14 NYCRR Part 599
Express Terms

A new Part 599 is added to read as follows:

PART 599
CLINIC TREATMENT PROGRAMS

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

Sec.

§ 599.1 Background and intent.

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

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

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

(d) The goals of a clinic in serving children are the early assessment and identification of childhood emotional disturbances, engagement of the child and family in the

development of a plan of care designed to minimize the symptoms and adverse effects of illness, maximize wellness, assist children in developing a resilient and hopeful approach to school, family, and community, and maintain them in their natural environments.

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

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

(g) This Part supersedes inconsistent provisions of Parts 587 and 588 of this Title as they relate to clinic treatment services operated by or under the auspices of the Office of Mental Health.

§ 599.2 Legal base.

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

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

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

(d) Section 31.11 of the Mental Hygiene Law requires every holder of an operating certificate to assist the Office of Mental Health in carrying out its regulatory functions by

cooperating with the Commissioner in any inspection or investigation, permitting the Commissioner to inspect its facility, books and records, including recipients' records, and making such reports, uniform and otherwise, as are required by the Commissioner.

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

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

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

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

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

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

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

§ 599.3 Applicability.

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

(b) This Part applies to Clinic Treatment programs and Diagnostic and Treatment Centers as defined in this Part.

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

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

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

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

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

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

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

(d) This Part and all other standards of Medical Assistance reimbursement applicable to clinics shall be effective contingent upon Federal financial participation.

(e) Programs which provide medical services that comprise more than five percent of total annual visits shall be licensed by the Department of Health.

§ 599.4 Definitions. For purposes of this Part:

(a) After hours means before 8 a.m., after 6 p.m., or during weekends.

(b) Ambulatory Patient Groups (APGs) shall mean 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 rates shall mean the numeric value that shall be multiplied by the weight for a given service to determine the Medicaid fee for a service.

(d) 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.

(e) Clinical staff is staff members who provide services directly to recipients, including licensed staff, non-licensed staff, and student interns.

(f) Collateral persons are members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition, and are identified in the treatment plan as having a role in treatment and/or are 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.

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

(h) 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.

(i) 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.

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

(k) Current Procedural Terminology (CPT) codes are 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.

(l) Designated mental illness is 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, other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) organic brain syndrome or (iv) social conditions (V-Codes). V-Code 61-20 Parent-Child (or comparable diagnosis in any subsequent editions of the DSM) is included for children.

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

(n) Diagnostic and treatment center, for purposes of this Part, is a program licensed as a diagnostic and treatment center licensed under Article 28 of the Public Health Law which provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits, except that a program providing fewer than 2,000 total visits annually shall not be considered a diagnostic and treatment center.

(o) 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.

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

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

(r) Health physical is the physical evaluation of an individual, including an age and gender appropriate history, examination, counseling, guidance (including risk factor avoidance or reduction) and the ordering of laboratory/diagnostic procedures.

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

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

(u) Homebound individuals are 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.

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

(1) self care;

(2) family life;

(3) social relationships;

(4) self-direction/self-control; or

(5) learning ability.

(w) Initial assessment is 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 program, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient.

(x) 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.

(y) Limited permits means that the New York State Department of Education 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 Department of Education law governing each of the professions.

(z) Linkage with primary care means services designed to promote the integration of the clinic and the primary care provider.

(aa) Local governmental unit (LGU) means the unit of local government given the authority in accordance with Article 41 of the Mental Hygiene Law to provide and plan for local or unified services.

(ab) Mental health screening for children is a broad-based approach to identify children and adolescents with emotional disturbances and to intervene at the earliest possible opportunity.

(ac) Modifiers are payment adjustments made to Medicaid fees for specific reasons such as billing for offsite services (within established limits), services in languages other than English, and services delivered after hours.

(ad) Non-licensed staff are individuals 18 years of age or older who do not possess a license issued by the New York State Department of Education in one of the clinic professional staff categories listed in this Part and who may not provide therapeutic mental health services. Non-licensed staff includes employees who have a life experience related to mental illness or have education and training in human services.

