solely under an operating certificate from the Office.

D&TCs and hospitals – Where a corporation operates a hospital and a D&TC, OMH will determine the primary relationship between the mental health clinic and the hospital or D&TC and assign the clinic to the appropriate peer group.

Federally Qualified Health Centers (FQHCs)

Part 599 clinic regulations apply to FQHC clinics licensed by OMH. However, the APG payment methodology is not applicable to Federally Qualified Health Centers (FQHCs), except when the FQHC has voluntarily agreed to participate in the APG reimbursement system. A decision by an FQHC to participate in the APG system will apply to all of the services they deliver and not just mental health services.

OMH Service Rates, Weights, CPT Codes

OMH maintains the most up-to-date proposed rates, weights, and CPT codes on our website. These can be found at

http://www.omh.state.ny.us/omhweb/clinic_restructuring/cpt_proc_weight_rate_sched.xls

Proposed rates for optional health monitoring and health physicals are still being developed.

Please note: CPT codes are maintained by the American Medical Association and are updated annually. Therefore, the codes used for mental health services could change. OMH will update these codes and procedure weights as appropriate.

Rate Codes

OMH will be using several rate codes to differentiate between onsite services, offsite services, medical services, and services to children with an SED designation. Providers must bill Medicaid with the appropriate rate code. These are listed in the table below.

OMH Clinic Rate Codes			
	Non hospital	Hospital	FQHC
Base Rate	1504	1516	4301
Offsite Base Rate	1507	1519	N/A
SED Base Rate	1510	1522	4601
SED Offsite Base Rate	1513	1525	N/A
Medical Visit (MV) Base	1480	TBD	N/A
SED MV Base	1483	TBD	N/A
Rate codes for additional health services	TBD	TBD	TBD

Please Note: Providers will be unable to bill Medicaid fee-for-service using the offsite rate code until OMH receives federal approval.

Payment Modifiers

Clinic providers may bill Medicaid for certain supplemental payments as described below.

Off-site Services: The off-site services modifier may be billed for services provided to children off-site and for services provided off-site to homebound adults. The rationale and location for offsite services needs to be documented in the progress note and/or the treatment plan. The continued need for offsite services must be documented in treatment plan updates.

For adults, the off-site services modifier is available for an Initial Assessment to determine if the adult is “homebound”, as determined by a licensed clinician. Thereafter, the off-site modifier is only available for adults whose service record documents that they are homebound. Homebound means the individual has been determined by a licensed clinician to have a physical and/or mental illness that prevent them from leaving their residence to access mental health services. The individual must have either;

- A physical barrier that makes it difficult, in the judgment of the clinician, to come to the clinic; or
- A mental health barrier. If the individual has a mental health barrier this must be documented in the treatment plan.

Off-site services are available for all children’s mental health services. Their service record must document that the service is medically appropriate for an off-site service.

Limitations: A clinic may only bill one off-site modifier for:

- Multiple procedures for 1 client in a day
- Procedures provided to more than 1 recipient in the same location in the same day.
- Procedures provided to recipients and their collaterals in the same visit.

Additionally, if the clinic is operated conjointly on the site of a hospital or day treatment program, this modifier does not apply within the conjoined physical space. For example, if your clinic occupies the same building as a pediatric care unit, meeting with the mother in the pediatric waiting room does not qualify for this modifier.

Similarly, offsite services are not billable in another Medicaid billable location or OMH licensed facility.

Services provided offsite are billed using the offsite rate code instead of the standard onsite rate code. (For more information on rate codes see page 23).

Note: Medicaid fee-for-service reimbursement for offsite services is dependent upon federal approval and will not be available until this approval is obtained.

- **Language Other Than English:** This modifier is applicable when the service to the recipient or collateral is provided in a language other than English (including sign language). The translation may be provided by a staff person fluent in the language or by a paid translator. This modifier cannot be activated when the translation is provided by a friend or family member.

At this time, procedures provided in languages other than English are billed to Medicaid fee-for-service using CPT code T1013.

- **After Hours:** This modifier is applicable when services to adults or children are provided after 6 PM and before 8 AM on weekdays and all day on weekends. In order to bill the modifier, the clinic’s operating certificate must identify extended hours of operation. If a clinic currently has extended hours, the modifier can be billed during these times. Clinics without extended hours that wish to bill this modifier must request a change to their operating certificate from OMH.

This modifier will be recorded using CPT code 99051. It is reported in addition to the CPT code for each particular service or services provided after hours.

