Clinic Treatment Programs
14 NYCRR Part 599
Express Terms
Adoption

Below is the full text of the new Part 599 of Title 14 NYCRR. Changes made to the final text as compared to the proposed rule, are available. The regulation is effective October 1, 2010.

A new Part 599 is added to read as follows:

PART 599
CLINIC TREATMENT PROGRAMS
(Statutory Authority: Mental Hygiene Law §§7.09, 31.02, 31.04, 31.06, 31.07, 31.09, 31.11, 31.13, 31.19, 41.13, 43.01, 43.02, Article 33 and Article 41; Social Services Law §§364, 364-a, 364-j)

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§ 599.1 Background and intent.

(a) This Part establishes standards for the certification, operation and reimbursement of clinic treatment programs serving adults and clinic treatment programs serving children.

(b) Clinic treatment programs serving adults serve individuals 18 years of age and older with a diagnosis of mental illness. Clinic treatment programs serving children serve individuals up to 21 years of age and may include 21-year old individuals while such individuals are currently admitted to a clinic serving children with a diagnosis of emotional disturbance. A clinic treatment program may serve both adults and children.

(c) The goals of a clinic treatment program that serves adults are to diagnose and treat an individual's mental illness, to work with the individual in developing a plan of care designed to minimize symptoms and adverse effects of illness, maximize wellness, and promote recovery toward the achievement of life goals such as, but not limited to, education and employment.

(d) The goals of a clinic treatment program that serves children are early assessment and identification of childhood emotional disturbances, and engagement of the child and family in the development of a plan

of care designed to minimize the symptoms and adverse effects of illness, maximize wellness, assist the child in developing a resilient and hopeful approach to school, family, and community, and maintain the child in his or her natural environment.

(e) It is the intent of the Office of Mental Health that the goals described in this section be achieved through the establishment and operation of programs that provide outreach to address the symptoms and adverse effects of mental illness at their earliest stages, to avoid mental health crises where possible, and to respond in a timely and effective manner to such crises when they occur. It is the intent of the Office to establish the clinic treatment program as a clinical home for the individual being served that provides a person-centered, recovery oriented and individualized approach to care. Providers should utilize high quality and evidence-based practices and other practices which are supported by scientific research or generally accepted clinical practice guidelines to maximize individuals' abilities; to minimize the symptoms, adverse effects and consequences of mental illness; to maintain and promote the individuals' integration into the community; to support family integrity; and to provide ongoing support to service recipients and their relevant collaterals.

(f) This Part supersedes Part 85 of this Title as it relates to clinic treatment services operated by or under the auspices of the Office of Mental Health.

(g) This Part supersedes Parts 587, 588 and 592 of this Title as they relate to clinic treatment services operated by or under the auspices of the Office of Mental Health, except where specifically noted in this Part.

§ 599.2 Legal base.

(a) Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health the power and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction, and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for adults diagnosed with mental illness or children diagnosed with emotional disturbance, pursuant to an operating certificate.

(b) Section 31.02 of the Mental Hygiene Law prohibits the operation of outpatient programs providing services for persons with mental illness unless an operating certificate has been obtained from the Commissioner.

(c) Sections 31.07, 31.09, 31.13 and 31.19 of the Mental Hygiene Law further authorize the Commissioner or his or her representatives to examine and inspect such programs to determine their suitability and proper operation. Section 31.16 authorizes the Commissioner to suspend, revoke or limit any operating certificate, under certain circumstances.

(d) Section 31.11 of the Mental Hygiene Law requires every holder of an operating certificate to assist the Office of Mental Health in carrying out its regulatory functions by cooperating with the Commissioner in any inspection or investigation, permitting the Commissioner to inspect its facility, books and records, including recipients' records, and making such reports, uniform and otherwise, as are required by the Commissioner.

(e) Section 31.06 of the Mental Hygiene Law requires every holder of an operating certificate to develop policies and training programs in regard to reporting child abuse or neglect.

(f) Section 43.02(b) of the Mental Hygiene Law authorizes the Commissioner to request from operators of facilities licensed by the Office of Mental Health such financial, statistical and program information as the Commissioner may determine to be necessary.

(g) Article 33 of the Mental Hygiene Law establishes basic rights of persons diagnosed with mental illness.

(h) Section 364-j of the Social Services Law requires the establishment of managed care programs throughout the State and provides for the provision of special care services to enrollees in Medicaid managed care programs who require such services.

(i) Sections 364 and 364-a of the Social Services Law give the Office of Mental Health responsibility for establishing and maintaining standards for medical care and services in facilities under its jurisdiction, in accordance with cooperative arrangements with the Department of Health.

(j) Section 43.01 of the Mental Hygiene Law gives the Commissioner authority to set rates for outpatient services at facilities operated by the Office of Mental Health. Section 43.02 of the Mental Hygiene Law provides that payments under the medical assistance program for outpatient services at facilities licensed by the Office of Mental Health shall be at rates certified by the Commissioner of Mental Health and approved by the Director of the Budget.

(k) Title XIX of the Federal Social Security Act, as identified in section 502.2(c) of such Title, authorizes Federal grants to states to fund medical assistance to needy persons in accordance with a State plan approved by the Federal Department of Health and Human Services.

(l) Article 41 of the Mental Hygiene Law gives the Local Governmental Unit the authority to direct and administer a local comprehensive planning process for its geographic area in which all providers of service shall participate and cooperate through the development of integrated systems of care and treatment for persons with mental illness.

(m) Section 41.13 of the Mental Hygiene Law establishes the powers and duties of the Local Governmental Unit.

§ 599.3 Applicability.

(a) This Part applies to any provider of service that operates or proposes to operate a clinic in which staff is assigned on a regular basis to provide services for the treatment of adults with a diagnosis of mental illness or children with a diagnosis of emotional disturbance.

(b) This Part applies to Clinic Treatment Programs, Diagnostic and Treatment Centers and hospital-based clinics, as defined in this Part.

(c) This Part does not apply to the following activities which do not require an operating certificate issued by the Office:

(1) professional practice, on an individual or partnership basis, within the scope of professional licensure or certificate issued by an agency of the State;

(2) professional practice by a professional service corporation duly incorporated pursuant to the Business Corporation Law;

(3) pastoral counseling by a clergyman or minister as defined in section 2 of the Religious Corporation Law;

(4) non-residential services that are provided in accordance with licensure or other supervision by a State agency other than the Office;

(5) non-residential services that are provided in accordance with purposes authorized in a charter or certificate of incorporation issued pursuant to the Education Law; and

(6) designated partial capitation programs, including the Pre-Paid Mental Health Plan operated by the Office.

(d) Medicaid reimbursement of outreach services and off-site services is contingent upon Federal approval.

(e) Programs which provide medical services, other than health monitoring and health screening, that comprise more than five percent of total annual visits shall also be licensed by the Department of Health.

§ 599.4 Definitions. For purposes of this Part:

(a) *After hours* means before 8 a.m., 6 p.m. or later, 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) *Clinician* means a person who is a member of the professional staff.

(h) *Collateral* means a person who is a member of the recipient's family or household, or other individual 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.

(i) *Commissioner* means the Commissioner of the New York State Office of Mental Health.

(j) *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.

(k) *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.

(l) *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.

(m) *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.

(n) *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:

(1) alcohol or drug disorders,

(2) developmental disabilities,

(3) organic brain syndrome or

(4) social conditions (V-Codes) . V-Code 61-20 Parent-Child (or comparable diagnosis in any subsequent editions of the DSM) is included for children.

(o) *Developmental testing* means the administration, interpretation, and reporting of screening and assessment 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.

(p) *Diagnostic and treatment center* for the purposes of this Part, means an outpatient program licensed as a diagnostic and treatment center pursuant to 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.

(q) *Director of Community Services* means the chief executive officer of the Local Governmental Unit.

