Mental Health Clinic Part 599 Overview

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Gary Weiskopf
New York State Office of Mental Health

Purpose of Presentation

- Brief Review
  - Part 599 Clinic Regulations
  - APG reimbursement
  - Medicaid Managed Care reimbursement

Part 599 Resources

- Recorded webinar
  - https://www1.gotomeeting.com/register/147905512 .
- PowerPoint slides
  - http://www.omh.state.ny.us/omhweb/clinic_restructuring/part_599_overview_presentation.pdf
- Guidance document
  - http://www.omh.state.ny.us/omhweb/clinic_restructuring/NYCRR_part_599_guidance.pdf .
- OMH Clinic Restructuring Website
  - http://www.omh.state.ny.us/omhweb/clinic_restructuring/default.html

Part 599 Clinic Regulation

- Effective October 1, 2010

599.1	Background and intent.
599.2	Legal base.
599.3	Applicability.
599.4	Definitions.
599.5	Certification.
599.6	Organization and administration.
599.7	Rights of recipients.
599.8	Clinic services.
599.9	Staffing.
599.10	Treatment planning.
599.11	Case records.
599.12	Premises.
599.13	Medical assistance clinic reimbursement system.
599.14	Medical assistance billing standards.
599.15	Indigent care.

Applicability – (599.3)

- Applies to OMH licensed clinic treatment programs,
- Hospital OPDs and Diagnostic and Treatment Centers (D&TC) which
  - provide more than 10,000 mental health visits annually, or
  - For which mental health visits comprise over 30 percent of the annual visits
  - Exception: Programs providing fewer than 2,000 total visits annually exempt

Organization & Administration (599.6)

- **Clinics will be required to have policies and procedures for:**
  - Initial and ongoing **risk assessments** and plans to address identified areas of elevated risk
  - Age appropriate health monitoring
    - e.g., smoking, blood pressure, weight, developmental status
  - Addressing **recipient engagement** and retention in treatment.
  - Screening for abuse or dependence on alcohol or other substances
  - Obtaining records from prior episodes of treatment and communicating with collaterals

Organization and Administration (599.6)

- Written criteria for 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.
  - Admission to the clinic or referral to appropriate provider

Premises (599.12)

- Program and non-program space may be shared
- Plan must be approved by OMH
- Shared space does not mean:
  - Billing using same rate codes
  - Waiving of confidentiality rules
  - Co-facilitating of sessions

Treatment Planning (599.10)

- Must be completed no later than 30 days after admission
- Updates no less frequently than every 90 days, or the next provided service, whichever is later
  - Federal Medicaid guidance **recommends** treatment plan updates every 90 days
  - It is not a statutory or regulatory requirement.
  - OMH believes that individuals should not present at the clinic for the sole purpose of reviewing the treatment plan, or that the treatment plan be reviewed without the participation of the individual.
- Timing exemption for individuals covered by managed care or other third party insurance

Treatment Planning (599.10)

- Plans and updates should include, as appropriate, the input and signatures of relevant staff, the recipient, family members and collaterals
- They ***must*** include the signature of one of the following:
  - Medicaid fee-for-service
    - only signed by a psychiatrist or other physician.
  - Other recipients for whom the program prescribes psychotropic medication
    - a psychiatrist, physician or nurse practitioner in psychiatry.
  - Other recipients who do not receive psychotropic medication
    - a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, or licensed clinical social worker.

Clinic Services (599.8)

- **Required Services**
  - ***Assessment***
    - Initial assessment
    - Psychiatric assessment
  - ***Therapies***
    - Psychotherapy - individual
    - Psychotherapy - family/collateral
    - Psychotherapy - group
    - Psychotropic medication treatment
    - Injectable psychotropic medication administration - (for clinics serving adults)
  - ***Enhanced Services***
    - Crisis intervention
    - Complex care management
    - Outreach

Clinic Services (599.8)

- **Optional Services**
  - Injectable Psychotropic Medication Administration
    - Optional for clinics only serving children
  - Developmental and Psychological Testing
    - For admitted individuals only
  - Health Physicals
  - Health Monitoring
  - Psychiatric Consultation

Medical Assistance Reimbursement System (599.14)

- Federal approval pending
  - Off-site billing rules will be engaged and or/revised upon federal approval

Modifiers and Add-ons (599.14)

- Physician add-on
  - Billed when a physician facilitates or participates for at least 15 minutes in appropriate services.
  - Will pay a fixed $56
  - Requires use of separate claim 837P
- U4 Modifier – Languages other than English
  - Line level modifier
  - Can be used for multiple services provided to a client in a day
- U5 Modifier – for school-based group sessions less than 60 minutes
  - Must be bell-to-bell
  - Clinic will use CPT code 90853 but code with modifier will pay 30% less than a 60 minute group session
- CPT Code 99051 – After-hours and Weekends
  - Weighted at .0759 of the base rate (ex. Downstate Art. 31 with QI would receive $11.46)
  - Can only be used once per client, per day

Pre-admission Assessments

- Two types of assessment
  - Initial Assessment and Psychiatric Assessment.
- Medicaid reimbursement limits
  - Adults: no more than 3 pre-admission assessment **procedures** for same recipient in same clinic within12 months.
  - Children: no more than 3 pre-admission assessment **visits** for same recipient in same clinic within12 months.
    - A visit is all procedures for a recipient or collateral in a day

Pre-admission Assessments

- Medicaid reimbursement for up to 3 preadmission assessments
  - Help clinicians improve engagement
  - Provide flexibility and more time to focus on the needs of the recipient.
- Part 599 ***does not*** mandate three pre-admission sessions.
- Multiple assessments should only be done if medically necessary.

Indigent Care (599.15)

- Uncompensated Care Pool proposed for:
  - D&TCs licensed by DOH and approved for the pool by DOH
  - Free-standing Article 31 mental health clinics
- Hospital operated clinics are not eligible for this pool
- See OMH website for more information
  http://www.omh.state.ny.us/omhweb/clinic_restructuring/uncompensated_care.html
- Services reimbursed by the Uncompensated Care Pool must comply with Medicaid rules

Financial Transition (599.13)

- Phased-in over time to enable transition
  - 1st year – 75% old, 25% new
  - 2nd year – 50% old, 50% new, etc.
- Clinics to submit APG claim only except for Physician add-on
- Medicaid Managed Care required to pay rates equivalent to APGs
  - OMH will publish provider specific blend rates
  - MMC blend phase out over same period as fee-for-service
  - Depends on availability of funds

County Role

- **Review and approve crisis plans.**
  - 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**.
- **Require, review and approve provider transition plans**
  - 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**.

Current Status

- Regulations effective 10-1-2010
- Finalizing rates
- Awaiting CMS approval on APGs
- Awaiting CMS approval on uncompensated care