- **Physician add-on:** Clinics may submit a supplemental bill under the Medical Assistance physician fee schedule when psychiatrists or psychiatric nurse practitioners spend at least 15 minutes serving the recipient during the time selected services are being provided by another licensed practitioner. The participation must be medically necessary and separate documentation is required from both providers. For information on how to bill for this service see page 30

Modifier Chart

Billing modifiers are available for particular services as indicated on the following chart.

Office of Mental Health Service Name	Off-site	After Hours	Language other than English	Physician/NPP
Complex Care Management	x	x	x	
Crisis Intervention Service - Per 15 minutes	x	x	x	
Crisis Intervention Service - Per Hour		x	x	
Crisis Intervention Service - Per Diem		x	x	
Developmental and Psychological Testing		x	x	
Psychotropic Medication Administration	x	x	x	
Psychotropic Medication Treatment - No Time Limit	x	x	x	
Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development	x	x	x	x
Psychiatric Assessment - Minimum of		x	x	

Office of Mental Health Service Name	Off-site	After Hours	Language other than English	Physician/NPP
30 Minutes				
Psychiatric Assessment - Minimum of 45 Minutes		x	x	
Individual Psychotherapy - Minimum of 30 Minutes	x	x	x	x
Individual Psychotherapy - Minimum of 45 Minutes	x	x	x	x
Group and Multifamily/Collateral Group Psychotherapy - Minimum of 60 Minutes		x	x	x
Family Therapy/Collateral w/o patient - Minimum of 30 minutes	x	x	x	x
Family Therapy/Collateral with patient - Minimum of 60 minutes	x	x	x	x
Outreach (outside visit)	x	x	x	

Medicaid Utilization Threshold

New York State Medicaid imposes a 40 visit threshold on mental health clinic visits. After 40 visits, approval for additional visits is needed. Under APG’s the threshold limit continues to be based on the number of visits. A visit under APGs is defined as all services or procedures provided to an individual or collateral in a single day.

Reimbursement for Collaborative Documentation/Concurrent Record Keeping

Concurrent documentation is a strategy that can be learned and applied in a relatively short period of time. Essentially, concurrent documentation means that a provider works with the client during assessment, service planning and intervention sessions to complete as much related documentation as possible and appropriate.

For Medicaid, the time spent on concurrent documentation may be included as part of a reimbursable, therapeutic encounter. This activity may or may not be reimbursable by other third-party payers.

Medicaid Billing Requirements for Specific Services

Several clinic services have specific Medicaid billing limitations. These are summarized below.

Complex Care Management

To bill Medicaid, this service requires at least 15 minutes of continuous time, not including standard report writing or brief follow up calls. It is above and beyond normal care management and must be medically necessary.

This service must be provided within 5 working days **following** a face to face therapy or crisis visit. It can be provided by phone or in person. If a therapy and crisis visit occurs on the same day, Medicaid can still only be billed for one complex care within 5 working days following the provision of these services.

Crisis Services

Crisis Intervention Services consist of three Medicaid billable levels of service. These are:

- **Crisis Intervention- Brief.** This may be done face to face or by telephone. For services of at least 15 minutes duration, one unit of service may be billed. For each additional service increment of at least 15 minutes, an additional unit of service may be billed, up to a maximum of six units per day.
- **Crisis Intervention – Complex.** This requires a minimum of one hour of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A skilled peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics will be permitted to bill Medicaid fee-for-service for individuals who have not engaged in services for a period of up to two years.
- **Crisis intervention – Per Diem.** This requires three hours or more of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A skilled peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics will be permitted to bill Medicaid fee-for-service for individuals who have not engaged in services for a period of up to two years.

Pre Admission Assessment

No more than three pre-admission assessment services may be billed to Medicaid fee-for-service by the same provider for a recipient within a 12-month period, whether they are initial assessments, psychiatric assessments, or a combination of the two.

- For adults, up to three pre-admission procedures per adult recipient may be billed, no more than one of which may be a collateral procedure.

- For children, claims may be submitted for up to three pre-admission visits. Each such visit may include an individual service, a collateral service, or both. If 2 procedures are completed on the same day (e.g., a procedure for a client and collateral) they are counted as 1 visit.

Outreach

Only Outreach services provided offsite are billable to Medicaid. Outreach services may be provided in any locations but they are not Medicaid reimbursable in jails, prisons or other locations already reimbursed by Medicaid.

Outreach visits are limited to two billable visits. Additional visits may be provided if the outreach worker receives written approval from a member of the clinical staff. The clinician may authorize two visits at a time. The clinical staff must document the reasons for the extension and benefits anticipated from additional Outreach visits.

