



# **New York State Office of Mental Health**

## **14 NYCRR Part 599**

### **“Clinic Treatment Programs”**

#### **Interpretive/Implementation Guidance**

**01-01-2021**

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



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## I. Part 599 Clinic Regulations

The New York State Office of Mental Health (OMH) adopted new mental health clinic regulations, 14 NYCRR Part 599 on October 1, 2010. The regulations were updated in November 2011, in February 2012 and January 2015.

These regulations are augmented by:

1. The OMH *Clinical Standards of Care* and the
2. OMH *Standards of Care Anchors*, which comprise the instrument used to measure performance for re-certification.

Both documents are found on the [OMH Clinic webpage](#).

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

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

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

## II. Purpose of this Guidance

Over the past several years, OMH has endeavored to involve and inform interested parties with respect to clinic restructuring. These efforts have included the provision of numerous training sessions. Additionally, the [OMH Clinic webpage](#) provides several program and fiscal projection tools.

Nonetheless, OMH recognizes that the Part 599 Clinic Treatment regulations are complex and the field would benefit from an integrated guidance manual. This guidance document is designed to provide an overview of program and billing requirements for the various clinic services, as well as guidance on how these services can be used to better meet the needs of consumers.

### III. Who is covered by the Regulations?

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

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

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

[Contact information for the OMH Field Offices](#)

### IV. What are the Clinic Services?

Section 599.8 of the regulations establishes 10 mental health clinic services that must be available and offered as needed at any mental health clinic licensed by OMH. As implied, the optional services are not required to be available at every clinic that is licensed by the OMH. Rather, these services are meant to enhance the constellation of services offered by clinics.

<b><u>Required and Optional Clinic Services</u></b>	
<b><u>Required</u></b>	<b><u>Optional</u></b>
<p><b><i>Assessment</i></b></p> <ol style="list-style-type: none"> <li>1. Initial Assessment</li> <li>2. Psychiatric Assessment</li> </ol> <p><b><i>Therapies</i></b></p>	<p><b><i>Testing</i></b></p> <ol style="list-style-type: none"> <li>1. Developmental Testing</li> <li>2. Psychological Testing</li> <li>3. Psychiatric Consultation</li> </ol>

<p>3. Psychotherapy - Individual</p> <p>4. Psychotherapy – Family/Collateral</p> <p>5. Psychotherapy - Group</p> <p>6. Psychotropic Medication Treatment</p> <p><b>Injections</b></p> <p>7. Injectable Psychotropic Medication Administration (for clinics serving adults)</p> <p>8. Injectable Psychotropic Medication Administration with Education and Monitoring (for clinics serving adults)</p> <p><b>Enhanced Services</b></p> <p>9. Crisis Intervention</p> <p>10. Complex Care Management</p>	<p><b>Physical Health</b></p> <p>4. Health Physicals</p> <p>5. Health Monitoring</p> <p><b>Injections</b></p> <p>6. Injectable Psychotropic Medication Administration (for clinics serving children)</p> <p>7. Injectable Psychotropic Medication Administration with Education and Monitoring (for clinics serving children)</p> <p><b>Enhanced Services</b></p> <p>8. Smoking Cessation Treatment – Individual and Group</p> <p>9. Screening, Brief Intervention and Referral to Treatment (SBIRT)</p>
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How does this work in practice? If an agency has several satellite sites in addition to its primary clinic, it may choose to offer an optional service at one or more of its satellite sites, but that optional service would not need to be available at all satellite sites, nor at the primary clinic. Required services must be available at all primary clinic sites but not necessarily at each satellite site. (Clients who would benefit from a required service/procedure NOT available at the satellite location MUST be linked to the primary clinic site for this service/procedure.)

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

If a clinic does not offer an optional service from which a specific recipient admitted to its program could benefit, it is possible to arrange for the receipt of such services from another OMH licensed clinic via a “Clinical Services Contract.” It is the expectation of OMH that this would be a time limited arrangement, which would not be used to address the ongoing service needs of an individual or group of individuals.

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

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

## V. Service Definitions and Guidance

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

### ***Assessment***

#### **1. Initial Assessment (new client)**

**Definition:** The term “initial assessment” means a face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient.

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

Assessment information collected must be used to determine admission to the clinic level of treatment (or other disposition). OMH has produced Standards of Care that provide guidance on what should be contained in a quality assessment. (See page 58.)

## 2. Psychiatric Assessment

**Definition:** A “psychiatric assessment” is an interview with an adult or child or his or her family member or other collateral, performed by a psychiatrist or nurse practitioner in psychiatry (NPP), or physician assistant with specialized training approved by the Office. A psychiatric assessment may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues.<sup>1</sup>

### *Therapies*

## 3. Psychotherapy (Services 3,4,5)

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

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

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

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

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

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

Guidance on Medicaid billing requirements for psychotherapy can be found on page 40.

## 6. Psychotropic Medication Treatment

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

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

Psychotropic Medication Treatment may also result in the identification of a need for Complex Care Management.

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

**Definition:** Injectable psychotropic medication administration is the process of preparing, and administering the injection of intramuscular psychotropic medications.

**Guidance:** This service must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 60.

This service is optional for clinics serving only children.

## 8. Injectable Psychotropic Medication Administration with Monitoring and Education (for clinics serving adults)

**Definition:** Injectable Psychotropic Medication Administration with monitoring and education is the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

**Guidance:** This service must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 60.

This service is optional for clinics serving only children.

## ***Enhanced Services***

### **9. Crisis Intervention**

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

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

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

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

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

### **10. Complex Care Management**

**Definition:** Complex care management is an ancillary service to psychotherapy, psychotropic medication treatment or crisis intervention services. It is provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which may be necessary as a follow up to psychotherapy, psychotropic medication treatment or crisis service for the purpose of preventing a change in community status or as a response to complex conditions.

**Guidance:** Complex Care Management is not a stand-alone service. It is a non-routine professional service designed to coordinate care. It may be provided subsequent to a psychotherapy, psychotropic medication treatment or crisis visit. It is designed to address immediate mental health issues or factors that are impacting on the individual's health or community status. It may be provided as an ancillary service to a psychotherapy, psychotropic medication treatment or crisis service. For Medicaid fee-for-service reimbursement, it must take place within 14 calendar days following the provision of eligible service.

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

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

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

- Coordination required to treat co-occurring disorders;
- Complex health status;
- Risk to self or others;
- Coordination necessary to break the cycle of multiple hospitalizations;
- Loss of home;
- Loss of Employment;
- Children and adults with multiple other service providers in need of coordination;
- Children at risk of school failure, expulsion or lack of school placement;
- Children at risk of out of home placement;
- Changes in custody status (from the parents' or child's perspective); and/or
- AOT status and process.

Frequently asked questions about Complex Care Management can be found on page 64.

## ***Optional Services***

### **1. Developmental Testing**

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

**Guidance:** Developmental testing may only be offered to individuals admitted to the clinic. See page 60 for a list of staff eligible to perform developmental testing.

### **2. Psychological Testing**

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

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

### **3. Psychiatric Consultation**

**Definition:** Psychiatric consultation means a face-to-face evaluation, which may be in the form of video telepsychiatry, of a consumer by a psychiatrist or nurse practitioner in psychiatry, including the preparation, evaluation, report or interaction between the psychiatrist or nurse practitioner in psychiatry and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care.

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

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

A written report must be provided by the consulting physician or nurse practitioner to the referring physician. For information on billing consultations on a Medicaid fee-for-service basis see page 42.

#### 4. Health Physicals

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

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

#### 5. Health Monitoring

**Definition:** Health monitoring is the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use and smoking cessation. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

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

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

**Definition:** Injectable psychotropic medication administration is the process of preparing, and administering the injection of intramuscular psychotropic medications.

**Guidance:** This service must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 60.

## 7. Injectable Psychotropic Medication Administration with Monitoring and Education (this service is optional for clinics serving only children)

**Definition:** Injectable Psychotropic Medication Administration with monitoring and education is the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

**Guidance:** This service must be provided by an appropriate medical staff person as shown in the staffing eligibility table on page 60.

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

## 8. Smoking Cessation Treatment – Individual or Group

**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 also allowed for both adults and children as a health monitoring service.

**Guidance:** This service must be provided face-to-face by a physician, physician assistant, nurse practitioner, or registered nurse. 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.

## 9. Screening, Brief Intervention and Referral to Treatment (SBIRT)

**Definition:** SBIRT is an evidence-based practice model which is proven to be successful in modifying the consumption/use patterns of at-risk substance users and in identifying individuals who need more extensive, specialized treatment. SBIRT is a comprehensive, integrated, public health approach that provides opportunities for early intervention before more severe consequences occur.