(r) *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.

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

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

(u) *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.

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

(w) *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) for purposes of informing an assessment and determination of its potential impact on a recipient's mental health diagnosis and treatment, and the need for additional health services or referral.

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

(y) *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 or for whom a physician determines that leaving the residence to access mental health services would be detrimental to their health or mental health.

(z) *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.

(aa) *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.

(ab) *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.

(ac) *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.

(ad) *Linkage with primary care* means activities designed to promote coordination, continuity and efficiency of mental health services and primary care services received by the recipient.

(ae) *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.

(af) *Mental health screening for children* means a broad-based approach to identify children and adolescents with emotional disturbances in order to allow for intervention at the earliest possible opportunity.

(ag) *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.

(ah) *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.

(ai) *Office* means the New York State Office of Mental Health.

(aj) *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.

(ak) *Peer advocate* means an individual with personal experience as a mental health recipient, who has training, credentials or experience recognized by the Office.

(al) *Peer group* mean a grouping of providers sharing similar features such as geography or auspice.

(am) *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.

(an) *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.

(ao) *Preadmission visit* means visits provided prior to admission to clinic services.

(ap) *Primary clinician* is a member of the professional staff responsible for the development and implementation of the treatment plan.

(aq) *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 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 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 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 from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

(ar) *Psychiatric assessment* means an interview with an adult or child or his or her family member or other collateral, performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office. An 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. 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.

(as) *Psychiatric consultation* means a face-to-face evaluation, which may be in the form of 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.

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

(au) *Psychotherapy* means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual'sdiagnosed 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.

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

(aw) *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.

(ax) *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) .

(ay) *Serious emotional disturbance* means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

(1) ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries) ; or

(2) family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting) ; or

(3) social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time) ; or

(4) self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability) ; or

(5) ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school) .

(az) *Specialty clinic* means a clinic 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 serious emotional disturbance.

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

(bb) *Treatment planning* is an ongoing process of assessing the mental health status and needs of a recipient, establishing his or her treatment and rehabilitative goals and determining what services may be provided by the clinic to assist the individual in accomplishing these goals.

(bc) *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.

(bd) *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.

§ 599.5 Certification.

(a) A provider of service intending to operate a clinic treatment program must obtain an initial operating certificate issued by the Office in accordance with procedures established in Part 551 of this Title. Renewals of such operating certificates shall be issued for terms of up to three years.

(b) Each clinic site shall be authorized by a separate operating certificate. The operating certificate shall specify for each site:

(1) the program type (clinic) to be operated;

(2) the location of the program;

(3) the hours of operation of the program;

(4) the population to be served;

(5) the term of the operating certificate; and

(6) any approved optional services to be provided.

(c) Each clinic authorized by an operating certificate pursuant to this Part shall be clearly identifiable. Each clinic shall have sufficient program space to provide safety, and to allow for a reasonable degree of privacy consistent with the effective delivery of services. Program space may be shared with other programs, pursuant to a plan approved by the Office. Non-program space, e.g., waiting rooms, restrooms, etc., may be shared with other programs.

(d) Clinics may provide services at off-site locations.

(1) To the extent that such services are provided in a given location on a regularly and routinely scheduled basis (full or part time) , such site shall be considered a satellite location and shall be in compliance with this section.

(2) In determining the regular and routine nature of services at a given site, the Office shall take into consideration the volume of services, the number of individuals receiving services, the number of staff assigned, the range of services provided, and whether the site will be utilized on a permanent or temporary basis.

(e) Off-site locations which are determined by the Office to be satellite locations of a primary program shall meet the following requirements:

(1) the satellite must be approved and certified by the Office in accordance with procedures established in Part 551 of this Title prior to operation;

(2) there shall be an explicit clinical and administrative linkage between the satellite and the primary program which includes, but is not limited to, methods of staff supervision, treatment planning, review of treatment plans, maintenance of the records of individuals receiving services and utilization review;

(3) there shall be adequate and sufficient staff to provide services at the satellite. The full range of the primary program's services must be available as clinically appropriate to recipients who utilize the satellite location, but not all services must be available at the satellite; and

(4) satellite locations must meet the physical plant requirements for program space set forth in Section 599.12 of this Part.

(f) Establishment of a new program or changes to the operating certificate requires prior approval of the Office in accordance with Part 551 of this Title.

(g) Changes in the hours of operation of a program may be made upon notification to the Office and the Office's determination that the changes will not negatively affect the program, consistent with the provisions of Part 551 of this Title.

(h) An operating certificate may be limited, suspended or revoked by the Office pursuant to Part 503 of this Title. The operating certificate is the property of the Office and as such shall be returned to the Office if it should be revoked.

(i) The provider of service shall frame and display the operating certificate within the clinic treatment program site in a conspicuous place which is readily accessible to the public.

(j) The provider of service shall cooperate with the Office or the local governmental unitduring any review or inspection of the clinic treatment program.

(k) The county director of community services shall be responsible for identifying specific licensed clinic treatment programs that may be designated by the Commissioner as specialty clinic programs serving children in accordance with the identified need within the county. In making such identifications, the county director of community services shall use the criteria specified in Part 587 of this Title.

(l) A clinic treatment program designated by the Office as a specialty clinic serving children shall be authorized to be reimbursed by Medicaid on a fee-for-service basis for providing clinic treatment services to children with a serious emotional disturbance up to but not including their 19th birthday, notwithstanding the child's enrollment in a Medicaid managed care program.

(m) The Commissioner shall have the authority to designate and approve demonstration projects for purposes of examining innovative program and administrative configurations, regulatory flexibility and alternative funding methodologies.

§599.6 Organization and administration.

(a) The provider of service shall identify a governing body which shall have overall responsibility for the operation of the program. The governing body may delegate responsibility for the day-to-day management of the program to appropriate staff pursuant to an organizational plan approved by the Office.

(b) In programs operated by not-for-profit corporations other than hospitals licensed pursuant to Article 28 of the Public Health Law, no person shall serve both as a member of the governing body and of the paid staff of the clinic treatment program without prior written approval of the Office.

(c) The governing body shall be responsible for the following duties:

(1) to meet at least four times a year;

(2) to review, approve and maintain minutes of all official meetings;

(3) to develop an organizational plan which indicates lines of accountability and the qualifications required for staff positions. Such plan may include the delegation of the responsibility for the day-to-day management of the program to a designated professional who is qualified by training and experience to supervise program staff;

(4) to review the program's compliance with the terms and conditions of its operating certificate, applicable laws and regulations;

(5) to ensure that the design and operation of the program is consistent with and appropriate to the ethnic and cultural background of the population served. This can include ethnic representation on the staff and board and inclusion of culturally and ethnically relevant content in service programs;

(6) to ensure that planning decisions are based upon input from recipients and, where appropriate, their family members;

(7) to develop, approve, and periodically review and revise as appropriate all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to, the following:

(i) written criteria for admission, and discharge from the program. Admission policies should include a mechanism for screening individuals at the time of referral and assuring that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those determined to be in urgent need by the Director of Community Services receive initial assessment services within five business days, and if indicated, are admitted to the clinic or referred to an appropriate provider of services. The county may establish, subject to the approval of the Office, categories of individuals to be considered in urgent need of services;

(ii) policies and procedures for conducting initial and ongoing risk assessments and for development of plans to address identified areas of elevated risk, including procedures to ensure that any health or mental health issues identified are treated appropriately by the clinic or that an appropriate referral to a treatment provider and subsequent follow up is made;

(iii) policies and procedures addressing recipient engagement and retention in treatment, including, at minimum, plans for outreach and re-engagement efforts commensurate with an individual's assessed risk;

(iv) policies and procedures for age appropriate health monitoring, which describe whether such monitoring will be performed by the provider or, if not, how the provider will seek to ascertain relevant health information. Such policies and procedures must include a requirement that an individual's refusal to provide access to such information be documented in the case record;

