



14 NYCRR Part 599

Mental Health Outpatient Treatment and Rehabilitative Service Guidance

Issued July 2023

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

Programs operated by hospitals, including psychiatric centers operated by the State, or hospitals licensed pursuant to article 31 of the mental hygiene law or article 28 of the public health law, which are Medicare certified and provide outpatient services reimbursed by Medicare, shall ensure services are provided consistent with applicable Medicare certification and coverage standards and policies, in addition to any other requirement contained in this Part.



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I. Part 599 Mental Health Outpatient Treatment and Rehabilitative Service (MHOTRS) Program Regulations Introduction

On November 23, 2022, the New York State Office of Mental Health (OMH) revised 14 NYCRR Part 599 regulations. The revised regulations reflect the transition of OMH's Clinic Treatment Services from the Medicaid State Plan Clinic option to the Rehabilitative Services option, which enables additional flexibility in service delivery. As part of this transition, OMH has changed the program name to Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS). Programs will not be required to change their program name.

The revised regulations promote several state policy objectives, including:

- The addition of Peer Support Services that promote recovery, resilience, and are person-centered and rehabilitative in nature.
- The implementation and inclusion of Peer Support Services.
- Flexibility for programs to provide quality, evidence-based services in off-site locations and via multiple modalities in the same day.

These regulations are augmented by the “OMH MHOTRS Standards of Care Anchor Elements,” (“Standards of Care”), available at [Standards of Care \(ny.gov\)](https://www.omh.ny.gov/standards-of-care), which provide additional context for the provision of high-quality services.

II. Purpose of this Guidance

It is the intent of OMH that the goals described in the regulations be achieved through the establishment and operation of programs that address the symptoms and adverse effects of mental illness at their earliest stages, to avoid mental health crises where possible, and to respond in a timely and effective manner to such crises when they occur. It is the intent of OMH to establish the MHOTRS program to provide a person/family centered, recovery oriented and individualized approach to care. Providers should utilize high quality and evidence-based practices and other practices which are supported by scientific research or generally accepted clinical practice guidelines to maximize individuals' abilities; to minimize symptoms, adverse effects, and impacts of mental illness; to maintain and promote the individuals' integration into the community; to support family integrity; and to provide ongoing support to individuals receiving services and their relevant collaterals.

Over the past several years, OMH worked with stakeholders wherein we gathered recommendations from providers on how to improve clinic practices. Additionally, the [OMH MHOTRS webpage](#) provides several program and fiscal projection tools, as well as separate billing-related guidance.

Nonetheless, OMH recognizes that the Part 599 MHOTRS regulations are complex, and the field would benefit from a guidance manual. This guidance document is designed to provide an overview of program requirements for the various MHOTRS components and the program

services, as well as guidance on how these services can be used to better meet the needs of individuals.

III. Who is covered by the Regulations?

14 NYCRR Part 599 applies to all Article 31 MHOTRS programs that are currently licensed by OMH. Additionally, these regulations apply to providers seeking to operate MHOTRS programs licensed either solely by OMH or jointly by OMH, Office of Addiction Supports and Services (OASAS), and the Department of Health (DOH). They also apply to hospital outpatient departments and non-hospital based DOH-licensed diagnostic and treatment centers (D&TC) which meet one of the following conditions:

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

Non-OMH licensed programs providing mental health services should seek consultation with the appropriate OMH Field Office to review the need for an OMH license when the volume of mental health services approaches the threshold limits.

IV. Required and Optional Services in the MHOTRS Programs

Required and Optional Services

Section 599.8 of the regulations establishes eight MHOTRS program services that must be available and offered as needed at any primary MHOTRS program licensed by OMH. While not required to be available at every satellite location that is licensed by OMH, all required services must be available to anyone enrolled in a MHOTRS program. Further, MHOTRS programs can choose to provide additional optional services which are meant to enhance the array of services offered. Certain optional services may be provided without obtaining additional approval from OMH.

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| Required Services: |
| Assessment, including Health Screening |
| Psychiatric Assessment |
| Crisis Intervention Services |
| Psychotropic Medication Treatment |
| Injectable Psychotropic Medication Administration (for programs serving adults) |



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| Injectable Psychotropic Medication Administration with Monitoring and Education (for programs serving adults) |
| Psychotherapy, including Individual, Group, Family/Collateral |
| Complex Care Management |
| Optional Services Without OMH Approval: |
| Peer Support Services |
| Health Monitoring, including Smoking Cessation |
| Health Physical |
| Injectable Psychotropic Medication Administration (for programs serving only children) |
| Injectable Psychotropic Medication Administration with Monitoring and Education (for programs serving only children) |
| Psychiatric Consultation |
| Optional Services with OMH Approval: |
| Testing Services <ul style="list-style-type: none">• Developmental Testing• Psychological Testing• Neurobehavioral Status Examination |
| Intensive Outpatient Program (IOP) |

As listed above, MHOTRS programs are required to provide Assessment, Psychiatric Assessment, Crisis Intervention Services, Injectable Psychotropic Medication Administration for programs serving adults (with or without monitoring and education), Psychotropic medication treatment, Psychotherapy (Individual, Group, Family/Collateral), and Complex Care Management.

Additionally, MHOTRS programs are encouraged to offer the optional services, including Peer Support Services, Health Monitoring, Health Physical, Injectable Psychotropic Medication Administration for programs serving only children (with or without monitoring and education), and Psychiatric Consultation. Licensed MHOTRS programs may implement these optional services without OMH approval.

Offering the full complement of required and optional services will help improve engagement and access to care. Additionally, services such as Health Monitoring and Health Physical services will help promote the integration of mental and physical health services via a

coordinated interdisciplinary framework to improve behavioral health outcomes for individuals and families.

Some MHOTRS program services are optional but still require OMH approval through an Administrative Action (AA). These include Intensive Outpatient Program (IOP) services, and the following Testing Services: Developmental Testing, Psychological Testing, and Neurobehavioral Status Examination.

MHOTRS programs may seek OMH approval to provide optional services requiring approval by completing the “Part 599 Mental Health Outpatient Treatment and Rehabilitative Services Regulation” Administrative Action form on OMH’s web-based application, the Mental Health Provider Data Exchange (MHPD). Information regarding the MHPD page and the above referenced regulations can be found on the [OMH MHPD Webpage](#). Following submission, and OMH support of the Administrative Action, OMH will issue a revised MHOTRS operating certificate specifying the optional services provided at that location pursuant to Part 599.

Required services must be available at all primary MHOTRS sites but not at each satellite site. Individuals who would benefit from a required service or procedure not available at a satellite location, must be offered those services at the primary MHOTRS site. Optional services can be offered at any site, including primary or satellite sites of the MHOTRS program.

Off-Site Services

Off-site services are services delivered based on individual need in a wide variety of settings other than the MHOTRS program’s primary or satellite locations. Off-site services are performed in locations in the community or in the individual’s place of residence. The setting in which a service is provided must be determined by the individual’s needs and goals documented in the individual’s record. Billing is restricted in some settings, which should be confirmed with the applicable payor. Off-site service availability is intended to enable MHOTRS programs to support person/family-centered clinical goals including transition between levels of care (e.g., after Comprehensive Psychiatric Emergency Program (CPEP)/Emergency Room (ER) visit or inpatient discharge), improve engagement in treatment, and provide services to individuals who are unable to take advantage of site-based services due to clinical or medical factors.

Off-site settings should be conducive to meeting treatment goals, objectives, and interventions, be accommodating to the conditions and needs of those being served, safe and accessible for all, and assure privacy for the delivery of services. All services, including required and optional services, can be provided off-site. This includes Peer Support Services and pre-admission services.

The requirement for a satellite license for locations in which services are provided on a regular and routine basis is still in place for all MHOTRS programs. The ability to provide off-site

services does not replace the need for OMH-approved satellite sites, including school-based satellite sites.

When services are provided off-site, the progress note should reflect that the service was provided off-site and the location in which the service was provided. If the provision of services off-site is identified as an ongoing need, it should be added to the individual's treatment plan to address the goals/objectives identified by the individual. If off-site services are provided on an ad hoc basis or for impromptu need, it does not need to be added to the treatment plan but should be documented in the progress note.

The provider will use clinical discretion to determine when it may be beneficial to the individual to receive services in the community. Such determinations should be made deliberately and jointly between the clinical team and the individual and their families or social supports. MHOTRS programs should have clear clinical practice guidelines and policies and procedures outlining processes for decision-making regarding off-site services that will best meet the needs of each individual. Applicable policies and procedures should outline processes to identify measures to promote individual and staff safety and mitigate potential safety risks during the provision of off-site services.