**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](#)<sup>24</sup>, 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](#) 

A clinic may be authorized to provide one or more of the optional services specified in Section 599.8(c) through completion of the “Part 599 Clinic Regulation” survey on the OMH web based application, Mental Health Provider Data Exchange (MHPD). Information regarding the Mental Health Provider Data exchange (MHPD) page and the above referenced regulations can be found on the [OMH MHPD Webpage](#). Following submission, OMH will issue a revised clinic operating certificate specifying the optional services provided at that location pursuant to Part 599. Smoking Cessation Treatment and SBIRT can be provided without authorization by OMH; a revised clinic operating certificate is not required.

## VI. Operational Requirements

### ***Staffing Requirements (14 NYCRR Section 599.9)***

In 2002, New York State adopted a “scope of practice law” that established four new types of mental health practitioners and required anyone proposing to provide psychotherapy to obtain a license to do so. This law also contained a temporary exemption for programs licensed, operated or funded by the Office of Mental Health. Recently that exemption was extended, meaning that staff providing psychotherapy in a program licensed, operated or funded by the Office of Mental Health do not need a license to do so until July 1, 2018. More information on the extension of the licensing social work exemption can be found at the [Office of the Professions website](#).  However, in all instances, a clinic is expected to employ and designate an adequate number of licensed staff who, by their training and experience, are qualified to provide clinical supervision and programmatic direction. Such individuals should be identified in the staffing plan and documentation of the lines of supervisory responsibility should be maintained by the clinic. When non-licensed staff is providing clinical services it is especially critical that regular and appropriate supervision is provided and documented. Arrangements which will assist these staff to meet licensure eligibility requirements should be considered. Staff should only provide services which are within their scope of practice and level of competence and under supervision which is commensurate with their training, experience and identified needs. The Clinic Standards of Care identify the importance of regular guidance and oversight for all staff in order to assist them in responding to both the ongoing and emergent needs of individuals served.



Appropriate clinic staff shown below:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Psychiatrist</li> <li>• Physician (MD)</li> <li>• Licensed Master Social Worker (LMSW)</li> <li>• Licensed Clinical Social Worker (LCSW)</li> <li>• Psychologist<sup>2</sup></li> </ul> | <ul style="list-style-type: none"> <li>• Licensed Marriage and Family Therapists (LMFT)</li> <li>• Licensed Mental Health Counselors (LMHC)</li> <li>• Licensed Psychoanalyst</li> <li>• Licensed Psychologist</li> <li>• Physician Assistant- physical health procedures only or mental health if OMH approved training</li> </ul> |
| <ul style="list-style-type: none"> <li>• Registered Nurse /Licensed Practical Nurse</li> <li>• Nurse Practitioner in Psychiatry (NPP)</li> <li>• Licensed Creative Arts Therapists (LCAT)</li> </ul>                             | <ul style="list-style-type: none"> <li>• Limited Permit staff (Permits issued by NYSED)</li> <li>• Students within approved NYSED programs</li> <li>• Qualified non-licensed staff including qualified peer advocates and family advisors</li> </ul>  |

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

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

For a crosswalk of services and allowable staffing, see the table on page 60.

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

- Substitution of another physician for a psychiatrist; or
- Use of a Physician Assistant to provide Psychiatric Assessments.

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

**Treatment Planning (14 NYCRR Section 599.10)**

A treatment plan should be a dynamic document that accurately reflects the current needs of the recipient. Review and, where clinically appropriate, revisions to the treatment plan should be made during periods of emerging stress/crisis or when significant positive changes occur. It is important that a treatment plan be regarded as an evolving “roadmap” for the clinician, to ensure that the most relevant

<sup>2</sup> Under New York State law, unlicensed psychologists may be employed by a federal, state, county or municipal agency or other political subdivision. In all other cases, psychologists working for OMH licensed clinics must be licensed.



issues are consistently addressed in the treatment sessions, and to ensure that goals and objectives are adjusted to reflect the recipient's situation and needs.

In August 2020, the Part 599.10 regulations specific to Treatment Planning were updated. Please review the regulations for additional details.

[https://govt.westlaw.com/nycrr/Document/I3285d829b45011df96a6e6294202215a?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)&bhcp=1](https://govt.westlaw.com/nycrr/Document/I3285d829b45011df96a6e6294202215a?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1)

Treatment planning is:

- required for every recipient;
- developed with the recipient, 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.

Recipient 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 recipient 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.

Treatment planning documentation may be completed 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/EMR.

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 recipient's case record;
- the recipient's needs;
- the recipient's treatment goals and objectives;

- the name and title of the recipient's primary clinician in the program, and identification of the types of personnel who will be furnishing services;
- the recommended and agreed upon clinic treatment service 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 recipients who are Medicaid fee-for-service beneficiaries, Initial Treatment Plans shall be signed by a psychiatrist or other physician.

However, Medicaid Managed Care (MMC) or Commercial Insurance Initial Treatment Plan signature requirements depend on whether or not medications are prescribed:

- psychiatrist, other physician, or PNP if medication is prescribed
- psychiatrist, other physician, licensed psychologist, PNP, 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 plan related signature and time frame requirements.

### **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 required more frequently as determined by the treating 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/lack of progress of the recipient in regard to 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 recipient's input, and where appropriate, the family's/collateral's/support's input on progress. For children there is evidence of recipient/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:

- new services are added or
- service intensity (frequency and/or duration) is increased.

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

However, Medicaid Managed Care (MMC) or Commercial Insurance Treatment Plan Update signature requirements depend on whether or not medications are prescribed:

- psychiatrist, other physician, or PNP if medication is prescribed
- psychiatrist, other physician, licensed psychologist, PNP, 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 plan related signature and time frame 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) shall only require the clinician's signature and may be recorded in progress notes.

### ***Progress Notes (14 NYCRR Section 599.10)***

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

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

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

### ***Documentation (14 NYCRR Section 599.11)***

Recipient records are not only an adjunct to good clinical care; they are a fundamental and integral part of care 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:

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

### ***Premises (14 NYCRR Section 599.12)***

The regulations contain several requirements for clinic program facilities. Part 599 allows a clinic to share space (both program space and non-program space) with other programs. Program space may be shared pursuant to a plan approved by OMH. For example, a clinic may wish to share space with a substance abuse or medical program. Plans would need to be submitted to the appropriate OMH Field Office for review and approval<sup>3</sup>. Among other things, clinics would need to show that the shared use is compatible with the operation of the clinic, that recipient privacy/confidentiality will be maintained, and that shared use will not interfere with

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

clinic operations. **Please Note:** Services provided by programs sharing space with the clinic cannot be claimed to Medicaid using the clinic's rate codes.

## VII. 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 clinics must have crisis plans (including after-hours coverage), and those plans must be approved by the county Director of Community Services except for plans for county run clinics, which must be approved by OMH. After-hours services may be provided directly by the clinic or pursuant to a Clinical Services Contract. After-hours crisis coverage must include, at a minimum, the ability to provide brief crisis intervention services by phone by a licensed clinician.
- Determine individuals in urgent need of clinic care. The county director can require a clinic to provide an Initial Assessment and appropriate treatment or referral to the individual within 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 Director of Community Services receive initial assessment services within five business days, and if indicated, are admitted to the clinic or referred to an appropriate provider of services. The county may establish, subject to the approval of OMH, categories of individuals to be considered in urgent need of services. The county may designate children's specialty clinic programs. This designation will allow the clinic to be reimbursed on a Medicaid fee-for-service basis for children who have a serious emotional disturbance (SED) and are enrolled in Medicaid managed care.

## VIII. Medicaid Fee-for-Service Reimbursement

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

### **APGs**

Part 599 uses APGs as the basis for Medicaid fee-for-service payments for mental health outpatient clinic services. The APG payment methodology is based on the Enhanced Ambulatory Patient Groups classification system, a product of the 3M Health Information

Systems, Inc. In the context of mental health services, APGs are a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes.

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

The most up-to date mental health service weights, diagnosis weights and APG peer group base rates can be found at the [OMH website](#).

## **Peer Groups**

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

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

1. **Upstate hospital** – All hospital-based mental health clinics in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates counties.
2. **Downstate hospital**– All hospital-based mental health clinics in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Dutchess, Orange, Putnam, Rockland and Westchester counties.
3. **Upstate D&TC** – All diagnostic and treatment centers in Albany, Allegheny, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler,



Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren and Washington, Wayne, Wyoming, and Yates counties.

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

### ***Federally Qualified Health Centers (FQHCs)***

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

### ***Children's Specialty Clinic***

A clinic treatment program designated by OMH as a specialty clinic serving children may be reimbursed by Medicaid on a fee-for-service basis for providing clinic treatment services to

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

### **OMH Service Rates, Weights, CPT Codes**

OMH maintains the most up-to-date proposed rates, weights, and CPT codes on our website. These can be found under [clinic projection tools](#) on the OMH website.