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

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

(ag) Peer advocates are individuals with personal experience as mental health recipients, who have training, credentials or experience recognized by the Office.

(ah) Peer groups are groupings of providers sharing similar features such as geography or auspice.

(ai) Physician fee schedule is a payment schedule established by the Department of Health which is used to enhance the payment for specific services included in this Part.

(aj) Preadmission status is the status of an individual who is being evaluated to determine whether he or she is appropriate for admission to the clinic.

(ak) Preadmission visits refer to visits provided prior to enrollment in clinic services.

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

(1) Creative arts therapist is an individual who is currently licensed as a creative arts therapist by the New York State Department of Education or possesses a creative arts therapist permit from the New York State Department of Education.

(2) Licensed practical nurse is an individual who is currently licensed as a licensed practical nurse by the New York State Department of Education or possesses a licensed practical nurse permit from the New York State Department of Education.

(3) Licensed psychoanalyst is an individual who is currently licensed as a psychoanalyst by the New York State Department of Education or possesses a permit from the New York State Department of Education.

(4) Licensed psychologist is an individual who is currently licensed as a clinical psychologist by the New York State Department of Education or possesses a permit from the New York State Department of Education, and who possesses a doctoral degree in psychology or an individual who has obtained at least a master's degree in clinical psychology who works in a federal, state, county or municipally operated clinic. Such master’s degree level psychologists may use the title “psychologist,” may be considered professional staff, but may not be assigned supervisory responsibility.

(5) Marriage and family therapist is an individual who is currently licensed as a marriage and family therapist by the New York State Department of

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

(6) Mental health counselor is an individual who is currently licensed as a mental health counselor by the New York State Department of Education or possesses a permit from the New York State Department of Education.

(7) Nurse practitioner is an individual who is currently certified as a nurse practitioner by the New York State Education Department of possesses a permit from the New York State Department of Education.

(7) 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 Department of Education or possesses a permit from the New York State Department of Education.

(8) Physician is an individual who is currently licensed as a physician by the New York State Department of Education or possesses a permit from the New York State Department of Education.

(9) Physician assistant is an individual who is currently registered as a physician assistant by the New York State Department of Education or possesses a permit from the New York State Department of Education.

(10) 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.

(11) Registered professional nurse is an individual who is currently licensed as a registered professional nurse by the New York State Department of Education or possesses a permit from the New York State Department of Education.

(12) Social worker is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Department of Education, or possesses a permit issued by the New York State Department of Education based upon participation in an approved educational program, to practice and use the title of either licensed master social worker or licensed clinical social worker.

(am) Psychiatric assessment is an interview with a consumer, child, family, or other collateral performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office, which may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning,

medication therapy, and/or consideration of general health issues. It may also include on-site psychiatric consultation which includes an evaluation, report or interaction between a psychiatrist or nurse practitioner in psychiatry or physician assistant with specialized training approved by the Office and a referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

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

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

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

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

(ar) Quality improvement is 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.

(as) 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).

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

(au) Supplemental payments are payments in addition to the service fee amount.

(av) 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.

(aw) Weight shall mean 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.

(ax) Wellness screening is the measuring and monitoring 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.

§ 599.5 Certification.

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

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

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

(2) the location of the program;

(3) the hours of operation of the program;

(4) the population to be served;

(5) the term of the operating certificate; and

(6) any approved optional services to be provided.

(c) Each clinic authorized by an operating certificate pursuant to this Part shall be clearly identifiable. Each clinic shall have sufficient program space which shall ensure privacy and safety. Program space may be shared with other programs, pursuant to a plan approved by the Office. Non-program space, e.g., waiting rooms, restrooms, etc., may be shared with other programs.