(v) policies and procedures for screening for abuse or dependence on alcohol or other substances;

(vi) policies and procedures ensuring that a reasonable effort shall be made to obtain records from prior recent episodes of treatment;

(vii) policies and procedures ensuring that a reasonable effort shall be made to communicate with family members, current service providers, and other collaterals, as appropriate;

(viii) written policies and procedures to ascertain whether individuals are currently receiving or are eligible to receive Medicare or Medicaid or other form of reimbursement for services provided. If it is determined that an individual is eligible for any such program but not currently enrolled, the policies and procedures shall include means of facilitating the enrollment of such individual in such program;

(ix) written policies and procedures concerning the prescription and administration of medication which shall be consistent with applicable Federal and State laws and regulations and which includes procedures for ensuring that individuals are receiving prescribed medications and using them appropriately;

(x) written policies and procedures governing recipients' records which ensure confidentiality consistent with sections 33.13 and 33.16 of the Mental Hygiene Law and 45 CFR Parts 160 and 164, and which provide for appropriate retention of such records pursuant to section 599.11 of this Part;

(xi) written policies and procedures describing a recipient grievance process which ensures the timely review and resolution of recipient complaints and which provides a process enabling recipients to request review by the Office when resolution is not satisfactory;

(xii) written personnel policies which shall prohibit discrimination on the basis of race, color, creed, disability, sex, marital status, age, HIV status, national origin, military status, predisposing genetic characteristics, or sexual orientation;

(xiii) written policies which are consistent with the obligations imposed by titles VI and VII of the Civil Rights Act, Federal Executive Order 11246, article 15 of the Executive Law (Human Rights Law) , article 15-a of the Executive Law (Minority and Women Business Enterprises Program) , section 504 of the Rehabilitation Act of 1973, the Vietnam Era Veteran's Readjustment Act, the Federal Age Discrimination in Employment Act of 1967, and the Federal Americans with Disabilities Act;

(xiv) for clinics that will provide services to minors, written policies which shall provide for screening of employees, through the New York Statewide Central Register of Child Abuse and Maltreatment, verification of employment history, personal references, work record and qualifications as well as requesting the Office to perform criminal history record checks in accordance with Part 550 of this Title;

(xv) for clinics that will provide services exclusively to adults, written policies which shall provide for verification of employment history, personal references, work record, and qualifications, as well as requesting the Office to perform criminal history record checks in accordance with Part 550 of this Title;

(xvi) written volunteer policies which shall provide for screening of volunteers,through the New York Statewide Central Register of Child Abuse and Maltreatment (for clinics that will provide services to minors) , verification of employment history, personal references, work history, and supervision of volunteers, as well as requesting the Office to perform criminal history checks in accordance with Part 550 of this Title;

(xvii) written policies regarding the selection, supervision, and conduct of students accepted for training in fulfillment of a written agreement between the clinic and a State Education Department accredited higher education institution, as well as requesting the Office to perform criminal history record checks in accordance with Part 550 of this Title;

(xviii) written policies regarding the employment, supervision and privileging of nurse practitioners and physician assistants. Such policies shall ensure that physician assistants have responsibilities related to physical health only. Such policies shall ensure compliance with Part 550 of this Title concerning the requirement for criminal history record checks, for obtaining clearance from the New York State Central Register of Child Abuse and Maltreatment for persons who have the potential for regular and unsupervised or unrestricted contact with children, and for appropriate consideration and confidentiality of such information;

(xix) written policies which shall establish that contracts with third party contractors that are not subject to the criminal history background check requirements established in Section 31.35 of the Mental Hygiene Law include reasonable due diligence requirements to ensure that any persons performing services under such contract that will have regular and substantial unsupervised or unrestricted contact with patients of the clinic do not have a criminal history that could represent a threat to the health, safety, or welfare of the patients of the clinic, including, but not limited to, the provision of a signed, sworn statement whether, to the best of his or her knowledge, such person has ever been convicted of a crime in this State or any other jurisdiction; and

(xx) written policies and procedures regarding the mandatory reporting of child abuse or neglect, reporting procedures and obligations of persons required to report, provisions for taking a child into protective custody, mandatory reporting of deaths, immunity from liability, penalties for failure to report, and obligations for the provision of services and procedures necessary to safeguard the life or health of the child. Such policies and procedures shall address the requirements for the identification and reporting of abuse or neglect regarding recipients who are children, or who are the parents or guardians of children; and

(8) to ensure the establishment and implementation of an ongoing training program for current and new employees and volunteers that addresses the policies and procedures regarding child abuse and neglect described in paragraph (7) of this subdivision.

(d) A provider of service shall ensure that no recipient who is otherwise appropriate for admission is denied access to services solely on the basis of having a co-occurring non-mental health diagnosis, or a diagnosis of HIV infection, AIDS, or AIDS-related complex.

(e) The provider of service shall establish mechanisms to ensure that priority access is given to individuals referred to the provider, who are enrolled in an assisted outpatient treatment program established pursuant to section 9.60 of the Mental Hygiene Law, in accordance with the following:

(1) The provider of service shall cooperate with the local governmental unit or the Commissioner, or their authorized representatives, in ensuring priority access by such individuals, and in the development, review and implementation of treatment plans for such individuals.

(2) Prior to discharge by a provider of service of an individual who is also enrolled in an assisted outpatient treatment program, the provider of service shall notify the individual's case manager and the director of the assisted outpatient treatment program for the county.

(3) Any and all related information, reports and data that may be requested by the Commissioner or the local governmental unit shall be furnished by the provider of service. Any requests for clinical records from persons or entities authorized pursuant to section 33.13 or 33.16 of the Mental Hygiene Law, regarding individuals who are the subject of, or under consideration for, a petition for an order authorizing assisted outpatient treatment shall be given priority attention and responded to without delay.

(f) The provider of service shall establish mechanisms for the meaningful participation of recipient and/or family representatives either through direct participation on the governing body, or through the creation of a recipient advisory board. If a recipient advisory board is used, the provider of service shall ensure a mechanism for the recipient advisory board to make recommendations to the governing body.

(g) The provider of service shall develop and make available to recipients and collaterals, a plan which will assure an appropriate response to recipients admitted to the program and their collaterals who need assistance when the program is not in operation. Such plan shall include the ability to speak with a member of the licensed staff of the clinic or a licensed staff person working under the auspices of the clinic pursuant to a plan approved by the local governmental unit or, for county-operated providers, by the Office.

(h) A provider of service shall ensure that any clinic subject to this Part does not:

(1) utilize restraint or seclusion for any purpose, including, but not limited to, as a response to a crisis situation, provided, however, that in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed, nothing in this Section shall be construed to prohibit the use of reasonable physical force when necessary to protect the life and limb of any person**;** and

(2) perform electroconvulsive therapy or aversive conditioning therapy for any purpose, including, but not limited to, as a treatment intervention.

(i) A provider of service shall ensure that recipient participation in research only occurs in accordance with applicable Federal and State requirements.

(j) A provider of service shall ensure the development, implementation and ongoing monitoring of a Risk Management Program that includes the requirements for identification, documentation, reporting, investigation, review, and monitoring of incidents pursuant to the Mental Hygiene Law and Part 524 of this Title.

(k) There shall be an emergency evacuation plan and staff shall be knowledgeable about its procedures.

