Regulatory Relief and Rapid Access in Article 31 Clinics
August 20th, 2020
Attendee Questions

Q#	Question	Answer/Notes
	Extent/Implication of Changes	
1.	Do the revised Part 599.10 regulations apply to 822 programs certified by OASAS?	No, these regulation changes are specific to Part 599 for Article 31 clinics.
2.	Are these changes to Treatment Plan review timelines consistent with Joint Commission requirements?	Yes. OMH's regulations require clinically appropriate review and adjustments to treatment plans to ensure recipients receive services appropriate to their needs which aligns with Joint Commissions requirements. Such review should be documented in a progress note.
3.	When Part 587 Children's Day Treatment Regulations ended, CDT programs were advised to use Part 599 Regulations for guidance. Do these changes apply to Children's Day Treatment services as well?	Part 587, Operation of Outpatient Programs, is an active regulation that stipulates the treatment planning requirements for OMH-licensed Continuing Day Treatment and Day Treatment programs serving children. The regulation can be found at: https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations . The Part 599.10 regulation changes apply to all Article 31 licensed clinics and does not apply to children's day treatment.
4.	Are the Section 599.10 regulation revisions related to both children's providers and adult clinics also?	Yes, Section 599.10 regulation changes apply to Article 31-licensed clinics serving both adults and children.
5.	Does this apply to CFTSS?	No, these regulation changes are specific to Part 599 clinic treatment programs.
6.	Does this apply to outpatient clinics within a general hospital as well?	These regulation changes apply to all OMH-licensed Article 31 clinics.
7.	If we were cited on our last MOR and submitted a PIP regarding 599.10 signatures, will we still be held accountable for the former reg if it no longer applies?	The updated 599.10 regulation changes are effective as of 8/19/20, Treatment Plans due prior to 8/19/20 should have been completed pursuant to the regulations then in effect. A provider with an active PIP regarding section 599.10 compliance should reach out to the office directly to discuss its applicability.
8.	Can medication be prescribed now during the pre-admission phase?	Yes, prescribing medication has been and is a billable service during pre-admission.

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9.	For clinics who participated in the CQI project for suicide care pathway, the suicide safer care best practices, including re-screening using the CSSRS, was attached to quarterly treatment plan for all clients. Will the implementation requirements change as well based on clinician assessment/determination for use of screening tool?	The Suicide Safer Care best clinical practice is still to re-screen clients quarterly, and when clinically indicated.
Treatment Plan Timeline/Requirements		
10.	Is it correct the say that the Initial Treatment Plan is due 30 days from the admission date, no longer the 30 days or 4th visit, whichever is sooner?	Yes, the timeline was revised to be clearer. The Initial Treatment Plan is due 30 calendar days from the date of admission.
11.	Is the Treatment Plan Review due within a year of the Initial Treatment Plan or the admission date?	The first Treatment Plan Review is due no less than annually based on the admission date. Subsequent Treatment Plan Reviews are due no less than annually from the date of the most recently completed Treatment Plan Review.
12.	If staff changes are made but not the services, is an updated treatment plan required?	No, the Treatment Plan is not required to be updated if staff changes are made. However, any changes related to the recipient's primary clinician in the program or the types of personnel who will be furnishing services should be identified in the treatment plan documentation, whether it be in the plan itself or in a progress note.
13.	Does the individual clinic decide whether they want to continue with quarterly treatment plans or change to minimum 1x per year?	Yes. The requirement is for no less than annually or as needed. Clinics may continue to review and update treatment plans on a quarterly basis.
14.	If a patient is admitted on 1/2/2020, and the initial treatment plan is completed on 1/31/20, is the treatment plan review due no later than 1/2/21 or 1/31/2021?	The Treatment Plan Review is due no less than annually based on the admission date, or the most recently completed Treatment Plan Review thereafter. In this scenario, the Treatment Plan Review would be due no later than 1/2/21.