(d) Clinics may provide services at off-site locations. To the extent that such services are provided in a given location on a regularly and routinely scheduled basis (full or part time), such site shall be considered a satellite location and shall be in compliance with this section. In determining the regular and routine nature of services at a given site, the Office shall take into consideration the volume of services, the number of individuals receiving services, the number of staff assigned, the range of services provided, and whether the site will be utilized on a permanent or temporary basis.

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

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

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

(3) there shall be adequate and sufficient staff to provide services at the satellite. The full range of the primary program's services must be available as clinically appropriate to recipients who utilize the satellite location; and

(4) satellite locations must meet the physical plant requirements for program space set forth in Part 587 of this Title.

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

(g) Changes in the hours of operation of a program may be made upon notification to the Office and the Office's determination that the changes will not negatively affect the program.

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

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

(j) The provider of service shall cooperate with the Office during any review or inspection of the clinic program.

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

(l) The Commissioner shall designate a licensed clinic treatment program to provide specialty children's services to children as defined in accordance with this Part. A clinic treatment program so designated shall be authorized to provide, and be reimbursed for providing, clinic treatment services to children up to but not including their 19th birthday,

notwithstanding the child's enrollment in a Medicaid managed care program. Such a clinic shall be designated as a specialty clinic treatment program serving children.

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

§599.6 Organization and administration.

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

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

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

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

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

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

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

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

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

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

(i) written criteria for admission, and discharge from the program: admission policies should include a mechanism for screening individuals at the time of referral and assuring that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those cases determined to be in urgent need by the Director of Community Services receive initial assessment services within five business days;

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

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

(iv) policies and procedures for age appropriate wellness screening;

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

(vi) policies and procedures ensuring that a reasonable effort shall be made to obtain records from prior recent episodes of treatment and for communicating with family members, current service providers, and other collaterals;

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

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

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

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

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

(xii) written policies which are consistent with the obligations imposed by titles VI and VII of the Civil Rights Act, Federal Executive Order 11246, article 15 of the Executive Law (Human Rights Law), article 15-a of the Executive Law (Minority and Women Business Enterprises Program), section 504 of the Rehabilitation Act of 1973, the Vietnam Era Veteran's Readjustment Act, the Federal Age Discrimination in Employment Act of 1967, the Federal Equal Pay Act of 1963, and the Federal Americans with Disabilities Act;

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

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

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

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

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

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

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

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

(e) The provider of service shall establish mechanisms to ensure priority access by individuals, referred to the provider, who are enrolled in an assisted outpatient treatment program established pursuant to section 9.60 of the Mental Hygiene Law. The provider of service shall cooperate with the local governmental unit or the Commissioner, or their authorized representatives, in ensuring priority access by such individuals, and in the development, review and implementation of treatment plans for such individuals. Prior to the discharge by a provider of service of an individual who is also enrolled in an assisted outpatient treatment program, the provider of service shall notify the individual's case manager and the director of the assisted outpatient treatment program. Any and all related information, reports and data which may be requested by the Commissioner or the local governmental unit shall be furnished by the provider of service. Any requests for clinical records from persons or entities authorized pursuant to section 33.13 or 33.16 of the Mental Hygiene Law, regarding individuals who are the subject of, or under consideration for, a petition for an order authorizing assisted outpatient treatment shall be given priority attention and responded to without delay.

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

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

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

(i) utilize restraint or seclusion for any purpose, including, but not limited to, as a response to a crisis situation**;** and

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

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

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

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

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

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

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

§ 599.7. Rights of recipients.

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

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

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

(3) Participation in treatment in a clinic program is voluntary and recipients are presumed to have the capacity to consent to such treatment. The right to participate voluntarily in and to consent to treatment shall be limited only to the extent that:

(i) section 330.20 of the Criminal Procedure Law and Part 541 of this Title provide for court-ordered receipt of clinic services;

(ii) article 81 of the Mental Hygiene Law provides for the surrogate consent of a court-appointed guardian for personal needs;

(iii) section 33.21 of the Mental Hygiene Law provides for the surrogate consent of a parent or guardian of a minor;

(iv) a recipient is enrolled in an assisted outpatient treatment program established pursuant to section 9.60 of the Mental Hygiene Law; or

(v) a recipient engages in conduct which poses a risk of physical harm to himself or others.