(l) There shall be a written utilization review procedure to ensure that all recipients are receiving appropriate services and are being served at an appropriate level of care. Such policies and procedures shall include provisions ensuring that utilization review is performed, at a minimum, on a random 25 percent sample of open cases, and shall be performed only by professional staff trained to do such reviews, or by staff who are otherwise qualified by virtue of their civil service standing, and shall ensure to the maximum extent possible that the designated utilization review authority functions independently of the clinical staff that is treating the recipient under review. Such utilization review procedure shall provide for:

(1) a review of the appropriateness of admission to a clinic treatment program;

(2) a review of the need for continued treatment in a clinic treatment program within seven months after admission and every six months thereafter unless the recipient is:

(i) discharged out of the program and subsequently readmitted, wherein the cycle begins again; or

(ii) receiving medication therapy and medication education services only, wherein the need for continued treatment shall be reviewed every 12 months thereafter.

(3) a determination by the treating clinician of the need for continued clinic treatment service beyond 40 visits per benefit year for adults to be documented in the case record no later than at the 40th visit during a benefit year.

(i) Such determination shall include an estimate of the number of visits beyond 40 required for the recipient within the remaining benefit year.

(ii) The need for continued clinic treatment service beyond this estimated number of visits shall be determined at or prior to the provision of the estimated number of visits during the benefit year. The need for any additional revised estimates shall be determined accordingly.

(4) a determination by the treating clinician of the need for continued clinic treatment services beyond 40 visits per benefit year for children with a diagnosis of emotional disturbance in clinic treatment programs to be documented in the case record no later than at the 40th visit during a benefit year.

(i) Such determination shall include an estimate of the number of visits beyond 40 required for the recipient within the remaining benefit year.

(ii) The need for continued clinic treatment service beyond this estimated number of visits shall be determined at or prior to the provision of the estimated number of visits during the benefit year. The need of any additional revised estimates shall be determined accordingly.

(m) The provider of service shall participate as requested by the local governmental unit in the local planning processes pursuant to Article 41 of the Mental Hygiene Law.

(n) The provider of service shall cooperate with the Office and the local governmental unit in monitoring the access to services of individuals or groups determined to be in urgent need of services pursuant to this section.

(o) In programs that are not operated by State government, there shall be an annual audit of the service provider, pursuant to a format prescribed by the Office, and in accordance with Generally Accepted Auditing Principles, of the financial condition and accounts of the provider, or in accordance with requirements established by the Department of Health for programs operated by agencies operated pursuant to Article 28 of the Public Health Law. This audit shall be performed by a certified public accountant who is not a member of the governing body or an employee of the program. In addition, the provider is required to submit an annual Consolidated Fiscal Report to the Office of Mental Health, signed by the Chief Executive Officer, and meet all requirements for submission as described in the instructions for this Report. Government-operated programs shall comply with applicable laws concerning financial accounts and auditing requirements.

§ 599.7 Rights of recipients.

(a) Recipients admitted to a clinic treatment program certified pursuant to this Part are entitled to the rights defined in this subdivision. A provider of service shall be responsible for ensuring the protection of these rights.

(1) Recipients have the right to an individualized plan of treatment services and to participate to the fullest extent consistent with the recipients' capacity in the establishment and revision of that plan.

(2) Recipients have the right to a full explanation of the services provided in accordance with their treatment plan.

(3) Participation in treatment in a clinic program is voluntary and recipients are presumed to have the capacity to consent to such treatment. The right to participate voluntarily in and to consent to treatment shall be limited only pursuant to a court order or in accordance with applicable provisions of law.

(4) While a recipient's full participation in treatment is a central goal, a recipient's objection to his or her treatment plan, or disagreement with any portion thereof, shall not, in and of itself, result in his or her termination from the program unless such objection renders continued participation in the program clinically inappropriate or would endanger the safety of the recipient or others.

(5) The confidentiality of recipients' clinical records shall be maintained in accordance with applicable State and Federal laws and regulations, which may include, but are not limited to section 33.13 of the Mental Hygiene Law, Article 27-F of the Public Health Law, the Health Insurance Portability and Accountability Act (HIPAA) , and 42 CFR Part 2.

(6) Recipients shall be assured access to their clinical records, including their mental illness diagnosis, consistent with section 33.16 of the Mental Hygiene Law and applicable Federal requirements.

(7) Recipients have the right to receive clinically appropriate care and treatment that is suited to their needs and skillfully, safely and humanely administered with full respect for their dignity and personal integrity.

(8) Recipients have the right to receive services in such a manner as to assure nondiscrimination.

(9) Recipients have the right to be treated in a way that acknowledges and respects their cultural environment.

(10) Recipients have the right to a reasonable degree of privacy consistent with the effective delivery of services.

(11) Recipients have the right to freedom from abuse and mistreatment by employees.

(12) Recipients have the right to be informed of the provider's recipient grievance policies and procedures, and to initiate any question, complaint or objection accordingly.

(b) A provider of service shall provide a notice of recipients' rights as described in subdivision (a) of this section to each recipient upon admission to a clinic treatment program. Such notice shall be provided in writing and posted in a conspicuous location easily accessible to the public. The notice shall include the address and telephone number of the Commission on Quality of Care and Advocacy for Persons with Disabilities, the nearest regional office of the Protection and Advocacy for Mentally Ill Individuals Program, the nearest chapter of the Alliance on Mental Illness of New York State and the Office of Mental Health.

§ 599.8 Clinic services.

(a) Eligibility for admission to a clinic treatment program shall be based on a designated mental illness diagnosis.

(b) Clinic treatment programs shall offer each of the following services, to be provided consistent with recipients' conditions and needs:

(1) Outreach;

(2) Initial assessment (including health screening) . The health screening documentation may be provided by the recipient or obtained from other sources such as the recipient's primary care physician, where appropriate;

(3) Psychiatric assessment;

(4) Crisis intervention. The clinic shall have 24 hour a day/7 day per week availability of crisis intervention services. After hours coverage shall include, at a minimum, the ability to provide brief crisis intervention services and shall be provided pursuant to a plan approved by the local governmental unit or the Office. Such services shall be provided either directly or pursuant to a Clinical Services Contract. Such contract shall include, at a minimum, provisions assuring that, in the event of a crisis, the nature of the crisis and any measures taken to address such crisis are communicated to the primary clinician or other designated clinician involved in the individual's treatment at the clinic, or the individual's primary care or mental health care provider, if known, on the next business day. At the request of the local governmental unit, State-operated clinics shall consult with the local governmental unit or units in their service area in the development of such clinic's crisis response plan;

(5) Injectable Psychotropic medication administration (for clinics serving adults) ;

(6) Psychotropic medication treatment;

(7) Psychotherapy services. Such services shall promote community integration and encompass interventions to facilitate readiness for and engagement of the client and family in wellness self management, schools, and employment;

(8) Family/Collateral psychotherapy;

(9) Group psychotherapy; and

(10) Complex Care Management.

(c) Clinics may offer the following optional services:

(1) Developmental testing;

(2) Psychological testing;

(3) Health physicals;

(4) Health monitoring;

(5) Psychiatric consultation**;** or

(6) Injectable Psychotropic medication administration (for clinics serving only children) .

(d) A clinic treatment program that has been approved to be a Child and Family Clinic-Plus provider shall also provide the following services:

(1) Mental health screening for children. Such services shall be provided in a community setting, in a manner approved by the local governmental unit or the Office, and shall be provided with the prior written consent of the child's parent or legal guardian;

(2) Linkage with primary medical care; and

(3) Community education.

§ 599.9 Staffing.

(a) A provider of service shall continuously have an adequate number and appropriate mix of staff to carry out the objectives of the clinic treatment program and to assure the outcomes of the program. The provider shall have a staffing plan that documents the staff qualifications, including training, clinical experience with adults diagnosed with mental illness or children diagnosed with emotional disturbance, and supervisory experience in a clinical setting, the appropriateness of the mix of staff, the assignment of staff to the primary program site and any approved satellite locations, and the supervisory relationships among the staff. The plan shall also detail any proposed use of students, or non-licensed staff, and their supervision and oversight. Such plan shall be subject to review and approval by the Office at the time of issuance or renewal of the program's operating certificate, and shall demonstrate sufficient coverage by qualified psychiatrists and medical staff to meet the needs of program enrollees.