Note: Medicaid fee-for-service reimbursement for offsite services is dependent upon federal approval and will not be available until this approval is obtained.

Psychiatric Assessment

Clinics may bill a psychiatric assessment for an on-site psychiatric consultation which includes an evaluation, report or interaction between a psychiatrist, Nurse Practitioner in Psychiatry or Physician Assistant with specialized training approved by OMH and a referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

- Up to one on-site Psychiatric Consultation service to a recipient in a calendar year may be billed as Brief or Extended Psychiatric Assessment services, as appropriate.
- Psychiatric Consultation services in excess of one service for the same recipient shall be billed as Consultation. Payment for Consultation services will be at the applicable fee for physician visits.

Psychotherapy

Psychotherapy Services-Individual may be reimbursed as follows:

- Brief Individual Psychotherapy Service. Requires documented face-to-face contact with the recipient of a minimum duration of 30 minutes. ***Sessions less than 30 minutes will not be reimbursed by Medicaid.***
- Extended Individual Psychotherapy Service. Requires documented face-to-face contact with the recipient of a minimum duration of 45 minutes. Providers are free to provide longer sessions but Medicaid will not reimburse for more than a 45 minute psychotherapy session.

Psychotropic Medication Treatment

This service must be a minimum of 15 minutes in length in order to be billed to Medicaid.

Health Physicals

Physical exams for people receiving mental health clinic services are considered to be ancillary to mental health services. Therefore, individuals with Medicaid Managed Care for physical health only will not need a referral from a Medicaid Managed Care primary care provider to receive this service in a mental health clinic. This service is presumed to complement a mental health service and can be paid fee-for-service.

Health Monitoring

Health monitoring services for people receiving mental health clinic services are considered to be ancillary to mental health services. Therefore, individuals with Medicaid Managed Care for physical health only will not need a referral from a Medicaid Managed Care primary care provider to receive this service in a mental health clinic. This service is presumed to complement a mental health service and can be paid fee-for-service.

Psychiatric Consultation

For this service, the referring physician may not be employed by the clinic doing the consultation. Psychiatric Consultation service may be provided off-site, but no off-site Medicaid payment modifier may be billed.

Psychiatric Consultation is billed off the physician's fee schedule.

Submitting Bills to Medicaid

Required Information

All Medicaid claims require the submittal of the appropriate CPT code for the procedure provided and the appropriate peer group rate code. Additionally, all claims submitted to Medicaid fee-for-service shall include, at a minimum:

- The Medicaid client identification number (“CIN”) of the recipient,
- The National Provider Identification of the clinic,
- The designated mental illness diagnosis or for pre-admission visits at least the code for diagnosis-deferred must be entered on the claim,
- The procedure code or codes corresponding to the procedure or procedures provided,
- The location of the service, specifically the licensed location where the service was provided or the clinician’s regular assigned licensed location from which the clinician departed for an off-site procedure. The location will be identified by the location’s “zip+4”, NOT by its historic Medicaid location number, and
- The National Provider Identification or equivalent Department of Health-approved alternative for unlicensed clinicians or the attending clinician.

Billing Multiple Services in the Same Day

Clinics can bill Medicaid for up to 2 services per day per client, except where noted below. The intent is to reduce the need to make multiple trips for complementary services. The clinic will receive 100% reimbursement for the most expensive service, with a 10% discount applied to each additional service with a lower APG weight.

The following services are excluded from this 2 service per day cap: crisis, medication treatment and/or administration, and health care services. This means they can be billed in the same day on top of other services if medically necessary. Discounting rules still apply.

Note: All procedures provided to an individual on the same day must be sent to Medicaid on one claim. This includes procedures provided by different clinicians. If services provided to one individual on the same day are submitted as separate claims, the subsequent claims will be denied. **For more information see OMH FAQs at**

http://www.omh.state.ny.us/omhweb/clinic_restructuring/faq/it_billing.html

Medicaid/Medicare dual eligible clients: If one procedure must be billed to Medicare first, the clinic must wait to bill the rest of the procedures provided on that day until Medicare pays for the cross-over procedure. If the claim is then submitted to Medicaid outside of the 90 day window for billing, it is considered by CMS to be an acceptable reason for delay. Use reason code “7” Third Party Processing Delay.

Billing the Physician Add-on

Information will be provided as answers become available.

Billing for Medical Residents in Teaching Hospitals

NYS Medicaid follows the Medicare requirements for teaching hospitals. Medicaid guidance on this can be found in the June, 2009 NYS Medicaid Update which is available in its entirety at http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-06.htm#sup.

