Part 599 Proposed Changes

August 2022

# Introduction

Changes to Title XIV Part 599 were proposed on July 12th, 2022. These changes encompass a switch from a clinic format for service delivery to the rehabilitation option.

The proposed changes would have significant effects on program policy, operations, as well as finance and billing procedures.

This introduction provides the overview of the nature of these changes, and the rest of the document lists each individual change and describes its implications for policy, operations, and billing.

Within the rehab option, states are meant to have more freedom to design behavioral health services than when using other options, such as clinic or outpatient.

These freedoms are reflected the 7/12/22 proposed changes, and include:

* Off-site services. A much wider variety of settings shall be permitted, including the client’s home
* Peer services. A variety of peer services shall be offered, and a variety of staff shall be eligible to deliver these services including non-licensed individuals
* Co-enrollment shall be permitted. An individual may be enrolled in your Mental Health Outreach Treatment and Rehabilitation program, simultaneously with another

Other changes proposed include:

* Ease of IOP inclusion
* Changes to service definitions, including a broader scope within some service definitions
* Lifting of limitation of services to clinical treatment only

This document is in a grid format for easy access to information. The specific changes are enumerated in rows, and the descriptions of each change are organized in sections, within columns that refer to the policy, operations, and billing implications of each one.

As more information is published, we will offer hands-on guidance on implementing Peer/Family Support Services and/or Off-Site services, as well as other trainings in other preparations for this change.