(b) The following individuals may provide services, within their defined scopes of practice or as otherwise permitted by law:

(1) Creative arts therapists;

(2) Family advisors;

(3) Licensed practical nurses;

(4) Marriage and family therapists;

(5) Mental health counselors;

(6) Nurse practitioners;

(7) Nurse practitioners in psychiatry;

(8) Peer advocates;

(9) Permit holders;

(10) Physicians;

(11) Physician assistants - for physical health only, except as otherwise provided in this Part;

(12) Psychiatrists;

(13) Psychoanalysts;

(14) Psychologists;

(15) Registered professional nurses;

(16) Social workers;

(17) Students, provided they are participating in a program approved by the New York State Education Department that leads to a degree or license in one of the clinic's professional disciplines, and in accordance with the following:

(i) Students must be supervised and evaluated according to a signed agreement between the clinic provider and a New York State Education Department-approved educational program, and pursuant to the clinic provider's policies and procedures for student placements and clinical supervision;

(ii) Students must be part of a staffing plan that is approved by the Office;

(18) Non-licensed staff is limited to the provision of Outreach and Crisis Intervention services pursuant to this Part, except as provided in subdivisions (d) or (e) of this section.

(c) All clinic staff of providers licensed solely under Article 31 of the Mental Hygiene Law who are directly involved in providing services shall submit to criminal background checks, and clearance by the New York Statewide Central Register of Child Abuse and Maltreatment.

(d) The Office may approve other qualified staff, as appropriate.

(e) The Office may approve the transition of programs to heightened licensure requirements set by the New York State Education Department or other licensing or credentialing authority to the extent permitted by law.

§ 599.10 Treatment planning.

(a) Treatment planning is an ongoing process of assessing the mental health status and needs of the individual, establishing his or her treatment and rehabilitative goals, and determining what services may be provided by the clinic to assist the individual in accomplishing these goals. The treatment planning

process includes, where appropriate, a means for determining when the individual's goals have been met to the extent possible in the context of the program, and planning for the appropriate discharge of the individual from the clinic. The treatment planning process is a means of reviewing and adjusting the services necessary to assist the individual in reaching the point where he or she can pursue life goals such as employment or education, without impediment resulting from his or her illness.

(b) The treatment plan shall include identification and documentation of the following:

(1) the recipient's designated mental illness diagnosis or a notation that the diagnosis may be found in a specific assessment document in the recipient's case record;

(2) the recipient's needs and strengths;

(3) the recipient's treatment and rehabilitative goals and objectives and the specific services necessary to accomplish those goals and objectives, as well as their projected frequency and duration;

(4) the name and title of the recipient's primary clinician in the program, and identification of the types of personnel who will be furnishing services; and

(5) criteria for determining when the recipient should be discharged from the program.

(c) The treatment plan for recipients receiving services reimbursed by Medicaid on a fee-for-service basis shall be signed by a psychiatrist or other physician, and shall include a projected schedule for service delivery and the projected frequency and duration of each type of planned therapeutic session or encounter.

(d) The treatment plan for recipients reimbursed by any other payer for whom the program prescribes psychotropic medication shall be signed by a psychiatrist, other physician or nurse practitioner in psychiatry.

(e) The treatment plan for recipients reimbursed by any other payer who do not receive psychotropic medication shall be signed by a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, or licensed clinical social worker.

(f) Recipient participation in treatment planning shall be documented by the signature of the recipient or the signature of the person who has legal authority to consent to health care on behalf of the recipient, or, in the case of a child, the signature of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate, provided, however, that the lack of such signature shall not constitute noncompliance with this requirement if the reasons for non-participation by the recipient are documented in the treatment plan. The recipient's family and/or collaterals may participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan.

(g) Treatment plans shall be completed not later than 30 days after admission, or 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, pursuant to such other plan's requirement as shall apply.

(h) The treatment plan shall include, where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status.

(i) Treatment plans shall be reviewed and updated as necessary based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. Such

reviews shall occur no less frequently than every 90 days, or the next provided service, whichever shall be later. 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, treatment plans may be reviewed pursuant to such other plan requirement as shall apply. Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate.

(j) The periodic review of the treatment plan shall include the following:

(1) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan;

(2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate;

(3) determination of continued homebound status, where appropriate; and

(4) the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment.

(k) Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient upon each occasion of service. These notes must summarize the service(s) provided, update the recipient's progress toward his or her goals, and include any recommended changes to the elements of the recipient's treatment plan. The progress notes shall also document the date and duration of each service provided, the location where the service was provided, whether collaterals were seen, and the name and title of the staff member providing each service. The need for complex care management and the actions taken by the clinic in response to this need shall also be recorded in the progress notes.

§ 599.11 Case records.

(a) There shall be a complete case record maintained for each person admitted to a clinic. Such case records shall be maintained in accordance with recognized and accepted principles of recordkeeping as follows:

(1) hard copy case record entries shall be made in non-erasable ink or typed, and shall be legible;

(2) electronic records which use accepted mechanisms for clinician signatures and are maintained in a secure manner, may be utilized. Such records may be kept in lieu of a hard copy case record; and

(3) all entries in case records shall be dated and signed by appropriate staff.

(b) The case record shall be available to all staff of the clinic who are participating in the treatment of the recipient and shall include the following information:

(1) recipient identifying information and history;

(2) preadmission screening notes, as appropriate;

(3) admission note;

(4) diagnosis;

(5) assessment of the recipient's goals regarding psychiatric, physical, social, and/or psychiatric rehabilitation needs;

(6) reports of all mental and physical diagnostic exams, mental health assessments, screenings, tests, and consultations, including risk assessments, health monitoring, and evaluative reports concerning co-occurring developmental, medical, substance use or educational issues performed by the program;

(7) the recipient’s treatment plan;

(8) dated progress notes that relate to goals and objectives of treatment;

(9) dated progress notes that relate to significant events and/or untoward incidents;

(10) periodic treatment plan reviews;

(11) dated and signed records of all medications prescribed by the clinic and other prescription medications being used by the recipient, provided that a failure to include such other prescription medications in the record shall not constitute non-compliance with this requirement if the recipient refuses to disclose such information and such refusal is documented in the case record;

(12) discharge plan;

(13) referrals to other programs and services, if applicable;

(14) consent forms, if applicable;

(15) record of contacts with collaterals if applicable; and

(16) discharge summary within three business days of discharge.

(c) The discharge summary shall be transmitted to the receiving program, where applicable, prior to the arrival of the recipient, or within two weeks, whichever comes first. When circumstances interfere with a timely transmittal of the discharge summary, notation shall be made in the record of the reason for delay. In such circumstances, a copy of all clinical documentation shall be forwarded to the receiving program, as appropriate, prior to the arrival of the recipient.

(d) When a recipient is transferred between programs offered by the same provider, a consolidated record format that follows the recipient may be used.

(e) Records must be retained for a minimum period of six (6) years from the date of the last service in an episode of service.

(f) Information in clinic case records that is subject to the confidentiality protections of Mental Hygiene Law Section 33.13 may be shared between facilities, agencies and programs responsible for the provision of services pursuant to an approved local or unified services plan (including programs that receive funding from the Office disbursed via a State Aid letter) ; the Office and any of the psychiatric centers and programs that it operates; and facilities, agencies, and programs that are not licensed by the Office and are not participants in an approved local or unified services plan, but are responsible for the provision of services to any patient pursuant to a written agreement with the Office as a party, provided, however, if a case record contains HIV or AIDS information that is protected by Public Health Law Article 27-F, or information provided by a federally-funded alcoholism/substance abuse provider that is protected under 42 CFR Part 2, such information shall only be redisclosed as permitted by such law or regulation.