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15.	Can you do treatment plan reviews in the treatment plan section for psychotherapy and groups, but for meds only individuals, can you choose to document treatment plan reviews in the progress note? Meaning can you have in your agency policy and procedures, a protocol that is not consistent between psychotherapy and meds only treatment - with one document in the treatment plan and one in the progress notes?	Yes, this would be an allowable distinction in your policy and procedures.
16.	Treatment Plans are due based on calendar days correct?	Yes, they are due based on calendar days.
17.	The initial Treatment Plan is due within 30 days, then no less than annually based on the admission date. If a review is done prior to 12 months then the next review is 12 months from that that review date, right?	Yes, the Treatment Plan Review is due no less than annually based on the admission date or the most recently completed Treatment Plan Review thereafter.
18.	Does reducing the minimum from 90 days to no less than annually or as clinically indicated (for the Treatment Plan review) relate to both fee-for-service and Medicaid Managed Care?	The regulations would apply to Managed Care members when MCOs do not specify treatment plan review timeframes for payment purposes. Where plans have their own treatment plan requirements, which cannot be less restrictive than the 599.10 regulations, agencies should defer to them.
19.	If the Initial Treatment Plan must be done within 30 days of admission, what happens if the client is not seen until after the 30 days due to no shows or cancellations? Do you just do the Initial Treatment Plan and review it with the client at their next billable session?	The Initial Treatment Plan is due 30 calendar days from admission. However, there are circumstances in which this is not possible, such as if an individual has not returned for appointments. This should be documented in the chart indicating the reason for the delay, and the Initial Treatment Plan should be completed at the next appointment the individual attends.

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		Physician/Clinician Signature
20.	If a treatment plan is in the progress note, how would an MD sign off on this?	Agencies shall develop policies and procedures for how this this will be operationalized as it may differ from agency to agency.
21.	Is a physician signature required for reducing or removing services?	No, the physician or psychiatrist signature is only needed for adding services or increasing the frequency and/or duration of services in Medicaid Fee-for-service cases.
22.	When you say physician, only psychiatrist or any physician?	A Treatment Plan is signed by a psychiatrist or other physician.
23.	For an added service or increased frequency of a service, can a Nurse Practitioner of Psychiatry authorize this, or must it be a physician?	Service increases (adding a service or increasing the frequency and/or duration of a service) require the following: Service increases under Medicaid Fee-for-service must be signed off by a psychiatrist or other physician. However, signature requirements for service increases under Medicaid Managed Care (MMC) or Commercial Insurance depend on whether 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
24.	Who can sign treatment plans, only physicians or can Psych Nurse Practitioners sign now also?	Medicaid Fee-for-service • Authorized/signed by a psychiatrist or other physician Medicaid Managed Care (MMC) or Commercial Insurance: • 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
25.	Nurse practitioners are prescribing medications. Is the signature of the NP on a treatment plan acceptable as an alternative to a physician?	Medicaid Fee-for-service • Authorized/signed by a psychiatrist or other physician Medicaid Managed Care (MMC) or Commercial Insurance: • 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

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26.	Can PNP's that prescribe sign Treatment Plans/Reviews for Medicaid Managed Care clients?	Yes, for Medicaid Managed Care (MMC) or Commercial Insurance: • 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
Recipient Signature		
27.	Can the individual/ family participation in the treatment plan be documented in a progress note as opposed to signing the actual plan?	The involvement of the individual/family in the treatment planning process should be documented in the treatment plan documentation, whether it be in the plan itself or in a progress note. Recipients are no longer required to sign the treatment plan.
28.	If a copy of the plan needs to be available to individual/family, do they need a copy of the plan and any revisions in progress notes to provide to the individual/family?	Agencies should develop policies and procedures on how best to make Treatment Plans available to individuals/families when requested.
29.	Is it correct that recipients do not need to sign treatment plans, is that just when it is goals and objectives and documented in a progress note or for Initial and Reviews too? Do recipients still need to sign the full Treatment Plan Reviews?	The involvement of the individual/family in the treatment planning process should be documented in the treatment plan documentation whether it be in the plan itself or in the progress note. Recipients are no longer required to sign the treatment plan.
30.	What about parent?	The regulation no longer requires the treatment plan to be signed by the parent/guardian. Agency policy should clearly indicate where and when consent for treatment will be documented by the parent, guardian or other person who has legal authority to consent to health care on behalf of the child (as well as the child, where appropriate).
Re-engagement/Rapid Access		
31.	How would re-engagement work to re-open last episode of care, specific "re-engagement.	Agencies will need to develop policies and procedures for re-engagement for their clinic(s).
32.	In rapid re-engagement is there a requirement that the patient be seen by the	Whenever possible, the individual should be able to continue working with their previous clinician, if desired by the recipient.