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| **ITEM** | **POLICY IMPACT** | **OPERATIONAL IMPACT** | **BILLING IMPACT** |
| **OVERARCHING CHANGES:** |  |  |  |
| 1. **Elimination of the use of the word “Clinic”:**   The word “clinic” shall no longer be used to refer to part 599 programs.  Going forward the term for the program shall be “Mental Health Outpatient Treatment and Rehabilitative Service” | No longer being called “Clinics”, 599 outpatient and rehabilitation programs will offer a wider variety of therapeutic services in addition to the existing clinic services. Some of the first items to consider are:  How the program shall be introduced within your outreach and marketing plans. You should determine all of the areas in which the changes shall be made in your literature.  How the program may now be more connected to other existing programs you have in terms of services provided, and therefore the program management policies may also change to fit this. | The operational impact is wide-reaching. The word clinic shall no longer be used to describe the program to clients or other providers. Training must be provided to staff to help them communicate the meaning of the new rehab program, and how it differs from the meaning of a “clinic”. | Remove the word clinic from all billing and EHR software. |
| 1. **Intent shift to “Preventing Progression”, rather than addressing symptoms and mental illness at earliest stages:**   Edit of para b and deletion of para e in the intent section, which refers to “the establishment and operation of programs that address the symptoms and adverse effects of mental illness at their earliest stages” | This change in language should be reflected in the policy and added to supervision and quality assurance procedures | In general, treatment shall not necessarily include prescriptions for all services, nor shall it include treatment plans that refer to goals of eliminating mental health issues. Rather, it may include acquisitions of skills and other personal routines that prevent progression.  The workflows that support these new rehab-oriented services shall be mapped out and a training provided to staff. | Billing systems shall include new service types and rates. Some are referred to in this document. |
| 1. **IOP Inclusion** | You will now only need an  Administrative Action (AA) to add IOP (Intensive Outpatient Services) to your license. You should discuss the needs in this area, and determine if your census could benefit. | This will simplify the setup of IOP, but may result in changes to your service delivery composition overall and possibly the census. Quality control metrics should be developed around IOP services delivery should you add IOP. | IOP will not be reduced by 25% for number of services over 30 - along with other services excluded from the 25% reduction. Also – restriction to provide no more than 3 per day (Medicaid) will not apply to IOP. |
| **NEW SERVICES AND STAFF:** |  |  |  |
| 1. **Addition of Off-site Services:**   It is the intent of OMH to expand a Mental Health  Outpatient Treatment and Rehabilitative Service program’s option to provide  off-site services. | A new procedure must be developed that reflects off-site versions of service descriptions, along with documentation, and supervision requirements for the off-site services.  This shall include:  Location appropriateness, requirements for documentation offsite with a mobile device  Safety policies and procedures for clients and staff. | In addition to the hiring that may be needed for peer support and offsite services, you may need revised staffing plans and budget projections to include travel time and other administrative tasks for the varying requirements. | For off-site services, Rate codes 1507/1519 shall still be used  Off-site shall be reimbursed at 150% of usual rate of service for all services  All of the Off-site versions of regular service rates should be setup in the billing system and tested  Any/All services can be provided off-site  Off-site services can be individual or group  Multiple services can be provided offsite in one day,  reimbursement regulations for 10% reduction apply  Off-site services shall be exempt from Utilization Threshold counts  For children, off-site services no longer limited to 1 per day |
| 1. **Addition of peer support services:**   It is the intent of OMH to expand a Mental Health  Outpatient Treatment and Rehabilitative Service program’s option to provide peer support services. | A new policy and procedure must be developed that reflects the new peer support service descriptions, along with documentation and supervision requirements for the new peer services.  The new *Peer and Family Peer Recovery Support Services shall include:*  Services for adults and children/youth,  including age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality.  Family Peer Recovery Support Services also include engagement, bridging support, parent skill development, and crisis support for families caring for a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community to promote recovery, self-advocacy, and the development of natural supports and community living skills. | There may be additional space required for peer services delivered on site, depending on the volume. Metrics should be developed for peer service quality assurance. | Peer/Family Support Services do not require OMH prior approval  Peer/Family Support Services do not need to be listed on your license  Pre-admission Peer/Family Support Services are NOT intended to be stand-alone Peer Services  Ongoing Peer/Family Support Services can only be provided to individuals who are enrolled in the clinic  Peer/Family Services can be provided as Individual/Family/Group  Peer/Family Support Services shall be exempt from Utilization Threshold counts  Expanded procedure code H0038 - Self-help/peer services  For services of a duration of at least 15 minutes, one unit of service shall be billed  For each additional service increment of at least 15 minutes, an additional unit of service may be billed.  *Applies to all billing;*  *No change has been proposed to APG Peer Group Base Rates*  *Rounding will follow CPT Federal minimum requirements* |
| 1. **Inclusion of paraprofessional staff and peer support staff** | Hiring procedures must reflect appropriate requirements for peer support staff and paraprofessionals, such as:  Identify as being actively in recovery from a mental health condition or major  life disruption and intentionally self-disclose their mental health recovery  journey  • Possess a certification from or are provisionally certified as a New York  Certified Peer Specialist by an OMH-approved Certified Peer Specialist certification program  This Includes - Certified Peer Specialists, Credentialed Family Peer Advocates, and Credentialed Youth Peer Advocates | Training specific to peer support and paraprofessional staff must be implemented.  New peer support staff must be supervised by professional staff as defined in 599.4  Please see:  http://nypeerspecialist.org/  https://www.academyofpeerservices.org | Peer staff to be added to the billing system will be:  YPA – Youth Peer Advocates  FPA – Family Peer Advocates  CRPA – Certified Recovery Peer Advocates  <https://oasas.ny.gov/system/files/documents/2019/08/PeerIntegrationToolKit-DigitalFinal.pdf> |