There are no restrictions on how many services may be provided as off-site services or which types of services may be provided off-site. Off-site services do not count towards the utilization thresholds for outpatient mental health service providers.

Billing for off-site services must be for in-person service delivery in the community. If the MHOTRS practitioner provides telehealth services to a patient who is at home and the practitioner is in another location, these do not count as "off-site" services and the MHOTRS program cannot bill the off-site modifier for the procedure. See Telehealth Guidance <https://omh.ny.gov/omhweb/telehealth/> for more details on providing services via telehealth.

For residents of a Skilled Nursing Facility (SNF): if the SNF provider has psychiatric services included as part of their services in their all-inclusive rate, then MHOTRS programs may provide services to residents of that facility but would be reimbursed by the SNF for the services. If the SNF does not have psychiatric services included, a MHOTRS program could provide those services and bill Medicaid. It will be necessary for the MHOTRS to communicate with the SNF to determine if psychiatric services are already provided, or if the MHOTRS could provide that service. MHOTRS providers should communicate and collaborate with the SNF medical providers if the MHOTRS program provides the psychiatric services for Nursing Home residents.

Co-Enrollment



To promote greater flexibility and service access, co-enrollment in multiple programs is permitted for individuals enrolled in MHOTRS programs. Co-enrollment is expected to be informed and guided by individual choice; be clinically indicated with distinct and separate objectives; and, inclusive of coordination and collaboration between service providers.

At the onset of program admission and throughout the treatment episode, information should be collected to understand what, if any, additional programs or services the individual/family are enrolled in. Coordination of care and consultation are critical aspects of co-enrollment not just with other MHOTRS programs, but with additional programming as well. Documentation should reflect occurrences of co-enrollment including, the agency(ies) and program(s) in which the individual is enrolled, the goals and objectives of the co-enrolled program treatment plan, and record of coordination between program staff. Monitoring instances of co-enrollment aid with avoiding service duplication and maximizing program outcomes through a coordinated approach to care.

Co-Enrollment between two MHOTRS Programs

If an individual is enrolled in a MHOTRS program but would benefit from a specialty service not provided at that MHOTRS program, it is possible to arrange for the receipt of that specialty service from another MHOTRS program. Co-enrollment allows reimbursement for services provided to an individual by two MHOTRS programs, including preadmission visits. However, reimbursement will not be made to more than one program for the same service on the same date of service.

MHOTRS programs should consider the following:

- Co-enrollment in two MHOTRS programs should be an exception to the rule, not a standard.
- Each MHOTRS program must have its own treatment plan.
- Two MHOTRS programs can provide different services to an individual on the same day, but they should not provide the same service on the same day.
- MHOTRS programs cannot use co-enrollment at another MHOTRS program to substitute for required services at their own program.

To avoid service and intervention duplication and maximize program coordination, MHOTRS programs should maintain records of co-enrollment and update accordingly to reflect progress. See Section VII Documentation for more information.

Please Note: Developmental Testing, Neurobehavioral Status Examination, and Psychological Testing are optional services that can only be provided to individuals admitted to the MHOTRS program. Co-enrollment is an option to meet this need when a program does not offer testing services. Additionally, co-enrollment for the sole purpose of receiving Peer Support Services is



not permissible. Peer Support Services must be integrated into the provision of other MHOTRS program services, and as such, may not be provided as a standalone service in a MHOTRS program which is not the individual’s primary MHOTRS provider.

Co-Enrollment between MHOTRS Programs and other Program Types

| Service Name | Service Combination with MHOTRS |
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| Assertive Community Treatment (ACT) Including Adult, Young Adult and Youth ACT | Limited Allowance |
| Children and Family Treatment and Support Services (CFTSS): <ul style="list-style-type: none"> • Other Licensed Practitioner (OLP) • Community Psychiatric Supports and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Family Peer Support (FPS) Youth Peer Support (YPS) | Limited Allowance |
| Community Oriented Recovery and Empowerment (CORE) Services: <ul style="list-style-type: none"> • Community Psychiatric Support and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Family Support and Training (FST) Empowerment Services – Peer Support | Allowable (see guidance below specific to CPST and Peer) |
| Continuing Day Treatment (CDT) | Limited Allowance |
| Crisis Services <ul style="list-style-type: none"> • Mobile Crisis Intervention • Crisis Stabilization Crisis Residences: Intensive Crisis Residence (ICR), Residential Crisis Support (RCS), Children’s Crisis Residence | Allowable |
| OASAS Outpatient Addiction Rehabilitation Services | Allowable |
| Partial Hospitalization | Not Allowable |

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| Personalized Recovery Oriented Services (PROS) with Clinic, only when the individual is receiving clinic services from the PROS | Not Allowable |
| PROS without Clinic | Allowable |

The following guidance is specific to allowable service combinations:

Assertive Community Treatment (ACT)

MHOTRS programs can provide and bill for pre-admission services while the individual is transitioning from an ACT team (Adult, Young Adult and Youth ACT) to MHOTRS. Once admitted to the MHOTRS program, the ACT team should discharge the individual.

Note, when an individual is discharged from ACT to another service provider within the team's primary service area or county, there is a three (3) month transfer period during which the individual may voluntarily return to the ACT program if they do not adjust well to their new program or level of service. During this period, the ACT team is expected to maintain contact with the new provider and review with that MHOTRS program whether the individual should be considered for return to the ACT team and discharge from MHOTRS.

Children and Family Treatment and Support Services (CFTSS)

For information specific to Other Licensed Practitioner (OLP) and MHOTRS co-enrollment, refer to applicable guidance [OMH Clinic and OLP \(ny.gov\)](https://www.omh.ny.gov/omh/clinic-and-olp). An individual cannot receive the same peer service through CFTSS and MHOTRS, except for pre-admission services. However, once the individual is admitted, they can no longer continue to receive the same service from both programs.

Community Oriented Recovery and Empowerment (CORE) Services

CORE Community Psychiatric Support and Treatment (CPST) provides therapeutic interventions such as clinical counseling and therapy, in the community, which assist the individual in achieving stability and functional improvement. These services may look similar to MHOTRS, however not all services provided at a MHOTRS program are available through CORE CPST. Enrollees may not access duplicative services through CORE CPST and a MHOTRS program in a single month.

For Example:

- Individuals may access a psychiatric prescriber (e.g., psychiatric assessment/evaluation, medication management, health monitoring) if the CORE CPST provider does not have a prescriber.



- Individuals cannot receive psychotherapy through a MHOTRS program and CORE CPST, as it is duplicative. Medication management and supporting activities through a MHOTRS program is duplicative if the CORE CPST provider has a prescriber on staff.
- Transition from CORE CPST to a MHOTRS program (including CCBHC), allowing for a warm handoff during the clinic pre-admission process (three sessions).

The CPST provider should maintain communication with the prescriber to ensure integrated treatment/care.

MHOTRS programs should not be providing ongoing peer support services if the individual is also enrolled in CORE Peer Support services. Pre-admission MHOTRS Peer Support Services are allowable.

Continuing Day Treatment (CDT)

Individuals admitted to a CDT program can also be admitted to a MHOTRS program for the sole purpose of clozapine medication therapy. Reimbursement to the MHOTRS program for these individuals is limited to five services per month per individual. See [Part 587 Regs and 588 Billing Regs](#) for the specific exceptions on concurrent enrollment in MHOTRS programs and CDT.

Personalized Recovery Oriented Services (PROS)

Individuals who are enrolled in the Clinic Treatment component of PROS may not be co-enrolled in MHOTRS programs. Care Managers and others who are coordinating care should be aware that there are two types of PROS Programs: PROS with Clinic and PROS without Clinic. Some individuals attend a PROS with Clinic and choose not to participate in the clinic treatment component. To verify whether an individual is enrolled in Clinic Treatment at a PROS, you can check their Medicaid RRE Codes in eMedNY/ePaces; RE Code 84 indicates that an individual *is enrolled* in Clinic Treatment in PROS.

Substance Use Disorder (SUD) Treatment/OASAS Licensed Outpatient Programs

Individuals who are diagnosed with a co-occurring substance use disorder can receive services at a MHOTRS program and at an OASAS licensed SUD outpatient treatment program simultaneously. This is not considered co-enrollment. OMH expects the providers in the MHOTRS program to communicate and collaborate with OASAS treatment providers.

Clinical Services Contract

A Clinical Services Contract allows a MHOTRS program to contract out for services not provided within their program. This differs from co-enrollment in that the Clinical Services Contract provider provides a service as an extension of the MHOTRS program in which the individual is admitted.