§ 599.12 Premises.

(a) A provider of service shall maintain premises that are adequate and appropriate for the safe and effective operation of a clinic program in accordance with the following:

(1) Programs shall provide for sufficient private and group rooms consistent with the number of people served and activities offered. There shall also be a sufficient number of restroom facilities to accommodate the population utilizing the clinic service.

(2) Programs shall provide for controlled access to and maintenance of medications and supplies in accordance with all applicable federal and state laws and regulations.

(3) Programs shall provide for controlled access to and maintenance of records.

(4) Programs shall ensure accessibility for persons with disabilities to program and bathroom facilities. Programs shall adjust service environments, as needed, for recipients who are blind, deaf or otherwise disabled.

(5) Programs shall have sufficient and appropriate furnishings maintained in good condition and appropriate program related equipment and material for the population served.

(6) Program space shall be sufficient to provide safety, and to allow for a reasonable degree of privacy consistent with the effective delivery of services. Program space may be shared with other programs, pursuant to a plan approved by the Office. Non-program space may be shared with other programs without such approval.

(7) There should be sufficient separation and supervision of various treatment groups to ensure the safety of the population receiving clinic services.

(b) The provider of service shall ensure life safety on the premises by possession of a certificate of occupancy in accordance with the Building Code of New York State and the Property Maintenance Code of New York State (19 NYCRR Chapter XXXIII, Subchapter A, Parts 1221 and 1226) or comparable local codes.

§ 599.13 Medical assistance clinic reimbursement system.

(a) Reimbursement for clinic treatment procedures will be fee based.

(b) A weight for each clinic procedure shall be established by the Office which reflects the relative anticipated resource utilization for such procedure. For some procedures, fees shall be enhanced pursuant to Section 599.14 of this Part through the use of billing modifiers for such things as procedures delivered off-site, after hours, services provided in languages other than English, and services of a minimum duration of 15 continuous minutes delivered by a physician or nurse practitioner in psychiatry.

(c) Providers will be categorized into peer groups pursuant to this section. The Office will establish a base fee for reimbursement for each peer group. Such fee shall be reduced by 25 percent during the period in which any such provider retains an operating certificate with a duration of less than six months as a result of having been determined to be deficient in meeting applicable standards and requirements, pursuant to this Part.

(d) Peer group specific base fees may be adjusted as applicable by the Office. Provider specific fee adjustments may be made to reflect pay for performance enhancements, penalties resulting from the Office inspection and certification process, or for other reasons described in the regulations of the Office.

(e) Payments for procedures will be determined by multiplying the assigned weight for the appropriate procedure code set forth at 10 NYCRR Part 86 by the base fee, and adjusting such fee for modifiers and discounts, as appropriate. When a modifier or discount is expressed as a percentage, it will adjust the payment by its percentage of the procedure weight. When more than one procedure applies to a visit, the highest value procedure shall be paid at its full fee value. Payments for additional procedures related to the visit will be discounted by 10 percent.

(f) The Office will annually review procedure weights, modifier values, peer groupings and the base fees for each of the peer groupings, and will update them as needed. Any changes will be published in the State Register and posted on the Office's website.

(g) The Office will establish and make public a list of weights associated with all CPT and HCPCS procedure codes which can be used to bill specific mental health clinic procedures through Medical Assistance. The Office will update this list as needed.

(h) Providers licensed solely under Article 31 of the Mental Hygiene Law shall be classified by the following peer groups. During the transition to the reimbursement methodology established in this Part, the fee paid to new clinics, or clinics commencing service in a new county, shall be equal to that of the lowest blended rate in the appropriate peer group.

(1) Upstate: 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.

(2) 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.

(3) 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.

(i) Hospital-based providers licensed under Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law shall be classified by the following peer groups. The base rates will be calculated pursuant to 10 NYCRR Part 86.

(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) The fee paid to new clinics, or clinics commencing service in a new county, shall be calculated pursuant 10 NYCRR 86-8.6.

(j) Diagnostic and treatment center (D&TC) providers licensed under Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law shall be classified by the following peer groups. The base rates will be calculated pursuant to this Part. During the transition to the reimbursement methodology established in this Part, the fee paid to new clinics, or clinics commencing service in a new county, shall be equal to that of the lowest blended rate in the appropriate peer group.

(1) 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.

(2) Downstate D&TC – All diagnostic and treatment centers in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties.

(k) D&TCs and hospitals – Where a corporation operates a hospital and a D&TC, the Office 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.

(l) Supplemental Payments:

(1) Provider peer group base fees paid pursuant to this section shall be supplemented as appropriate for individual providers participating in the Office of Mental Health quality improvement initiative, or other performance initiatives developed by the Office.

(i) In order to be enrolled in such quality improvement initiative or other Office of Mental Health performance-based payment system, the program shall execute an agreement with the Office under which the provider agrees to participate in such initiative, and undertake such measures as shall be developed by the Office.

(ii) Any program eligible to receive supplemental medical assistance reimbursement for participation in a quality improvement initiative, which fails at any time to meet the requirements set forth in the agreement, shall have its quality improvement supplement to its peer group base fee suspended until such time as the program meets such requirements, as determined by the Office.

(2) Payments pursuant to this section shall be supplemented for providers participating in the community support program, pursuant to section 588.14 of this Title.

(m) System Transition. During the transition, the procedures indicated in the table following as Full Procedures shall be reimbursed at the full payment described in (e) of this section, subject to the discount for multiple procedures related to a visit. For all other procedures, there will be a transition to full procedure based reimbursement. During the transition, payment for such procedures will consist of a blended payment comprised of a legacy portion of the fees established under Part 588 and Part 592 of this Title and the procedure payment established under Part 599. For such procedures, the blended payment will be calculated as follows:

(1) For providers licensed solely under Article 31 of the Mental Hygiene Law and all mental health clinics licensed by the Office located in diagnostic and treatment centers:

(i) The Office will identify the amount of base Medical Assistance paid to the clinic pursuant to Part 588 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009.

(ii) For clinics possessing an operating certificate with a duration of six months or more, the Office will identify the volume of visits with supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009. Providers who had an operating certificate with a duration of less than six months during the period July 1, 2008 through June 30, 2009, will be considered to have had an operating certificate with a duration of six months or more during this period for the purposes of this calculation. For all providers, the calculation of the total supplemental payment shall utilize the supplemental rate in effect June 30, 2009, or rates made effective subsequent to June 30, 2009, and prior to the effective date of this Part which result from provider appeals or are made pursuant to applicable regulations.

(iii) For each provider, the Office will divide the sum of the reimbursement from subparagraphs (i) and (ii) of this paragraph by the number of Medicaid visits associated with the relevant provider. The result will be the legacy component of the fee.

(2) For hospital-based providers licensed under both Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law, the blended payment promulgated by the Office, in consultation with the Department of Health, shall be determined as follows:

(i) The Office will identify the amount of base Medical Assistance paid to the clinic pursuant to Part 588 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009.

(ii) For clinics possessing an operating certificate with a duration of six months or more, the Office will identify the volume of visits with supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for the period July 1, 2008 through June 30, 2009. Providers who had an operating certificate with a duration of less than six months, during the period July 1, 2008 through June 30, 2009, will be considered to have had an operating certificate with a duration of six months or more during this period for the purposes of this calculation. For all providers, the calculation of the total supplemental payment shall utilize the supplemental rate in effect June 30, 2009, or rates made effective subsequent to June 30, 2009, and prior to the effective date of this Part which result from provider appeals or are made pursuant to applicable regulations.

(iii) For each provider, the sum of the amounts calculated pursuant to (i) and (ii) of this paragraph shall be included in the calculation of the rates utilizing the methodology set forth at 10 NYCRR Part 86.

