

NEW YORK STATE OFFICE OF MENTAL HEALTH

14 NYCRR Part 599

“Clinic Treatment Programs”

Interpretive/Implementation Guidance

8-17-2010

This document is intended to provide interpretive/implementation guidance with respect to certain provisions of 14 NYCRR Part 599. Because this guidance document addresses only selected portions of regulations and does not include or reference the full text of the final and enforceable Part 599, it should not be relied upon as a substitute for these regulations.

Contents

Table of Contents

I. Part 599 Clinic Regulations.....	5
II. Purpose of this Guidance.....	5
• Supplemental Program Guidance.....	5
III. Who is Covered by the Regulations?.....	6
IV. What are the Clinic Services?.....	7
V. Service Definitions and Guidance.....	8
• Assessment.....	8
• Therapies.....	9
• Enhanced Services.....	10
• Optional Services.....	12
VI. Operational Requirements.....	15
• Premises (14 NYCRR Section 599.12).....	15
• Staffing Requirements (14 NYCRR Section 599.9).....	15
• Documentation (14 NYCRR Section 599.11).....	18
• Treatment Plans (14 NYCRR Section 599.10).....	18
• Progress Notes (14 NYCRR Section 599.10).....	20
VII. County Role.....	21
VIII. Medicaid Fee-for-Service Reimbursement.....	22
• APGs.....	22
• Peer Groups.....	22
• Federally Qualified Health Centers (FQHCs).....	24
• Children’s Specialty Clinic.....	24

- OMH Service Rates, Weights, CPT Codes 24
- Rate Codes..... 25
- Payment Modifiers 25
 - Modifier Chart* 27
- Medicaid Utilization Threshold 28
- Reimbursement for Collaborative Documentation/Concurrent Record Keeping 28
- Medicaid/Medicare Crossover Billing 28
- National Provider Identifier (NPI) 28
- Billing Medicaid for Multiple Procedures on the Same Day 29
- Billing Multiple Procedures for Individuals Covered by Medicaid and Private Insurance 29
- IX. Medicaid Billing Requirements for Specific Services..... 31
 - Complex Care Management..... 31
 - Crisis Services 31
 - Developmental Testing 32
 - Outreach 32
 - Pre-Admission Assessment 32
 - Psychiatric Assessment 33
 - Psychological Testing 33
 - Psychotherapy 33
 - Psychotropic Medication Treatment 34
 - Health Physicals 34
 - Health Monitoring 34
 - Psychiatric Consultation..... 35
- X. Submitting Bills to Medicaid 36

- Required Information 36
- Billing Multiple Services in the Same Day 36
- Billing the Physician Add-on 37
- Billing for Medical Residents in Teaching Hospitals 37
- Claiming for Procedures Performed by Students 37

XI. Uncompensated Care 38

XII. System Transition..... 41

- Financial Transition..... 43
- Reimbursement for New Clinics 43

Appendix..... 45

Crosswalk to Regulations 46

Definitions..... 47

Frequently Asked Questions 55

OMH Financial Modeling Tools:..... 55

Standards of Care 55

- Mental Health Clinic Standards of Care for Adults - Interpretive Guidelines..... 55
- Standards of Care for Children, Adolescents, and their Families 55

Staff Eligible to Deliver Mental Health Services 56

CPT Codes, APG Codes and Service Blend Status 57

APGs for Physicals, Psychiatric Assessments and Consultations 59

Complex Care Management FAQs..... 60

I. Part 599 Clinic Regulations

The New York State Office of Mental Health (OMH) has adopted a new set of mental health clinic regulations. These regulations, 14 NYCRR Part 599, are effective October 1, 2010. These regulations are augmented by:

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

Part 599 defines services, financing and program rules for mental health clinic treatment programs, while the above-referenced Standards of Care provide a quality of care context for these services.

The regulations are designed to foster several policy objectives, including:

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

II. Purpose of this Guidance

Over the past several years, OMH has endeavored to involve and inform interested parties with respect to clinic restructuring. These efforts have included the provision of numerous training sessions on clinic restructuring. Additionally, the OMH website provides several program and fiscal projections tools at http://www.omh.state.ny.us/omhweb/clinic_restructuring/.

Nonetheless, OMH recognizes that clinic restructuring is complex and the field would benefit from an integrated guidance manual. This guidance document is designed to provide an overview of program and billing requirements for the various clinic services, as well as guidance on how these services can be used and integrated to better meet the needs of consumers.

Supplemental Program Guidance

To complement this Guidance document, supplemental program guidance is also being developed to assist clinicians and others in integrating these new services into existing clinical practice. One set of supplemental guidance will be focused on clinics serving children and one set will be focused on clinics serving adults. **When completed, these documents will be posted on the OMH website.**

III. Who is Covered by the Regulations?

14 NYCRR Part 599 applies to all clinic treatment programs that are currently licensed by OMH and are now subject to 14 NYCRR Parts 587, 588 and 592. Going forward, these regulations will apply to providers seeking to operate clinics licensed either solely by OMH or jointly by OMH and the Department of Health (DOH). They will also apply to hospital outpatient departments and diagnostic and treatment centers which also operate under the general auspice of DOH, and which meet either of the following conditions:

- They provide more than 10,000 mental health visits annually; or
- Their mental health visits comprise over 30 percent of their total annual visits except that;
- A program providing fewer than 2,000 total visits annually shall not be considered a diagnostic and treatment center for the purposes of Part 599.

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

Contact information for the OMH Field Offices can be found on the OMH public website at:

<http://www.omh.state.ny.us/omhweb/aboutomh/FieldOffices.html>

IV. What are the Clinic Services?

Section 599.8 of the regulations establishes 10 mental health clinic services that must be available and offered as needed at any mental health clinic licensed by OMH. This Section also identifies several optional services (see page 42 for more information). As implied, the optional services are not required to be available at every clinic that is licensed by the OMH. Rather, these services are meant to enhance the constellation of services offered by clinics.

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

How does this work in practice? If an agency has several satellite sites in addition to its primary clinic, it may choose to offer an optional service at one or more of its satellite sites, but that optional service would not need to be available at all satellite sites, nor at the primary clinic. Required services must be available at all primary clinic sites but not necessarily at each satellite site.

Taken together, this full complement of required and optional services will help recipients, families and providers by improving engagement and access to care. Additionally, services such as the optional health and wellness services will help clinics improve the integration of mental and physical health services.

If a clinic does not offer an optional service from which a specific recipient admitted to its program could benefit, it is possible to arrange for the receipt of such services from another OMH licensed clinic via a “Clinical Services Contract.” It is the expectation of OMH that this

would be a time limited arrangement, which would not be used to address the ongoing service needs of an individual or group of individuals.

An example of an optional service that would lend itself to a Clinical Services Contract is “Psychiatric Consultation.” This service could provide valuable input into the diagnosis or treatment of clinic recipients by qualified practitioners with specialized expertise, but would not be an ongoing service needed by a clinic program’s recipients.

Please Note: “Developmental Testing” and “Psychological Testing” are optional services that can only be provided to recipients admitted to the clinic.

V. Service Definitions and Guidance

The following provides the definition of each clinic service, as well as some brief guidance that further describes how these services are provided:

Assessment

1. Initial Assessment, (new client)

Definition: The term “initial assessment” means 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.

Guidance: This service requires an assurance that a health screening has been done and is documented in the recipient’s record. Health screening documentation may be provided by the recipient, or it can be obtained from other sources, such as the recipient’s primary care physician, where appropriate. Health information should be reviewed by a Psychiatrist, nurse practitioner in psychiatry (NPP), or other appropriate health care professional. Initial Assessments may be provided pre and post admission.

Assessment information collected must be used to determine admission to the clinic level of treatment (or other disposition). OMH has produced Standards of Care that provide guidance on what should be contained in a quality assessment. (See page 55.)

The 1st pre-admission assessment visit can take place off-site to assess the homebound status of adults. (See page 25 for additional information on off-site services.)

2. Psychiatric Assessment

Definition: A “psychiatric assessment” is 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.¹

Therapies

3. Psychotherapy (Services 3,4,5)

Definition: Psychotherapy means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual’s diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual’s capacity to achieve age-appropriate developmental milestones.