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

**Please Note: Procedure codes 90805 and 90807 were replaced by 90833 and 90836 (with accompanying E&M code) effective January 1, 2013.**

1. **Psychiatric Assessment.** To be reimbursed properly for a 30 or 45 minute Psychiatric Assessment, the clinic must report an office E&M code on one claim line AND 90833 (or 90836) on the second claim line. The following E&M codes are available when claiming a Psychiatric Assessment:

- 99202-99205 (new patient)
- 99212-99215 (established patient).

These E/M codes may be used without 90833 or 90836 if the psychiatrist does straight medical evaluation and management without psychotherapy. However, OMH defines psychotherapy as "any type of interpersonal counseling and/or care coordination including but not limited to evidence based treatments that has as its aims support and/or assistance through engaging in a focused discussion about patients' problems and possible solutions". Medicaid reimbursement amounts for E&M codes vary by diagnosis.

Psychiatrists/Psychiatric Nurse Practitioners should choose the appropriate code based on the complexity of service provided. Regardless of which code is used, the minimum 30 minute OMH regulatory requirement for this service must be met before Medicaid reimbursement can be requested;

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

### 3. **Health Monitoring.** Monitoring services are coded using time-based E/M codes.

- **Generic Health Monitoring can be billed with codes** 99401-99404 (individual sessions) and 99411-99412 (group sessions).
- **Smoking Cessation Counseling** is allowed for both adults and children as a health monitoring service. Smoking Cessation Counseling (SCC) can be coded using 99406 (Intermediate SCC, 3 to 10 minutes – billable only as an individual session) or 99407 (Intensive SCC, 3 to 10 minutes – billable as an individual or group session; using the ‘HQ’ modifier to indicate a group SCC session, up to eight patients in a group). Claims for SCC must include ICD-9-CM diagnosis code, 305.1 tobacco use disorder. SCC must be provided face-to-face by a physician, physician assistant, nurse practitioner, or registered nurse. Medicaid reimbursement is available for six counseling sessions during any 12 continuous months; including any combination of individual or group counseling sessions. 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.
- **Screening, Brief Intervention and Referral to Treatment (SBIRT)** tool can be coded using Medicaid HCPCS codes H0049 (Alcohol and/or drug screening) or H0050 (Alcohol and/or drug service, brief intervention, per 15 minutes).

Medicaid reimbursement amounts for Health Monitoring codes do not vary by diagnosis.

Physical Exams and Health Monitoring must be claimed using the Health services rate code.

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

### **Off-site Services**

Medicaid fee-for-service reimbursement for off-site is available only for select children’s services (for children up to age 19) and crisis intervention-brief for both adults and children.

**Claims are submitted with a separate rate code.** Providers should not attempt to claim Medicaid reimbursement for any other type of off-site service that may be provided to a Medicaid fee-for-service recipient.

There are several things to keep in mind when claiming for eligible off-site services:

1. Off-site services are paid using 100% state-funding, there is no federal participation.
2. Off-site services will be paid at 150% of the full APG on-site procedure payment.
3. No modifiers will be paid for these services. Additional payments will not be made for languages other than English, after-hours and physician services.
4. Only one off-site service for children will be reimbursed per client, per day (excluding crisis).
5. Crisis Intervention – Brief has a limit of 6 units per client, per day.
6. Reimbursement for off-site services will require the use of a different rate code than used for on-site services and a separate claim for each rate code will be required if on-site and off-site services are delivered on the same day.
7. Off-site services will not count toward the individual’s utilization threshold (UT).
8. The need for off-site services must be documented in the individual’s treatment plan.
9. Even though these services are being funded with state-only funded dollars, they are being paid through the eMedNY system. Therefore, reimbursement will only be provided for individuals enrolled in the Medicaid program and, except for children with serious emotional disturbance (SED) served by specialty clinics, not enrolled in comprehensive Medicaid Managed Care.

**The following services may be provided off-site by the same staff determined eligible to deliver these services on-site:**

- Crisis Intervention – Brief (for adults and children) (H2011)
- The following children’s services (for children up to age 19):
  - Initial Assessment (90791, 90792)
  - Psychiatric Assessment (30 & 45 minute) (90833 & 90836 PLUS E&M code)
  - Injectable Psychotropic Medication Administration with Monitoring and Education (15 minute minimum) (H2010)
  - Psychotropic Medication Treatment (15 minutes) (E&M code)
  - Individual Psychotherapy (30 & 45 minutes) (90832 & 90834)
  - Family Psychotherapy with or without the client (30 minutes) (90846)
  - Family Psychotherapy with the client (60 minutes) (90847)

### ***Rate Codes***

OMH will be using several rate codes to differentiate between onsite services, off-site services, on-site crisis, medical services, and services provided to Medicaid managed care children with

an SED designation. Providers must submit claims to Medicaid with the appropriate rate code and CPT code. These rate codes are listed in the table below.

<b>OMH Clinic Rate Codes</b>			
	<b>Non hospital*</b>	<b>Hospital</b>	<b>FQHC</b>
Base Rate	1504	1516	4301
Group Rate (separate code for FQHC only)	N/A	N/A	4303
Off-site Base Rate (available for select children’s services and crisis-brief for both adults and children.	1507	1519	4306
SED Child Base Rate (Medicaid managed care SED children only)	1510	1522	4601
Group Rate (separate code for FQHC only)	N/A	N/A	4603
SED Child Off-site Base Rate (Medicaid managed care SED children only)	1513	1525	4606
Health Services (e.g., Health Monitoring, Health Physicals)	1474	1588	N/A
SED Child Health Services (e.g., Health Monitoring, Health Physicals) (Medicaid managed care SED children only)	1477	1591	N/A
Crisis Intervention	1579	1576	N/A
SED Child Crisis Intervention (Medicaid managed care SED children only)	1585	1582	N/A

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

**Injections with education and monitoring and Psychotropic Medication Treatment services may be claimed using either the Health Services rate codes or the Clinic base rate codes.**

***Payment Modifiers***

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

- 1. Language Other Than English (LOE):** Each procedure provided in languages other than English is claimed to Medicaid fee-for-service using the U4 modifier. This modifier pays an additional 10% for each service.

This modifier is applicable when the service to the recipient and/or collateral is provided in a language other than English, including sign language. Translation may be provided by a staff person fluent in the language or by a paid translator. It is expected that the individual

providing language assistance services will have a sufficient level of fluency to ensure effective communication. Clinics should develop a process to assess or verify the language competency of those persons who will be providing language assistance services. Resources might include local organizations, universities or schools where the relevant languages are taught. In all instances, the confidentiality of information and respect for those served and for their culture must be assured.

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

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

**Additional resources:**

[Code of Ethics for Interpreters in Health Care](#) 

[NYS Office of Mental Health-Cultural Competence](#)

NYS OMH regulations- [14 NYCRR section 527.4 “Communication Needs”](#) 

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

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

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

The “after-hours” modifier will be recorded using CPT code 99051. It is reported in addition to the CPT code for each particular service or services provided after hours. The CPT code 99051 is weighted at .0759 of the clinic’s peer group base rate. **It is important to note that**

**Medicaid will reimburse for only one after-hours CPT code per Medicaid recipient per day.**

- 3. Physician modifier:** Clinics may claim one of the following modifiers: AF (psychiatrist), AG (Physician) or SA (Nurse Practitioner) when a psychiatrist, physician practicing in lieu of a psychiatrist with approval by OMH, or psychiatric nurse practitioner spends at least 15 minutes participating in the provision of services being provided by another licensed practitioner or when the service is provided fully by a psychiatrist/MD/NPP.

The modifier can also be claimed for each recipient when a psychiatrist/MD/NPP runs a group session or participates in the group for at least 15 minutes.

The modifier will add 45% to the payment for the individual service and will add 20% to the payment for group services for each recipient participating in the group.

In all cases, the psychiatrist/MD/NPP participation must be documented separately.

- 4. Reduced Services for School-based Group session:** For a school-based group psychotherapy service, the duration of the service may be that of the school period provided the school period is of duration of at least 40 minutes. When the service meets the time requirement the clinic will claim Medicaid using the U5 modifier. This modifier will reduce the payment by 30%. **Note:** For school-based services, the duration of Extended Individual Psychotherapy may be that of the school period provided the school period is at least 40 minutes. This does not require a modifier.
- 5. Reduced Services for 20 minute Individual Psychotherapy session:** Effective January 1, 2015, sessions of at least 20 minutes but less than 30 minutes will be reimbursed by Medicaid; however, this will require the use of the U5 modifier which will reduce the reimbursement amount by 30%.
- 6. Injection Only Service with or without drug reimbursement: Please note a change from the previous guidance dated 1/4/12: The FB modifier used in conjunction with Psychotropic Medication Administration is no longer available.**

In instances where the injection was given but the drug was not paid for by the clinic, providers must submit the injection-only procedure code 96372 to Medicaid using a professional claim – 837P – (same as institutional but without a rate code). The clinic will receive \$13.23 for the injection. There are no modifiers available.



