

ONEIDA COUNTY DEPARTMENT OF MENTAL HEALTH

NYS OMH CLINIC RESTRUCTURING

FREQUENTLY ASKED QUESTIONS (FAQs)

QUESTION	RESPONSE
Where can the most recent Part 599 information be found?	<p>The NYS OMH website (http://www.omh.state.ny.us) contains its own FAQs link under Clinic and Ambulatory Restructuring. This was last updated on 11/19/10.</p> <p>E-mail questions can also be sent directly to Gary Weiskopf @ gary.weiskopf@omh.state.ny.us.</p>
Under Part 599, how is Crisis Intervention defined?	<p>Crisis Intervention, as an Enhanced Service, 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.</p> <p><u>Guidance:</u> 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 make 24 hours a day, 7 days per week crisis services available for its clients via an approved Crisis Response Plan (see below).</p>
When should required Crisis Response Plans be submitted?	<p>All program-specific plans, including after hours coverage, were due into OCDMH for initial review and approval by 2/1/11. The county will decide whether all or some clinics will have their own plan or whether all or some clinics will have a consolidated plan. All approved plans must then be submitted to OMH 3/31/11.</p>
When MCAT (Mobile Crisis Assessment Team) is not physically present in the office (i.e. either in the field or working from home in the case of nights, weekends or holidays), they utilize an <i>answering service</i> to dispatch calls to staff. Is this OK?	<p>An <i>answering service</i> used to provide contact with clinicians is acceptable.</p>

<p>Some mental health clinics employ an <i>answering machine</i> for after hours contact which directs callers to leave a message or else call MCAT/911. One local provider transfers its phone directly to MCAT (which, again, may have its phone forwarded to an <i>answering service</i>). Are these options acceptable?</p>	<p>The intent is for clinics to respond to their clients after hours by phone in order to have the caller linked immediately with a human voice. Clinics should either forward directly to the <i>answering service</i> or the on-call staff. Recipients should <u>not</u> be instructed to call 911.</p>
<p>At what point can clinics begin to submit APG claims for service?</p>	<p>Per OMH, CMS has not yet approved the amendment to NYS's Medicaid Plan for OMH licensed mental health clinics. As a result, while Part 599 program regulations went into effect on October 1, 2010 mental health clinics will not transition to APG claiming until CMS approval has been received. Once federal approval is received, claims for services delivered after October 1, 2010 will be automatically reprocessed under APGs.</p> <p>A letter to OMIG co-signed by OMH and DOH, in part, temporarily waives the 90 days claims submission requirement and gives clinics 3 months from the date of federal Medicaid State Plan approval to adjust all claims and make any corrections as appropriate. The letter also requests that OMIG allow a time-limited moratorium on Article 31 clinic audits and disallowances.</p> <p>Please note: When submitting claims more than 90 days from date of service during the period the waiver is in effect, clinics must enter reason code 3 (Authorized Delays - Delays previously approved). Keep a copy of said letter in your files.</p>
<p>Under Part 599, what official relationship, if any, exists between an OMH Article 31 clinic and a DOH Article 28 clinic?</p>	<p>This is an evolving issue. OCDMH will seek clarification from OMH, particularly in relation to the Medication Management Only service category.</p>

<p>What is the service provision definition of Complex Care Management?</p>	<p>Complex Care Management is an Ancillary Service to psychotherapy or crisis intervention (see above) provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which is required as a follow up to psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions. It must be deemed as <i>medically necessary</i>.</p> <p><u>Guidance:</u> Complex Care Management is not a stand-alone service. It is a non-routine professional service designed to coordinate care, provided subsequent to a psychotherapy 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 must be provided as an ancillary service to a crisis service or a face-to-face-psychotherapy service. For Medicaid fee-for-service reimbursement, it must take place within five (5) working days following the provision of either service.</p>
<p>What is the LGU’s role in OMH Clinic Restructuring?</p>	<p>Counties play an important role in ensuring the success of the clinic treatment reform. 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 NYS Mental Hygiene Law. These include:</p> <ul style="list-style-type: none"> • <u>Review & approve crisis plans.</u> All clinics must have crisis plans (see above) 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 hour services may be provided directly by the clinic or pursuant to a <i>Clinical Services Contract</i>. • <u>Determine individuals in urgent need of clinic care.</u> The county director can require a clinic to provide an Initial Assessment and appropriate treatment or referral to the individual <u>within five (5) business days</u>. 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 (5) business days and, if indicated, are admitted to the clinic or referred to an appropriate provider of services. The county may establish, subject to OMH approval, categories of individuals to be considered in urgent need of services. • <u>Require, review and approve provider transition plans describing the level and type of non-Medicaid reimbursable services that will continue to be provided to the community</u>