Guidance: Psychotherapy should promote community integration, and may encompass interventions to facilitate readiness for and engagement of the client and family in wellness self-management, school, and employment training services, which are provided by specialized programs and service providers.

Psychotherapy may also result in the identification of a need for Complex Care Management.

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

- Individual Psychotherapy;
- Family/Collateral Psychotherapy; and
- Group Psychotherapy.

Guidance on Medicaid billing requirements for psychotherapy can be found on page 33.

6. Psychotropic Medication Treatment

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

Guidance: This service must be provided by a physician (MD) or nurse practitioner in psychiatry (NPP).

¹ A significant difference between a psychiatric assessment and psychiatric consultation is that the former is provided to an individual who has been admitted to the clinic or for whom admission is anticipated. The latter is delivered upon referral from another physician to an individual not currently admitted to the clinic. A report must be transmitted to the referring provider. The Medicaid fee-for-service reimbursements are identical.

7. Injectable Psychotropic Medication Administration (for clinics serving adults)

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

Guidance: This service includes the administration of medication as well as consumer education as necessary and health status screening as appropriate. It must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 56.

This service is optional for clinics serving only children.

Enhanced Services

8. Crisis Intervention

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

Guidance: A crisis is an unplanned event that requires a rapid response. As such, crisis covered services need not be anticipated in a treatment plan.

OMH does not expect that each clinic will have, or become, a community-wide mobile crisis team. However, all clinics will need to provide 24 hours a day/7 days per week availability of crisis services for its clients. Every clinic must have a plan for providing crisis services and after-hours coverage, which must be approved by the Local Governmental Unit. In the case of county providers, this plan must be approved by OMH.

The clinic plan must demonstrate the ability to accommodate crisis intakes and walk-ins during normal business hours. The after-hours crisis response plan, for clinics and satellites, must provide the ability for recipients and their collaterals that need assistance to be able to contact a licensed professional. The primary clinician must be contacted the next business day with information from the licensed professional who provided the after-hours services. Additionally, the clinic must ensure that the after-hours contact procedure is explained to all recipients and their collaterals, where appropriate, during the intake process.

After-hours services may be provided in person or by phone. They may be provided directly by the clinic or pursuant to a Clinical Services Contract. The contracting option allows clinics to pool resources in ways that may make more sense in their community, depending on the community's circumstances. If this mechanism is pursued, the contract must include a process for transmitting information about an after-hours call to the appropriate clinic by the next business day.

Providers will be given a reasonable time to prepare and submit their plan to the local governmental unit for approval, but it is expected that all plans will be submitted and approved by March 31, 2011.

9. Complex Care Management

Definition: Complex care management is 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.

Guidance: Complex Care Management is not a stand-alone service. It is a non-routine professional service designed to coordinate care, provided subsequent to a psychotherapy or crisis visit. It is designed to address immediate mental health issues or factors that are impacting on the individual's health or community status. It must be provided as an ancillary service to a crisis service or a face-to-face psychotherapy service. For Medicaid fee-for-service reimbursement, it must take place within 5 working days following the provision of either service.

Complex Care does not include required and routine paperwork or required and routine follow up. The need for the Complex Care and the persons contacted must be documented in the progress note.

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

The need for Complex Care Management can be driven by a variety of situations such as (but not limited to):

- Coordination required to treat co-occurring disorders;
- Complex health status;
- Risk to self or others;
- Coordination necessary to break the cycle of multiple hospitalizations;
- Loss of home;
- Loss of Employment;
- Children and adults with multiple other service providers in need of coordination;
- Children at risk of school failure, expulsion or lack of school placement;

- Children at risk of out of home placement;
- Changes in custody status (from the parents' or child's perspective); and/or
- AOT status and process.

Frequently asked questions about Complex Care Management can be found on page 60.

10. Outreach (new or existing individuals) – These services will be required once Federal approval is received.

Definition: The term “outreach” means face-to-face services with an individual, or, in the case of a child, the child and/or family member for the purpose of beginning or enhancing the engagement process, or reengaging with individuals who are reluctant to participate in services, or to promote early intervention to prevent a psychiatric crisis.

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

If a recipient has stopped coming to a clinic and the clinic is concerned that he or she is at risk to self or others, outreach will be required. This service may also be provided at the clinic’s discretion to individuals not admitted to the clinic in response to a request from community members or a family member. The name of the referring entity and the individual for whom outreach was requested would need to be documented.

Outreach services, by their very definition, are provided off-site.

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

Optional Services

1. Developmental Testing

Definition: Developmental testing is 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.

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

2. Psychological Testing

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

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

3. Psychiatric consultation

Definition: 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.

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

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

A written report must be provided by the consulting physician or nurse practitioner to the referring physician. For information on billing consultations on a Medicaid fee-for-service basis see page 35.

4. Health physicals

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

Guidance: This service must be provided by a physician, nurse practitioner or other medical professional acting within scope of practice. The clinic must have a policy in place for ascertaining this information as part of the initial assessment or when otherwise required.

5. Health monitoring

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

For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

Guidance: This service must be provided by a physician, nurse or other medical professional acting within scope of practice. Section 599.6 requires that a provider have 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.

6. Injectable Psychotropic Medication Administration (this service is optional for clinics serving only children)

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

Guidance: This service includes the administration of medication as well as consumer education as necessary and health status screening as appropriate. It must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 56.

Providers serving only children are not required to offer this service. However, it is advisable that if they do not offer this service, they have a plan for ensuring that recipients who need Injectable medications are referred to a provider that can administer them.

VI. Operational Requirements

Premises (14 NYCRR Section 599.12)

The regulations contain several requirements for clinic program facilities. Part 599 allows a clinic to share space (both program space and non-program space) with other programs. Program space may be shared pursuant to a plan approved by OMH. For example, a clinic may wish to share space with a substance abuse or medical program. Plans would need to be submitted to the appropriate OMH Field Office for review and approval². Among other things, clinics would need to show that the shared use is compatible with the operation of the clinic, that recipient privacy/confidentiality will be maintained, and that shared use will not interfere with clinic operations.

Staffing Requirements (14 NYCRR Section 599.9)

In 2002, New York State adopted a “scope of practice law” that established four new types of mental health practitioners and required anyone proposing to provide psychotherapy to obtain a license to do so. This law also contains a temporary exemption for programs licensed, operated or funded by the Office of Mental Health. However, unless extended, the exemption provision expires on July 1, 2013. Given New York State law, Part 599 establishes licensing requirements for most services provided in OMH licensed mental health clinics. With the exception of outreach, on and after July 1, 2013, all services must be delivered by licensed staff unless the exemption is extended and the Commissioner approves other qualified staff. Additionally, the Legislature has required the State Education Department, in consultation with OMH and other executive agencies to evaluate and make recommendations regarding the scope of practice laws.

During the exemption period, OMH is allowing a transition to licensed staff as described on page 16. Staff authorized to work in OMH licensed clinics **after** July 1, 2013 include the following:

- | | |
|--|--|
| • Psychiatrist | • Licensed Marriage and Family Therapists (LMFT) |
| • Physician (MD) | • Licensed Mental Health Counselors (LMHC) |
| • Licensed Master Social Worker (LMSW) | • Licensed Psychoanalyst |
| • Licensed Clinical Social Worker (LCSW) | • Licensed Psychologist |
| • Psychologist ³ | • Physician Assistant- physical health procedures only or mental health if OMH approved training |
| • Registered Nurse /Licensed Practical Nurse | • Limited Permit staff |
| • Nurse Practitioner in Psychiatry (NPP) | • Students within approved SED programs |
| • Licensed Creative Arts Therapists (LCAT) | • Qualified non-licensed staff including qualified peer advocates and family advisors |

² Approvals from other regulatory agencies such as the Office of Alcoholism and Substance Abuse Services or the Department of Health may also be required.

³ Under New York State law, unlicensed psychologists may be employed by a federal, state, county or municipal agency or other political subdivision. In all other cases, psychologists working for OMH licensed clinics must be licensed.