If the clinic pays for the drug, the claim for the drug and the injection-only procedure 96372 is also submitted using the same 837P professional claim. The clinic must include both the appropriate J-code and CPT code 96372 for the injection. The clinic will receive payment for the drug cost and \$13.23 for the injection. There are no modifiers available.

**Note:** The injection-only CPT code 96372 is not considered a mental health carve-out service. This code will not be reimbursed by Medicaid FFS for managed care individuals.

## 7. Modifier Chart

Billing modifiers are available for particular services as indicated on the following chart. The time durations within the chart are consistent with and reflect the enforceable provisions set forth in the text of 14 NYCRR Section 599.14.

Office of Mental Health Service Name	After Hours	Language other than English	Physician/NP P	Reduced services
Complex Care Management	X	x		
Crisis Intervention Service - Per 15 minutes	X	x		
Crisis Intervention Service – Min 1 hour	X	x		
Crisis Intervention Service - Per Diem Min 3 hours	x	x		
Developmental and Psychological Testing	x	x		
Injectable Psychotropic Medication Administration – No minimum time				
Injectable Psychotropic Medication Administration with Education and Monitoring – Min 15 minutes	x	x		
Psychotropic Medication Treatment – 15 minute min	x			
Initial Mental Health Assessment, Diagnostic Interview, and Treatment Plan Development - Min 45 minutes	x	x	x	
Psychiatric Assessment - Min 30 minutes	x	x		
Psychiatric Assessment - Min 45 minutes	x	x		
Individual Psychotherapy - Min 30 minutes	x	x	x	
Individual Psychotherapy - Min 20 minutes, less than 30 minutes	x	x	x	x
Individual Psychotherapy - Min 45 minutes	x	x	x	
Group and Multifamily/Collateral Group Psychotherapy - Min 60 minutes	x	x	x	

Office of Mental Health Service Name	After Hours	Language other than English	Physician/NP P	Reduced services
Group and Multifamily/Collateral Group Psychotherapy – School-based - Min 40 minutes, less than 60 minutes	x	x	x	x
Family Therapy/Collateral with or without patient - Min 30 minutes	x	x	x	
Family Therapy/Collateral with patient - Min 60 minutes	x	x	x	

### ***Telepsychiatry***

OMH has amended the Part 599 regulations to include a new section 599.17 which permits providers to obtain approval to provide telepsychiatry services. Telepsychiatry is defined as the use of two-way real time-interactive audio and video equipment to provide and support clinical psychiatric care at a distance. Such services do not include a telephone conversation, electronic mail message or facsimile transmission between a clinic and a recipient or a consultation between two professional or clinical staff. The regulations prescribe that, when authorized by OMH, telepsychiatry services can be utilized for assessment and treatment services provided by physicians or psychiatric nurse practitioners (NPP) from a site distant from the location of a recipient, where both the recipient and the physician or NPP are physically located at clinic sites licensed by the Office.

Telepsychiatry is optional but if a clinic plans to provide services using telepsychiatry it must be added to the clinic operating certificate by requesting an “Administrative Action” via MHPD.

Detailed information regarding telepsychiatry, including billing guidelines, clinical guidance, training resources and technology and telecommunication standards can be found on the [OMH website](#).

### ***Medicaid Utilization Threshold***

As a result of 2011-12 NYS budget which adopted Medicaid Redesign Team (MRT) Proposal #26 (utilization thresholds), OMH has implemented utilization thresholds for individuals receiving services from OMH-licensed clinics. As of April 1, 2011 and resetting to zero every State Fiscal Year (April-March) thereafter, OMH will calculate “countable service days” claimed to Medicaid by a clinic organization for an individual. When an individual receives services in excess of the utilization threshold, payment reductions will occur.

The payment reductions linked to utilization thresholds are:

- For individuals whose age on April 1 of each state fiscal year was LESS than 21 years old, Medicaid payments for their “countable” services will be reduced by 50% beginning with their 51<sup>st</sup> service day during the fiscal year. This count will reset to zero at the beginning of each SFY thereafter (April 1<sup>st</sup>).
- For individuals whose age on April 1 of each state fiscal year was equal to or greater than 21 years old, Medicaid payments for their countable clinic services will be reduced by 25% for their 31<sup>st</sup> through 50<sup>th</sup> service days during the state fiscal year. Payments for clinic services will be reduced by 50% beginning on their 51<sup>st</sup> service day during the fiscal year. This count will reset to zero at the beginning of each SFY thereafter.

The following rules are critical to understanding utilization thresholds:

- A “countable service day” is the accumulation of all procedures provided in one day that have been claimed to Medicaid using rate codes: 1504, 1510, 1516 and 1522. The services that may be claimed using these rate codes are: Initial Assessment; Psychiatric Assessment; Injectable Psychotropic Medication Administration (with and without monitoring and education); Psychotropic Medication Treatment; Psychotherapy, including Individual, Family, Collateral and Group; Developmental Testing; Psychological Testing; and Complex Care Management (if billed using one of the above rate codes). Note: if psychotropic medication treatment and/or complex care management are the only services provided on a day, providers should use the appropriate health services rate code to avoid having the visit count toward the utilization threshold for that individual.
- Countable service days do NOT include days in which only crisis services (on and off-site), health monitoring services, health physicals, psychotropic medication treatment, complex care management or children’s off-site services were provided (so long as the claim is submitted using the appropriate rate codes for those services).
- A clinic organization includes all clinics and clinic satellites operated by the same entity.
- The threshold applies to individuals whose clinic claims are paid in whole or part by Medicaid on a fee-for-service basis (i.e., including Medicare/Medicaid dual enrollees and individuals with 3<sup>rd</sup> party coverage whose claims are partially paid by other payers).

### **Services Exempt from the Utilization Threshold Count**

To ensure that providers receive the full reimbursement for mandated services, Part 599 has been amended, effective January 1, 2015, to allow a utilization threshold exemption when a

**specific** level of additional services exceeding the utilization threshold is required pursuant to one of the following:

- Court Order
- Assisted Outpatient Treatment (AOT)
- Strict and Intensive Supervision and Treatment (SIST)
- Other (as specifically approved by OMH)

Providers must use the following rate codes for services that fall under the exemption rule. These rate codes are only to be used for the circumstances specified above and will be subject to audit.

- 1136 – Free-standing Article 31 Clinic (equivalent to 1504)
- 1138 – Free-standing Article 31 Clinic (equivalent to 1510)
- 1140 – Hospital-based Article 31 Clinic (equivalent to 1516)
- 1142 – Hospital-based Article 31 Clinic (equivalent to 1522)

### ***Reimbursement for Collaborative Documentation/Concurrent Record Keeping***

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

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

### ***Medicaid/Medicare Crossover Billing***

For individuals with both Medicaid and Medicare coverage, Medicaid will pay the “higher of” what Medicare or Medicaid would pay for the mental health clinic visit. The Part 599 Clinic Treatment regulations have not changed the way Medicaid adjudicates Medicaid/Medicare cross-over claims.

However, as a result of an MRT Medicaid recommendation, Medicaid will not pay for Medicare co-pays or deductibles for non-Medicaid covered services. This includes off-site services that may be approved by Medicare.

### ***National Provider Identifier (NPI)***

Clinics, hospitals and other facilities billing Medicaid fee-for-service are required to maintain an up-to-date “roster” of Attending Providers (practitioners). Claims containing NPIs of licensed practitioners not “affiliated” (i.e., associated), with the facility will result in a denial of payment by Medicaid. The facilities Affiliated Practitioners NPI Application can be accessed by going to [www.emedny.org](http://www.emedny.org) and clicking on "Enter Facilities Practitioner’s NPIs" located in the green box on the right of the page.

There is also a batch Facilities Practitioner’s NPI Reporting (FPR) submission method, which was developed to accommodate facilities that have a large quantity of affiliations to record with NYS Medicaid. For information on the FPR, please visit [https://www.emedny.org/hipaa/NPI/Facility%20Practitioner%20NPI%20Reporting%20\(Batch%20Instructions\).pdf](https://www.emedny.org/hipaa/NPI/Facility%20Practitioner%20NPI%20Reporting%20(Batch%20Instructions).pdf).