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

(5) The confidentiality of recipients' clinical records shall be maintained in accordance with section 33.13 of the Mental Hygiene Law and applicable Federal requirements under the Health Insurance Portability and Accountability Act (HIPAA).

(6) Recipients shall be assured access to their clinical records consistent with section 33.16 of the Mental Hygiene Law and applicable Federal requirements under HIPAA.

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

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

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

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

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

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

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

§ 599.8 Clinic services.

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

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

(1) Outreach.

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

(3) Psychiatric assessment;

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

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

(6) Psychotropic medication treatment;

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

(8) Family/Collateral psychotherapy;

(9) Group psychotherapy; and

(10) Complex Care Management.

(c) Clinics may offer the following optional services:

(1) Developmental testing;

(2) Psychological testing;

(3) Health physicals;

(4) Wellness Screening;

(5) Psychiatric consultation**;** or

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

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

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

(2) Linkage with primary medical care; and

(3) Community education.

§ 599.9 Staffing.

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

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

(1) Creative arts therapists;

(2) Family advisors;

(3) Licensed practical nurses;

(4) Marriage and family therapists;

(5) Mental health counselors;

(6) Nurse practitioners;

(7) Nurse practitioners in psychiatry;

(8) Peer advocates;

(9) Permit holders;

(10) Physicians;

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

(12) Psychiatrists;

(13) Psychoanalysts;

(14) Psychologists;

(15) Registered professional nurses;

(16) Social workers;

(17) Students may be considered part of the clinical staff if participating in a program approved by the New York State Department of Education that leads to a degree or license in one of the clinic's professional disciplines.

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

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

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

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

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

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

§ 599.10 Treatment planning.

(a) Treatment planning is an ongoing process of assessing the mental health status and needs of the individual, establishing his or her treatment and rehabilitative goals, and determining what services can be provided by the clinic to assist the individual in accomplishing these goals. The treatment planning process includes, where appropriate, a means for determining when the individual's goals have been met to the extent possible in the context of the program, and planning for the appropriate discharge of the individual from the clinic. The treatment planning process is a means of reviewing and adjusting the services necessary to assist the individual in reaching the point where they can pursue life goals such as employment or education, without impediment resulting from their illness.

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

(1) the recipient's designated mental illness diagnosis;

(2) the recipient's needs and strengths;

(3) the recipient's treatment and rehabilitative goals and the specific services necessary to accomplish those goals;

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

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

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

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

(e) The treatment plan for recipients receiving services reimbursed by Medicaid on a fee-for-service basis shall be signed by the psychiatrist or physician.

(f) Recipient participation in treatment planning shall be documented by the signature of the recipient or, in the case of a child, of a parent or guardian, as well as the child where appropriate. Reasons for non-participation and/or non-approval by the recipient, parent or

guardian shall be documented in the case record. The recipient's family and/or collaterals may participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan.

(g) Treatment plans shall be completed not later than 30 days after admission, or for services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Department of Insurance, pursuant to such other plan requirement as shall apply.

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

(i) Treatment plans shall be reviewed and updated as necessary based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. Such reviews shall occur no less frequently than every 90 days, or the next scheduled service, whichever shall be later. For services provided to a recipient enrolled in a managed care plan which is certified by the Commissioner of the Department of Health or commercial insurance plan which is certified or approved by the Superintendent of the Department of Insurance, treatment plans may be reviewed pursuant to such other plan requirement as shall apply. Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate.

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

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

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

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

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

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

and the actions taken by the clinic in response to this need shall also be recorded in the progress notes.

§ 599.11 Case records.