The Centers for Medicare and Medicaid Services (CMS) Guidelines for Teaching Physicians, Interns and Residents is helpful as well and can be found at:

<http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctshs.pdf>.

Indigent Care

New York State has submitted a federal Medicaid waiver request to establish an indigent care funding pool for mental health clinics that is jointly funded by the state and federal government. Assuming the waiver is approved, the pool would offset a portion of losses from indigent care experienced by:

1. Most Diagnostic and Treatment Centers licensed by DOH; and
2. Mental health clinics licensed by OMH that are not affiliated with hospitals or directly operated by OMH and clinics operated by D&TCs not eligible to participate in DOH's Indigent Care distribution.

Payments from the indigent care pool will be made in accordance with payment rules established by the OMH and DOH. **For participation in the pool, agencies must submit annual data for each of their clinic locations by dates established by OMH. Otherwise they will be excluded from the pool for that year.**

Periodic partial payments from the pool will be made by the Department of Health. After a transition period for mental health clinics (described below), payments from the pool will be based on annual data from two years prior.

The percent of indigent care paid by the pool is dependent on the total funds in the pool and the total volume of allowable indigent care visits. To be eligible for an allocation of funds from the pool, a mental health clinic must demonstrate that a minimum of five percent of total clinic visits during the applicable period were uncompensated.

Mental health clinics qualifying for a distribution from the fund will need to provide OMH with assurances that it undertook reasonable efforts to maintain financial support from community and public funding sources and made reasonable efforts to collect payments for services from third-party insurance payers, governmental payers and self-paying patients. This is subject to audit.

OMH anticipates that visits can be counted toward indigent care volume if they meet the following conditions:

1. Self pay, including partial pay or no pay visits (does not include partial payment associated with co-pays or deductibles). Clinic Plus visits (**not revenues**) for comprehensive assessments that are not reimbursed by any other insurance should be recorded as self pay visits. State aid for Clinic Plus comprehensive assessments does not need to be reported as self-pay revenue.
2. Required or optional mental health clinic procedures (as defined in OMH regulations) provided but **not** covered under a clinic's agreement with an insurer. The service must be provided by a practitioner qualified to deliver the service under state regulations.
3. Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member not approved for payment by a third party payor in contract with the

clinic. The provider must document that the clinic or recipient received a denial of payment.

4. Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member when the procedure is not reimbursed by a third party payer **not** in contract with the clinic. Only visits for which the clinic received a denial of payment from the insurer or an attestation from the client/insured that the insurer made no payment will be considered uncompensated. This documentation must be retained by the clinic and will be subject to an audit by the New York State Office of the Medicaid Inspector General or other party empowered to conduct such audits.

Visits **will not be counted** if they meet the following conditions:

1. Visits paid in whole or part by a third party payer (including Medicaid Managed Care).
2. Visits not authorized (considered not medically necessary) by an insurer/managed care plan.
3. Visits provided to a recipient who has coverage from a third party payer not in contract with the clinic when an insurer **does** reimburse the insured for the visit, irrespective of the amount of the reimbursement..
4. Visits delivered by persons unqualified to deliver the services under state regulations.

Additionally services to forensic populations do not count toward uncompensated care visit volume.

Transition - Visit Value and Data Collection

The method of pricing indigent care visits and calculating indigent care volume will transition over time as follows:

Indigent Care Value:

1. In 2010 and 2011, OMH will base indigent care reimbursement on the appropriate peer group Medicaid rate for a 45 minute psychotherapy procedure delivered by an LCSW.
2. In 2012 and after, payments will be based on the current peer group average value of total Medicaid APG payments (no blend).

Indigent Care Volume:

1. Indigent Care payments to Article 31 clinics during calendar year 2010 will be based on annualized indigent care visit volume and total care visit volume delivered July 1, 2009 through December 31, 2009.
2. Indigent Care payments to Article 31 clinics during calendar year 2011 will be based on indigent care visit volume and total care visit volume for the period July, 2009 through June, 2010.

3. Indigent Care payments to Article 31 clinics during calendar year 2012 will be based on data as follows:
 1. Payments to clinics in NYC will be based on data from July, 09 through June, 2010.
 2. Payments to clinics in the rest of the state will be based on data from calendar year 2010.

Reimbursement Calculation

Clinics must provide eligible indigent care visits equal to 5% of their visit volume to qualify for reimbursement from the pool. Reimbursement is then calculated according to the following schedule. Assuming sufficient funds in the pool, the first 15% of clinic visits (assuming they are uncompensated and qualify for reimbursement) are reimbursed at 50% of their Medicaid value minus self pay revenues received. The second 15% are reimbursed at 75% of their Medicaid value minus self pay revenues received. Eligible visits exceeding 30% are reimbursed at 100% of their Medicaid value minus self pay revenues received.