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	same provider as they saw previously, or can they be re-assigned to expedite their re-engagement?	
33.	For rapid reengagement, if a patient was discharged 4 months ago and we are doing rapid reengagement, is a new Initial Treatment Plan required?	No, the most recent treatment plan should be reviewed and updated as needed based on any change in presenting needs, symptoms or conditions.
34.	In re-engagement, can we use and update the initial assessment and psych evaluation?	Yes, prior assessments and evaluations should be utilized and updated as needed.
35.	If needed is it still ok to provide a code 90791 for more than one time (ie a second 90791) when a client re-engages?	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. NOTE: These rules apply to FFS only. Managed care companies may pay for additional initial assessment procedures. This is not a change.
36.	Is the rapid re-engagement change a requirement for all patients, or is there room for clinician discretion? One recurring stressor for providers is engaging patients who are repeatedly lost to follow up, discharged, and return to treatment (only to disengage from treatment again soon after).	The recent changes in Part 599.10 are intended to promote effective rapid re-engagement by reducing the documentation burden on the clinic. Agencies will need to develop policies and procedures for re-engagement.
37.	Can a client returning within a year from discharge stay in preadmit for a couple of visits even if we don't need to reassess them?	Re-engaged individuals would not be in pre-admission status upon re-engagement.

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		Assessment/Admission
38.	Any change in the need of the initial assessment and when it is due?	No, the Part 599.10 regulation revisions are specific to treatment planning only.
39.	If services are provided prior to completing the Initial Assessment what should the admission date be?	Part 599.10 regulation changes are specific to treatment planning only and do not apply to admission. There is no timeframe from when someone needs to be admitted by after the first visit. The admission process should be individualized. However, you are limited to Medicaid payment for 3 procedures if the adult or child is not admitted to the clinic by the 4th visit.
40.	Is the psychosocial update still a regulatory requirement on an annual basis?	OMH regulations do not require an annual psychosocial update.
		Billing
41.	Will any of the billing codes be changing?	The regulatory revisions do not affect any billing codes.
42.	For billing purposes, will this affect the pre-admission status that prevents billing for services until the client has been officially admitted to a unit?	No, there is no change to billing or services provided during pre-admission in the updated regulations. Most services can be provided during pre-admission status. Developmental Testing services; Psychological Testing services; and Complex and Per Diem Crisis Intervention for individuals who have not been a client within the past 2 years are the only services that cannot be billed during pre-admission.
43.	Will there be a grace period for agencies that may utilize an EMR that is set by default NOT to bill a claim out if the treatment plan is outdated? We will need time to work with our EMR to update this process.	The Section 599.10 Regulations were effective upon publication in the state register on 8/19/20. Agencies may wish to implement alternative claiming strategies to take advantage of the new flexibilities until such time as their EMR is updated to remove restrictions related to the prior regulations.
		Documentation
44.	Will there be any change in the utilization process regarding chart reviews?	No, there has been no change in the utilization review process.
45.	Why is there a distinction with documentation between FFS and Medicaid managed care?	We wanted to support any flexibility allowed by a Managed Care Organization.

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46.	What if a person comes back for a new issue than what they were previously seen for, how should we document? It appears that a new assessment is warranted.	If an individual returns to the clinic with a new presenting issue, you would document this in the progress note, update the Treatment Plan accordingly, and update the current assessment as needed.
47.	Our clinical team has questions pertaining to re-engagement.	OMH will provide additional guidance related to rapid access and reengagement.
Medicaid		
48.	For the revisions to Part 599.10 in-regards to the no less than annually treatment plans and signature requirements, will Medicaid regulations follow this?	Providers should comply with all applicable regulations.
NYSCRI		
49.	Does this mean you're no longer promoting the initial assessment from the NYSCRI form set?	NYSCRI is an optional resource available to clinics. NYSCRI documents may be modified according to a clinic's needs
Clarification		
50.	Please clarify again the differences between interventions vs services, thanks.	Examples of Service types include: • Psychiatric Assessment; Psychotherapy – Individual; Psychotherapy – Family/Collateral; Psychotherapy – Group; Psychotropic Medication Treatment; Injectable Psychotropic Medication Administration; Injectable Psychotropic Medication Administration with Education and Monitoring • Optional Service Types: Developmental Testing; Psychological Testing; Psychiatric Consultation; Health Physicals; Health Monitoring Interventions reflect what clinic treatment staff will do to help the individual accomplish their objective. Interventions should be action-oriented (e.g., the individual therapist will… teach, discuss, facilitate, review, instruct, rehearse, assist, etc.).
51.	Can we re- open closed episodes of care?	Yes, agencies should develop policies and procedures to re-open closed episodes of care to promote rapid re-engagement in services.
52.	When can we start using these new regs?	The Section 599.10 regulations are effective as of 8/19/20.