V. Service Definitions and Guidance

This section contains definitions of each MHOTRS program service, as well as guidance regarding how services are to be provided:

Assessment/Screening and Health Screening

Definition: Assessment/Screening are services conducted through evaluation and information gathering of an individual's current psychiatric, physical and behavioral health condition(s) and history for the purpose of establishing a diagnosis and determining appropriate services to meet their needs. Assessments include health screenings and physicals to determine the need for and referral to additional physical health services. Assessments also include interactions with an individual's collateral supports to obtain necessary information for the benefit of the treatment planning for the individual.

A **Health Screening** means the initial gathering and assessment of information concerning the individuals' medical history and current physical health status (including physical examination and determination of substance use) for purposes of informing an assessment and determination of its potential impact on an individual's mental health diagnosis and treatment, and the need for additional health services or referral.

Guidance: Initial assessment information collected is used to determine admission and treatment needs at the MHOTRS program (or other disposition). The initial assessment must be completed within 30 days of admission and should not delay access to other services needed. Assessment services may be provided both before and after an individual is admitted to the MHOTRS program.

The assessment process should include gathering psychosocial information and screenings for co-occurring disorders, risk of self-harm or harm to others, and tobacco use. The assessment process should also include obtaining and reviewing the result of a health screening either performed by the program or outside of the program. Health screening documentation may be provided by the individual or it can be obtained from other sources, such as the individual's primary care provider, where appropriate. Health information obtained should be reviewed by a psychiatrist, nurse practitioner in psychiatry (NPP), or other appropriately licensed health care professional and such review should be documented in the individual's record.

A single clinician who is appropriately licensed and trained should oversee the assessment process.

Please refer to the [Standards of Care \(ny.gov\)](https://www.ny.gov/standards-of-care) for detailed guidance on what should be contained in a quality assessment.

Psychiatric Assessment

Definition: A psychiatric assessment is an interview with an adult, child, or their family member/other collateral, performed by a physician, psychiatrist, or nurse practitioner in psychiatry (NPP). With OMH approval, a Physician's Assistant (PA) with a current Certificate of

Added Qualifications (CAQ) in psychiatry from the National Commission of Certification of Physician Assistants (NCCPA) or with an equivalent training, experience, and certification in psychiatry, and who is supervised by a psychiatrist may also perform a psychiatric assessment. Psychiatric assessments may include such elements as a diagnostic interview and treatment plan development. Psychiatric Assessments may be performed for the purposes of diagnosis, treatment planning, medication or other therapy, or consideration of general health issues.

Guidance: A psychiatric assessment may occur at any time during the course of treatment, including prior to admission and there is no limit on the number of medically necessary psychiatric assessments that may be provided. Psychiatric assessments may also be used for the purposes of initiating buprenorphine treatment for co-occurring opioid use disorder.

Please note, that while the Medicaid fee-for-service reimbursement amounts are identical, a psychiatric assessment is provided to an individual who has been or is being considered for admission to the MHOTRS program and a psychiatric consultation is provided to an individual not currently admitted to the MHOTRS program upon the request of another provider. MHOTRS programs that provide psychiatric consultations must prepare and transmit a report to the referring provider.

Crisis Intervention, including crisis response, and crisis planning

Definition: Crisis intervention refers to services, including medication and verbal therapy, which are designed to address acute distress and associated behaviors and rehabilitate individuals who are experiencing or who are at risk of experiencing acute mental health crises and to avoid the need for emergency or inpatient psychiatric hospital services. Crisis intervention services include:

- Crisis response services, which are services to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention; and
- Crisis planning services, which are rehabilitative skills training services to assist individuals to effectively avoid or respond to mental health crises by identifying triggers that risk their remaining in the community or that result in functional impairments.

Crisis intervention services assist the individual or family members, or other collaterals as necessary for the benefit of the individual, with identifying a potential psychiatric or personal crisis, developing a crisis management or safety plan, or as appropriate, seeking other supports to restore stability and functioning.

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

Crisis planning services consist of preparing an individual, or their family or collateral supports, to handle potential crises. This can include identifying supports and their role during crises, identifying coping skills and strategies to utilize, planning for increased contact with supports or providers during times of higher intensity of symptoms, or how to access emergency services if

needed. Crisis planning can be provided with the individual present, or with collateral contacts without the individual present.

All MHOTRS programs are required to provide 24 hours a day/7 days per week availability of crisis services for individuals admitted to their program. OMH does not expect MHOTRS programs to operate as community-wide crisis hotlines or provide mobile crisis services. Every MHOTRS program must have a plan for providing crisis services and after-hours coverage, which must be approved by the Local Governmental Unit (LGU). In the case of county providers, this plan must be approved by OMH.

The plan must demonstrate the ability to accommodate crisis intakes and walk-ins during normal business hours. The after-hours crisis response plan must provide for individuals or their collaterals to contact a licensed professional or professional under the supervision of a licensed professional. The primary clinician for the individual contacting after-hours crisis, must be contacted the next business day with any updates or information provided from the after-hours services. Additionally, the MHOTRS program must ensure that the after-hours contact procedure is explained to all individuals and their collaterals, where appropriate, during the intake process.

After-hours services may be provided in person or by phone. They may be provided directly by the MHOTRS program or pursuant to a Clinical Services Contract. The contracting option allows MHOTRS programs to pool resources in ways that may make more sense, depending on the community's circumstances. If a program contracts for after-hours services, the contract must provide for transmitting information about after-hours calls to the MHOTRS program by the next business day.

Psychotropic Medication Treatment

Definition: Psychotropic medication treatment means using pharmacologic agents to treat underlying psychiatric illness, monitoring and evaluating target symptom response, ordering and reviewing laboratory and diagnostic studies, prescribing medications, and psychoeducation as appropriate.

Guidance: This service must be provided by a psychiatrist or nurse practitioner in psychiatry (NPP). With OMH approval, a Physician's Assistant (PA) with a current Certificate of Added Qualifications (CAQ) in psychiatry from the National Commission of Certification of Physician Assistants (NCCPA) or with equivalent training, experience, and certification in psychiatry, and supervised by a psychiatrist may provide Psychotropic medication treatment services. Pharmacological treatment of addiction disorders, including tobacco use disorder, alcohol use disorder, and opioid use disorder is highly recommended in MHOTRS programs for individuals with co-occurring conditions. This includes FDA-approved medications such as varenicline or nicotine replacement therapy (NRT) for tobacco use disorder and buprenorphine for opioid use disorder. Abnormal Involuntary Movement Scale (AIMS) testing or equivalent is conducted on a regular basis for individuals taking psychotropic medications with a known potential side effect



of tardive dyskinesia (TD) or other extra-pyramidal symptoms (EPS) and for all individuals with a diagnosis of TD regardless of current medication regimen. Metabolic monitoring is conducted regularly for individuals taking medications that increase risk of metabolic syndrome.

Psychotropic medication treatment may also result in the identification of a need for Complex Care Management.

Injectable Psychotropic Medication Administration, with or without Monitoring and Education (required for MHOTRS programs serving adults, optional for children)

Definition: Injectable psychotropic medication administration is the process of preparing and administering the injection of intramuscular psychotropic medications. Monitoring and Education includes consumer education related to the use of the medication.

Guidance: Injectable Psychotropic Medication Administration is a required service for MHOTRS programs serving adults. Injectable medications (IMs) include long-acting intramuscular naltrexone and other long-acting medications for co-occurring substance use disorders. Individuals on IMs, including individuals discharged from a hospital setting on IMs, who are referred to a MHOTRS program, should not be refused services. This service must be provided by an appropriate medical staff person.

This service is optional for MHOTRS programs serving only children (youth under 18 years old). However, it is advisable that if a MHOTRS program serving only children does not offer these services, it maintains a plan for ensuring that children who need IMs are referred to a provider that can administer them. This could be achieved through co-enrollment if there is a need to maintain connection with other services within the program that does not provide this service.

Psychotherapy

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

Guidance: Psychotherapy services should include evidence-based interventions offered by appropriately trained staff. All therapeutic approaches must be trauma-informed and embrace cultural competence/humility. Psychotherapeutic interventions should be person-centered, focused on achieving individual goals, and promote community integration.

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

Psychotherapy services may be provided in three types in MHOTRS programs:

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

Please refer to the [Medicaid Billing and Fiscal Guidance](#) for Medicaid billing requirements for psychotherapy.

Clinical staff can and should integrate treatment for Tobacco Use Disorder into clinical treatment services for individuals who have identified this need in their treatment plan. Clinic staff may provide treatment for Tobacco Use Disorder as a part of individual or group clinical treatment billed as a psychotherapy service. Please see [Billing Guidance for Tobacco Use Disorder in Clinic Settings](#).

Complex Care Management (CCM)

Definition: Complex Care Management (CCM) means time-limited interventions to 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. It is provided by MHOTRS professional staff or paraprofessional staff under supervision of professional staff, in person or by telephone, with or without the individual. It is a clinical service which may be necessary as a follow up to psychotherapy, psychotropic medication treatment or crisis services for the purpose of preventing a change in community status or as a response to complex conditions.