It is important to note, that if the amount of eligible indigent care visits in the pool (D&TC and Article 31) exceeds the funding available in the pool, payments to providers are proportionately reduced.

Additional Information

Additional information about the OMH uncompensated care pool can be found at the OMH website at http://www.omh.state.ny.us/omhweb/clinic_restructuring/uncompensated_care.html

System Transition

Transition to Part 599 License

- **Continued Operation of the Clinic.** The requirements for operation of a clinic treatment program as specified in Part 599 supersede the requirements for a clinic as specified in Parts 587 and 588. Until the effective date for Part 599, an existing clinic treatment program operates by authority of the operating certificate (license) issued by the Office of Mental Health pursuant to Part 587. For purposes of implementation of these new regulations, OMH assumes that a provider intends to continue operation of the clinic in accordance with the requirements of Part 599 unless otherwise notified by the provider. Except as discussed below, it is not necessary for a provider to submit an application for a license, or any other license-related information, to OMH solely for the purpose of continuing operation of the existing clinic program.
- **Clinic Transition Plan.** Although Part 599 replaces Parts 587 and 588 for clinic programs on the effective date of the new regulations, OMH recognizes that a clinic (and any satellite sites associated with the clinic) may need a reasonable period of time to fully transition to the new requirements. A provider operating a clinic under Part 587 will need to develop and implement a transition plan to operate the clinic in accordance with applicable requirements specified in Part 599 and these Guidelines. It is not necessary to submit the transition plan to OMH. However, OMH expects the provider to substantially complete implementation of the plan for the clinic within 6 months of the effective date of Part 599, including, but not limited to, initiation of an approved plan for after hours assistance as specified in sections 599.6(g) and 599.8(b)(4) of the regulations.

Please Note: There is no transition regarding procedure documentation and compliance with billing rules.

- **License Renewal.** There will be no disruption to the OMH license renewal process during transition to Part 599. In fact, OMH intends to continue implementation and refinement of the new Clinic Standards of Care Tracer Methodology which replaces the Tiered Certification process for clinic programs. A provider whose clinic license is due for renewal will still need to submit a license renewal application; the Field Office will conduct an on-site visit as required by law and regulations; and OMH will issue a renewal license pursuant to Part 599 as warranted. However, for those clinic licenses subject to renewal within the 6 month period after the effective date of Part 599, OMH will take into consideration that implementation of the transition plan for the clinic may still be in process. As long as there is evidence of good faith progress in the transition to Part 599 and the program is continuing to provide quality services, the absence of full compliance with the program-related

requirements of Part 599 will not negatively impact the issuance and duration of the renewal license under the new regulations.

- **Revised Licenses.** OMH will revise all existing clinic licenses consistent with these regulations as soon as possible, beginning with those programs whose license renewal dates are most distant from the effective date of Part 599. Until the clinic receives a revised license or a renewal license pursuant to Part 599, the current operating certificate issued pursuant to Part 587 remains valid for operation of the clinic program. However, except for Child and Family Clinic Plus services, any additional and optional services specified on the current license are no longer authorized as of the effective date of Part 599. Note that most of the additional services of Part 587 have been subsumed into the required services of Part 599.
- **Optional Services.** A clinic may be authorized to provide one or more of the optional services specified in section 599.8(c) through submission of an administrative action request pursuant to section 551.6(d) of Part 551. Administrative Actions are submitted via the OMH web based application, Mental Health Provider Data Exchange (MHPD). Information regarding administrative action requests may be obtained from the OMH webpage via the Mental Health Provider Data exchange (MHPD) page and the above referenced regulations. Upon a determination of support for the request, OMH will revise the clinic operating certificate to specify the optional services pursuant to Part 599.
- **Notification to OMH.** If a provider determines that a clinic is unable to operate under Part 599, or intends to substantially change the current operation of the clinic (other than to comply with the requirements of Part 599), the provider must notify OMH in accordance with the requirements of Part 551. No final action to change or terminate operation of the clinic should be undertaken without prior approval of OMH.

Financial Transition

APG reimbursement will be phased in. During the transition, some procedures will be paid at the full APG rate and others will receive a blend. The blend is based on the historical provider specific Medicaid payment.

Payment for procedures receiving a blend will consist of a blended payment and an APG payment. Reimbursement for blended procedure will be based on a mix of 25% APG payment (based on coded procedures, payment modifiers, and base rate) and 75% of a provider specific blend amount. **However, only one blend will be paid per visit.**

The existing payment used for calculating the blend is a provider's average per visit Medicaid reimbursement (base plus COPS) for services moving to APGs for the period July 08 through June 09.