| **REVISED SERVICE DEFINITIONS:** |  |  |  |
| 1. **New Counseling service component definition added** | Counseling services are currently defined in the proposed changes as “the provision of assistance and guidance in resolving personal, social, or psychological problems and difficulties” | As more guidance is provided, this definition can be added as a service under peer counseling where applicable and should be reflected in the EHR. | Information regarding any new criteria for billing for counseling has not yet been made available |
| 1. **Changed Definition of Complex Care Management Services:**   This service shall no longer be described as an ancillary service to psychotherapy, psychotropic medication treatment, or crisis intervention | Complex care management shall be defined as: “provided as a time-limited intervention that shall restore functioning and address  the symptoms of mental illness, including skill-building to help individuals identify solutions to  problems that threaten recovery and care coordination services to help individuals connect with medical or other remedial services.” | Formerly, the service was described as follows: “an ancillary service to psychotherapy, psychotropic medication treatment, 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, psychotropic medication treatment, or crisis intervention service for the purpose of preventing a change in community status or as a response to complex conditions.”  This definition was struck, and the change in definition implies more freedom to determine when CCM is needed | Billing and modifier rules are the same.  Complex care management must be provided no later than within 14 calendar days following a face-to-face psychotherapy, psychotropic medication treatment, or crisis intervention mental health outpatient program service.  A maximum of four units of at least five consecutive minutes of complex care management may be billed following each face-to-face psychotherapy, psychotropic medication treatment, or crisis intervention service. Each full five-minute unit may be provided on separate days within the 14-calendar day limit, with a maximum of four full five-minute units associated with each eligible Mental Health Outpatient Treatment and Rehabilitative  Service program visit. The time spent documenting the provision of complex care management or in other documentation activities shall not be included in the service time. |
| 1. **Elimination of concurrent review** | Concurrent Review is currently defined in part 599 as – “the review of the clinical necessity for continued inpatient Behavioral  Health Services, resulting in a non-binding recommendation regarding the need for such continued  inpatient services.” This will be eliminated in MHOTRS programs | Clinical Necessity will no longer be officially used as a criteria for service provision, which may mean simpler and more streamlined service delivery operations. However, you should determine what aspects of concurrent review are useful to your quality control and therefore shall be maintained. | N/A at this time |
| 1. **Some Optional Services will still require prior approval, others will not** | Mental Health Outpatient Treatment and Rehabilitative  Service Programs may offer –  *with* prior approval by OMH:  Testing Services, including  Developmental Testing, Neurobehavioral Status Examination, and Psychological Testing.  *Without* prior approval by OMH:  Peer/Family Support Services; Health monitoring; Psychiatric  Consultation | Ensure that staff are trained accordingly. | Add Peer Support services to billing system as per this document. |
| 1. **Elimination of current definition of Crisis Intervention – and expansion of the definition** | The definition proposed is expanded to include –  Crisis response, which includes strategies to de-escalate potentially harmful situations, and  Crisis planning, which includes rehabilitative skill development to support management of potential / actual mental health crises, and crises planning and prevention services | Procedures must be devised that outline these two additional, allowable components to crisis intervention, and training must be delivered in these two components.  Furthermore, Your EHR may need to be updated to allow for documentation of these 2 components so that they can tie to the treatment plan (if applicable) and drop to billing. | No billing changes required at this time, though they may be forthcoming. |
| 1. **Requirement to establish mechanisms to ensure priority access for individuals receiving ACT and transitioning** | Your policies must reflect mechanisms to ensure priority access for individuals receiving ACT and transitioning, for continuity of care for such individuals, including the provision of appropriate services and medications, including injectable medications. | Procedures to ensure that the team that works with individuals with SMI coming from ACT programs follows steps for working with the ACT program to transfer those individuals to the Mental Health Outpatient Treatment and Rehabilitative Service Program. | N/A at this time |
| 1. **Initial assessment definition has been edited** | Previous definition: “Initial assessment means a face-to-face interaction between a clinician and recipient and/or  collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate  mental health diagnosis, and the development of a treatment plan for such recipient.]” is edited.  The new definition is as follows:  “initial assessment Services shall include performance or consideration, as applicable, of the  Health Screening” | Staff must be trained in telehealth - face-to-face initial assessments are no longer required.  Telehealth policies and procedures must be devised, along with trainings. | Billing system can submit face to face as well as telehealth versions of the Initial Assessment (health screening) services. |
| 1. **Injectable psychotropic medication administration can be with or without monitoring and education** | This definition is streamlined, and now states only that psychotropic medication can be administered with or without monitoring and education, rather than as two separate service definitions. With monitoring and education, it includes individual education related to the use of the medication, as necessary. | Staff must be trained to ensure this is clear | No billing changes required at this time. |
| 1. **Assistive Language Services must be provided** | Language assistance services must be provided at no cost to the Individual and/or collaterals and all necessary documents shall be made available in the recipient’s preferred language.  Your policy must outline who shall provide these services, whether you will hire a consulting translation services, and who you will ensure availability of these services at all times | Staff should be made aware that these services will be available and to offer them to clients. Staff must clearly mark in the recipient’s treatment plan and case record that language assistance Is necessary for the client | There shall be no cost for language assistance services |
| **OTHER REVISED WORKFLOWS:** |  |  |  |
| 1. **NPP may now sign treatment plans for Medicaid FFS** | NPP has been added as authorized signer of treatment plans for Medicaid FFS clients | This functionality must be added to EHR, and staff should be informed that this is now allowed. | Update billing system to clearly indicate type of provider who may sign / has signed to include NPP |