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		Miscellaneous
53.	Was this presented to the MCO companies?	Yes, the regulation changes were presented at the Statewide BH Medical Directors meeting.
54.	Our pre-admission screening and assessment has been driven by SOC / added items from OMH, what is minimally needed for "admission criteria" (i.e. health screening, TOB screening, SUD screening, risk, suicidality, violence, etc.)? Are these "assessment" or pre-admission requirements?	Per OMH Clinic Treatment Regulations at 14 NYCRR § 599.8, eligibility for admission to a clinic treatment program shall be based on a designated mental illness diagnosis. As per Standards of Care, a note is written upon decision to admit which includes the reason for referral, primary clinical need, services to meet those needs, and admission diagnosis. The initial assessment is due 30 calendar days after the first visit. The assessment may be completed before or after the recipient's admission.
55.	Is there any expectation that discharge criteria will even be included in subsequent reviews?	Discharge criteria is no longer required as part of the treatment plan. However, discharge is still part of the overall planning and should be based on progress made towards goals and objectives even though it is not documented in the treatment plan.
56.	This is a document from the webinar co-hosted by OMH last week on the new treatment plan and readmission guidelines. Before we make changes to our electronic health record, I would like to know whether we are able to use this document as official advice on treatment plans and rapid re-admissions. I haven't found this on the OMH website, so I am a bit wary to change our processes without getting official advice. https://ctacny.org/training/regulatory-relief-and-rapid-access-article-31-clinics	OMH did in fact release the archived webinar to CTAC for program use, so it is an approved webinar. Also, the provider may refer to pages 14 and 15 of the Depart of State Register to view the regulations: https://www.dos.ny.gov/info/register/2020/081920.pdf
		Integrated Outpatient Services (IOS)
57.	With the recent change in Part 599 treatment planning guidelines, should OMH IOS Host Site licensed under Part 587	Article 31 Clinic Treatment Programs with an Integrated Outpatient Services (IOS) license must ensure compliance with 14 NYCRR Part 599 in addition to the requirements of 14 NYCRR Part 598 (14 NYCRR Part 598.3). The New York State

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	follow the new regulations or continue to follow Part 587.7 treatment planning regulations?	Office of Mental Health (OMH) adopted new mental health clinic regulations, 14 NYCRR Part 599 on **DATE**. Although it is broadly still in line with Part 598 there are some key changes regarding treatment planning (14 NYCRR XIII Part 599.10). To improve quality of care and provide additional clarity for Integrated Clinic Treatment providers the NYS Office of Mental Health is issuing the following guidance in regard to Part 598.7. (*see Below for details)

***The following sections of Part 598.7 conflict with the revised Part 599.10. OMH-licensed IOS Host sites should adhere to the revisions in Part 599.10 listed below.**

598.7 Treatment Planning Regulation	Revised Part 599.10 Treatment Planning Regulation
§ 598.7.b Patient participation in treatment planning shall be documented by the signature of the patient or the signature of the person who has legal authority to consent to care on behalf of the patient or, in the case of a child, the signature of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate, provided, however, that the lack of such signature shall not constitute noncompliance with this requirement if the reasons for non-participation by the patient are documented in the treatment plan. The patient's family and/or collaterals (i.e., significant others) may participate as appropriate in the development of the treatment plan and shall be specifically identified in the treatment plan.	**§ 599.10.f** Recipient participation in the treatment planning process, including initial treatment planning and treatment plan reviews, shall be documented by notation in the record of the participation of the recipient or of the person who has legal authority to consent to health care on behalf of the recipient, or, in the case of a child, of a parent, guardian, or other person who has legal authority to consent to health care on behalf of the child, as well as the child, where appropriate. The recipient's family and/or collaterals may participate as appropriate in the development of the treatment plan. Collaterals participating in the development of the treatment plan shall be specifically identified in the plan.
§ 598.7.e The treatment plan shall include identification and documentation of the following: (1) patient-identified problem areas specified in the admission assessment; (2) treatment goals for these problem areas (unless deferred);	**§ 599.10.c** The treatment plan shall include identification and documentation of the following: (1) the recipient's designated mental illness diagnosis or a notation that the diagnosis may be found in a specific assessment document in the recipient's case record; (2) the recipient's needs and strengths;