The APG portion of the blend will increase in each phase according to the following schedule.

- Year 1: Providers will receive 75 percent of the legacy payment amount and 25 percent of the calculated value of the procedure-related fee established in this section.
- Year 2: Providers will receive 50 percent of the legacy payment amount and 50 percent of the calculated value of the procedure related fee established in this section.
- Year 3: Providers will receive 25 percent of the legacy payment amount and 75 percent of the calculated value of the procedure related fee established in this section.
- Year 4: Providers will receive 100 percent of the procedure fee payment.

Multiple procedure discounts: When more than one procedure is billed during a visit, a 10% discount will be applied to the procedures with the lowest APG weight. During the transition, the discount will apply solely to the APG fee component of the reimbursement.

Reimbursement for New Clinics

During the transition period (see page 37) providers will be paid a blend of their historical Medicaid reimbursement (legacy amount) and the new APG reimbursement. However, new providers do not have an historical reimbursement amount. Therefore, OMH will establish a surrogate for the historical Medicaid component.

For new providers (new clinics, or clinics commencing service in a new county) that will be licensed either solely under Article 31 of the Mental Hygiene Law or jointly with the Department of Health, the historical fee will equal the lowest historical blend rate in the appropriate peer group.

For hospital- based clinics the historical fee paid to new clinics, or clinics commencing service in a new county, shall be calculated by OMH pursuant to **New York State Department of Health** regulations 10 NYCRR 86-8.6.

Hospital-based mental health clinics are joining the transition of other hospital ambulatory services to APG which is already underway. Hospitals are now in the second year of the transition, so hospital-based mental health clinics will, when Part 599 becomes effective, immediately receive 50% blend payments and 50% APG payments.

Appendix

Definitions

- (a) After hours means before 8 a.m., after 6 p.m., or during weekends.
- (b) Ambulatory Patient Groups (APGs) means a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes. The groupings are based on the intensity of the services provided and the medical procedures performed.
- (c) Base rate means the numeric value that shall be multiplied by the weight for a given service to determine the Medicaid fee for a service.
- (d) Clinic treatment program means a program licensed as a clinic treatment program under Article 31 of the Mental Hygiene Law.
- (e) Clinical services contract means a written agreement between the governing authority of an existing or proposed provider of services and another organization separate from the provider of services for the purpose of obtaining some of the clinical services or some of the clinical staff necessary to operate the program in compliance with requirements for an operating certificate.
- (f) Clinical staff means staff members who provide services directly to recipients, including licensed staff, non-licensed staff, and student interns.
- (g) Collateral means a person who is a member of the recipient's family or household, or a significant other who regularly interacts with the recipient and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient prior to admission. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.
- (h) Commissioner means the Commissioner of the New York State Office of Mental Health.
- (i) Community education means activities designed to increase community awareness of the manifestations of mental illness and emotional disturbance and the benefits of early identification and treatment.
- (j) Complex care management means an ancillary service to psychotherapy or crisis intervention services. It is provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which is required as a follow up to psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions.

(k) Crisis intervention means activities, including medication and verbal therapy, designed to address acute distress and associated behaviors when the individual's condition requires immediate attention.

(l) Current Procedural Terminology (CPT) means codes used in a coding system for health care procedures as defined in the publication *Current Procedural Terminology* which is published by the American Medical Association.

(m) Designated mental illness means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) organic brain syndrome or (iv) social conditions (V-Codes). V-Code 61-20 Parent-Child (or comparable diagnosis in any subsequent editions of the DSM) is included for children.

(n) Developmental testing means the administration, interpretation, and reporting of screening instruments for children or adolescents to assist in the determination of the individual's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes.

(o) Diagnostic and treatment center, means an outpatient program licensed as a diagnostic and treatment center under Article 28 of the Public Health Law which provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. A program providing fewer than 2,000 total visits annually shall not be considered a diagnostic and treatment center.

(p) Episode of service means a series of services provided during a period of admission. An episode of service terminates upon completion of the treatment objectives or cessation of services.

(q) Evidence-based treatment means an intervention for which there is consistent scientific evidence demonstrating improved recipient outcomes.

(r) Family advisor means an individual who has experience, credentials, or training recognized by the Office and has been the parent or primary caregiver of a child with emotional, behavioral or mental health issues.

(s) Health monitoring means the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), and smoking status. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

(t) Health physical means the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures.