Guidance: CCM is not a stand-alone service. It is a non-routine service to coordinate care. CCM should be provided to address immediate mental health issues or factors that are impacting on the individual's health or community status. It must be provided as an ancillary service and subsequent to a psychotherapy, psychotropic medication treatment or crisis service. The progress note for the service and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the individual's mental health status, the need for services and the persons contacted. For Medicaid fee-for-service and Medicaid Managed Care (MMC) reimbursement, CCM services must be provided within 14 calendar days following the provision of an eligible MHOTRS service.

CCM does not include required and routine paperwork, or required and routine follow-up, or the completion of SPOA or housing applications, referrals, writing letters to obtain benefits or entitlements, activities related to a practitioner's role as a mandated reporter, or time spent documenting services provided.

CCM services are provided by professional staff or paraprofessional staff under supervision of professional staff. CCM services may be provided by staff other than the staff who provided a psychotherapy, psychotropic medication treatment or crisis service. However, if CCM services are performed by different staff, the activities must be coordinated with the primary clinician and documented in the progress note.

The need for CCM can be driven by a variety of situations. Examples of such situations include, but are not limited to:

- Collaboration:

- Communication conducted between treating practitioners and other service providers to facilitate collaborative care for complex behavioral health needs. For instance, a psychiatrist communicating with a Primary Care Physician (PCP) regarding increased medical symptoms which previously had been in remission or under control, after starting a new psychotropic medication.
- Collaboration among cross-system agencies, organizations and other entities including, school, employment, court/juvenile justice/AOT, prevention/child welfare, etc. to facilitate an organized and coordinated approach to care. For instance, attending an AOT related meeting or court appearances regarding the individual's needs as it relates to their treatment; or communicating with the child's school to develop a specific plan of action to address any social, emotional, or behavioral issues that might be threatening the youth's educational status including efforts to maintain the youth in their current educational program or the exploration of alternative education programming that might better serve the youth's needs.
- Service Coordination:
 - Coordination of services and supports including the attendance and/or convening of multidisciplinary team meeting(s) to address elevated risk to self or others, multiple hospitalizations. For instance, convening a meeting held between an individual's service providers to re-evaluate and refine the individual's crisis plan to better address the behaviors resulting in frequent presentation to emergency or other crisis services.
- Service and Support Connection
 - Providing education and referral/linkage to needed supports and services to meet the comprehensive needs of individuals/families including facilitating connection to supports addressing social determinants of health. For instance, communicating with an individual's landlord who is threatening eviction to negotiate a specific plan of action between the individual, collaterals (if applicable), and the landlord to address the behavioral issues that threaten their housing.

Youth, Family, Adult, and Older Adult Peer Support Services

Definition: Peer Support Services are services for adults, children/youth, and families including age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, advocacy, and facilitating community connections and crisis support to reduce symptomology and restore functionality. Peer 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.



Guidance: Peer Support Services must be performed by a New York Certified Peer Specialist (NYCPS), Credentialed Family Peer Advocate (FPA-C), or Credentialed Youth Peer Advocate (YPA-C). Each certification pathway offers a provisional credential to enable staff to begin service provision while seeking full credentialing. Any professional staff as defined in 599.4 are eligible to supervise peer specialists/advocates, however, recovery values and principles should be embedded in the supervision practice. The supervisor should promote the core concepts of Peer Support Services and trauma-informed approaches to care. In addition to professional staff supervision, agencies should, when possible, provide peer specialists/advocates with access to in-discipline supervision, mentoring and support from experienced peer specialists/advocates. Connections with other peer service providers should be encouraged, either within their organization or in collaboration with local agencies or through contracting with peer-run agencies. See [Peer Support Service Guidance](#) for additional details.

When Peer Support Services are provided on the same day as any other Medicaid billable services (mental health or otherwise), the Peer Support Service may be provided before or after the other service, but not during. It may be appropriate for the Peer Specialist/Advocate to accompany an individual or family member to an appointment as a support, in alignment with the definition and scope of Peer Support Services; however, the Peer Support Service cannot be provided at the same time as another Medicaid billable service.

It is possible that individuals admitted to MHOTRS programs are already receiving peer support services, such as Children and Family Treatment and Support Services (CFTSS) Family Peer Support or Youth Peer Support, or Community Oriented Recovery and Empowerment (CORE) Services – Peer Support (referred to as “CORE Peer Support”). An individual may simultaneously receive CFTSS Family Peer Support or Youth Peer Support or CORE Empowerment Services - Peer Support and MHOTRS pre-admission Peer Support. However, once the individual is admitted to a MHOTRS program, they can no longer continue to receive the same service from both programs.

MHOTRS programs serving adults may contact the individual’s Medicaid Managed Care Plan (MMCP) to verify whether an individual is receiving CORE Peer Support Services. Note that CORE Services are only available to individuals who are Health and Recovery Plan (HARP)-eligible and who are enrolled in a HARP, HIV Special Needs Plan (HIV SNP), or Medicaid Advantage Plus (MAP) Plan. Additional information on CORE Services can be found on the [CORE Overview](#) webpage.

MHOTRS programs serving children may verify whether children or their families are receiving CFTSS Family Peer Support or Youth Peer Support Services. Note that these services may be provided to both Medicaid fee-for-service, Medicaid Managed Care, and Child Health Plus beneficiaries. Additional information on CFTSS can be found on the [Behavioral Health Managed Care Children’s Health and Behavioral Health System Transformation](#) webpage.



The [Peer Support Services Technical Assistance Center](#) (PeerTAC) delivers training, technical assistance and consultation to mental health organizations serving people across the lifespan including children, youth, families, and adults/older adults living with mental health conditions. Their focus is on the expansion of Peer Support Services within mental health organizations.

Please Note: “Peer Support Services” is an umbrella term to encompass the various types of peer services including, youth peer, family peer and adult/older adult peer support services. It is possible for an individual to receive one type of peer service via a MHOTRS program while receiving a different type through other programming. It is important that MHOTRS programs identify the type of Peer Support Service rendered via progress note to ensure duplication of service does not occur.

As the MHOTRS peer workforce develops service access may initially be limited. Therefore, MHOTRS programs may consider referring individuals to CFTSS/CORE Services to meet the individual's needs. For a list of designated providers, please visit:

- For CFTSS: [Children and Family Treatment and Support Services/Home and Community Based Services](#) site map webpage.
- For CORE: [CORE Provider Application and Designation](#) webpage.
- See MHOTRS [Peer Support Services Guidance](#) for additional information. for additional information.

Health Monitoring, including Tobacco Use Disorder

Definition: Health monitoring means diagnostic and therapeutic services for preventive medicine counseling and risk factor reduction interventions. These interventions are intended to address conditions and lifestyle factors associated with increased risk of medical illness and early death, including but not limited to blood pressure, metabolic syndrome, diet and exercise, alcohol, tobacco and other drug use, sexual practices, injury prevention, and dental health, diagnostic and laboratory test results available at the time of the encounter. These interventions are also intended to address issues related to social determinants of health including but not limited to food insecurity, housing instability, poverty, and exposure to violence.

Health monitoring includes obtaining documentation of, or conducting, a **health physical**. A health physical means the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures, as appropriate.

Guidance: Upon admission, the MHOTRS program should gather information concerning the individual's medical history and current physical health status. Health information is reviewed by a physician, NPP, NP, RN, or PA who documents review of health information, potential impact on mental health diagnosis and treatment, and any need for additional health services or referrals. Any medical hospitalizations are reviewed, and issues are incorporated into mental health treatment where appropriate. This service must be provided by a physician, nurse or



other medical professional acting within their scope of practice. Section 599.6 requires that a provider have policies and procedures for age-appropriate health monitoring, which describe whether such monitoring will be performed by the provider or, if not, how the provider will seek to ascertain relevant health information. Such policies and procedures must include a requirement that an individual's refusal to provide access to such information be documented in the case record.

Health Monitoring Services must include screening for HIV and hepatitis C¹ because these conditions are under-identified in individuals with mental illness, treatments have excellent prognosis, and lack of treatment lead to catastrophic consequences.

Smoking Cessation Treatment (Tobacco Use Disorder Treatment)

Definition: Smoking cessation treatment (individual or group) is counseling that complements the use of prescription and non-prescription smoking cessation products. These products are also covered by Medicaid. Smoking cessation treatment is a health monitoring service for both adults and children.

Guidance: To bill the smoking cessation rate code, this service must be provided face to face by a physician, physician assistant, nurse practitioner, or registered nurse.