For the purpose of Part 599, a qualified peer hired as a Peer Advocate must demonstrate to OMH evidence of completion of a peer training program or certification as a peer counselor.

During and after the exemption period, Clinics may use students if they are in a New York State Education Department (NYSED) approved program leading to a license allowable in an OMH licensed clinic. A plan for the use of students must be included as part of the clinic's OMH approved staffing plan. Appropriate procedures performed by students working in this capacity are reimbursable by Medicaid. See OMH FAQs for more information http://www.omh.state.ny.us/omhweb/clinic_restructuring/faq/students.html.

Unless the Legislature acts to extend the exemption, after July 1, 2013 licensed or certified staff not mentioned in the above list (e.g., Certified Rehabilitation Counselors (CRCs), Certified Alcoholism and Substance Abuse Counselors (CASACs), Occupational Therapists) are not authorized to work as professional clinic staff under Part 599.

For a crosswalk of services and allowable staffing, see the table on page 56.

Licensing Exemption: The scope of practice exemption discussed above allows programs licensed or funded by OMH to continue utilizing both licensed and non-licensed staff. Therefore, OMH is allowing a multi-year transition to the licensing requirements required by Part 599. Clinic staffing requirements are being phased in as follows:

- By the end of transition year 1 (October 1, 2011), all services billed to the uncompensated care pool (except outreach) must be provided by appropriately licensed staff. For information on provider eligibility for the uncompensated care pool, see page 38.
- By July 1, 2013, unless extended by the Legislature, all clinic services (except outreach) must be provided by appropriately licensed staff.

During this transition period, providers are required to maintain staffing patterns which allow for the appropriate provision of all required and approved optional services and for carrying out the objectives of the clinic treatment program.

Staff should only provide services which are within their scope of practice and level of competence and under supervision which is commensurate with their training, experience and identified needs. The Clinic Standards of Care identify the importance of regular guidance and oversight for all staff in order to assist them in responding to both the ongoing and emergent needs of individuals served.

In all instances, a clinic is expected to employ and designate an adequate number of licensed staff who, by their training and experience, are qualified to provide clinical supervision and

programmatic direction. Such individuals should be identified in the staffing plan and documentation of the lines of supervisory responsibility should be maintained by the clinic.

When non-licensed staff is providing clinical services under the New York State Education Department (NYSED) exemption, it is especially critical that regular and appropriate supervision is provided and documented. Arrangements which will assist these staff to meet licensure eligibility requirements should be considered.

Clinics that continue to employ non-licensed staff to provide clinical services under the NYSED exemption will need to adhere to the licensing requirements of the scope of practice law by July 1, 2013, unless the exemption is extended. During the transition period, clinics should prepare to address the following issues:

1. Identify appropriate roles for non-licensed staff;
2. Plan to transition non-licensed staff to licensed staff, or permit holders;
3. Plan to transition supervisory responsibility for licensed staff; and
4. Prepare supervision plan for non-licensed staff including how and when licensed clinical staff shall review the work of non-licensed therapists.

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

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

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

The Commissioner does not have the authority to approve the performance of functions outside of an individual's scope of practice.

Clinics wishing to use Physician Assistants for mental health therapy services must apply to OMH for a waiver.

Clinics wishing to use Physician Assistants for psychotropic medication injections **will not** need to apply to OMH for a waiver. OMH is waiving Physician Assistant specialized mental health training requirements for this service.

Documentation (14 NYCRR Section 599.11)

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

- Recipient identifying information and history;
- Preadmission screening notes, as appropriate;
- Admission note;
- Diagnosis;
- Assessment of the recipient's goals regarding psychiatric, physical, social, and/or psychiatric rehabilitation needs;
- Reports of all mental and physical diagnostic exams, mental health assessments, screenings, tests, and consultations, including risk assessments, health monitoring, health screenings, and evaluative reports concerning co-occurring developmental, medical, alcohol/substance use or educational issues performed by the program;
- The recipient's treatment plan;
- Dated progress notes which relate to goals and objectives of treatment;
- Dated progress notes which relate to significant events and/or untoward incidents;
- Periodic treatment plan reviews;
- Dated and signed records of all medications prescribed by the clinic, as well as a record of other prescription medications being used by the recipient. 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;
- Discharge plan;
- Referrals to other programs and services;
- Consent forms;
- Record of contacts with collaterals, if applicable; and
- Discharge summary within three business days of discharge.

Treatment Plans (14 NYCRR Section 599.10)

A treatment plan should be a dynamic document that accurately reflects the current strengths and needs of the recipient. Review and, where clinically appropriate, revisions to the treatment plan should be made during periods of emerging stress/crisis or when significant positive changes occur. It is important that a treatment plan be regarded as an evolving “roadmap” for the clinician, to ensure that the most relevant issues are consistently addressed in the treatment sessions, and to ensure that goals and services are adjusted to reflect the recipient's situation and needs.

Under Part 599, the treatment/care plan is:

- Required for every recipient;

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

It is also important that treatment plans be periodically reviewed. The regulations require that such periodic review include the following:

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

Treatment plan approvals

It is critical that treatment plans and treatment plan updates include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. To document this participation, all of these individuals should sign the treatment plan whenever possible. However, treatment plans must include the signature of one of the following:

- For recipients receiving services reimbursed by Medicaid fee-for-service - **the treatment plan must be signed by a psychiatrist or other physician, as a condition of such reimbursement;**
- With respect to services reimbursed by any payer other than Medicaid where the recipient does not receive psychotropic medication – the treatment plan may be signed by a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, or licensed clinical social worker⁴; or
- With respect to services reimbursed by any payer other than Medicaid but where the recipient exhibits complex medical conditions or takes psychotropic medication - the treatment plan must be signed by a psychiatrist, other physician or nurse practitioner in psychiatry.

Treatment plan timeframes:

Treatment planning is not a “moment in time” activity; it is an ongoing process. However, certain regulatory standards in the regulations must be met for treatment plans.

⁴ Note – third-party payers may require a physician’s signature as a condition of coverage.

- Treatment plans must be completed no later than 30 days after admission, unless the services are covered by a third-party payer with a different requirement. In such circumstance, this requirement can be modified to reflect the requirements of the third-party payer.
- Treatment plans must be reviewed and updated as necessary, based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. This must be done no less frequently than every 90 days, or the next provided service, whichever is later. While Federal Medicaid guidance recommends treatment plan updates every 90 days, it is not a statutory or regulatory requirement. OMH believes that individuals should not present at the clinic for the sole purpose of reviewing the treatment plan, or that the treatment plan should be reviewed without the participation of the individual.

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

Essentially, if the managed care/third party payer has a different time standard or requirement for updating treatment plans, then that would be the controlling requirement. Otherwise, the Section 599.10 requirement will apply.

It is the expectation of the Office that existing treatment plans will continue to be followed until the first treatment plan review which occurs subsequent to the effective date of the Part 599 regulations.

Progress Notes (14 NYCRR Section 599.10)

Progress notes must accompany the provision of any procedure. To meet the Part 599 standards, a progress note needs to document:

- The date of service;
- The duration of service;
- Participants;
- The goals and objectives that were addressed;
- Progress since last appointment;
- Interventions that were discussed/provided; and
- Need for Complex Care Management, if applicable.

In every case, a progress note must be completed for each procedure by the clinician delivering the procedure(s). Progress notes of this nature must comply with the Electronic Data Interchange standards established in HIPAA.