| 1. **New options for co-enrollment** | Co-enrollment across mental health programs now easier. It must be clear in the p and p that this will be permitted, so referrals with an existing enrollment elsewhere will not be denied enrollment at your clinic | Both MHOTRS programs shall formally enroll the individual in their program.  Your Clinic must collaborate with the other around treatment, and this must be documented.  Each program must have its own treatment plan for the individual, and each shall address specific and distinct treatment goals. There must be coordination of care around this, added to the procedures staff are trained on. | Reimbursement cannot be made to more than one program for the same service on the same *date* of service.  Therefore, billing coordination must be organized between you and other programs / organizations with whom co-enrollment may occur. |
| **NEW POLICY REQUIREMENTS AND OTHER COMPLIANCE IMPLICATIONS:** |  |  |  |
| 1. **Policy on Efforts to Reduce Disparities**   **Required** | You must devise policies and procedures that outline the steps you will take to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved and/or marginalized populations,  including but not limited to: people of color, members of the LBGTQ+ community, older adults, pregnant persons, Veterans, individuals who are hearing impaired, individuals with limited English proficiency, immigrants, individuals with intellectual/developmental disabilities and all justice system-involved populations. | When policies have been determined, the implementation of the procedures that support them must include all staff. Staff should be asked to contribute to ideas for how to reduce disparities in access and care. Staff input should be included and documented in the procedures.  Trainings in these new procedures should be given to all staff.  Quality control metrics should be developed to monitor consistency and progress in this area. | N/A |
| 1. **Personnel Policies prohibiting discrimination required** | You must devise personnel policies which shall prohibit discrimination on the basis of race or ethnicity, religion, disability, gender identity or sexual orientation, marital status, age, documentation status, or national origin, as well as, written policies on affirmative action which are consistent with the affirmative action and equal employment opportunity obligations imposed by title VII of the Civil Rights Act, Federal Executive Order 11246, the Rehabilitation Act of 1973,  section 504, as amended, and the Vietnam Era Veteran's Readjustment Act. | Documented procedures for non-discriminatory policies around hiring and service delivery should be followed, and staff should be trained in such procedures.  Regular Quality control practices, as referred to above, should be followed for maintaining compliance with the policy and procedures. | N/A |
| 1. **Policies are required that outline the performance of overall criminal history reviews along with SCR checks** | Policies outlining the performance of Criminal history information reviews are now required  pursuant to Section 31.35 of the Mental Hygiene Law, Sections 424-a and 495 of the Social  Services Law, and 14 NYCRR 550.  Such reviews shall be conducted in accordance with such laws and regulations and any guidance issued by the Office. All prospective employees,  contractors and volunteers who have the potential for, or may be permitted, regular and  substantial unsupervised or unrestricted contact with Recipients shall submit to a criminal history information review. All staff with the potential for regular and substantial contact with Recipients in performance of their duties shall submit to clearance by the New York Statewide Central Register of Child Abuse and Maltreatment. Mental Health Outpatient Treatment and  Rehabilitative Service program Staff who have not been screened by the New York Statewide  Central Register of Child Abuse and Maltreatment shall not perform duties requiring contact with  individuals unless there is another staff member present. | Ensure that the HR department has access to all appropriate documentation for the reviews, and that a regular, documented procedure is followed. | N/A |
| 1. **Policies covering the delivery of Off-Site Services Required** | Offsite service delivery policies concerning types and parameters of service delivery offsite and in clients’ homes must be devised.  In addition, offsite services will require HR policies around the responsibilities of the staff and the organization with regard to safety, emergency preparedness, confidentiality, transportation, and other areas that will need new procedures when not on premises. | Trainings in procedures for service delivery in various locations alongside safety and confidentiality and documentation trainings must be given to all staff before providing off-site services.  Time and location tracking mechanisms should be put in place (often offered within the EHR system) for accuracy as well as safety purposes | The billing department must also have trainings in implementing the offsite service types in the billing system, and how to perform appropriate review and QA. For example, |
| 1. **Policies to address personal safety of staff and provide appropriate training in de-escalation techniques are required** | The personal safety policies shall be devised to cover all situations in which services may be delivered, either on or off-site, with individuals or with groups. They shall also cover personal safety during all working hours, whether in transit to service or otherwise in between services.  The personal safety policies shall cover procedures for how you will handle all areas of potential vulnerability, including physical threats from clients or others, the s safety of the physical plant, outside threats, airborne threats, or natural disasters.  De-escalation policies shall refer to reliable, generally accepted techniques for de-escalation. | All staff – including administrative and management staff - shall participate in trainings in these two areas. They must be offered at least once a year to ensure that everyone can attend.  De-escalation trainings must also be attended by all staff. Often, these are one day or several days long trainings in a specific technique. You should determine which technique will work best for your staff, and work with a training consultant to provide the training. | N/A |
| 1. **More frequent / more stringent audits are possible** | Agencies should develop internal quality control procedures and “mock audit” procedures that will test and ensure compliance to the wider variety of services permitted under the rehab option. | Quality control and supervision must be enhanced to include discussion around the nuances of the new services permitted, and what strategies can be used to ensure that services are delivered within acceptable parameters that promote the well-being of the individual, and prevent the progression of mental | Internal billing audits should be performed with a focus on revenue cycle management compliance concerning all changes to services outlined in this document. If possible, a third party should be engaged to perform an internal billing audit. |