However, all clinical staff can and should integrate treatment for Tobacco Use Disorder into clinical treatment services for individuals who have identified this need in their treatment plan. MHOTRS program staff may provide treatment for Tobacco Use Disorder as a part of individual or group clinical treatment billed as a psychotherapy service. If smoking cessation counseling is part of a psychotherapy session (group or individual), the time spent on smoking cessation can be counted toward the duration of the psychotherapy session but cannot be billed as an additional smoking cessation session. Clinical staff that provide treatment for Tobacco Use Disorder as a part of a MHOTRS treatment service such as individual or group psychotherapy must do so within their scope of practice and under appropriate supervisory oversight. Psychiatrists, physician assistants, and nurse practitioners may also provide treatment for Tobacco Use Disorder as part of a psychiatric assessment or psychotropic medication treatment service.

¹ The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adolescents and adults ages 15 to 65 years for HIV infection. The Center for Disease Control (CDC) recommends screenings for hepatitis C virus between the ages of 18 and 79 years. In both cases, younger adolescents and older adults who are at increased risk should also be screened.

Psychiatric Consultation

Definition: Psychiatric consultation means an evaluation of an individual by a physician, nurse practitioner of psychiatry, or physician's assistant², including the preparation, evaluation, report or interaction between the practitioner and a referring practitioner for the purposes of diagnosis, integration of treatment and continuity of care.

Guidance: This service is intended to support primary care doctors and other community providers external to the MHOTRS program in their treatment of individuals with mental illness. Consultation services can support:

- The treatment of mental illness in primary care settings; or
- The transition from MHOTRS based mental health care to primary care mental health treatment.

A written report must be provided by the consulting physician or nurse practitioner to the referring physician. A copy of the report and other documentation produced during the consultation must be kept by the MHOTRS program in its own medical record. Psychiatric consultation services must be either in person or through audio-visual telehealth with the individual.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Definition: SBIRT is an evidence-based assessment, counseling, and referral service which provides: (1) screening to identify individuals exhibiting or who are at risk of substance use-related problems; (2) early intervention, including counseling and skills restoration services to modify risky consumption patterns and behaviors; and (3) referral to appropriate services for individuals who need more extensive, specialized treatment to address such substance consumption patterns and behaviors.

Guidance: Licensed practitioners must complete an OASAS-approved SBIRT training of at least four hours; however, if the licensed practitioner holds certification as indicated in [OASAS Table 1 or 2](#), then the training is recommended, but not required. Health educators and unlicensed practitioners must complete at least 12 hours of training facilitated by an OASAS approved SBIRT training provider prior to offering SBIRT services. [Further details on SBIRT.](#)

Developmental Testing

Definition: Developmental testing means diagnostic services including the administration, interpretation, and reporting of screening and assessment instruments for children or

² Physician's Assistant (PA) with a current Certificate of Added Qualifications (CAQ) in psychiatry from the National Commission of Certification of Physician Assistants (NCCPA) or with an equivalent training, experience, and certification in psychiatry, and who is supervised by a psychiatrist.

adolescents to assist in the determination of the individual's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes.

Guidance: Developmental testing must be provided by a physician or other qualified health care professional and may only be offered to individuals admitted to the MHOTRS program. Developmental testing services must be in-person or by audio-visual with the individual; audio-only services are not allowed.

Psychological Testing

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

Guidance: Psychological testing must be provided by a physician or other qualified health care professional and can only be provided to individuals admitted to the MHOTRS program. Psychological testing must be in-person or by audio-visual with the individual; audio-only services are not allowed.

See MHOTRS Billing Guidance for more information specific to Psychological Testing including Evaluation, Administration and Scoring, and Neurobehavioral Status Examination.

Neurobehavioral Status Examination

Definition: Neurobehavioral Status Examination is a clinical assessment of thinking, reasoning and judgment, including attention, language, memory, problem solving and visual spatial abilities and interpretation of the results for treatment planning.

Guidance: Neurobehavioral Status Examinations must be provided by a physician or other qualified health care professional and can only be provided to individuals admitted to the MHOTRS program. Neurobehavioral Status Examination must be in-person or by audio-visual with the individual, audio-only is not allowed.

Intensive Outpatient Program (IOP)

Definition: Intensive Outpatient Programs are MHOTRS programs approved to provide additional and intensive outpatient program services to individuals who may benefit from more intensive treatment for a limited time.

Guidance: MHOTRS-Based Intensive Outpatient Program Services are MHOTRS program services provided at an intensive level, exceeding the typical frequency of MHOTRS program services with specific allowances related to daily billing and Medicaid thresholds. Providers must obtain OMH approval to implement IOP through the submission of an Administrative Action.

IOP provides additional options and increased continuity of care to individuals. The individual who participates in IOP services may experience less disruption to their community life than if they sought treatment from Comprehensive Psychiatric Emergency Room (CPEP), Partial



Hospitalization Program (PHP), or inpatient psychiatric hospitalization. The individual may continue to participate in services in their current MHOTRS program at a more intensive level, rather than seek IOP treatment at another agency. This may improve clinical outcomes as a result of improving continuity of care (e.g., removing the referral barrier for individuals unsure about changing programs temporarily, removing barriers to collaboration between MHOTRS programs and IOP clinicians). However, programs providing IOP services should also accept referrals from other MHOTRS programs as well.

Guidance specific to the provision of Intensive Outpatient services may be found here:

[MHOTRS-Based Intensive Outpatient Program Guidance](#)

VI. Operational Requirements

Staffing (14 NYCRR Section 599.9)

MHOTRS programs are expected to employ and designate an adequate number of licensed staff who, by their training and experience, are qualified to provide programmatic direction and clinical supervision to members of the treatment team, as appropriate to the individuals' credentials and experience. All staff and lines of supervisory responsibility should be identified in the staffing plan maintained by the MHOTRS program. When unlicensed staff is providing clinical services, it is especially critical that regular and appropriate supervision is provided and documented. Additionally, supervisory arrangements which will assist these staff to meet licensure eligibility requirements should be considered. It is recommended that direct service staff receive a minimum of one hour of clinical supervision for every 40 hours of service provision.

It is a provider's responsibility to ensure that all services are provided by staff within their scopes of practice, level of competence, and under supervision, which is commensurate with their training, experience, and skills.

Professional staff means practitioners possessing a license or a limited permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness.

Student interns are allowed to perform services within their scope of practice, in accordance with requirements of their approved educational programs. Some staff may be eligible to perform certain activities under legal exemptions, including under the grandparenting provision. Please refer to Office of the Professions (nysed.gov) for additional information.



Certified Peer Specialists, Credentialed Family Peer Advocates, and Credentialed Youth Peer Advocates are qualified by personal experience and should be certified or provisionally certified. See MHOTRS [Peer Support Services Guidance](#) for additional information.

Peer Specialists/Advocates who hold a credential from a certifying authority recognized by the Commissioner of the Office of Addiction Services and Supports (Certified Recovery Peer Advocate) are eligible to work in MHOTRS programs provided they qualify for and obtain provisional OMH Peer Certification or Credentialing within 12 months of being hired. It is expected that, within a reasonable amount of time, they will then complete their full OMH Peer Certification or Credential work experience hours post provisional certification/credentialing.

Psychiatrist Definition

OMH recently amended 14 NYCRR Section 599.4 to define a psychiatrist as an individual who is currently licensed or possesses a permit to practice medicine in New York State and to remove the requirement for psychiatrists to be Board Certified.

A psychiatrist is a physician who completed an ACGME-accredited general adult psychiatry residency. A child psychiatrist is a physician who completed an ACGME-accredited fellowship program in child and adolescent psychiatry.

Medical Director

MHOTRS programs should include the role of a medical director to lead their clinical operations. A medical director is a vital position to ensure the quality of care, providing guidance regarding clinical service delivery, providing clinical consultation, training and supervision, and involvement in case reviews. The medical director may be an employee or be contracted by the facility. The medical director may provide services on a full- or part-time basis and should have sufficient training, experience, and administrative ability to effectively carry out their responsibilities. These include supervision of the medical staff and reporting to the governing body. The medical director should also be responsible for development and implementation of policies and procedures related to individuals' care, medical staff and clinical privileges.

Students

MHOTRS programs may use students if they are in a New York State Education Department (NYSED) approved program leading to a license allowable in OMH licensed MHOTRS programs. A plan for the use of students must be included as part of the MHOTRS programs' OMH approved staffing plan. Appropriate procedures performed by students working in this capacity are reimbursable by Medicaid.



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

- Substitution of another physician for a psychiatrist; or
- Use of a Physician's Assistant (PA) with a current Certificate of Added Qualifications (CAQ) in psychiatry from the National Commission of Certification of Physician Assistants (NCCPA) or with an equivalent training, experience, and certification in psychiatry, and who is supervised by a psychiatrist.