VII. County Role

Counties play an important role in ensuring the success of the clinic treatment reform. Part 599 identifies several significant functions for the county Director of Community Services (DCS), which reflect DCS responsibilities and authority established in Article 41 of the New York State Mental Hygiene Law. These include the following:

- Review and approve crisis plans. All clinics must have crisis plans (including after hours coverage), and those plans must be approved by the county Director of Community Services except for plans for county run clinics, which must be approved by OMH. After hours services may be provided directly by the clinic or pursuant to a Clinical Services Contract. After hours crisis coverage must include, at a minimum, the ability to provide brief crisis intervention services by phone by a licensed clinician. Providers will be given a reasonable time to prepare and submit their plan to the local governmental unit for approval, but it is expected that all plans will be submitted and approved by March 31, 2011.
- Determine individuals in urgent need of clinic care. The county director can require a clinic to provide an Initial Assessment and appropriate treatment or referral to the individual within 5 business days. Providers must have 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 OMH, categories of individuals to be considered in urgent need of services.
- Require, review and approve provider transition plans describing the level and type of non-Medicaid reimbursable services that will continue to be provided to the community (clinic and non-clinic services). These plans must describe the level of services that will be maintained during the transition, consistent with the level of funding available. **The clinic's ability to receive the COPS component of the legacy payment will be contingent upon county approval of this plan and compliance with the plan.**
- Designate children's specialty clinic programs. This designation will allow the clinic to be reimbursed on a Medicaid fee-for-service basis for children who have a serious emotional disturbance and are enrolled in Medicaid managed care.

VIII. Medicaid Fee-for-Service Reimbursement

Medicaid fee-for-service reimbursement provisions for mental health clinics can be found in 14 NYCRR Sections 599.13 and 599.14.

APGs

Part 599 uses Ambulatory Patient Groups (APGs) as the basis for Medicaid fee-for-service payments for mental health outpatient clinic services. The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information Systems, Inc. In the context of mental health services, “APGs” mean a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes.

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

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

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

Peer Groups

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

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

1. Upstate hospital – All hospital-based mental health clinics in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates counties.

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

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

Federally Qualified Health Centers (FQHCs)

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

Children's Specialty Clinic

A clinic treatment program designated by OMH as a specialty clinic serving children may be reimbursed by Medicaid on a fee-for-service basis for providing clinic treatment services to children diagnosed with a serious emotional disturbance up to but not including their 19th birthday, notwithstanding the child's enrollment in a Medicaid managed care program. The clinic may continue to serve children up to 21 years of age (and may include 21-year old individuals while they are currently admitted to the clinic) but after they turn 19 they may not be reimbursed by Medicaid fee-for-service if they are covered by Medicaid Managed Care.

OMH Service Rates, Weights, CPT Codes

OMH maintains the most up-to-date proposed rates, weights, and CPT codes on our website.

These can be found at

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

In addition to standard procedure codes, OMH is allowing reimbursement for specific Evaluation and Management (E/M) procedure codes. These include the following:

1. **Psychiatric Assessment.** In place of CPT codes 90805 and 90807, a psychiatrist could code a psychiatric assessment as one of the following E/M codes:
 - a. 99201-99205 (new patient)
 - b. 99212-99215 (established patient).

These E/M codes should be used if the psychiatrist does straight medical evaluation and management without psychotherapy. Medicaid reimbursement amounts for these codes vary by diagnosis. Psychiatrists should choose the appropriate code based on the complexity of service provided. Regardless of which code is used, the minimum 30 minute OMH regulatory requirement for this service must be met before Medicaid reimbursement can be requested;

2. **Physical Exams.** Can be coded using E/M codes - 99382-99387 (new patient) and 99392-99397 (established patient). These codes are age specific. Medicaid reimbursement amounts for these codes vary by diagnosis; and

3. **Health Monitoring.** Can be coded using time-based E/M codes - 99401-99404 (individual sessions) and 99411-99412 (group sessions). Medicaid reimbursement amounts for these codes do not vary by diagnosis.

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

Rate Codes

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

OMH Clinic Rate Codes			
	Non hospital*	Hospital	FQHC
Base Rate	1504	1516	4301
Off-site Base Rate (Not Active)	TBD	TBD	N/A
SED Child Base Rate	1510	1522	4601
SED Child Off-site Base Rate (Not Active)	TBD	TBD	N/A
Medical Visit (MV) Base (Services to be established)	1480	TBD	N/A

*Non hospital includes D&TCs, LGUs, and freestanding Art 31s

Important to Note: Providers will be unable to claim Medicaid fee-for-service using the off-site rate code until OMH receives federal approval.

Payment Modifiers

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

(1) Off-site Services: Important to Note: Medicaid fee-for-service reimbursement for off-site services is dependent upon federal approval and will not be available until this approval is obtained. Once federal approval is received, OMH will update this guidance to address the proper use of this modifier. Providers should not attempt to bill Medicaid for the provision of off-site services until federal approval has been received.

(2) Language Other Than English: Procedures provided in languages other than English are claimed to Medicaid fee-for-service using the U4 modifier. **Note: The claiming procedure for the Language other than English modifier is a change from previous guidance.**

This modifier is applicable when the service to the recipient and/or collateral is provided in a language other than English, including sign language. Translation may be provided by a staff person fluent in the language or by a paid translator. It is expected that the individual providing language assistance services will have a sufficient level of fluency to ensure effective communication. Clinics should develop a process to assess or verify the language competency of those persons who will be providing language assistance services. Resources might include local organizations, universities or schools where the relevant languages are taught. In all instances, the confidentiality of information and respect for those served and for their culture must be assured.

Although the use of friends or family members as interpreters is not generally recommended, it is not prohibited. However, decisions to do so should be subject to careful clinical review and should be documented. It is critical to remember that the “language other than English” billing modifier cannot be utilized when translation is provided by a friend or family member.

The use of language assistance services and the method of providing the service should be documented in a progress note.

Additional resources:

Code of Ethics for Interpreters in Health Care:

<http://hospitals.unm.edu/language/documents/ncihc.pdf>

NYS Office of Mental Health-Cultural Competence:

http://www.omh.state.ny.us/omhweb/cultural_competence/regs.html

NYS Office of Mental Health regulations - 14 NYCRR section 527.4 “Communication Needs”

(3) After Hours: The purpose of the “after-hours” modifier is to encourage providers to make services available at times that are more convenient for the individuals they serve. There does not need to be a special justification for the provision of services during these hours.

This modifier is applicable when services to adults or children are provided weekdays before 8 AM, weekdays 6 PM or later, or all day on weekends. Services must begin before 8:00 a.m. or 6:00 p.m. or later.

In order to claim this modifier for all procedures except crisis services, the procedure must be provided during the extended hours of operation listed on the clinic’s operating certificate. If a clinic currently has extended hours, the modifier can be claimed during these times. Clinics without extended hours that wish to bill this modifier must have an approved change in their operating certificate before being able to bill the modifier. Only services provided after such approval are subject to the modifier.

The “after-hours” modifier will be recorded using CPT code 99051. It is reported in addition to the CPT code for each particular service or services provided after hours. **It is important to note that Medicaid will reimburse for only one after-hours CPT code per Medicaid recipient per day.**

(4) Physician add-on: Clinics may submit a supplemental bill under the Medical Assistance physician fee schedule when a psychiatrist or psychiatric nurse practitioners spend at least 15 minutes participating in the provision of services being provided by another licensed practitioner or when the service is provided fully by a psychiatrist/NPP.

The add-on can also be claimed when a psychiatrist/NPP runs a group session or participates in the group for at least 15 minutes. In this case the add-on may be claimed for only one of the participants in the group.

In all cases, the psychiatrists/NPP participation must be documented separately. For information on how to bill for this service, see page 37.

Modifier Chart

Billing modifiers are available for particular services as indicated on the following chart. The time durations within the chart are consistent with and reflect the enforceable provisions set forth in the text of 14 NYCRR Section 599.14. Please note that the modifier chart included in Section 599.14 is inconsistent with the text of the regulation in that it indicates that there is no minimum time duration for Psychotropic Medication Treatment. This is an error; steps are being taken to facilitate correction of this error.

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 – Min 1 hour		x	x	
Crisis Intervention Service - Per Diem Min 3 hour		x	x	
Developmental and Psychological Testing		x	x	
Injectable Psychotropic Medication Administration	x	x	x	
Psychotropic Medication Treatment – 15 minute min	x	x	x	
Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development - Min 45 minutes	x	x	x	x
Psychiatric Assessment - Min 30 Minutes	x	x	x	

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

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

Medicaid Utilization Threshold

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

Reimbursement for Collaborative Documentation/Concurrent Record Keeping

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

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

Medicaid/Medicare Crossover Billing

For individuals with both Medicaid and Medicare coverage, Medicaid will pay the "higher of" what Medicare or Medicaid would pay for the mental health clinic visit. Clinic restructuring will not change the way Medicaid adjudicates Medicaid/Medicare cross-over claims.