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

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

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

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

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

(1) recipient identifying information and history;

(2) preadmission screening notes, as appropriate;

(3) admission note;

(4) diagnosis;

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

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

(7) the recipient’s treatment plan;

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

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

(10) periodic treatment plan reviews;

(11) dated and signed records of all medications prescribed;

(12) discharge plan, if applicable;

(13) referrals to other programs and services;

(14) consent forms;

(15) record of contacts with collaterals; and

(16) discharge summary, if applicable.

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

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

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

(f) Information in clinic case records may be shared between facilities, agencies and programs responsible for the provision of services pursuant to an approved local or unified services plan (including programs which receive funding from the Office disbursed via a State Aid letter); the Office, including any of the psychiatric centers and programs that it operates; and facilities, agencies, and programs which are not licensed by the Office and are not participants in an approved local or unified services plan, but which are responsible for the provision of services to any patient pursuant to a written agreement with the Office as a party.

§ 599.12 Premises.

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

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

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

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

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

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

(6) Program space shall be sufficient to ensure privacy and safety of the clients. Program and non-program space may be shared with other programs, pursuant to a plan approved by the Office.

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

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

§ 599.13 Medical assistance clinic reimbursement system.

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

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

(c) Providers will be categorized into peer groups pursuant to this section. The Office will establish a base fee for reimbursement for each peer group.

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

(e) Payments for procedures will be determined by multiplying the assigned weight for the appropriate procedure code set forth at 10 NYCRR Part 86 by the base fee, and

adjusting such fee for modifiers and discounts, as appropriate. When a modifier or discount is expressed as a percentage, it will adjust the payment by its percentage of the peer group base rate. When more than one modifier or discount applies to a procedure, they shall be summed before being applied to the base rate. When more than one procedure applies to a visit, the highest value procedure shall be paid at its full fee value. Payments for additional procedures related to the visit will be discounted by 10 percent.

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

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

(h) Providers licensed solely under Article 31 of the Mental Hygiene Law shall be classified by the following peer groups with the following base rates:

(1) Upstate: All non-Local Governmental Unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the upstate peer group: Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex. Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates counties. The base rate shall be $130.29.

The fee paid to new clinics, or clinics commencing service in a new county, shall be $89.15 for services provided up to and including December 31, 2010. For services provided on or after January 1, 2011 up to and including December 31, 2011, such fee shall be $96.35. For services provided on or after January 1, 2012 up to and including December 31, 2012, such fee shall be $103.55.

(2) Downstate: All non-Local Governmental Unit operated mental health clinics operating solely under an Office of Mental Health operating certificate and located in the following counties shall be considered to be included in the downstate peer group: Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties. The base rate shall be $141.62.

The fee paid to new clinics, or clinics commencing service in a new county, shall be $96.90 for services provided up to and including December 31, 2010. For services provided on or after January 1, 2011 up to and including December 31, 2011, such fee shall be $104.73. For services provided on or after January 1, 2012 up to and including December 31, 2012, such fee shall be $112.55.

(3) Local Governmental Unit-Operated: All mental health clinics operated by a local governmental unit which are operating solely under an operating certificate from the Office. The base rate shall be $181.28.

The fee paid to new clinics, or clinics commencing service in a new county, shall be $124.04 for services provided up to and including December 31, 2010. For services provided on or after January 1, 2011 up to and including December 31, 2011, such fee shall be $134.06. For services provided on or after January 1, 2012 up to and including December 31, 2012, such fee shall be $144.07.

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

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

(2) Upstate diagnostic and treatment center (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.

(3) Downstate hospital– All hospital-based mental health clinics in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester 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) D&TCs and hospitals – Where a corporation operates a hospital and a diagnostic and treatment center, OMH will determine the primary relationship between the mental health clinic and the hospital or diagnostic and treatment center and assign the clinic to the appropriate peer group.