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

Policies and Procedures

14 NYCRR Section 599.6 requires MHOTRS programs to develop programmatic and administrative policies and procedures to ensure services are addressing the needs of individuals in our communities and meeting compliance with State and Federal requirements. The following list serves as a summary of the policies and procedures and is not comprehensive (see 14 NYCRR Section 599.6 for the full requirements and further details):

- Criteria for admission and discharge from the program
- Conducting initial and ongoing risk assessments
- Engagement and retention in treatment
- Off-Site Services
- Emergency preparedness and response including an evacuation plan and safety of staff in the community (providing off-site services)
- Personal safety of staff and training in de-escalation techniques
- Age-appropriate health monitoring, which describe whether such monitoring will be performed by the provider or, if not, how the provider will seek to ascertain relevant health information
- Ensuring reasonable efforts to obtain records from prior episodes of treatment
- Ensuring that reasonable efforts are made to communicate with family members, current service providers, and other collaterals, as appropriate
- Ascertaining whether individuals are currently receiving or are eligible to receive Medicare or Medicaid or other form of reimbursement for services provided, and if not, include means of facilitating the enrollment of such individual in such program
- Concerning the prescription and administration of medication 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



- Governing an individual's records which ensure confidentiality consistent with sections 33.13 and 33.16 of the Mental Hygiene Law and 45 CFR parts 160 and 164, and which provide for appropriate retention of such records
- Describing an individual grievance process which ensures the timely review and resolution of individual complaints, and which provides a process enabling individuals to request review by OMH when resolution is not satisfactory
- Written personnel policies which guide efforts to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved and/or marginalized populations
- Written personnel policies which prohibit discrimination
- Written policies for the availability of crisis intervention services at all times
- Written policies for the performance of criminal history information reviews
- Written policies regarding the selection, supervision, and conduct of students accepted for training
- Written policies regarding the employment, supervision and privileging of nurse practitioners and physician assistants
- Written policies which shall establish that contracts with third party contractors that are not subject to the criminal history background check requirements include reasonable due diligence requirements to ensure that any persons performing services under such contract that will have regular and substantial unsupervised or unrestricted contact with individuals served in the program do not have a criminal history that could represent a threat to the health, safety, or welfare of the individuals served
- 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

Updates Needed in Policies and Procedures:

Diversity, Equity and Inclusion Policies

MHOTRS programs must have written policies which guide efforts 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.

MHOTRS programs must have written 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.

Availability of Crisis Intervention Services

MHOTRS programs must have written policies for the availability of crisis intervention services at all times.

After-hours coverage should:

- At a minimum, have the ability to provide brief crisis intervention services.
- The plan for after-hours crisis services should be approved by the LGU or OMH.
- These services should be provided either directly or pursuant to a Clinical Services Contract.
- A Clinical Services Contract should include, at a minimum, provisions assuring that, in the event of a crisis, the nature of the crisis and any measures taken to address such crisis are communicated to the primary clinician or other designated clinician involved in the individual's treatment at the MHOTRS program, or the individual's primary care or other mental health care provider, if known, on the next business day.
- At the request of the LGU, State-operated MHOTRS programs should consult with the LGU(s) in their service area in the development of such MHOTRS program's crisis response plan.

Assisted Outpatient Treatment (AOT) and Assertive Community Treatment (ACT)

MHOTRS programs must establish mechanisms to ensure priority access for individuals receiving Assisted Outpatient Treatment (AOT) or Assertive Community Treatment (ACT) (Adult, Young Adult and Youth ACT) and transitioning, for continuity of care for such individuals, including the provision of appropriate services and medications, including injectable medications.

AOT

AOT, also known as "Kendra's Law", establishes a procedure for obtaining court orders for persons with Serious Mental Illness who also meet a high level of eligibility criteria including treatment disengagement. The intent of AOT is to prevent repetitive hospitalizations and help persons living with Serious Mental Illness remain successful in the community while keeping the community safe. Kendra's Law also gives priority access to services that are included in the court-ordered treatment plans.

The county Director of Community Services (DCS) is responsible for oversight and ensuring the individual is receiving services identified in the AOT treatment plan. To this effect, providers should prioritize persons under AOT orders for MHOTRS program services due to an established history of need and disengagement. MHOTRS programs must develop policies and



procedures to prioritize individuals with AOT orders for the intake and admission process. These policies should include:

- Cooperation with the LGU or the Commissioner, or their authorized representatives, in ensuring priority access by individuals with AOT, and in the development, review and implementation of treatment plans for such individuals.
- Prior to discharge of an individual who is also enrolled in an AOT program, the provider must notify the individual's case manager and the director of the AOT program for the county.
- Providers must give priority attention to respond without delay to the request for any and all related information, reports, and data that may be requested by the Commissioner or the LGU.

ACT

ACT (Adult, Young Adult, and Youth) is an intensive level of service, which includes treatment, case management, and rehabilitation by a multi-disciplinary team. ACT is not intended to be long-term, instead it is meant as a higher level of service with a goal for step down to less intensive service provision.

ACT is delivered using the Transitional Care Framework, which has three (3) overlapping dimensions. The third dimension in this framework is transition of care toward recovery and community integration and inclusion. ACT teams engage in an active process of linkage, tryouts, and transfer of care with an emphasis on warm handoffs. The ACT team is responsible for identifying existing and new supports that will be firmly in place to support the individual during the transition and beyond.

MHOTRS programs must develop program policies and procedures that prioritize individuals for admission who are transitioning from ACT services and participate in the warm handoff process to engage the individual. Program policies must establish mechanisms to ensure priority access for continuity of care, including the provision of appropriate services and medications, including injectable medications if needed.

Utilization Review

MHOTRS programs must have a written utilization review policy and procedure to ensure that all individuals are receiving appropriate services and are being served at an appropriate level of care.

The policy and procedure developed by the agency shall ensure that utilization review is performed, at a minimum, on 10% of all cases, including the following reviews:

- Appropriateness of admission reviews for individuals admitted within 30 days of the date the program performs utilization review;



- Appropriateness of continued treatment reviews for individuals admitted within seven (7) months of the date the program performs utilization review; and
- Appropriateness of continued treatment reviews for individuals who have been admitted seven (7) months or longer prior to the date the program performs utilization review, including individuals receiving psychotropic medication treatment and medication education services only.

The utilization review process shall ensure utilization review functions are performed randomly, by identified professional staff, and independently of the clinical staff treating the individual under review.

The MHOTRS program must also have policies and procedures in place to ensure all individuals are receiving appropriate services. These policies shall include:

- Supervisory review of appropriateness of services and level of care, as needed; and
- Regular and routine case reviews, including a process to determine individuals in need of such case reviews (e.g., high risk, length of stay) and who should participate in the case review, which shall include physician or nurse practitioner.



VII. Documentation

Case Records (14 NYCRR Section 599.11)

Individuals' records are not only an adjunct to good clinical care; they are a fundamental and integral part of care and are often the focus of both the Office of the Medicaid Inspector General (OMIG) and the Office of the Inspector General (OIG) audits. The following components are required elements of the clinical case record:

- Individual identifying information and history
- Preadmission screening notes, as appropriate
- Admission note
- Diagnosis
- Assessment of the individual's goals regarding psychiatric, physical, social, and/or psychiatric rehabilitation needs
- Reports of all mental and physical diagnostic exams, mental health assessments, screenings, tests, and consultations, including risk assessments, health monitoring, health screenings, and evaluative reports concerning co-occurring developmental, medical, alcohol/substance use, or educational issues performed by the program
- The individual's treatment plan
- Dated progress notes which relate to goals and objectives of treatment
- Dated progress notes which relate to significant events and/or untoward incidents
- Periodic treatment plan reviews
- Dated and signed records of all medications prescribed by the MHOTRS program, as well as a record of other prescription medications being used by the individual. A failure to include such other prescription medications in the record shall not constitute non-compliance with this requirement if the individual refuses to disclose such information and such refusal is documented in the case record
- Discharge plan
- Referrals to other programs and services
- Consent forms
- Record of contacts with collaterals, if applicable; and
- Discharge summary within three business days of discharge.

Assessments

Assessment documentation should be comprehensive, including evaluation of history and current status, needs, goals and desires. There are key elements that should be included in assessment documentation, including but not limited to:

- Individual's reasons for seeking services
- Individual and family's current strengths, supports, and stressors



- Mental status
- Physical health – review of medical history, health screenings including tobacco use screening
- History of mental health services
- Traumatic experiences
- Perception of own risks and safety
- Risk assessment for self-harm and harm to others
- Legal and/or forensic involvement
- Family, significant others, social functioning, finances, housing
- Education, employment, and other community roles
- Literacy needs; and
- Screening for co-occurring disorders
- Additionally, for children:
 - Developmental history
 - Assessment of academic achievement, school performance, and social issues; and
 - Child Protective Services (CPS) involvement, foster care, placements, contact with abuser(s), and/or domestic violence.