National Provider Identifier (NPI)

A practitioner NPI is required on all claims except when all the procedures are provided by a non-licensed practitioner. Clinics, hospitals and other facilities billing Medicaid fee-for-service

are required to maintain an up-to-date “roster” of Attending Providers (practitioners). Claims containing NPIs of licensed practitioners not “affiliated”, (i.e., associated) with the facility will result in a denial of payment by Medicaid. The facilities Affiliated Practitioners NPI Application can be accessed by going to www.emedny.org and clicking on "Enter Facilities Practitioner’s NPIs" located in the green box on the right of the page. Note: For ePACES users, attending providers (practitioners) are referred to as servicing providers (practitioners).

There is also a batch Facilities Practitioner’s NPI Reporting (FPR) submission method, which was developed to accommodate facilities that have a large quantity of affiliations to record with NYS Medicaid. For information on the FPR, please visit <http://www.emedny.org/hipaa/NPI/index.html>.

Claims by non-licensed practioners. When claiming for services provided by a non-licensed practitioner (including students), the OMH unlicensed practitioner ID is the ONLY practitioner information that should be put on the claim. Use the ID in place of the NPI and be sure that ALL other information - name, license etc. - is blank.

For all questions and concerns regarding Facility Practitioner NPI Reporting, or for assistance, please contact eMedNY Provider Services Call Center at 1-800-343-9000.

Questions about communicating NPI information to NYS Medicaid should be directed to the New York State Provider Enrollment at (518) 474-8161.

Billing Medicaid for Multiple Procedures on the Same Day

All procedures provided to an individual in the same day must be submitted to eMedNY on the same claim. Currently there is only room for one practitioner ID number on the claim. There is currently no New York State requirement regarding which NPI should be placed on a claim when the claim contains multiple procedures. The clinic must include an NPI that belongs to one of the practitioners who performed one or more of the procedures being claimed. The NPI must match a practitioner who performed a procedure in the case file. OMH recommends that clinics keep a copy of this billing guidance in their files.

Please note: The NPIs of all practitioners providing Medicaid reimbursable services in the clinic must be “affiliated” (associated) with the clinic in the eMedNY system. Practitioners may be associated with more than one clinic or clinic provider.

Billing Multiple Procedures for Individuals Covered by Medicaid and Private Insurance

Medicaid regulations at 18 NYCRR § 540.6(e) (6) require a provider to pursue any available commercial insurance prior to submitting a claim to Medicaid. This means that providers must

bill available commercial insurance, but are not required to contract with all available commercial insurers.

Effective February 1, 2007, Medicaid pays the lower of either:

- The Medicaid rate minus the insurance payment, or
- The Patient Responsibility Amount.

When a provider contracts with a commercial insurance payer, the Medicaid Program pays the difference between the commercial insurance payment amount and the commercial insurance patient coverage amount. Essentially, Medicaid pays the commercial insurance co-payment, deductible and/or co-insurance.

When a provider does not contract with a commercial insurance payer, Medicaid pays the patient responsibility. In this case, this is the difference between the commercial insurance payment amount and the provider's usual and customary charge, up to the Medicaid rate.

Where multiple services are provided on the same day, the patient responsibility depends upon whether or not a provider is under contract with a private insurer and the rules of the clinic's contract.

- If the clinic's contract with the insurer requires that the patient only be billed for co-pays and deductibles regardless of the number of procedures provided in a day, the patient responsibility amount will be limited to the co-pays and deductibles. This is true even if the third party insurer only paid for one procedure.
- If the terms of the clinic's contract allow the clinic to bill the recipient for any procedures not covered by his/her primary insurance plan, Medicaid will pay for the patient responsibility for the uncompensated procedure(s) up to the Medicaid amount. The total patient responsibility must be associated on the claim with the procedure(s) it pertains to. This works on ePACES as well. The user must fill out a line level claim response. Select the "More" button to enter the deductible and co-insurance information.

Line	Date Of Service	*Rev Code	HCPCS & Mod	*Charge Amount	*Service Count	Service Line Rate	More	Del.
1	From: 10/01/2003 To:	0250		1500.50	2 Unit			

IX. Medicaid Billing Requirements for Specific Services

Several clinic services have specific Medicaid billing limitations. These are summarized below. Please note that where services have a minimum duration, the duration of services must be documented.

Complex Care Management

Medicaid reimbursement for this service requires at least 15 minutes of continuous time, not including standard report writing or routine follow up calls. It is not routine care management and must be medically necessary.

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

Additional questions and answers related to complex care can be found on page 60.

Crisis Services

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

(1) Crisis Intervention- Brief. This may be done face to face or by telephone. For services of at least 15 minutes duration, one unit of service may be billed. For each additional service increment of at least 15 minutes, an additional unit of service may be billed, up to a maximum of six units per day.

(2) Crisis Intervention – Complex. This requires a minimum of one hour of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics may be reimbursed by Medicaid fee-for-service for individuals who have not engaged in services at their clinic for a period of up to two years.

(3) Crisis intervention – Per Diem. This requires three hours or more of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A peer advocate, family advisor, or non-licensed staff may substitute for one clinician. Clinics may be reimbursed by Medicaid fee-for-service for individuals who have not engaged in services at their clinic for a period of up to two years.

Crisis Intervention – Brief can be reimbursed by Medicaid fee-for-service for individuals regardless of whether or not they have previously received services from the clinic. Crisis

Intervention – Complex and Per Diem are Medicaid reimbursable only for those individuals that have been seen by the clinic within the previous two years.

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. The fee that is paid includes the expected cost of testing, including the scoring and report writing.

Outreach

Only Outreach services provided off-site are billable to Medicaid. Outreach services may be provided in any location, but they are ***not Medicaid reimbursable*** if provided in jails, prisons or other locations that are already reimbursed by Medicaid.

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

Important to Note: Medicaid fee-for-service reimbursement for off-site services is dependent upon federal approval and will not be available until such approval is obtained.

Pre-Admission Assessment

Assessment services consist of two types of assessment – Initial Assessment and Psychiatric Assessment.

- For adults, no more than three pre-admission assessment **procedures** for the same recipient in the same clinic shall be reimbursed within a 12-month period, whether they are initial assessments or psychiatric assessments.
- For children, no more than three pre-admission assessment **visits** (a visit is all procedures for a recipient or collateral in a day) for the same recipient in the same clinic shall be reimbursed 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. Medically necessary psychiatric assessments are not limited after admission to the clinic.

OMH is allowing three preadmission assessment procedures and/or visits to help clinicians improve engagement by giving them flexibility and more time to focus on the needs of the

recipient. However, Part 599 does not mandate three pre-admission sessions. Multiple assessments should only be done if medically necessary.

Psychiatric Assessment

Psychiatric assessments may be performed for admitted recipients where medically necessary without limitations. Two levels of psychiatric assessment may be reimbursed by Medicaid fee-for-service:

- 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; and
- 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.

In place of CPT codes 90805 and 90807, a psychiatrist could code a psychiatric assessment as one of the following E/M codes:

- 99201-99205 (new patient)
- 99212-99215 (established patient)

These E/M codes should be used if the psychiatrist does straight medical evaluation and management without psychotherapy. Medicaid reimbursement amounts for these codes vary by diagnosis. Psychiatrists should choose the appropriate code based on the complexity of service provided. Regardless of which code is used, the minimum 30 minute OMH regulatory requirement for this service must be met before Medicaid reimbursement can be requested.

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. The regulation does not limit the number of medically necessary sessions for this service. The reimbursement includes the expected cost of testing, including the scoring and report writing.

Psychotherapy

Psychotherapy Services-Individual may be reimbursed as follows:

(1) Brief Individual Psychotherapy Service requires documented face-to-face contact with the recipient of 30 minutes minimum duration. ***Sessions less than 30 minutes will not be reimbursed by Medicaid.***

(2) Extended Individual Psychotherapy Service requires documented face-to-face contact with the recipient of a minimum duration of 45 minutes. Providers are free to provide longer sessions,

but Medicaid will not reimburse for more than a 45 minute psychotherapy session. For school-based services, the duration of Extended Individual Psychotherapy may be that of the school period provided the school period is at least 40 minutes.