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

(j) Supplemental Payments:

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

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

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

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

(k) System Transition. Except as noted in subparagraph (v) of paragraph (1) of this subdivision, there will be a transition to full procedure based reimbursement. During the transition, payment for select procedures will consist of a blended payment comprised of a legacy portion of the fees established under Part 588 and Part 592 of this Title and the procedure payment established under Part 599. For such procedures, the blended payment will be calculated as follows:

(1) For providers licensed solely under Article 31 of the Mental Hygiene Law:

(i) The Office will identify the amount of base Medical Assistance paid to the clinic pursuant to Part 588 of this Title.

(ii) The Office will identify supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for July 1, 2008 and June 30, 2009

(iii) For each provider, the Office will divide the sum of the reimbursement from subparagraphs (i) and ii) of this paragraph by the

number of Medicaid visits associated with the relevant provider group. The result will be the legacy component of the fee.

(iv) During the transition period, the Office will adjust the blend payment to account for the fact that select services indicated in the following table will not receive a blend payment. The Office will publish the adjustment methodology in the State Register and on its website.

(v) During the transition, the procedures indicated in the table following as Full Procedures shall be reimbursed at the full payment described in subdivision (e) of this section, subject to the discount for multiple procedures related to a visit.

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

(i) The Office will identify the amount of base Medical Assistance paid to the clinic pursuant to Part 588 of this Title.

(ii) The Office will identify supplemental payments pursuant to Part 592 of this Title for services delivered by the clinic for July 1, 2008 and June 30, 2009

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

Blend	Full Procedure Code	Office of Mental Health Service Name
	X	Complex Care Management
	X	Crisis Intervention Service - Per 15 minutes
	X	Crisis Intervention Service - Per Hour
	X	Crisis Intervention Service - Per Diem
	X	Developmental and Psychological Testing
	X	Psychotropic Medication Administration
	X	Psychotropic Medication Treatment - No Time Limit
X		Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development
X		Psychiatric Assessment - Minimum of 30 Minutes
X		Psychiatric Assessment - Minimum of 45 Minutes
X		Individual Psychotherapy - Minimum of 30 Minutes
X		Individual Psychotherapy - Minimum of 45 Minutes
X		Group and Multifamily/Collateral Group Psychotherapy - Minimum of 60 Minutes
X		Family Therapy/Collateral w/o patient - Minimum of 30 minutes
X		Family Therapy/Collateral with patient - Minimum of 60 minutes
	X	Outreach (outside visit)

(3) For providers licensed solely under Article 31 of the Mental Hygiene Law, for procedures paid as a blend, there will be a transition to a full procedure code based reimbursement system as follows:

(i) Year 1 (Services provided on or before December 31, 2010) – Providers will receive 75% of the legacy payment amount and 25% of the calculated value of the procedure related fee established in this section.

(ii) Year 2 (Services provided on or after January 1, 2011 up to and including December 31, 2011) - Providers will receive 50% of the legacy payment amount and 50% of the calculated value of the procedure related fee established in this section.

(iii) Year 3 (Services provided on or after January 1, 2012 up to and including December 31, 2012)- Providers will receive 25% of the legacy payment amount and 75% of the calculated value of the procedure related fee established in this section.

(iv) Year 4- For services provided on or after January 1, 2013, providers will receive 100% of the procedure fee payment.
(v) When more than one procedure fee applies to a visit, the applicable discount will be applied solely to the procedure fee component of the reimbursement for such visit.

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

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

(6) For programs licensed under Article 31 of the Mental Hygiene Law and operated by corporations operating programs licensed under Article 28 of the Public Health Law an additional capital payment per visit shall be determined by dividing all allowable capital costs for all Article 31 licensed programs operated by that corporation after deducting any exclusions, by the sum of the total number of visits to all of the Article 31 licensed programs operated by that corporation. For the capital payment that will be paid commencing with the implementation of this regulation, the total number of clinic visits in the denominator shall be the total number from the corporations annual report of visits reduced by the adjustment referred to in subdivision (j) of this section. Beginning with the third year of implementation of the procedure based reimbursement system, the capital payment calculation shall use the sum of visits, not procedures, reported by the corporation to the Department of Health.