(u) Health screening means the initial gathering and assessing of information concerning the recipient's medical history and current physical health status (including physical examination and determination of substance use) to determine potential impact on the recipient's mental health diagnosis and treatment, and the need for additional health services or referral.

(v) Healthcare common procedure coding system (HCPCS codes) means a comprehensive, standardized coding and classification system for health services and products.

(w) Homebound individuals means people who have been determined by a licensed clinician to have a physical and/or mental illness that prevents them from leaving their residence to access mental health services.

(x) Hospital-based clinic means an outpatient program licensed solely under Article 28 of the Public Health Law which is located in a general hospital and provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. A program providing fewer than 2,000 total visits annually shall not be considered a hospital-based clinic.

(y) Impairment in functioning due to emotional disturbance means a child has experienced functional limitations due to emotional disturbance over the past six months or more on a continuous or intermittent basis. The functional problems must be moderate in at least two of the following areas, or severe in at least one of the following areas:

- (1) self care;
- (2) family life;
- (3) social relationships;
- (4) self-direction/self-control; or
- (5) learning ability.

(z) Initial assessment means a face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient.

(aa) Injectable psychotropic medication administration means the process of preparing, administering, and managing the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

- (ab) Limited permit means that the New York State Education Department has determined that permit holders have met all requirements for licensure except those relating to the professional licensing final examination, and that pending licensure limited permit holders are functioning under proper supervision as outlined in the New York State Education Department law governing each of the professions.
- (ac) Linkage with primary care means services designed to promote the integration of the clinic and the primary care provider.
- (ad) Local governmental unit (LGU) means the unit of local government authorized in accordance with Article 41 of the Mental Hygiene Law to provide and plan for local or unified services.
- (ae) Mental health screening for children means a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity.
- (af) Modifiers means payment adjustments made to Medicaid fees for specific reasons such as billing for off-site services (within established limits), services in languages other than English, and services delivered after hours.
- (ag) Non-licensed staff means individuals 18 years of age or older who do not possess a license issued by the New York State Education Department in one of the clinic professional staff categories listed in this Part and who may not provide therapeutic mental health services, except as may be authorized in section 599.9 of this Part. Non-licensed staff includes employees who have a life experience related to mental illness or have education and training in human services.
- (ah) Office means the New York State Office of Mental Health.
- (ai) Outreach means face-to-face services with an individual, or, in the case of a child, the child and/or family member(s) for the purpose of beginning or enhancing the engagement process, or reengaging with individuals who are reluctant to participate in services, or to promote early intervention to prevent a psychiatric crisis.
- (aj) Peer advocate means an individual with personal experience as a mental health recipient, who has training, credentials or experience recognized by the Office.
- (ak) Peer group mean a grouping of providers sharing similar features such as geography or auspice.
- (al) Physician fee schedule means a payment schedule established by the Department of Health which is used to enhance the payment for specific services included in this Part.
- (am) Preadmission status means the status of an individual who is being evaluated to determine whether he or she is appropriate for admission to the clinic.

(an) Preadmission visit means visits provided prior to enrollment in clinic services.

(ao) Professional staff means practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the assessment and treatment of mental illness and shall include the following:

- (1) Creative arts therapist is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.
- (2) Licensed practical nurse is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.
- (3) Licensed psychoanalyst is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.
- (4) Licensed psychologist is an individual who is currently licensed as a clinical psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in clinical psychology who works in a federal, state, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility.
- (5) Marriage and family therapist is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
- (6) Mental health counselor is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.
- (7) Nurse practitioner is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
- (8) Nurse practitioner in psychiatry is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the

New York State Education Department or possesses a permit from the New York State Education Department.

- (9) Physician is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.
- (10) Physician Assistant is an individual who is currently registered as a Physician Assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
- (11) Psychiatrist is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.
- (12) Registered professional nurse is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.
- (13) Social worker is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit issued by the New York State Education Department based upon participation in an approved educational program, to practice and use the title of either licensed master social worker or licensed clinical social worker.

(ap) Psychiatric assessment means an interview with a consumer, child, family, or other collateral performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office, which may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues. A psychiatric assessment may also include on-site psychiatric consultation which includes an evaluation, report or interaction between a psychiatrist or nurse practitioner in psychiatry or physician assistant with specialized training approved by the Office and a referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

(aq) Psychiatric consultation means a face-to-face evaluation, including video tele-psychiatry, of a consumer by a psychiatrist or nurse practitioner in psychiatry, including the preparation, evaluation, report or interaction between the psychiatrist or nurse practitioner in psychiatry and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

(ar) Psychological testing means a psychological evaluation using standard assessment methods and instruments to assist in mental health assessment and the treatment planning processes.