(3) Psychotherapy Family/Collateral and Client. This is a 60 minute visit. The patient and family/collateral must be present together for the majority of the time.

(4) Psychotherapy –Multi-Recipient Group. This 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 duration of at least 40 minutes. (The reimbursement for school based group services of less than 60 minutes will be reduced).

(5) Psychotherapy – Multi-Family/Collateral Group. This 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.

Psychotropic Medication Treatment

Psychotropic medication treatment involves the in-depth management of psychopharmacologic agents with frequent serious side effects and represents a very skilled aspect of patient care. This service is not intended to refer to a brief evaluation of the patient's state or a simple dosage adjustment of long-term medication.

This service must be a minimum of 15 minutes in length in order to be reimbursed by Medicaid. This service cannot be reimbursed by Medicaid if a psychiatric assessment or psychiatric consultation was done for the same individual on the same day. In that case, only the appropriate psychiatric assessment or psychiatric consultation code should be claimed on that day. The pharmacologic management is included as part of the E&M service by definition.

Health Physicals

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

Health Monitoring

Health monitoring services for people receiving mental health clinic services are considered to be ancillary to mental health services. Therefore, individuals with Medicaid Managed Care for physical health only will not need a referral from a Medicaid Managed Care primary care

provider to receive this service in a mental health clinic. This service is presumed to complement a mental health service and can be paid fee-for-service.

Health monitoring groups require documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum of either 30 or 60 minutes duration.

Psychiatric Consultation

For this service, the referring physician cannot be employed by the clinic doing the consultation.

Please Note: OMH is changing its previous guidance regarding claiming for psychiatric consultation. Consultation CPT codes will not be available in OMH licensed clinics for Medicaid reimbursement. Consultation is to be coded using the appropriate evaluation and management codes (see page 57 for allowable codes).

A consultation must meet the following conditions:

1. It must be performed at the request of another physician requesting advice regarding evaluation and/or management of a specific problem;
2. The request for the consultation and the reason for it must be recorded in the patient's medical record; and
3. A written report must be prepared on the findings and provided to the referring practitioner.

X. Submitting Bills to Medicaid

Required Information

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

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

Billing Multiple Services in the Same Day

Clinics will be able to bill Medicaid for up to two services per day per client, except where noted below. The intent is to reduce the need to make multiple trips for complementary services. The clinic will receive 100% reimbursement for the APG procedure with the highest APG weight and a 10% discount applied to each additional procedure with a lower APG weight.

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

Important to Note: All procedures provided to an individual on the same day must be transmitted to Medicaid on one claim. This includes procedures provided by different clinicians. If services provided to one individual on the same day are submitted as separate claims, the subsequent claims will be denied. **For more information, see OMH FAQs at http://www.omh.state.ny.us/omhweb/clinic_restructuring/faq/it_billing.html**

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

Billing the Physician Add-on

The physician/NPP add-on payment must be billed off the Medicaid physician fee schedule. In cases where the requirements for the 15 minute add-on are met, clinics will submit a claim to eMedNY for the basic procedure using the 837I claim form. An additional claim with the same procedure code is also filed with eMedNY using the 837P form. This second claim will generate a payment off the physician fee schedule.

Billing for Medical Residents in Teaching Hospitals

NYS Medicaid follows the Medicare requirements for teaching hospitals. Medicaid guidance with respect to these requirements can be found in the June, 2009 NYS Medicaid Update, which is available in its entirety at

http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-06.htm#sup.

The Centers for Medicare and Medicaid Services (CMS) Guidelines for Teaching Physicians, Interns and Residents also contains information with respect to this topic; it can be found at:

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

OMH is currently working with the Department of Health to revise the Medicaid policy for reimbursement for medical Residents in Article 31 licensed clinics. OMH will update this guidance when this policy is final.

Claiming for Procedures Performed by Students

Students may perform clinical work in an OMH licensed clinic. They must be enrolled in a New York State Education Department (NYSED) approved program leading to a license allowable in an OMH clinic. A plan for the use of students and student supervision must be included as part of the clinic's OMH approved staffing plan. Appropriate procedures performed by students working in this capacity are reimbursable by Medicaid.

At this time, a properly supervised student may bill Medicaid as the servicing provider using the MMIS unlicensed provider ID. There is currently no requirement for the Medicaid number and/or NPI of the supervising clinician to be on the claim submitted by the student. See OMH FAQs for more information

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

XI. Uncompensated Care

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

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

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

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

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

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

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

1. Self pay, including partial pay or no pay visits (does not include partial payment associated with co-pays or deductibles).
2. Required or optional mental health clinic procedures (as defined in 14 NYCRR Part 599) provided but **not** covered under a clinic's agreement with an insurer. The service must be provided by a practitioner qualified to deliver the service under State regulations,
3. Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member not approved for payment by a third party payer in contract with the clinic. The provider must document that the clinic or recipient received a denial of payment; and

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

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

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

Additionally services to individuals served in forensic settings do not count toward uncompensated care visit volume.

Transition - Visit Value and Data Collection

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

Uncompensated Care Value:

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

Uncompensated Care Volume:

1. Uncompensated Care payments to Article 31 clinics during calendar year 2010 will be based on annualized uncompensated care visit volume and total care visit volume delivered July 1, 2009 through December 31, 2009.
2. Uncompensated Care payments to Article 31 clinics during calendar year 2011 will be based on uncompensated care visit volume and total care visit volume for the period January 1, 2010 through June 30, 2010.

3. Uncompensated Care payments to Article 31 clinics during calendar year 2012 will be based on data as follows:
 1. Payments to clinics in NYC will be based on data from July 1, 2009 through June 30, 2010.
 2. Payments to clinics in the rest of the State will be based on data from calendar year 2010.

Reimbursement Calculation

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

To be eligible for reimbursement from this pool, claims must be consistent with the Medical Assistance billing standards set forth in Part 599.

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

Additional Information

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

XII. System Transition

- The requirements for operation of a clinic treatment program as specified in Part 599 supersede the requirements for clinics as specified in 14 NYCRR Parts 587, 588 and 592. Part 599 shall become effective on October, 1, 2010. Existing clinic treatment programs will be responsible for compliance with Part 599 on that date. However, they will continue to operate pursuant to the operating certificate (license) issued by the Office of Mental Health under Part 587. Except as discussed below, it is not necessary for a provider to submit a new application for a license, or any other license-related information, to OMH solely for the purpose of continuing operation of an existing clinic program.

OMH recognizes that some clinics (and any satellite sites associated with the clinic) may need a reasonable period of time to fully transition to the new requirements. To accommodate this, existing clinic providers will need to develop and implement a transition plan to operate the clinic in accordance with applicable requirements specified in Part 599 and these Guidelines.

Although it will not be necessary to submit the transition plan to OMH, providers should be prepared to produce the plan if requested by OMH. Providers will be given a reasonable time to transition to Part 599, but it is expected that all providers will have completed their transition by March 31, 2011.

- **Important to Note: There will be no transition regarding procedure documentation and compliance with billing rules, which are in effect on and after October 1, 2010.**
- **License Renewal.** It is the expectation of OMH that there will be no disruption to the OMH license renewal process during transition to Part 599. OMH intends to continue implementation and refinement of the new Clinic Standards of Care Tracer Methodology, which will replace the Tiered Certification process for clinic programs. A provider whose clinic license is due for renewal will still need to submit a license renewal application, the Field Office will conduct an on-site visit as required by law and regulations, and OMH will issue a renewal license pursuant to Part 599 as warranted. However, for those clinic licenses subject to renewal within the six month period after the effective date of Part 599, OMH will take into consideration that implementation of the transition plan for the clinic may still be in process.
- **Revised Licenses.** OMH will revise all existing clinic licenses consistent with these regulations as soon as possible. All renewed licenses on or after October 1, 2010 will reflect Part 599 requirements. Additionally, OMH will review and issue revised licenses for other clinics beginning with those programs whose license renewal dates are most distant from the effective date of Part 599. Until the clinic receives a revised license or a renewal license

pursuant to Part 599, the current operating certificate issued pursuant to Part 587 will remain valid for operation of the clinic program. However, except for Child and Family Clinic Plus services, any additional and optional services specified on the current Part 587 license that are not required services under Part 599 will no longer be authorized as of the effective date of Part 599. A provider wishing to provide Part 599 optional services must follow the procedure below.