An Attending practitioner NPI is required on all claims except when all the procedures are provided by a non-licensed practitioner. The NPI of a practitioner performing one of the procedures is entered as the Attending Provider on the claim. If the Attending Provider reported on the claim is enrolled in NYS Medicaid, the Referring field may be left blank as the Attending will be considered the Referring Provider. Licensed Master Social Workers, Creative Arts Therapists, Marriage and Family Therapists, Mental Health Counselors, and Psychoanalysts cannot currently enroll in NYS Medicaid. When they, or a non-licensed practitioner, are the Attending Provider reported on the claim, an enrolled Referring Provider must be added to the claim. As appropriate, you should report the NPI of the (enrolled) physician who signed the treatment plan or the NPI of the (enrolled) individual who supervises the Attending Provider. Using your agency’s NPI in the referring field may be appropriate in some cases. Referring Providers do not need to be affiliated with the clinic. However, Referring Providers must be enrolled Medicaid providers. Claims with a non-enrolled Referring Provider will be denied. Attending and Referring Providers may be enrolled with Medicaid as either billing providers, or as Order/Prescribe/Refer/Attend (OPRA) providers.

***Claims by non-licensed practitioners.*** When claiming for services provided by a non-licensed practitioner (including students), the OMH unlicensed practitioner ID (02249154) is the ONLY Attending practitioner information that should be put on the claim. Use the ID in place of the NPI and be sure that ALL other information - name, license etc. - is blank. Again, in the case of a



non-licensed practitioner using the unlicensed practitioner ID in the Attending field, the claim must also include the NPI of a Medicaid enrolled practitioner in the Referring field.

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

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

Medicaid enrollment forms and instructions are available on the ["Provider Enrollment"](#) tab of the eMedNY website.

### ***Billing Medicaid for Multiple Procedures on the Same Day***

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

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

### ***Billing Multiple Procedures for Individuals Covered by Medicaid/Private Insurance***

Medicaid regulations at 18 NYCRR § 540.6(e) (6) require a provider to pursue any available commercial insurance prior to submitting a claim to Medicaid. This means that providers must bill available commercial insurance, but are not required to contract with all available commercial insurers.

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

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

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

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

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

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

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

## IX. Medicaid Billing Requirements for Specific Services

Several clinic services have specific Medicaid billing limitations. These are summarized below. Please note that where services have a minimum duration, the duration of services must be documented. Minimum staffing requirements for each service can be found on page 60.

### ***Complex Care Management***

The Part 599 regulations were amended effective 10/1/2014 to allow for more flexibility when providing Complex Care Management. The information below is a change from the previous January 4, 2012 guidance.

Complex Care Management is billable in full 5-minute units, with a four unit maximum (20 minutes). Each full 5-minute unit may be provided on a separate day (within the 14 calendar day limit), with a maximum of 4, full 5-minute units associated with each eligible clinic visit. This service does not include standard report writing or routine follow up calls. It is not routine care management and must be medically necessary.

This service must be provided within 14 calendar days **following** a psychotherapy service, psychotropic medication treatment service or crisis intervention service. It can be provided by phone or in person. If a combination of psychotherapy, psychotropic medication treatment or crisis service occurs on the same day, Medicaid will only reimburse for up to 4 units of complex care within 14 calendar days following the provision of these services.

Additional questions and answers related to complex care can be found on page 64.

### ***Crisis Services***

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

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

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

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

**Note:** Crisis Intervention – Brief can be reimbursed by Medicaid fee-for-service for individuals regardless of whether or not they have previously received services from the clinic. Crisis Intervention – Complex and Per Diem are Medicaid reimbursable only for those individuals that have been seen by the clinic within the previous two years.

### ***Developmental Testing***

Medical Assistance may reimburse for this service solely for individuals admitted to the clinic. Developmental Testing services must be face-to-face with the recipient. The fee that is paid includes the expected cost of testing, including the scoring and report writing.

### ***Injectable Psychotropic Medication Administration***

The clinic will submit a professional claim (without a rate code) using the J Code for the drug (if the clinic paid for the drug) and CPT code 96372 for the injection. Medicaid will pay for the acquisition cost of the drug (if applicable) and \$13.23 for Injection. No modifiers are available.

### ***Injectable Med Admin with Monitoring & Education***

The clinic submits an APG claim with CPT H2010. This procedure has a 15 minute minimum and cannot be provided by LPN staff. When claiming H2010, you cannot claim 96372 on the professional claim on the same day for the same client.

### ***Pre-Admission***

OMH allows three preadmission procedures for adults and three preadmission visits for children/families to help clinicians improve engagement by giving them flexibility and more time to focus on the needs of the recipient. However, Part 599 does not mandate three pre-admission sessions. Multiple assessments should only be provided if medically necessary.

### ***Assessment***

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

#### **Initial Assessment**

No more than three initial assessment procedures will be reimbursed during an episode of service. An episode of service means a series of services provided during a period of admission. An episode of service terminates upon completion of the treatment objectives or cessation of services.

For recipients previously served by the clinic, additional initial assessment procedures in excess of the allowable three shall not be eligible for Medicaid reimbursement if less than 365 days have transpired since the most recent Medicaid reimbursed visit to the clinic.

### **Psychiatric Assessment**

Psychiatric assessments may be performed for admitted recipients where medically necessary without limitations. Psychiatric assessments may also be provided to determine whether an individual should be admitted to the clinic and will count toward the pre-admission service cap of three.

Two levels of psychiatric assessment may be reimbursed by Medicaid fee-for-service:

- A Psychiatric Assessment of at least 30 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry; and
- A Psychiatric Assessment of at least 45 minutes of documented face-to-face interaction between the recipient and the psychiatrist or nurse practitioner in psychiatry.

### ***Psychological Testing***

Medicaid may reimburse for this service solely for individuals admitted to the clinic.

Psychological testing services must be face-to-face with the recipient. The regulation does not limit the number of medically necessary sessions for this service. The reimbursement includes the expected cost of testing, including the scoring and report writing.

### ***Psychotherapy***

Psychotherapy Services may be reimbursed as follows:

(1) Brief Individual Psychotherapy Service requires documented face-to-face contact with the recipient of 30 minutes minimum duration. **Note:** Effective January 1, 2015, sessions of at least 20 minutes but less than 30 minutes will be reimbursed by Medicaid; however, this will require the use of the U5 modifier which will reduce the reimbursement amount by 30%.

(2) Extended Individual Psychotherapy Service requires documented face-to-face contact with the recipient of a minimum duration of 45 minutes. Providers are free to provide longer sessions, but Medicaid will not reimburse for more than a 45 minute psychotherapy session. For school-based services, the duration of Extended Individual Psychotherapy may be that of the school period provided the school period is at least 40 minutes. This does not require a modifier **Note:** Effective January 1, 2015, the extended individual psychotherapy service (45 minutes) will allow for 30 minutes to be spent with the individual (with or without the collateral) and the remaining 15 minutes to be spent with the collateral (with or without the individual). Documentation must include the split in time between the individual and collateral. No change in billing is required.

(3) Psychotherapy Family/Collateral and Client. This is a 60 minute visit. The patient must be present for the majority of the time. It is not required that the family/collateral be present for the entire session.

(4) Psychotherapy –Multi-Recipient Group. This requires documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum duration of 60 minutes. For school-based services, the duration of such services may be that of the school period provided the school period is of duration of at least 40 minutes. (The reimbursement for school based group services of less than 60 minutes will be reduced using the U5 modifier which will reduce the reimbursement by 30%).

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

### ***Psychotropic Medication Treatment***

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

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

### ***Health Physicals***

Physical exams delivered at the clinic for people receiving mental health clinic services are considered to be ancillary to mental health services. Therefore, individuals with Medicaid Managed Care for physical health only will not need a referral from a Medicaid Managed Care primary care provider to receive this service in a mental health clinic. This service is presumed to complement a mental health service and can be paid fee-for-service. No more than one health physical may be claimed in one year. Health physicals will be claimed using a health service rate code and will be excluded from the utilization threshold count. The language other than English modifier (U4) is not available.

### ***Health Monitoring***

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

Health monitoring services groups require documented face-to-face service with a minimum of two recipients and a maximum of 12 recipients for services of a minimum of either 30 or 60 minutes duration, or in the case of Smoking Cessation Counseling, greater than 10 minutes. The language other than English modifier is not available.

### ***Psychiatric Consultation***

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

**Consultation is coded using the appropriate evaluation and management codes (see page 61 for allowable codes).** The language other than English modifier is not available.

A consultation must meet the following conditions:

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

## X. Submitting Bills to Medicaid

### ***Required Information***

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

- The Medicaid client identification number (CIN) of the recipient;
- The National Provider Identification (NPI) of the clinic;
- The designated mental illness diagnosis. For pre-admission visits the code for “diagnosis-deferred” may be entered on the claim, where appropriate;
- The location of the service, specifically the licensed location where the service was provided or the clinician’s regular assigned licensed location from which the clinician departed for an off-site procedure. The location will be identified by the location’s “zip+4”, NOT by its historic Medicaid locator code. Do NOT enter the location’s historic locator code on the claim; and
- The National Provider Identification of the attending clinician or the Department of Health-approved alternative for non-licensed clinicians (02249154).
- If the attending clinician is not enrolled in Medicaid (e.g., non-licensed), the referring field must include the NPI of a Medicaid enrolled provider.