§ 599.14 Medical assistance billing standards.

(a) Medicaid claims for individuals who have been admitted to a clinic program shall include, at a minimum, the Medicaid identification number of the recipient, the designated mental illness diagnosis, the procedure code or codes corresponding to the procedure or procedures provided, the location of the service, specifically the licensed location where the service was provided or the clinician's regular assigned licensed location from which the clinician departed for an "off-site" procedure, and the "NPI" or equivalent DOH-approved alternative as appropriate of the attending clinician. The provider must also document in the individual's service record compliance with the requirements associated with any procedure code being billed.

(b) Medicaid claims may be submitted for up to three pre-admission visits per adult recipient, no more than one of which may be a collateral visit. For children, claims may be submitted for up to three pre-admission visits. Each such visit may include an individual service, a collateral service, or both. Such claims shall include, at a minimum, the Medicaid identification number of the recipient, the designated mental illness diagnosis, the procedure code or codes corresponding to the procedure or procedures provided, the location of the service, specifically the licensed location where the service was provided or the clinician's regular assigned licensed location from which the clinician departed for an "off-site" procedure, and the "NPI" or equivalent DOH-approved alternative as appropriate of the attending clinician. For pre-admission visits at least the code for diagnosis-deferred must be entered on the claim.

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

(d) Billing services:

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

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

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

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

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

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

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

(ii) A Psychiatric Assessment may be provided to either an individual being assessed for admission to the clinic, or an individual who is currently admitted. Psychiatric Assessments may include such elements as a Diagnostic Interview and Treatment Plan Development.

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

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

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

(*d*) A Psychiatric Assessment may be provided off-site, but no off-site modifier is allowed and no additional Medical Assistance payment will be made.

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

(3) Psychiatric Consultation. Psychiatric Consultation may be provided by a psychiatrist or nurse practitioner in psychiatry to a referring physician for the

purposes of assisting in the diagnosis, integration of treatment, or assistance in ensuring continuity of care, for a patient of the referring physician. Psychiatric Consultation services must be face-to-face with the recipient, or through video tele-psychiatry, where available.

(i) Up to one on-site Psychiatric Consultation service to a recipient in a calendar year may be billed as Brief or Extended Psychiatric Assessment services, as appropriate.

(ii) Psychiatric Consultation services in excess of one for the same recipient shall be billed as Consultation. Payment for consultation services will be at the fee for physician visits regardless of the length of visit.

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

(4) Crisis Intervention.

(i) Clinics will be permitted to bill for individuals who have not engaged in services for a period of up to 2 years. The clinic may make contractual arrangements for after hours crisis coverage by clinicians but contracts for this service must be approved by the local governmental unit in which the clinic is located, or by the Office, as appropriate.

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

(*a*) Crisis Intervention- Brief. Brief Crisis Intervention Services may be done face to face or by telephone. For services of a duration of at least 15 minutes, one unit of service shall be billed. For services of a duration of one hour and 15 minutes or more, two units of service shall be billed. The maximum that can be billed for this service is two units per day.

(*b*) Crisis intervention – Complex. Complex Crisis Intervention require a minimum of one hour of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A skilled peer advocate, parent advisor, or non-licensed staff may substitute for one clinician.

(*c*) Crisis intervention – Per Diem. Per Diem Crisis Intervention require three hours or more of face-to-face contact by two or more clinicians. Both clinicians must be present for the majority of the duration of the total contact. A skilled peer advocate, parent advisor, or non-licensed staff may substitute for one clinician.

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

(6) Psychotropic Medication Treatment services are reimbursed for face-to-face contact of at least 15 minutes in duration between a physician or nurse practitioner in psychiatry and the recipient. Service can be provided off-site but no additional payment will be made.

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

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

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

(*b*) Extended Individual Psychotherapy Service requires documented face-to-face service with the recipient of a minimum duration of 45 minutes.