- **Optional Services.** A clinic may be authorized to provide one or more of the optional services specified in Section 599.8(c) through completion of the “Part 599 Clinic Regulation” Survey on the OMH web based application, Mental Health Provider Data Exchange (MHPD). Information regarding the Mental Health Provider Data exchange (MHPD) page and the above referenced regulations can be found on the OMH Website at <http://www.omh.state.ny.us/omhweb/mhpd/>. Following submission, OMH will issue a revised clinic operating certificate specifying the optional services provided at that location pursuant to Part 599.
- **Notification to OMH.** If a provider determines that a clinic is unable to operate under Part 599, or intends to substantially change the current operation of the clinic (other than to comply with the requirements of Part 599), the provider must notify OMH in accordance with the requirements of Part 551. No final action to change or terminate operation of the clinic should be undertaken without the prior approval of OMH.

Financial Transition

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

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

The existing payment used for calculating the blend is a provider's average per visit Medicaid reimbursement (base plus COPS) for services moving to APGs for the period July 2008 through June 2009. 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 Part 599 which result from provider appeals or are made pursuant to applicable regulations.

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

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

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

Reimbursement for New Clinics

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

For new providers (new clinics, or clinics commencing service in a new county) that will be licensed either solely under Article 31 of the Mental Hygiene Law or Diagnostic and Treatment

Centers licensed jointly by OMH and the Department of Health, the historical fee will equal the lowest historical blend rate in the appropriate peer group.

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

Hospital-based mental health clinics are joining the transition of other hospital ambulatory services to APG, which is already underway. As of October 1, 2010, hospitals are in the second year of the APG transition, so when Part 599 becomes effective, hospital-based mental health clinics will immediately receive 50% blend payments and 50% APG payments.

Appendix

Crosswalk to Regulations

OMH is developing a table which crosswalks information in this guidance to the sections of the Part 599 regulations it pertains to. When completed, this guidance will be updated to reflect this information.

Definitions (from regulations 14 NYCRR Section 599.4)

- (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) *Licensed 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) *Licensed 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's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones.

(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.

Frequently Asked Questions

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

OMH Financial Modeling Tools:

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

Standards of Care

***Mental Health Clinic Standards of Care for Adults - Interpretive Guidelines*⁵**

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

Clinical standards for adult outpatient licensed clinics result from recent reviews of care. These reviews revealed that too often these standards, which we believe to be fundamental to good care and a longstanding expectation of clinic services, may not be explicitly understood. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

Standards of Care for Children, Adolescents, and their Families

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

⁵ Taken from Appendix E of the New York State/New York City Mental Health-Criminal Justice Panel Report and Recommendations June 2008.

Staff Eligible to Deliver Mental Health Services

It is a provider's responsibility to ensure that all services are provided by staff within their scopes of practice. OMH has identified the staff eligible to provide services within their scope of practice as of July 1, 2013. However, OMH is currently waiving many of these requirements as permitted by New York State Law. See Page 16 for more information.

Part 599 also provides the Commissioner with authority to waive certain staffing requirements as allowable by law. Services 3, 4, and 7 below must be provided by a Psychiatrist/NPP unless an OMH waiver for another physician is received.

	Service	Staff
1	Outreach	Peer advocate or Family Advisor as the minimal qualification.
2	Initial Assessment	MD/NPP, LMSW, LCSW, Licensed Psychologist, RN, Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), and Licensed Creative Arts Therapist (LCAT), Licensed Psychoanalysts
3	Psychiatric Assessment	Psychiatrist /NPP or PA with specialized training approved by the Office
4	Psychiatric Consultation	Psychiatrist /NPP
5	Crisis Intervention	MD/NPP, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
6	Injectable Psychotropic Medication Administration	MD/NPP/RN/LPN/PA
7	Psychotropic Medication Treatment	Psychiatrist /NPP
8	Psychotherapy	MD/NPP, Licensed Psychologist, LMSW, LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
9	Developmental Testing	Clinic professional staff
10	Psychological Testing - various	MD/Licensed Psychologist
11	Complex Care Management	MD/NPP, Licensed Psychologist, LMSW LCSW, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts
12	Health Physicals	MD/NPP/PA
13	Health Monitoring	MD/NPP/RN/LPN/PA

CPT Codes, APG Codes and Service Blend Status⁶

Please note: the chart in the regulations incorrectly states that there is no minimum time duration for Psychotropic Medication Treatment. This table contains APG numbers and CPT codes that are current as of the time of this guidance. These codes are subject to change. OMH will update its website to reflect the most current codes available.

Blend/Full Pay	APG	Procedure - OMH Regulatory Name	CPT Codes	Alternate Codes
Full	490	Outreach (Not active, pending federal approval)	H0023	
Blend	323	Initial Assessment- 45 minutes minimum	90801	
Blend	315	Psychiatric Assessment - 30 minutes minimum	90805	99201-99205 (New Patient) or 9999212-99215 (Established Patient) APG numbers vary by diagnosis when alternate code used.
Blend	316	Psychiatric Assessment - 45-50 minutes minimum	90807	99201-99205 (New Patient) or 9999212-99215 (Established Patient) APG numbers vary by diagnosis when alternate code used.
Full	Depends on diagnosis. See table below	Psychiatric Consultation	99201-99205 (New Patient) or 9999212-99215 (Established Patient)	
Full	321	Crisis Intervention Brief - 15 minute minimum	H2011	
Full	321	Crisis Intervention Complex – 1 hour minimum	S9484	
Full	312	Crisis Intervention Per Diem – 3 hour minimum	S9485	
Full	490	Injectable Psychotropic Medication Administration	H2010	

⁶ For CPT and HCPCS code definitions see manuals developed by the American Medical Association and the federal Centers for Medicaid and Medicare Services. For Medicaid billing purposes, clinics must comply with the service standards in Part 599.

Blend/Full Pay	APG	Procedure - OMH Regulatory Name	CPT Codes	Alternate Codes
Full	426	Psychotropic Medication Treatment – 15 minutes minimum	90862	
Blend	315	Psychotherapy - Individual 30 minutes minimum	90804	
Blend	316	Psychotherapy - Individual 45 minutes minimum	90806	
Blend	317	Psychotherapy - Family 30 minutes minimum	90846	
Blend	317	Psychotherapy – Family & Client 1 hr minimum	90847	
Blend	318	Psychotherapy - Family Group 1hr minimum	90849	
Blend	318	Psychotherapy - Group 1 hr minimum	90853	
Full	310	Developmental Testing - limited	96110	
Full	310	Developmental Testing - extended	96111	
Full	310	Psychological Testing - Various	96101	
Full	310	Psychological Testing - Neurobehavioral	96116	
Full	310	Psychological Testing - Various	96118	
Full	490	Complex Care Management - 15 continuous minutes minimum	90882	
Full	Depends on diagnosis. See table below	Health Physicals (coding is age specific)	99382-99387(New Patient) or 99392-99397 (Established Patient)	
Full	490	Health Monitoring – 15 minute minimum	99401	
Full	490	Health Monitoring – 30 minute minimum	99402	
Full	490	Health Monitoring – 45 minute minimum	99403	
Full	490	Health Monitoring – 60 minute minimum	99404	
Full	490	Health Monitoring Group – 30 minute minimum	99411	
Full	490	Health Monitoring Group – 60 minute minimum	99412	

APGs for Physicals, Psychiatric Assessments and Consultations

Psychiatric Assessments (using Evaluation and Management codes) and Consultations will be claimed using the same procedure codes. Physicals have different procedure codes. The Medicaid APG and procedure weight for these are identical and dependent on the diagnosis of the individual.