### ***Billing Multiple Services in the Same Day***

Clinics will be able to claim Medicaid for up to three services per day per client, not including crisis services. However, of those three services, there is a maximum of two Psychiatric or two Health services allowed per-day. Psychotropic Medication Treatment, Injectable Psychotropic Medication Administration with Monitoring and Education and Complex Care Management services may be counted as either health services or psychiatric services (distinguished by using either the base rate codes or the health services rate codes). This flexibility will allow for these services to be provided on the same day with any other types of services, up to the three per day cap. Injectable Psychotropic Medication (injection only) is billed using the professional claim (837P) and may be counted as either a psychiatric or health service.

The intent is to reduce the need for the client to make multiple visits for complementary services. The clinic will receive 100% reimbursement for the APG procedure with the highest APG weight and a 10% discount applied to each additional procedure with a lower APG weight. This rule applies for services submitted on the same rate coded claim.

**Important to Note:** All same rate coded procedures provided to an individual on the same day must be transmitted to Medicaid on one claim. This includes procedures provided by different clinicians. If same rate coded procedures provided to one individual on the same day are submitted as separate claims, only one of the claims will be paid. For more information, see page 36 above.

**Medicaid/Medicare dual eligible clients:** If one procedure must be billed to Medicare first, the clinic must wait to bill the rest of the procedures provided on that day until Medicare pays for the cross-over procedure. If the claim is then submitted to Medicaid outside of the 90 day window for billing but within 30 days of receipt of the adjudication by Medicare, it is considered by CMS to be an acceptable reason for delay. Use reason code “7” Third Party Processing Delay.

### ***Billing for Medical Residents in Teaching Hospitals***

NYS Medicaid follows the Medicare requirements for teaching hospitals. Medicaid guidance with respect to these requirements can be found in the [June, 2009 NYS Medicaid Update](#) .

The Centers for Medicare and Medicaid Services (CMS) [Guidelines for Teaching Physicians, Interns and Residents](#) also contains information with respect to this topic.

### ***Claiming for Procedures Performed by Students***

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

At this time, a properly supervised student may bill Medicaid as the servicing provider using the MMIS unlicensed provider ID (02249154). There is currently no requirement for the Medicaid number and/or NPI of the supervising clinician to be on the claim submitted by the student.

## **XI. Safety Net**

In 2016 the Centers for Medicare and Medicaid Services (CMS) denied the continuation of the waiver for the Clinic Uncompensated Care Pool (UCP). The Safety Net is the replacement of the UCP and is fully funded by NYS; there is no federal financial participation (FFP). The Safety Net will offset a portion of losses from uncompensated care experienced by:

1. Most Diagnostic and Treatment Centers licensed by DOH; and

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

Payments from the Safety Net are made in accordance with payment rules established by the OMH and DOH. Periodic partial payments from the pool will be made by the Department of Health. To participate, agencies must submit annual data for each of their clinic locations using the OMH-4, an OMH form in the Consolidated Fiscal Report (CFR). Clinics that fail to submit the OMH-4 will be excluded from the pool. Successive year OMH-4s will be used for successive years' calculations for uncompensated care (i.e., a two-year lag).

The percent of uncompensated care paid by the Safety Net is dependent on the total funds in the pool and the total value of allowable uncompensated care visits. To be eligible for an allocation of funds from the pool, a mental health clinic must demonstrate that a minimum of 5% of total clinic visits during the applicable period were uncompensated.

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

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

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

payment from the insurer or a written attestation from the client/insured that the insurer made no payment will be considered uncompensated. This documentation must be retained by the clinic and will be subject to an audit by the New York State Office of the Medicaid Inspector General or other party empowered to conduct such audits.

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

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

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

### Safety Net Calculation Method

Each eligible clinic will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

% of eligible uninsured visits to total visits	
Upstate	Downstate

Low (At Least)	High (Less Than)	Amt	Tier	Low (At Least)	High (Less Than)	Amt	Tier
0%	5%	\$0	0	0%	5%	\$0	0
5%	10%	\$30	1	5%	15%	\$47	1
10%	15%	\$40	2	15%	20%	\$57	2
15%	20%	\$51	3	20%	25%	\$68	3
20%	25%	\$63	4	25%	35%	\$80	4
25% or more		\$76	5	35% or more		\$93	5

Safety Net payments will be calculated by multiplying each facility’s rate add-on by the number of Medicaid visits reported in the base year certified cost report. Per CMS requirements, Medicaid visits include Medicaid fee-for-service (FFS) visits only.

The Safety Net rate adjustment total payment for each eligible clinic, which is determined based on the tier system, will be scaled based on the ratio of the total amount that was allocated for payment, using the tier system, to the total statewide safety net funds available for distribution to all eligible clinics.

**New Providers without Cost/Visit Experience**

New providers with less than two full years of cost experience may qualify to be included in the distribution. To be eligible:

- The provider must meet the eligibility criteria for the Safety Net Payment.
- The provider must be eligible to receive a Medicaid rate.
- The provider must submit a request to the Department of Health to participate in the distribution.



- The annual distribution for a new provider will not exceed \$100,000.

It is important to note that if the amount of eligible uncompensated care visits in the Safety Net calculation exceeds the funding available, payments to providers are proportionately reduced.

***Additional Information***

[Department of Health Safety Net](#) 



## Appendices

## Definitions (from regulations 14 NYCRR Section 599.4)

- (a) *After hours* means before 8 a.m., 6 p.m. or later, or during weekends.
- (b) *Ambulatory Patient Groups (APGs)* means a defined group of outpatient procedures, encounters or ancillary services grouped for payment purposes. The groupings are based on the intensity of the services provided and the medical procedures performed.
- (c) *Base rate* means the numeric value that shall be multiplied by the weight for a given service to determine the Medicaid fee for a service.
- (d) *Behavioral Health Organization* or BHO means an entity selected by the Commissioner of the Office of Mental Health and the Commissioner of the Office of Alcoholism and Substance Abuse Services pursuant to Section 365-m of the New York State Social Services Law to provide administrative and management services for the purposes of conducting concurrent review of Behavioral Health admissions to inpatient treatment settings, assisting in the coordination of Behavioral Health Services, and facilitating the integration of such services with *physical health care*.
- (e) *Clinic treatment program* means a program licensed as a clinic treatment program under Article 31 of the Mental Hygiene Law.
- (f) *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.
- (g) *Clinical staff* means staff members who provide services directly to recipients, including licensed staff, non-licensed staff, and student interns.
- (h) *Clinician* means a person who is a member of the professional staff.
- (i) *Collateral* means a person who is a member of the recipient's family or household, or other individual who regularly interacts with the recipient and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient prior to admission. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.

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

(k) *Community education* means activities designed to increase community awareness of the manifestations of mental illness and emotional disturbance and the benefits of early identification and treatment.

(l) *Complex care management* means an ancillary service to psychotherapy, psychotropic medication treatment, or crisis intervention services. It is provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which is required as a follow up to psychotherapy, psychotropic medication treatment, or crisis intervention service for the purpose of preventing a change in community status or as a response to complex conditions.

(m) *Concurrent Review* means the review of the clinical necessity for continued inpatient Behavioral Health Services, resulting in a non-binding recommendation regarding the need for such continued inpatient services.

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

(o) *Current Procedural Terminology (CPT)* means codes used in a coding system for health care procedures as defined in the publication *Current Procedural Terminology* which is published by the American Medical Association.

(p) *Designated mental illness* means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than:

- (1) alcohol or drug disorders,
- (2) developmental disabilities,
- (3) organic brain syndrome or
- (4) social conditions (V-Codes). V-Code 61-20 Parent-Child (or comparable diagnosis in any subsequent editions of the DSM) is included for children.

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

(r) *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.

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

(t) *Episode of service* means a series of services provided during a period of admission. An episode of service terminates upon completion of the treatment objectives or cessation of services.

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

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

(w) *Health monitoring* means the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use and smoking cessation. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status.

(x) *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.

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

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

(aa) *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.

(ab) *Hospital-based clinic* means a mental health clinic which is operated by a psychiatric hospital, or is located in 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 program licensed solely under Article 28 which provides fewer than 2,000 total visits annually shall not be considered a hospital-based clinic.

(ac) *Initial assessment* means a face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient.

(ad) *Injectable psychotropic medication administration* means the process of preparing and administering the injection of intramuscular psychotropic medications.

(ae) *Injectable psychotropic medication administration with monitoring and education* means the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

(af) *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.

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

(ah) *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.



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

(aj) *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.