(as) Psychotherapy means therapeutic communication and 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, encouraging personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones.

(at) Psychotropic medication treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate.

(au) Quality improvement means a systematic and ongoing process for measuring and assessing the performance of clinic services and for conducting initiatives and taking action to improve safety, effectiveness, timeliness, person centeredness or other aspects of services.

(av) Satellite means a physically separate adjunct site to a certified clinic treatment program, which provides either a full or partial array of outpatient services on a regularly and routinely scheduled basis (full or part time).

(aw) Specialty clinic means clinics designated by the Commissioner as specializing in the provision of services to children who have a designated mental illness diagnosis and an impairment in functioning due to emotional disturbance

(ax) Supplemental payment means payments in addition to the service fee amount.

(ay) Visit means an interaction consisting of one or more procedures occurring between a recipient and/or collateral and the clinic staff on a given day.

(az) Weight means a numeric value that reflects the relative expected average resource utilization for each service as compared to the expected average resource utilization for all other services.

Frequently Asked Questions

OMH maintains a list of frequently asked questions on the OMH website. These can be found at the following link http://www.omh.state.ny.us/omhweb/clinic_restructuring/faq/

OMH Financial Modeling Tools:

OMH maintains a variety of modeling tools. These can be found at the OMH website at http://www.omh.state.ny.us/omhweb/clinic_restructuring/

Standards of Care

Mental Health Clinic Standards of Care for Adults - Interpretive Guidelines³

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.

The attached description of clinical standards for adult outpatient licensed clinics result from 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.

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.

³ Taken from Appendix E of the New York State/New York City Mental Health-Criminal Justice Panel Report and Recommendations June 2008.

Staff Eligible to Deliver Mental Health Services

	CPT Codes	Service	Staff
1		Outreach & Engagement	Skilled peer advocate or Parent Advisor as the minimal qualification.
2		Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development	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
3		Psychiatric Assessment (established patient)	MD/NPP
4		Psychiatric Consultation	MD/NPP
5		Crisis Intervention	MD/NPP, Physician's Assistant with a mental health specialty, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
6		Psychotropic Medication Administration	MD/NPP/RN/LPN/PA (with a mental health specialty)
7		Psychotropic Medication Treatment	MD/NPP/PA
8		Psychotherapy	MD/NPP, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
9		Developmental Testing	Licensed Practitioner of the Healing Arts (LPHA)
10		Psychological Testing - various	MD/Licensed Psychologist
11		Complex Care Management	Licensed Psychologist, LMSW LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
12		Health Physicals	TBD
13		Health Monitoring	TBD

CPT Codes, APG Codes and Service Blend Status⁴

Blend/Full Pay	APG	CPT Procedure - OMH Regulatory Name	CPT Codes
Full	490	Outreach and Engagement	H0023
Blend	323	Initial Assessment Diagnostic & Treatment Plan	90801
Blend	315	Psychiatric Assessment - 30 mins	90805
Blend	316	Psychiatric Assessment - 45-50 mins	90807
Full	Fixed Fee	Psychiatric Consultation	99241
Full	Fixed Fee	Psychiatric Consultation	99242
Full	Fixed Fee	Psychiatric Consultation	99243
Full	Fixed Fee	Psychiatric Consultation	99244
Full	Fixed Fee	Psychiatric Consultation	99245
Full	321	Crisis Intervention - 15 min	H2011
Full	321	Crisis Intervention - per hour	S9484
Full	312	Crisis Intervention - per diem	S9485
Full	490	Psychotropic Medication Administration	H2010
Full	426	Psychotropic Medication Treatment	90862
Blend	315	Psychotherapy - Individ 30 mins	90804
Blend	316	Psychotherapy - Individ 45 mins	90806
Blend	317	Psychotherapy - Family 30 mins	90846
Blend	317	Psychotherapy – Family & Client 1 hr	90847
Blend	318	Psychotherapy - Family Group 1hr	90849
Blend	318	Psychotherapy - Group 1 hr	90853
Full	310	Developmental Testing - limited	96110
Full	310	Developmental Testing - extended	96111
Full	310	Psychological Testing - Various	96101
Full	310	Psychological Testing - Neurobehavioral	96116
Full	310	Psychological Testing - Various	96118
Full	490	Complex Care Management - 15 mins	90882

⁴ For CPT and HCPCS code definitions see manuals developed by the American Medical Association and the federal Centers for Medicaid and Medicare Services. For Medicaid billing purposes, clinics must comply with the service standards in Part 599.