(3) During the transition, procedures will be reimbursed as a blended rate or full procedure code based rate pursuant to the following table:

Blend	Full Procedure Code	Office of Mental Health Service Name
	X	Complex Care Management
	X	Crisis Intervention Service – Brief
	X	Crisis Intervention Service - Complex
	X	Crisis Intervention Service - Per Diem
	X	Developmental and Psychological Testing
	X	Injectable Psychotropic Medication Administration
	X	Psychotropic Medication Treatment - No Time Limit
X		Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development
X		Psychiatric Assessment - Minimum of 30 Minutes

Blend	Full Procedure Code	Office of Mental Health Service Name
X		Psychiatric Assessment - Minimum of 45 Minutes
X		Individual Psychotherapy – Minimum of 30 Minutes
X		Individual Psychotherapy – Minimum of 45 Minutes
X		Group and Multifamily/Collateral Group Psychotherapy - Minimum of 60 Minutes
X		Family Therapy/Collateral w/o patient - Minimum of 30 minutes
X		Family Therapy/Collateral with patient - Minimum of 60 minutes
	X	Outreach (off-site visit)

(4) For providers licensed solely under Article 31 of the Mental Hygiene Law and mental health clinics licensed by the Office located in diagnostic and treatment centers for procedures paid as a blend, there will be a transition to a full procedure code based reimbursement system as follows:

(i) 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.

(ii) 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.

(iii) 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.

(iv) Year 4: Providers will receive 100 percent of the procedure fee payment.

(v) When more than one procedure is delivered during a visit, the applicable discount will not be applied to the blend component of the payment.

(5) For hospital-based providers licensed under both Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law, the transition to full procedure code reimbursement will be consistent with the transition schedule described in 10 NYCRR Part 86.

(6) During the transition, upon the request and subject to the approval of the Director of Community Services, the provider shall furnish the Director of Community Services and the Office with a transition plan describing the level and type of services not funded by Medical Assistance that will be provided to the community. The component of the legacy payment associated with Part 592 of this Title shall be contingent upon the provider's compliance with such plan. For providers operated by a county, the component of the legacy payment associated with Part 592 will be contingent upon compliance with such a transition plan that has been approved by the Office.

(7) For hospital-based programs licensed under Article 31 of the Mental Hygiene Law and operated by corporations operating programs licensed under Article 28 of the Public Health Law, an additional capital payment per visit shall be determined by dividing all allowable capital costs for all Article 31 licensed programs operated by that corporation after deducting any exclusions, by the sum of the total number of visits to all of the Article 31 licensed programs operated by that corporation.

§ 599.14 Medical Assistance billing standards.

(a) Medicaid claims for individuals who have been admitted to a clinic treatment program shall include, at a minimum, the Medicaid identification number of the recipient, the designated mental illness diagnosis, 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, and the National Provider Identification or equivalent Department of Health-approved alternative as appropriate of the attending clinician. The provider must also comply with the requirements associated with any procedure code being billed.

(b) Medicaid claims may be reimbursed for up to three pre-admission procedures per adult recipient, no more than one of which may be a collateral procedure. For children, claims may be reimbursed for up to three pre-admission visits. Such claims shall include, at a minimum, the Medicaid identification number of the recipient, the designated mental illness diagnosis, 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, and the National Provider Identification or equivalent Department of Health-approved alternative as appropriate of the attending clinician. For pre-admission visits at least the code for diagnosis-deferred must be entered on the claim.

(c) Medicaid claims may be submitted for no more than two services per day for any individual, not including crisis, injectable psychotropic medication administration, psychotropic medication treatment, and health care services.

(d) Billing services:

(1) Outreach. This service can be provided in any off-site location at the clinic's discretion to address engagement issues for recipients already admitted to the clinic or in response to a request from clients, staff, family members, or members of the community to serve individuals not receiving treatment. No more than two outreach procedures can be provided to an individual, unless appropriately qualified licensed staff document in the record that additional outreach is clinically necessary and appropriate. Additional outreach services may be furnished in increments of up to two services if such need and appropriateness is so documented in the record.

(2) Assessment services consist of two types of assessment – Initial Assessment and Psychiatric Assessment. For adults, no more than three pre-admission assessment procedures shall be reimbursed for a recipient within a 12-month period, whether they are initial assessments or psychiatric assessments. For children, no more than three pre-admission assessment visits shall be reimbursed for a recipient within a 12-month period. For recipients previously served by the clinic, additional initial assessment procedures shall not be eligible for Medicaid reimbursement if less than 365 days have transpired since the most recent Medicaid reimbursed visit to the clinic.

(i) Initial Assessments shall include performance or consideration, as applicable, of the Health Screening.

(*a*) The first Initial Assessment interview for an adult may be provided off-site to assess homebound status or for individuals for whom the clinic documents immediate assessment is necessary. Subsequent initial assessments may be provided off-site to adults for whom the clinic documents a determination of homebound status. The location and reason for delivering the service off-site must be documented in the treatment plan.

(*b*) Initial Assessment interviews for children may be provided off-site. The location and reason for delivering the service off-site must be documented in the treatment plan.

(*c*) The clinic must document a minimum of 45 minutes face-to-face contact with the recipient.

(*d*) Clinics may submit a supplemental bill under the Medical Assistance physician fee schedule when psychiatrists or nurse practitioners in psychiatry spend at least 15 minutes serving the recipient during the time the initial assessment is being conducted by another licensed practitioner.

(ii) A Psychiatric Assessment may be provided to either an individual being assessed for admission to the clinic, or an individual who is currently admitted. Psychiatric assessments may be performed for admitted recipients where medically necessary without limitations.Psychiatric Assessments may include such elements as a diagnostic interview and treatment plan development.

(*a*) A Psychiatric Assessment may be provided by a psychiatrist, nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office, and may include an evaluation report or interaction with a referring physician, to an individual who has been admitted to the clinic, or one for whom the appropriateness of admission is being assessed.

(*b*) A Psychiatric Assessment of at least 30 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry shall be billed as a Brief Psychiatric Assessment.

(*c*) A Psychiatric Assessment of at least 45 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry shall be billed as an Extended Psychiatric Assessment.

(*d*) A Psychiatric Assessment may be provided off-site.

(*e*) A family therapy/collateral procedure without the recipient may be billed if it assists with the initial assessment of the recipient. This session must be for a minimum of 30 minutes.

(3) Psychiatric Consultation.

(i) Psychiatric Consultation may be provided by a psychiatrist or nurse practitioner in psychiatry to a referring physician for the purposes of assisting in the diagnosis, integration of treatment, or assistance in ensuring continuity of care, for a patient of the referring physician.

(ii) Psychiatric Consultation services must be face-to-face with the recipient, or through video tele-psychiatry, where available.

(iii) Psychiatric Consultation services may be provided off-site, but no off-site modifier may be billed.

(4) Crisis Intervention.

(i) The clinic may make contractual arrangements for after-hours crisis coverage by clinicians, but contracts for this service must be approved by the local governmental unit in which the clinic is located, or by the Office for county-operated clinics.

(ii) Crisis Intervention Services consist of three billable levels of service.

(*a*) Crisis Intervention - Brief. Brief Crisis Intervention Services shall be done face-to-face or by telephone. For services of a duration of at least 15 minutes, one unit of service shall 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.

(*b*) Crisis intervention – Complex. Complex Crisis Intervention 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 peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics may be reimbursed for crisis services provided to individuals who have not engaged in services for a period of up to two years.

(*c*) Crisis intervention – Per Diem. Per Diem Crisis Intervention 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 peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics may be reimbursed for crisis services provided to individuals who have not engaged in services for a period of up to two years.

(5) Injectable Psychotropic Medication Administration services are reimbursed for face-to-face contact of any duration between a clinician and the recipient.

(6) Psychotropic Medication Treatment services are reimbursed for face-to-face contact of at least 15 minutes in duration between a physician or nurse practitioner in psychiatry and the recipient.