(ak) *Non-licensed staff* means individuals 18 years of age or older who do not possess a license issued by the New York State Education Department in one of the clinic professional staff categories listed in this Part and who may not provide therapeutic mental health services, except as may be authorized in section 599.9 of this Part. Non-licensed staff includes employees who have a life experience related to mental illness or have education and training in human services.

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

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

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

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

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

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

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

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

- (1) *Creative arts therapist* is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.
- (2) *Licensed practical nurse* is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.
- (3) *Licensed psychoanalyst* is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.
- (4) *Licensed psychologist* is an individual who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a federal, state, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility.
- (5) Licensed *Marriage and family therapist* is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
- (6) Licensed *Mental health counselor* is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.
- (7) *Nurse practitioner* is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
- (8) *Nurse practitioner in psychiatry* is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.
- (9) *Physician* is an individual who is currently licensed as a physician by the New York State Education Department or possesses a permit from the New York State Education Department.

- (10) *Physician assistant* is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
- (11) *Psychiatrist* is an individual who is currently licensed to practice medicine in New York State, who (i) is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or (ii) is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.
- (12) *Registered professional nurse* is an individual who is currently licensed as a registered professional nurse by the New York State Education Department or possesses a permit from the New York State Education Department.
- (13) *Social worker* is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker (LCSW) by the New York State Education Department, or possesses a permit from the New York State Education Department to practice and use the title of either licensed master social worker or licensed clinical social worker.

(at) *Psychiatric assessment* means an interview with an adult or child or his or her family member or other collateral, performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office. An assessment may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues. A psychiatric assessment may include psychotherapy, as appropriate.

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

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

(aw) *Psychotherapy* means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging

personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones.

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

(ay) *Quality improvement* means a systematic and ongoing process for measuring and assessing the performance of clinic services and for conducting initiatives and taking action to improve safety, effectiveness, timeliness, person centeredness or other aspects of services.

(az) *Satellite* means a physically separate adjunct site to a certified clinic treatment program, which provides either a full or partial array of outpatient services on a regularly and routinely scheduled basis (full or part time).

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

- (1) ability to care for self (e.g., personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- (2) family life (e.g., capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- (3) social relationships (e.g., establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- (4) self-direction/self-control (e.g., ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- (5) ability to learn (e.g., school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

(bb) *Specialty clinic* means a clinic designated by the Commissioner as specializing in the provision of services to children who have a designated mental illness diagnosis and an impairment in functioning due to serious emotional disturbance.

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

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

(be) *Visit* means an interaction consisting of one or more procedures occurring between a recipient and/or collateral and the clinic staff on a given day.

(bf) *Weight* means a numeric value that reflects the relative expected average resource utilization for each service as compared to the expected average resource utilization for all other services.

## Frequently Asked Questions

OMH maintains a list of [frequently asked questions](#) on the OMH website.

## OMH Financial Modeling Tools:

OMH maintains a variety of [clinic projection tools](#) on the OMH website.

## Standards of Care

*The Standards of Care found at the links below are interpretive, general guidelines that are based on the existing OMH regulatory requirements.*

### **[Mental Health Clinic Standards of Care for Adults - Interpretive Guidelines](#)<sup>4</sup>**

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

Clinical standards for adult outpatient licensed clinics result from recent reviews of care. These reviews revealed that too often these standards, which we believe to be fundamental to good

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<sup>4</sup> Taken from Appendix E of the New York State/New York City Mental Health-Criminal Justice Panel Report and Recommendations June 2008.

care and a longstanding expectation of clinic services, may not be explicitly understood. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements.

### **Standards of Care for Children, Adolescents, and their Families**

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

## **Clinic Standards of Care Anchors and Survey Process**

In April 2010, the Bureau of Inspection and Certification (BIC) implemented a new process for surveying Clinic Treatment programs. While the revised licensing process set high standards for the delivery of clinic services which are individualized, integrated and effective, this initiative also made resources available to the clinics to assist them in meeting the challenge. Training modules on best practices, links to online resources, and other opportunities for identifying and sharing successful programs and practices are some of the types of materials which were made available. Feedback from providers has described the new licensing process as more clinically relevant than the former methodology.

The survey instruments have also been updated. It is intended that the modifications to the Clinic Standards of Care anchors provide greater clarity and less redundancy while continuing to promote practices and procedures associated with quality services and positive outcomes for individuals served.

In addition, a new resource document has been developed to assist providers in implementing best practices in clinics. The document provides links to a variety of tools and information associated with many of the survey anchor areas, and will be updated periodically.

A copy of the revised anchors and resource document was sent to all licensed clinic programs. More information regarding the Clinic Standards of Care Anchors and the resource document may be found on the [OMH website](#).

Licensing staff began using the updated version of the survey standards on **May 1, 2013**. The survey protocol and scoring for clinic surveys remain unchanged at this time.

## Staff Eligible to Deliver Mental Health Services

It is a provider’s responsibility to ensure that all services are provided by staff within their scopes of practice. OMH has identified the staff eligible to provide services within their scope of practice as of July 1, 2016. However, OMH is currently waiving many of these requirements as permitted by New York State Law. More information on the extension of the licensing social work exemption can be found at the [Office of the Professions website](#).

Part 599 also provides the Commissioner with authority to waive certain staffing requirements as allowable by law. Services 2, 3, and 7 below must be provided by a Psychiatrist/NPP unless an OMH waiver for another physician is received.

	<b>Service</b>	<b>Staff</b>
1	Initial Assessment	MD/NPP, LMSW, LCSW, Licensed Psychologist, RN, Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), and Licensed Creative Arts Therapist (LCAT), Licensed Psychoanalysts, non-licensed staff under appropriate supervision.
2	Psychiatric Assessment	Psychiatrist /NPP or PA with specialized training approved by the Office
3	Psychiatric Consultation	Psychiatrist /NPP or PA with specialized training approved by the Office
4	Crisis Intervention	MD/NPP, Licensed Psychologist, LMSW, LCSW, PA, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts, non-licensed staff under appropriate supervision
5	Injectable Psychotropic Medication Administration	MD/NPP/RN/LPN/PA
6	Injectable Psychotropic Medication Administration with monitoring and education	MD/NPP/RN/PA
7	Psychotropic Medication Treatment	Psychiatrist /NPP
8	Psychotherapy	MD/NPP, Licensed Psychologist, LMSW, LCSW, PA, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts, , non-licensed staff under appropriate supervision
9	Developmental Testing	Clinic professional staff
10	Psychological Testing - various	MD/Licensed Psychologist
11	Complex Care Management	MD/NPP, Licensed Psychologist, LMSW, LCSW, PA, RN, LMFT, LMHC, LCAT, Licensed Psychoanalysts, non-licensed staff under appropriate supervision
12	Health Physicals	MD/NPP/NP/PA



	Service	Staff
13	Health Monitoring	MD/NPP/NP/RN/LPN/PA
14	Smoking Cessation Counseling	MD/NP/PA/RN
15	SBIRT	Licensed practitioners must complete an OASAS approved SBIRT training of at least four hours. <a href="#">See required Training/Certification</a>

## CPT Codes, APG Codes and Service Blend Status<sup>5</sup>

This table contains APG numbers and CPT codes that are current as of the time of this guidance. These codes are subject to change. OMH will update its website to reflect the most current codes available.

APG	Procedure - OMH Regulatory Name	CPT Codes
323	Initial Assessment- 45 minutes minimum	90791/90792
E&M codes depend on diagnosis. See table below  315 for add-on code	Psychiatric Assessment - 30 minutes minimum	90833 with E&M 99202-99205 (New Patient) or 9999212-99215 (Established Patient)
E&M codes depend on diagnosis. See table below  316 for add-on code	Psychiatric Assessment - 45 minutes minimum	90836 with E&M 99202-99205 (New Patient) or 9999212-99215 (Established Patient)
E&M codes depend on diagnosis. See table below  316 for add-on code	Psychiatric Consultation	90833 (30 minute) or 90836 (45 minute) with E&M code 99202-99205 (New Patient) or 9999212-99215 (Established Patient)
321	Crisis Intervention Brief - 15 minute minimum	H2011
321	Crisis Intervention Complex – 1 hour minimum	S9484

<sup>5</sup> For CPT and HCPCS code definitions see manuals developed by the American Medical Association and the federal Centers for Medicaid and Medicare Services. For Medicaid billing purposes, clinics must comply with the service standards in Part 599.