Assessments should result in a clinical formulation and recommendations which inform the treatment plan. Diagnosis must be performed by appropriate staff within their scope of practice, per NYSED requirements. Other professional staff may assist with forming diagnostic impressions.

Treatment Planning (14 NYCRR Section 599.10)

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

Treatment planning is:

- required for every individual
- developed with the individual, family, collaterals and supports, as appropriate
- responsive to cultural and linguistic needs
- reflective of needs identified during assessment
- reflective of the individual’s/family’s preferences and priorities; and
- signed by the clinician.



An individual's participation in the treatment planning process shall be documented. The rationale for deferring any needs identified during assessment are documented. The plan shows evidence (e.g., language, written comments, etc.) of being co-authored by the individual as well as by the family/collaterals/supports, as appropriate. For children, the involvement of caregivers in the development of the plan is clearly evident.

Programs shall develop a policy which indicates the location of treatment plan related documentation and the mechanism for identifying it within the case record/Electronic Health Record (EHR).

MHOTRS programs are expected to develop and implement clear protocols to advise workflow when making a targeted adjustment to the treatment plan. These protocols should account for and promote a coordinated multidisciplinary team approach in accordance with regulation and this guidance.

Treatment planning is not a "moment in time" activity; it is an ongoing process. Changes are made in real time. However, certain regulatory standards in the regulations must be met for treatment planning documentation.

The Initial Treatment Plan

The Initial Treatment Plan must be completed 30 calendar days from the admission date unless the services are covered by a third-party payer with a different requirement.

The Initial Treatment Plan shall include documentation of the following:

- the designated mental illness diagnosis or a notation that the diagnosis may be found in a specific assessment document in the individual's case record
- the individual's needs
- the individual's treatment goals and objectives
- the name and title of the individual's primary clinician in the program, and identification of the types of personnel who will be furnishing services
- the recommended and agreed upon MHOTRS treatment and the projected frequency and duration for each service
- where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status; and
- the signature of the clinician.

For individuals who are Medicaid fee-for-service beneficiaries, Initial Treatment Plans shall be signed by a psychiatrist, Nurse Practitioner of Psychiatry (NPP), or other physician.

However, Medicaid Managed Care (MMC) or Commercial Insurance Initial Treatment Plan signature requirements depend on whether medications are prescribed:

- psychiatrist, other physician, or NPP if medication is prescribed

- psychiatrist, other physician, licensed psychologist, NPP, LCSW, or other licensed practitioner (LMHC, LMFT, LCAT) if no medication is prescribed.

The Treatment Plan Review

Treatment Plan reviews must be completed no less than annually after admission, or from the most recently completed Treatment Plan Review thereafter, unless the services are covered by a third-party payer with a different requirement. In such circumstance, this requirement can be modified to reflect the requirements of the third-party payer.

Treatment Plan reviews may be performed more frequently, as determined by the primary clinician and the individual/family.

The Treatment Plan is also reviewed when there are significant clinical changes (e.g., behavioral or medical diagnosis/condition, risk level, increased/new symptoms, functioning, stressors, needs, circumstances, etc.). Treatment Plan reviews must include the following:

- an assessment of the progress or lack thereof of the individual toward the mutually agreed upon goal(s) and objective(s);
- adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate
- evidence of the individual's input, and where appropriate, the family's/collateral's/support's input on progress. For children there is evidence of individual/caregiver/family input
- determination of continued homebound status, where appropriate; and
- signature of the clinician.

The Treatment Plan Update

Treatment Plan updates are required when, based on a Treatment Plan review or other routine assessment, either

- new services are added to the Treatment Plan; or
- service intensity (frequency and/or duration) is increased for services currently included in the Treatment Plan.

For individuals who are Medicaid fee-for-service beneficiaries, Treatment Plan updates shall be signed by a psychiatrist, NPP, or other physician.

For Medicaid Managed Care (MMC) or Commercial Insurance enrollees, Treatment Plan update signature requirements depend on whether medications are prescribed, as follows:

- psychiatrist, other physician, or NPP if medication is prescribed
- psychiatrist, other physician, licensed psychologist, NPP, LCSW, or other licensed practitioner if no medication is prescribed.

Please consult other payors such as Medicare, Medicaid Managed Care, and other Commercial Insurance to verify treatment planning requirements.



All Other Treatment Plan Changes

All other changes to information in the treatment plan (goals, objectives, interventions, time periods required for achievement and staff), based on Treatment Plan review or other routine assessment, shall only require the clinician's signature and may be recorded in progress notes. Programs shall develop a policy which indicates the location of treatment plan related documentation and the mechanism for identifying it within the case record/Electronic Health Record (EHR).

Progress Notes (14 NYCRR Section 599.10)

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

- the service provided
- the date of service
- the duration of service
- location of service
- modality (individual, family group, etc.) and method (in-person, telehealth – audio or audio/visual)
- names of participants
- the goals and objectives that were addressed and progress made
- interventions that were discussed/provided and individual's response; and
- need for CCM, if applicable.

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

When a psychiatrist, physician practicing in lieu of a psychiatrist with approval by OMH, or NPP spends at least 15 minutes participating in the provision of services being provided by another practitioner or when the service is provided fully by a psychiatrist, other physician, or NPP, each psychiatrist, other physician, or NPP must document separately in each individual's case record with documentation specific to the individual receiving the service. The psychiatrist, physician, or NPP who provided the service must sign their documentation. This allows for additional billing for this practitioner's involvement. See the [Medicaid Billing and Fiscal Guidance](#) for additional information on MD/NPP modifiers.

Collaborative Documentation/Concurrent Record Keeping

Commonly, practitioners will utilize collaborative documentation while in session by ensuring progress notes are contemporaneously completed while also enabling a mutual understanding

between the practitioner and client regarding the activities that occurred during the session including, information shared, interventions that occurred, and next steps.

Concurrent documentation is a strategy that can be learned and applied in a relatively short period of time. Essentially, “concurrent documentation” means that a provider works with an individual during assessment, service planning and intervention sessions to complete as much related documentation as appropriate. Practitioners are encouraged to adopt collaborative documentation practices, when appropriate, for assessments, treatment plans, and progress notes to promote engagement and a person-centered approach to care.

VIII. Premises (14 NYCRR Section 599.12)

The regulations contain several requirements for MHOTRS program facilities. Part 599 allows a MHOTRS program to share space (both program space and non-program space) with other programs. Program space may be shared pursuant to a plan approved by OMH. For example, a MHOTRS program may wish to share space with a substance use disorder treatment or medical program. Plans would need to be submitted to the appropriate OMH Field Office for review and approval³. Among other things, MHOTRS programs would need to show that the shared use is compatible with the operation of the program, that individual privacy/confidentiality will be maintained, and that shared use will not interfere with program operations. **Please Note:** Services provided by programs sharing space with the MHOTRS program cannot be claimed to Medicaid using the MHOTRS’ rate codes.

Additionally, services can be provided off-site for both adults and children. Off-site services should be provided in settings that are conducive to meeting treatment goals, objectives, and interventions, be accommodating to the conditions and needs of those being served, be safe and accessible for all, and assure privacy for the delivery of services. Off-site should be considered as part of person/family-centered and recovery-oriented Treatment Planning. Some important points about off-site services:

- Reimbursed at 150% of rate of service
- All services can be provided off-site
- Off-site services cannot be combined with use of Telehealth
- Services can be provided as individual or group
- Multiple services can be provided off-site in one day, reimbursement regulations for 10% reduction apply
- Services are exempt from Utilization Threshold counts

³ Approvals from other regulatory agencies such as the Office of Alcoholism and Substance Abuse Services or the Department of Health may also be required.



If services are provided on a regular and routinely scheduled basis at an off-site location for multiple individuals, the MHOTRS program should consider applying for a Satellite site.

See [Medicaid Billing and Fiscal Guidance](#) for rate codes and more details on billing for off-site services.