APG	APG Description	July 2010 Weight
820	Schizophrenia	0.8969
821	Major Depressive Disorders & Other/Unspecified Psychoses	0.9476
822	Disorders Of Personality & Impulse Control	0.8945
823	Bipolar Disorders	0.8574
824	Depression Except Major Depressive Disorder	0.6982
825	Adjustment Disorders & Neuroses Except Depressive Diagnoses	0.8061
826	Acute Anxiety & Delirium States	0.6352
827	Organic Mental Health Disturbances	0.7817
828	Mental Retardation	0.7149
829	Childhood Behavioral Disorders	0.6982
830	Eating Disorders	0.9135
831	Other Mental Health Disorders	0.7248

Complex Care Management FAQs

	Question	Answers
1.	Does a referral to housing & legal services in an effort to avoid eviction count as CCM?	NO. A referral does not constitute CCM.
2.	Does talking with the recipient’s landlord (who is threatening eviction proceedings due to the condition of the apartment) to negotiate a specific plan of action between the recipient, their family (if applicable) and the landlord to address the behavioral issues that threaten their housing status constitute CCM?	YES. Provided that it occurs within the 5 working days following a psychotherapy or crisis service where this issue was discussed and the communication is a minimum duration of 15 continuous minutes. The psychotherapy or crisis progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the recipient’s mental health status.
3.	A recipient with multiple medical problems has recently started a new medication. He reports to his therapist that since starting the new medication his medical symptoms, which had been in remission/under control, have flared up and he is concerned that it is connected to the new psychotropic medication. However, the new psychotropic medication has been effective in mitigating his psychiatric symptoms. If the prescribing psychiatrist contacts the recipients PCP within 5 working days following the psychotherapy service to discuss the potential drug interactions and the contact is of 15 minutes in duration, does this constitute CCM?	YES. The psychiatrist is coordinating with the PCP re: a specific situation that has the potential to significantly alter the recipients’ physical and/or mental health status. The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the recipients’ physical and/or mental health status. The communication must be a minimum duration of 15 continuous minutes.
4.	Does a CPS/ACS hotline report that is made in response to information that is revealed during a psychotherapy session constitute CCM?	NO. Activities related to a practitioner’s role as a mandated reporter DO NOT constitute CCM.

	Question	Answers
5.	During a family psychotherapy session the discussion centers on the development of a plan to mitigate the youth's frequent presentation to the ER for high risk behaviors or very aggressive, violent outbursts. It is agreed that in an effort to address the behaviors resulting in this frequent presentation to the ER and to prevent the possibility of an inpatient hospitalization, a meeting will be held with all of the youth's service provider's to re-evaluate and refine the youth's crisis plan. Does this meeting constitute CCM?	YES. Provided the meeting occurs within 5 working days following the psychotherapy or crisis service where this issue was discussed and the meeting is a minimum duration of 15 continuous minutes. The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youths' mental health status.
6.	The content of a psychotherapy session focuses on the ongoing, problematic behaviors of the child at school. The youth's parent reports that they have received notice that if the behavior continues, the youth is going to be placed on home instruction. It is agreed that the social worker will contact the school in an effort to explore what other options exist regarding the youth's ability to remain in their current educational program or the possibility of alternative education programming that might better serve the youth's needs. Does this communication with the school social worker constitute CCM?	YES. Provided that it occurs within the 5 working days following the aforementioned psychotherapy visit and the communication is a minimum duration of 15 continuous minutes. The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth's mental health status.
7.	Does the completion and/or submission of documentation re: a referral (i.e. day treatment, respite, housing, etc.) constitute CCM?	NO. The completion and/or submission of paperwork related to a referral does not constitute CCM.
8.	The content of a psychotherapy session focuses on the youth and their parent's concerns that a day treatment program is not going to accept the youth. They are concerned re: the youth's	YES. Provided that it occurs within the 5 working days following the aforementioned psychotherapy visit and the communication is a minimum duration of 15 continuous minutes. The psychotherapy

	Question	Answers
	educational status as it is their understanding that the youth cannot return to their previous educational placement if denied. It is agreed that the social worker will contact the school and/or school district to clarify the student's current educational situation and develop a specific plan of action to address any social, emotional, or behavioral issues that might be threatening the youth's educational status. Does this phone call constitute CCM?	progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth's mental health status.
9.	If a youth is in foster care, does regular and routine contact (e.g. sharing updates, relaying information, etc.) with the foster care agency, biological parents, foster parents, etc. constitute CCM?	NO. If the contact is regular and routine then it does not constitute CCM.
10.	If a youth is in foster care and attends an individual psychotherapy session where the content of the discussion is exceptional (i.e. there is the potential for the youth's community status to be significantly altered, significant impact on the persons mental/emotional status or functioning) and the social worker contacts the foster and/or biological parent(s) to develop and/or coordinate around the presenting issue, does that constitute CCM?	YES. Provided that the contact occurs within the 5 working days following the psychotherapy session and the communication is a minimum duration of 15 continuous minutes. The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth's mental health status. However, if the contact takes place during the therapy session it cannot be reimbursed as a separate complex care management service.
11.	A patient comes in stating that they want/need supportive housing. Does the clinician's completion of the HRA application form constitute CCM?	NO. The completion and/or submission of routine and required paperwork related to a referral does not constitute CCM.
12.	A patient comes in stating that their residential program needs an updated psycho-social assessment. Can the clinician bill the	NO. The completion of routine and required paperwork and/or referral related paperwork does not constitute CCM.

	Question	Answers
	completion of the psycho-social as CCM?	
13.	The content of a psychotherapy session focuses on a recipient's concern that they are going to be evicted from their housing program due to their ongoing difficulties with another resident. If the social worker contacts the housing program to discuss this issue and coordinates a plan of action with the residential manager, does this constitute CCM?	YES. Provided that the communication takes place within the 5 working days following the psychotherapy session and the communication is a minimum duration of 15 continuous minutes. The psychotherapy progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.
14.	A patient is having difficulty in the community gaining access to necessary resources. Does the clinician's completion of a SPOA application in order to get the patient an ICM worker constitute CCM?	NO. The completion of a referral does not constitute CCM. However, attendance at a SPOA meeting to coordinate re: the recipient's needs as it relates to their treatment would constitute CCM if the meeting occurs within the 5 working days of a psychotherapy or crisis service (where the scope and purpose of case management services was discussed); and if the clinician's participation in the meeting is a minimum duration of 15 continuous minutes. The psychotherapy or crisis service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.
15.	Does the completion of documentation related to an AOT order constitute CCM?	NO. The completion of routine and required paperwork does not constitute CCM. However, attendance at an AOT related meeting/court appearances re: the recipient's needs as it relates to their treatment would constitute CCM if the meeting/appearance occurs within 5 working days of a psychotherapy or crisis service (where AOT concerns were discussed); and if the clinician's participation in the meeting/appearance is a minimum duration of 15 continuous

	Question	Answers
		minutes. The psychotherapy or crisis service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.
16.	A patient is in need of a higher level of care. Does the clinician's submission of a referral to a Day Treatment Program or Partial Hospitalization program constitute CCM?	NO. The completion and/or submission of referral paperwork does not constitute CCM. However, attendance at a meeting to coordinate services re: the recipient's needs as it relates to their treatment would constitute CCM if the meeting occurs within the 5 working days of a psychotherapy or crisis service (where the scope and purpose of the program was discussed); and if the clinician's participation in the meeting is a minimum duration of 15 continuous minutes. The psychotherapy or crisis service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.
17.	Patients often request letters in order to obtain benefits/entitlements. Can clinician's bill for writing letters for pts. Ex: for public housing, for public assistance, for SSI.	NO. Letter writing does not constitute CCM.
18.	Calls for referral to Domestic Violence Shelter/Program.	NO. The completion of a referral does not constitute CCM. However, a phone call that is a minimum duration of 15 continuous minutes and occurs within the 5 working days of a psychotherapy or crisis service where the situation was discussed could constitute CCM. The psychotherapy or crisis service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.