(8) Psychotherapy – Family/Collateral with the Recipient requires documented cumulative, continuous face-to-face service with the recipient and the collateral of a minimum duration of 60 minutes.

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

(10) Psychotherapy –Multi-Recipient Group requires documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum duration of 60 minutes

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

(12) Developmental Testing may be billed solely for individuals enrolled in the clinic. Developmental Testing services must be face-to-face with the recipient.

(13) Psychological Testing. Medical Assistance may be billed for this service only for individuals enrolled in the clinic. Psychological testing services must be face-to-face with the recipient.

(14) Complex Care Management must be provided within five working days of a face-to-face psychotherapy or crisis service. Only one complex care management visit can be billed following each face-to-face psychotherapy or crisis service. To bill Medical Assistance, this service requires at least 15 minutes of time, not including standard report writing or brief follow up calls.

(e) Modifiers:

(1) Billing modifiers, including modifiers paid as supplementary rates to visits, are available pursuant to this Section as indicated on the following chart. For adults, the off-site services modifier is available for an initial assessment to determine if the adult is "homebound", as clinically determined by a licensed clinician. Thereafter, the off-site modifier is only available for adults whose service record documents that they are homebound. For children, off-site services are available for all children. Their service record must document that the service is medically appropriate for an off-site service. Off-site modifiers are not available for any services provided by a physician or nurse practitioner in psychiatry.

Modifier Chart

Office of Mental Health Service Name	Offsite	After Hours	Language other than English	Physician/ NPP
Complex Care Management	x	x	X	
Crisis Intervention Service - Per 15 minutes	x	x	X	
Crisis Intervention Service - Per Hour		x	X	
Crisis Intervention Service - Per Diem		x	X	
Developmental and Psychological Testing		x	X	
Psychotropic Medication Administration		x	X	
Psychotropic Medication Treatment - No Time Limit		x	X	
Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development	x	x	X	x
Psychiatric Assessment - Minimum of 30 Minutes		x	X	
Psychiatric Assessment - Minimum of 45 Minutes		x	X	
Individual Psychotherapy - Minimum of 30 Minutes	x	x	X	x
Individual Psychotherapy - Minimum of 45 Minutes	x	x	X	x
Group and Multifamily/Collateral Group Psychotherapy - Minimum of 60 Minutes		x	X	x
Family Therapy/Collateral w/o patient - Minimum of 30 minutes	x	x	X	x
Family Therapy/Collateral with patient - Minimum of 60 minutes	x	x	X	x
Outreach (outside visit)	x	x	X	

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

(3) Clinics which provide offsite procedures to multiple recipients in the same location, including multiple apartments in the same building, the same school, the same residence, etc., on the same day shall only bill the offsite modifier for one of the services.

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

(5) For group therapy, a provider may only bill the Medical Assistance physician fee schedule once per group session and only when the group session is run by the physician.

(6) A payment for any visit including one or more procedures may be adjusted by the off-site modifier, or the language-other-than-English modifier, as appropriate, but not both.

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

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

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

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

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

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

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

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

(3) The provider of service shall be notified in writing of the Commissioner's

determination, including a statement of the reasons therefor.

(h) Billing rules for specialty clinics

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

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

§ 599.15 Indigent care.

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

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

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

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

(2) Required or optional mental health clinic procedures provided but NOT covered under a clinic's agreement with an insurer;

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

(4) Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member when the procedure is not reimbursed by a third party payer not in contract with the clinic.

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

allocation of funds pursuant to this section, the agency must demonstrate that a minimum of five percent of its total clinic visits meets these requirements. To be eligible, clinics must further demonstrate that they maintain a sliding fee scale for uninsured individuals.

(e) Documentation of uncompensated care need must be retained by the clinic and will be subject to an audit by the New York State Office of the Medicaid Inspector General or other party empowered to conduct such audits.

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

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

(h) Payments from the indigent care pool are made in accordance with the payment rules established by the Office and the Department of Health.

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

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

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