IX. County Role

Part 599 identifies several significant functions for the county Director of Community Services (DCS), which reflect DCS responsibilities and authority established in Article 41 of the New York State Mental Hygiene Law. These include the following:

- Review and approve crisis plans. All MHOTRS programs must have crisis plans (including after-hours coverage), and those plans must be approved by the county DCS except for plans for county run MHOTRS programs, which must be approved by OMH. After-hours services may be provided directly by the MHOTRS program or pursuant to a Clinical Services Contract. After-hours crisis coverage must include, at a minimum, the ability to provide brief crisis intervention services by phone by a professional staff.
- Determine individuals in urgent need of MHOTRS care. The county director can require a MHOTRS program to provide an Initial Assessment and appropriate treatment or referral to the individual within five business days. Providers must have written criteria for admission, and discharge from the program. Admission policies should include a mechanism for screening individuals at the time of referral and assuring that those referred from inpatient, forensic, or emergency settings, those determined to be at high risk, and those determined to be in urgent need by the DCS receive initial assessment services within five business days, and if indicated, are admitted to the MHOTRS program or referred to an appropriate provider of services. The county may establish, subject to the approval of OMH, categories of individuals to be considered in urgent need of services.

X. Definitions (from regulations 14 NYCRR Section 599.4)

1. *After-hours* means before 8 a.m., 6 p.m. or later, or during weekends.
2. *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.
3. *Clinical staff* means staff members who provide services directly to individuals, including professional staff, non-licensed professional staff, paraprofessional staff, and student interns.
4. *Clinician* means a person who is a member of the professional staff, or non-licensed professional staff.
5. *Collateral* means a person who is a member of the individual's family or household, or other person who regularly interacts with the individual and is directly affected by or has the capability of affecting their condition and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the individual prior to admission. A group composed of collaterals of more than one individual may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the individual in the management of their illness.
6. *Commissioner* means the Commissioner of the New York State Office of Mental Health.
7. *Counseling* means the provision of assistance and guidance in resolving personal, social, or psychological problems and difficulties.
8. *Designated mental illness* means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the International Classification of Diseases (ICD), other than:
 - a. substance use disorders in the absence of other mental health conditions defined in the DSM or ICD;
 - b. Neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD except Attention-Deficit/Hyperactivity Disorder and Tic Disorders;
 - c. major neurocognitive disorder, traumatic brain injury, or mental disorders due to another medical condition; or
 - d. V-Codes Other conditions that may be a focus of clinical attention (commonly described with Z codes), except Parent-Child Relational Problem (V61.20/Z62.820) for children.
9. *Diagnostic and treatment center* for the purposes of this Part, means an outpatient program licensed as a diagnostic and treatment center pursuant to Article 28 of the



Public Health Law which provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. A program providing fewer than 2,000 total visits annually shall not be considered a diagnostic and treatment center.

10. *Director of Community Services* shall mean the director of community services for the mentally disabled appointed pursuant to Mental Hygiene Law.
11. *Evidence-based treatment* means an intervention for which there is consistent scientific evidence demonstrating improved outcomes.
12. *Homebound individuals* means people who have been determined by a licensed clinician to have a physical and/or mental illness that prevents them from leaving their residence to access mental health services or for whom a physician determines that leaving the residence to access mental health services would be detrimental to their health or mental health.
13. *Hospital-based MHOTRS programs, or hospital outpatient departments*, means a mental health program which is operated by a psychiatric hospital, or a general hospital and is licensed under Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law, or is licensed solely under Article 28 of the Public Health Law and provides more than 10,000 mental health visits annually, or for which mental health visits comprise over 30 percent of the annual visits. A MHOTRS program licensed solely under Article 28 which provides fewer than 2,000 total visits annually shall not be required to be licensed by OMH.
14. *Limited permit* means that the New York State Education Department has determined that permit holders have met all requirements for licensure except those relating to the professional licensing final examination, and that pending licensure limited permit holders are functioning under proper supervision as outlined in the New York State Education Department law governing each of the professions.
15. *Local governmental unit (LGU)* means the unit of local government authorized in accordance with Article 41 of the Mental Hygiene Law to provide and plan for local or unified services.
16. *Mental Health Outpatient Treatment and Rehabilitative Service Program* means a program licensed as a MHOTRS program under Article 31 of the Mental Hygiene Law.
17. *Modifiers* means payment adjustments made to Medicaid fees for specific reasons such as billing for services in languages other than English and services delivered after hours.
18. *Office* means the New York State Office of Mental Health.
19. *Off-site services* are services delivered on an individual basis in a wide variety of settings other than the MHOTRS program's primary or satellite locations, including locations in the community or in the individual's place of residence. The location in which the service is provided is determined by the individual's needs and goals documented in the individual's record.
20. *Peer Staff* - Qualified Individuals who may provide Peer Support Services include:

- a. OMH New York Certified Peer Specialists (NYCPS) who:
 - i. Identify as being actively in recovery from a mental health condition and intentionally self-disclose one's mental health recovery journey;
 - ii. Possess a certification from, or are provisionally certified as, a New York Certified Peer Specialist by an OMH-approved Certified Peer Specialist certification program; and
 - iii. Are supervised by any professional staff as defined in 599.4
 - b. OMH Credentialed Family Peer Advocate (FPA-C) who:
 - i. Demonstrate lived experience as a parent or primary caregiver who has navigated multiple child-serving systems on behalf of their child(ren) with social, emotional, developmental and/or behavioral healthcare needs;
 - ii. Possess a credential from, or are provisionally credentialed as a Family Peer Advocate by an OMH-approved credentialing program; and
 - iii. Are supervised by any professional staff as defined in 599.4.
 - c. OMH Credentialed Youth Peer Advocate (YPA-C) who:
 - i. Is an individual 18 to 30 years old who has self-identified as a person who has first-hand experience with, emotional (mental health), behavioral challenges, and/or co-occurring disorders;
 - ii. Is able to use lived experience with a disability, mental illness, and involvement with juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness;
 - iii. Possess a credential from, or are provisionally credentialed as a Youth Peer Advocate by an OMH-approved credentialing program; and
 - iv. Are supervised by any professional staff as defined in 599.4.
 - d. Peer Specialists/Advocates can be hired directly by MHOTRS programs or can be contracted to provide Peer Support Services.
 - e. Peer Specialists/Advocates who hold a credential from a certifying authority recognized by the Commissioner of the Office of Addiction Services and Supports (Certified Recovery Peer Advocate) are eligible to work in MHOTRS programs provided they qualify for and obtain provisional OMH Peer Certification or Credentialing within 12 months of being hired. It is expected that, within a reasonable amount of time, they will then complete full OMH Peer Certification or Credential their work experience hours post provisional certification/credentialing.
21. *Peer Support Services* means 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.

22. *Preadmission visit* means visits provided prior to admission to a MHOTRS program, during which the individual is evaluated to determine appropriate services, and support may be provided to the individual to make informed decisions about their services.
23. *Primary clinician* is the clinician responsible for the development and implementation of the treatment plan, also referred to as the treating clinician.
24. *Professional staff* means practitioners possessing a license or a limited permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness and shall include the following:
 - a. *Licensed Creative arts therapist* is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist limited permit from the New York State Education Department.
 - b. *Licensed practical nurse* is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse limited permit from the New York State Education Department.
 - c. *Licensed psychoanalyst* is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - d. *Psychologist* is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - e. *Licensed Marriage and family therapist* is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - f. *Licensed Mental health counselor* is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - g. *Nurse practitioner* is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - h. *Nurse practitioner in psychiatry* is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a limited permit from the New York State Education Department.

- i. *Physician* is an individual who is currently licensed as a physician by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - j. *Physician assistant* is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - k. *Psychiatrist* is an individual who is currently licensed or possesses a limited permit to practice medicine in New York State. A psychiatrist is a physician who completed an ACGME-accredited general adult psychiatry residency. A child psychiatrist is a physician who completed an ACGME-accredited fellowship program in child and adolescent psychiatry.
 - l. *Registered professional nurse* is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a limited permit from the New York State Education Department.
 - m. *Social worker* is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department or possesses a limited permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.
25. *Quality improvement* means a systematic and ongoing process for measuring and assessing the performance of MHOTRS programs and for conducting initiatives and taking action to improve safety, effectiveness, timeliness, person centeredness or other aspects of services.
26. *Satellite* means a physically separate site to a certified MHOTRS program, which provides either a full or partial array of outpatient services on a regularly and routinely scheduled basis (full or part time).
27. *Serious emotional disturbance* means a child or adolescent has a designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) and has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:
- a. ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
 - b. family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
 - c. social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or



- d. self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
 - e. ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).
28. *Specialty MHOTRS program* means a program designated by the Commissioner as specializing in the provision of services to children who have a designated mental illness diagnosis and an impairment in functioning due to serious emotional disturbance.
29. *Treatment planning* is an ongoing process of assessing the mental health status and needs of an individual, establishing his or her treatment and rehabilitative goals and determining what services may be provided by the MHOTRS program to assist the individual in accomplishing these goals.
30. *Visit* means an interaction consisting of one or more procedures occurring between an individual and/or collateral and the clinical staff on a given day.