<b>APG</b>	<b>Procedure - OMH Regulatory Name</b>	<b>CPT Codes</b>
312	Crisis Intervention Per Diem – 3 hour minimum	S9485
NA	Injectable Psychotropic Medication Administration	Non-APG Claim. Must be submitted using a professional claim (without a rate code) using CPT code 96372
490	Injectable Psychotropic Medication Administration with Education and Monitoring	H2010
426	Psychotropic Medication Treatment – 15 minutes minimum	E&M 99202-99205 (New Patient) or 999212-99215 (Established Patient)
315	Psychotherapy - Individual 30 minutes minimum	90832
316	Psychotherapy - Individual 45 minutes minimum	90834
317	Psychotherapy - Family with or without the client 30 minutes minimum	90846
317	Psychotherapy – Family & Client 1 hour minimum	90847
318	Psychotherapy - Family Group 1 hour minimum	90849
318	Psychotherapy - Group 1 hour minimum	90853
310	Developmental Testing - limited	96110
310	Developmental Testing – First Hour	96112
310	Developmental Testing – Additional 30 min.	96113
310	Psychological Testing Evaluation – First Hour	96130
310	Psychological Testing Evaluation– Additional Hour	96131
310	Psychological Testing Admin and Scoring – First 30 Min	96136
310	Psychological Testing Admin and Scoring - Additional 30 Min	96137
310	Psychological Testing – Neurobehavioral First Hour	96116
310	Psychological Testing – Neurobehavioral Additional Hour	96121
490	Complex Care Management – 5 minute minimum	90882
E&M codes depend on diagnosis. See table below	Health Physicals (coding is age specific)	99382-99387(New Patient) or 99392-99397 (Established Patient)
490	Health Monitoring – 15 minute minimum	99401
490	Health Monitoring – 30 minute minimum	99402
490	Health Monitoring – 45 minute minimum	99403
490	Health Monitoring – 60 minute minimum	99404
490	Health Monitoring Group – 30 minute minimum	99411
490	Health Monitoring Group – 60 minute minimum	99412
	Alternative codes available for Smoking Cessation Counseling and SBIRT	



## APGs for Physicals, Psychiatric Assessments and Consultations

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

<b>APG</b>	<b>APG Description</b>	<b>July 2013 Weight</b>
820	Schizophrenia	0.6620
821	Major Depressive Disorders & Other/Unspecified Psychoses	0.6620
822	Disorders Of Personality & Impulse Control	0.6620
823	Bipolar Disorders	0.6620
824	Depression Except Major Depressive Disorder	0.6620
825	Adjustment Disorders & Neuroses Except Depressive Diagnoses	0.6620
826	Acute Anxiety & Delirium States	0.6620
827	Organic Mental Health Disturbances	0.8078
829	Childhood Behavioral Disorders	0.6846
830	Eating Disorders	0.6620
831	Other Mental Health Disorders	0.6620



## Complex Care Management FAQs

	Question	Answers
1.	Does a referral to housing & legal services in an effort to avoid eviction count as CCM?	NO. A referral does not constitute CCM.
2.	Does talking with the recipient's landlord (who is threatening eviction proceedings due to the condition of the apartment) to negotiate a specific plan of action between the recipient, their family (if applicable) and the landlord to address the behavioral issues that threaten their housing status constitute CCM?	YES. Provided that it occurs within the 14 calendar days following a psychotherapy, psychotropic medication management or crisis intervention service where this issue was discussed and the communication is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy or crisis progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the recipient's mental health status.
3.	A recipient with multiple medical problems has recently started a new medication. He reports to his therapist that since starting the new medication his medical symptoms, which had been in remission/under control, have flared up and he is concerned that it is connected to the new psychotropic medication. However, the new psychotropic medication has been effective in mitigating his psychiatric symptoms. If the prescribing psychiatrist contacts the recipients PCP within 5 working days following the psychotherapy service to discuss the potential drug interactions and the contact is of 15 minutes in duration, does this constitute CCM?	YES. The psychiatrist is coordinating with the PCP re: a specific situation that has the potential to significantly alter the recipients' physical and/or mental health status. The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the recipients' physical and/or mental health status. The communication must be a minimum duration of 5 continuous minutes (to bill for one unit of service).

	Question	Answers
4.	Does a CPS/ACS hotline report that is made in response to information that is revealed during a psychotherapy session constitute CCM?	NO. Activities related to a practitioner's role as a mandated reporter DO NOT constitute CCM.
5.	During a family psychotherapy session the discussion centers on the development of a plan to mitigate the youth's frequent presentation to the ER for high risk behaviors or very aggressive, violent outbursts. It is agreed that in an effort to address the behaviors resulting in this frequent presentation to the ER and to prevent the possibility of an inpatient hospitalization, a meeting will be held with all of the youth's service providers to re-evaluate and refine the youth's crisis plan. Does this meeting constitute CCM?	YES. Provided the meeting occurs within 14 calendar days following the psychotherapy, psychotropic medication treatment or crisis intervention service where this issue was discussed and the meeting is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youths' mental health status.
6.	The content of a psychotherapy session focuses on the ongoing, problematic behaviors of the child at school. The youth's parent reports that they have received notice that if the behavior continues, the youth is going to be placed on home instruction. It is agreed that the social worker will contact the school in an effort to explore what other options exist regarding the youth's ability to remain in their current educational program or the possibility of alternative education programming that might better serve the youth's needs. Does this communication with the school social worker constitute CCM?	YES. Provided that it occurs within the 14 calendar days following the aforementioned psychotherapy visit and the communication is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth's mental health status.
7.	Does the completion and/or submission of documentation re: a referral (i.e. day treatment, respite, housing, etc.) constitute CCM?	NO. The completion and/or submission of paperwork related to a referral does not constitute CCM.

	<b>Question</b>	<b>Answers</b>
8.	<p>The content of a psychotherapy session focuses on the youth and their parent’s concerns that a day treatment program is not going to accept the youth. They are concerned re: the youth’s educational status as it is their understanding that the youth cannot return to their previous educational placement if denied. It is agreed that the social worker will contact the school and/or school district to clarify the student’s current educational situation and develop a specific plan of action to address any social, emotional, or behavioral issues that might be threatening the youth’s educational status. Does this phone call constitute CCM?</p>	<p>YES. Provided that it occurs within the 14 calendar days following the aforementioned psychotherapy visit and the communication is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth’s mental health status.</p>
9.	<p>If a youth is in foster care, does regular and routine contact (e.g. sharing updates, relaying information, etc.) with the foster care agency, biological parents, foster parents, etc. constitute CCM?</p>	<p>NO. If the contact is regular and routine then it does not constitute CCM.</p>
10.	<p>If a youth is in foster care and attends an individual psychotherapy session where the content of the discussion is exceptional (i.e. there is the potential for the youth’s community status to be significantly altered, significant impact on the persons mental/emotional status or functioning) and the social worker contacts the foster and/or biological parent(s) to develop and/or coordinate around the presenting issue, does that constitute CCM?</p>	<p>YES. Provided that the contact occurs within the 14 calendar days following the psychotherapy session and the communication is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy progress note and the CCM progress note should clearly document the intended impact of the follow-up as it relates to the youth’s mental health status. However, if the contact takes place during the therapy session it cannot be reimbursed as a separate complex care management service.</p>



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

	Question	Answers
15.	Does the completion of documentation related to an AOT order constitute CCM?	<p>NO. The completion of routine and required paperwork does not constitute CCM.</p> <p>However, attendance at an AOT related meeting/court appearances re: the recipient's needs as it relates to their treatment would constitute CCM if the meeting/appearance occurs within 14 calendar days of a psychotherapy, psychotropic medication treatment or crisis intervention service (where AOT concerns were discussed); and if the clinician's participation in the meeting/appearance is a minimum duration of 5 continuous minutes (to bill for one unit of service). The psychotherapy or crisis service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.</p>
16.	A patient is in need of a higher level of care. Does the clinician's submission of a referral to a Day Treatment Program or Partial Hospitalization program constitute CCM?	<p>NO. The completion and/or submission of referral paperwork does not constitute CCM.</p> <p>However, attendance at a meeting to coordinate services re: the recipient's needs as it relates to their treatment would constitute CCM if the meeting occurs within the 14 calendar days of a psychotherapy, psychotropic medication treatment or crisis intervention service (where the scope and purpose of the program was discussed); and if the clinician's participation in the meeting is a minimum duration of 5 continuous minutes (to bill one unit of service). The psychotherapy, psychotropic medication treatment or crisis intervention service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.</p>



	Question	Answers
17.	Patients often request letters in order to obtain benefits/entitlements. Can clinician's bill for writing letters for pts. Ex: for public housing, for public assistance, for SSI.	NO. Letter writing does not constitute CCM.
18.	Calls for referral to Domestic Violence Shelter/Program.	NO. The completion of a referral does not constitute CCM. However, a phone call that is a minimum duration of 5 continuous minutes and occurs within the 14 calendar days of a psychotherapy, psychotropic medication treatment or crisis intervention service where the situation was discussed could constitute CCM. The psychotherapy, psychotropic medication treatment or crisis intervention service progress note and the CCM progress note should clearly document the intended impact on the recipient's mental health status.