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(3) objectives that will be used to measure progress toward attainment of treatment goals and target dates for achieving completion of treatment goals; (4) methods and treatment approaches that will be utilized to achieve the goals developed by the patient and primary counselor; (5) schedules of individual and group counseling; (6) each diagnosis for which the patient is being treated at the program; (7) descriptions of any additional services (e.g., vocational, educational, employment) or off-site services needed by the patient, as well as a plan for meeting those needs; and (8) the signature of the qualified health professional, or other licensed individual within his/her scope of practice, involved in the treatment and responsible for review of the treatment plan.	(3) the recipient's treatment and rehabilitative goals and objectives and the specific services necessary to accomplish those goals and objectives, as well as their projected frequency and duration; (4) the name and title of the recipient's primary clinician in the program, and identification of the types of personnel who will be furnishing services; (5) the recommended and agreed upon clinic treatment service and the projected frequency and duration for each service; (6) where applicable, documentation of the need for the provision of off-site services, special linguistic arrangements, or determination of homebound status; and (7) the signature of the treating clinician, as appropriate. For recipients who are Medicaid Fee-for-service beneficiaries, treatment plans shall be signed by a psychiatrist or other physician. For all other payers or plans, treatment plans containing prescribed medications shall be signed by a psychiatrist, other physician or nurse practitioner in psychiatry and treatment plans which do not contain prescribed medications shall be signed by a psychiatrist, other physician, licensed psychologist, nurse practitioner in psychiatry, licensed clinical social worker, or other licensed practitioner to the extent permitted by such other payer or plan's requirements.
§ 598.7.f All treatment plans shall be reviewed and updated as clinically necessary based upon the patient's progress, changes in circumstances, the effectiveness of services, and/or other appropriate considerations. Such reviews shall occur no less frequently than every 90 days, or by the next occasion when a service is to be provided to the patient, whichever shall be later. For services provided to a recipient enrolled in a managed care plan which is certified by the commissioner of Health or a commercial insurance plan which is certified or approved by the Superintendent of the Department of Financial Services, treatment plans may be reviewed pursuant to such other plan requirements as shall apply.	**§ 599.10.d** Treatment plans shall be reviewed no less frequently than annually based on the date of admission or additionally as determined by the recipient's treating clinician. Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. The Treatment Plan Review may be documented in progress notes and shall include the following: (1) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan; (2) adjustment of goals and treatment objectives, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate; and (3) determination of continued homebound status, where appropriate.

§ 598.7.g.4	**§ 599.10.e**
Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. The periodic review of the treatment plan shall include the following: (4) the signature of the qualified health professional, or other licensed individual within his/her scope of practice, involved in the treatment and responsible for review of the treatment plan.	Treatment plans shall be updated when new services are added, service intensity is increased or as necessary as determined by the recipient's treating clinician. When the treatment plan is updated the treating clinician as appropriate, pursuant to paragraph (7) of subdivision (c) of this section, shall sign the updated treatment plan. All other changes to information in the treatment plan shall only require the treating clinician's signature and may be recorded in progress notes.

The following sections of Part 598.7 are specific to IOS and should be adhered to by Integrated Outpatient Article 31 Clinics.

- **§ 598.7.c.3**
  If the patient is a minor, the treatment plan must also be developed in consultation with his/her parent or guardian unless the minor is being treated without parental consent as authorized by MHL section 22.11 or 33.21, as applicable.
- **§ 598.7.c.4**
  For patients moving directly from one program offered by an integrated services provider to another program offered by the same provider, whether or not it is a program approved to provide integrated services, the existing treatment plan may be used if there is documentation that it has been reviewed and, if necessary, updated within 14 days of transfer.
- **§ 598.7.d**
  The treatment plan shall include physical health, behavioral health, and social services needs. In addition, specific consideration of the need for health home care coordination should be noted when appropriate.
- **§ 598.7.g.3**
  (g) Treatment plan reviews shall include the input of relevant staff, as well as the recipient, family members and collaterals, as appropriate. The periodic review of the treatment plan shall include the following:
  (3) an evaluation of physical health status;

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