(7) Psychotherapy Services. Psychotherapy Services consist of the following levels of billable service.

(i) Psychotherapy Services-Individual shall be reimbursed as follows:

(a) Brief Individual Psychotherapy Service requires face-to-face service with the recipient of a minimum duration of 30 minutes; or

(*b*) Extended Individual Psychotherapy Service requires documented face-to-face service with the recipient of a minimum duration of 45 minutes. For school-based services, the duration of such services may be that of the school period provided the school period is of a duration of at least 40 minutes.

(ii) Psychotherapy – Family/Collateral with the Recipient requires documented cumulative, continuous face-to-face service with the recipient and the collateral of a minimum duration of 60 minutes,during which time the recipient shall be present for at least the majority of the time.

(iii) Psychotherapy – Family/Collateral Without the Recipient requires documented face-to-face service with the collateral of a minimum duration of 30 minutes.

(iv) Psychotherapy –Multi-Recipient Group requires documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum duration of 60 minutes. For school-based services, the duration of such services may be that of the school period provided the school period is of a duration of at least 40 minutes.

(v) Psychotherapy – Multi-Family/Collateral Group requires documented face-to-face service with a minimum of two multi-family/collateral units and a maximum of eight multi-family/collateral units in the group, with a maximum total number in any group not to exceed 16 individuals, and a minimum duration of 60 minutes of service.

(8) Developmental Testing. Medical Assistance may reimburse for this service solely for individuals admitted to the clinic. Developmental Testing services must be face-to-face with the recipient.

(9) Psychological Testing. Medical Assistance may reimburse for this service solely for individuals admitted to the clinic. Psychological testing services must be face-to-face with the recipient.

(10) Complex Care Management must be provided within five working days following a face-to-face psychotherapy or crisis service. Only one complex care procedure shall be billed following each face-to-

face psychotherapy or crisis service. To bill Medical Assistance, this service requires at least 15 minutes of continuous time, not including standard report writing or brief follow up calls.

(e) Modifiers:

(1) Billing modifiers, including modifiers paid as supplementary rates to visits, are available pursuant to this section as indicated in the modifier chart included in this subdivision. For adults, the off-site services modifier is available for an initial assessment to determine if the adult is "homebound", as clinically determined by a licensed clinician. Thereafter, the off-site modifier is only available for adults whose service record documents that they are homebound. For children, off-site services are available for all children. Their service record must document that the service is medically appropriate for an off-site service.

Modifier 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	
Injectable 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 30 Minutes	x	x	x	
Psychiatric Assessment - Minimum of 45 Minutes	x	x	x	
Individual Psychotherapy - Minimum of 30 Minutes	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 (off-site visit)	x	x	x	

(2) Clinics that provide separate off-site procedures to a collateral and a recipient in the same location and on the same day shall only bill the off-site modifier for one of the services.

(3) Clinics that provide off-site procedures by the same staff person to multiple recipients in the same location, including multiple apartments in the same building, the same school, the same residence, etc., on the same day shall only bill the off-site modifier for one of the services.

(4) Clinics which provide multiple off-site procedures to a recipient on the same day shall only bill the off-site modifier for one of the services.

(5) Physicians who participate in a group session for a minimum of 15 continuous minutes shall only receive the billing modifier for one Medicaid recipient.

(f) A clinic may not be reimbursed for services provided to an individual currently enrolled in another licensed mental health outpatient program for which Medicaid reimbursement is being made, except as provided in this subdivision.

(1) Reimbursement shall be made for up to three pre-admission assessment visits when a recipient is in transition from another outpatient program, including another clinic, to the clinic. After completion of the three initial assessment visits, a clinic provider may not bill Medical Assistance for a service unless it is medically necessary, performed pursuant to a treatment plan approved pursuant to this Part, and, except as specified in this subdivision, the recipient has been discharged from the other outpatient program.

(2) Reimbursement shall be made for a recipient currently admitted to a continuing day treatment program in accordance with Part 587 of this Title when such recipient shall also be admitted to a clinic treatment program solely for the purpose of clozapine medication therapy. Reimbursement shall be made for no more than five clozapine medication treatment visits per month per recipient.

(3) Reimbursement shall be made for no more than five clinic visits per month for a recipient concurrently admitted to an intensive psychiatric rehabilitation treatment program.

(4) Reimbursement shall not be made for services rendered by a clinic to residents of a residential health care facility. Reimbursement shall be made to the clinic by the residential health care facility.

(g) The Office will only consider requests for revisions of fees calculated under the provisions of this Part due to errors made by the Office in its calculation.

(1) A request for revision of a fee calculated in accordance with this section shall be sent to the Commissioner by registered or certified mail and shall contain a detailed statement of the basis for the requested revision together with any documentation that the provider of service wishes to submit.

(2) A request for revision must be submitted within 120 days of receipt by the provider of service of the rate computation.

(3) The provider of service shall be notified in writing of the Commissioner's determination, including a statement of the reasons therefor.

(h) Miscellaneous billing rules.

(1) Services provided by clinics operated by agencies licensed under Article 28 of the Public Health Law, which are also licensed pursuant to Article 31 of the Mental Hygiene Law, shall not be considered to be specialized services pursuant to section 2807 of the Public Health Law.

(2) Specialty clinics providing procedures to children with a serious emotional disturbance enrolled in Medicaid Managed Care may be paid Medicaid Fee-for-Service reimbursement for those procedures.

§ 599.15 Indigent care.

(a) The indigent care program for clinics has been established by New York State to offset a portion of the losses from uncompensated care experienced by diagnostic and treatment centers licensed by the New York State Department of Health and mental health clinics licensed by the Office that are not also licensed by the New York State Department of Health and/or not directly operated by the Office.

(b) Eligible mental health clinics for purposes of this section shall mean non-profit or county-sponsored clinics that can demonstrate losses from a disproportionate share of uncompensated care during a base period two years prior to the grant period; with the exception of the transition period to be established by the Office in guidance.

(c) Uncompensated care need, for purposes of this section, means the following, subject to limitations to be provided in guidance by the Office:

(1) Self pay, including partial pay or no pay visits;

(2) Required or optional mental health clinic procedures provided but NOT covered under a clinic's agreement with a third-party payer;

(3) Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member not approved for payment by a third party payer in contract with the clinic; or

(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.

(d) To be eligible for an allocation of funds pursuant to this section, a mental health clinic must demonstrate that a minimum of five percent of total clinic visits reported during the applicable base year period meet the eligibility requirements for the pool. For clinics operated by an agency that operates more than one clinic, to be eligible for an allocation of funds pursuant to this section, the agency must demonstrate that a minimum of five percent of its total clinic visits meets these requirements. To be eligible, clinics must further demonstrate that they maintain a sliding fee scale for uninsured individuals.

(e) Documentation of uncompensated care need 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.

(f) Rules for the reporting of data on uncompensated care visits to the Office will be established in guidance. Providers participating in the uncompensated care pool that do not submit annual data by dates to be established by the Office will be excluded from the pool for that year.

(g) A mental health clinic qualifying for a distribution pursuant to this section shall provide assurances satisfactory to the Commissioners of Health and Mental Health that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payers, governmental payers and self-paying patients.

(h) To be eligible for reimbursement pursuant to this section, claims must be consistent with the Medical Assistance billing standards set forth in this Part. Payments from the indigent care pool shall be made in accordance with the payment rules established by the Office and the Department of Health.

(i) The allocations of funds to a mental health clinic may be reduced if the Office determines that provider management actions or decisions have caused a significant reduction for the grant period in the delivery of mental health services to uncompensated care residents of the community.

(j) After a transition period established by the Office in guidance, the value of uncompensated care payments are based on the average APG peer group Medicaid payment for the second year prior, less expected client payments.

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