	<p>(clinic and non-clinic services). These plans must describe the level of services that must be maintained during the transition, consistent with the level of funding available. The clinic’s ability to receive the COPS component of the legacy payment will be contingent upon county approval of, and compliance with, the plan.</p> <ul style="list-style-type: none"> • <u>Designate children’s specialty clinic programs.</u> This designation will allow the clinic to be reimbursed on a Medicaid fee-for-service basis for children who have a serious emotional disturbance and are enrolled in Medicaid managed care. (Locally, The Neighborhood Center currently has this designation but not CHBS.).
<p>During 2009-2010, The New York State Clinical Record Initiative (NYSCRI) was piloted. What’s the latest?</p>	<p>In 2009, the OMH Long Island Field Office in collaboration with the OASAS Regional Office and the Long Island Coalition of Behavioral Health Providers, initiated development of a standardized set of clinical case records. Recipients and families were instrumental in this collaboration. Working closely with consultants from MTM Services, Inc., a representative group of providers and state agency staff designed an enhanced compliant clinical records format during 2009, provided training to clinicians to pilot use of the draft forms in the spring of 2010, and made the final version of the NYSCRI package available for all providers on Long Island late last year.</p> <p>There has been great interest in the NYSCRI among providers, and county representatives across New York State. Many have indicated that they are eager for this kind of standardized record to provide more uniformity for their staff, to improve documentation, to facilitate movement between various levels of care and to reduce the investment in maintaining their records over time. The Long Island teams look forward to sharing their work with the rest of the state.</p> <p>September 21, 2010</p> <p>NYSCRI – OMH/OASAS Joint Announcement</p> <p>Dear Colleagues:</p> <p>We are pleased to announce the roll-out of the New York State Clinical Records Initiative (NYSCRI). This initiative offers a standardized and integrated clinical case records form set designed for select non-inpatient programs that are regulated by OMH and OASAS. The NYSCRI form set was developed over a two year period through active partnership and collaboration among OMH, OASAS, and a variety of providers from the Long</p>

Island area. We now invite your participation as we make this clinical records form set available statewide to selected providers.

The decision to adopt NYSCRI by a provider is a purely voluntary determination. There is no State mandate on providers to do so. However, when properly implemented by clinicians and supported by a provider's leadership team, we believe NYSCRI affords a number of advantages to providers, including technical assistance; enhanced compliance with State, Federal, and Accreditation requirements; support for medical necessity documentation; promoting more efficient use of clinician time; and compatibility with either electronic health records (EHR) formats or with paper-version case records.

Training efforts for NYSCRI implementation will be offered in each region of the state using a two-part format. The first session will provide a conceptual overview for key members of a provider's leadership team, with emphasis on attendance at the CEO/executive director and senior management level. The second session will offer a more detailed training on the NYSCRI form set using a clinical case study format. This session will be targeted to clinical supervisors, clinical trainers, and key clinical staff. In addition, we expect to make available separate sessions on EHR vendor certification for the NYSCRI format. If you are currently using an electronic medical record, please inform your vendor to check the OMH or OASAS website for further information about the new vendor certification process.

More information about NYSCRI as well as all of the above training will be posted on the OMH and OASAS websites in the near future.

When considering your decision to participate in NYSCRI, please bear in mind that initial development of the NYSCRI format is complete and implementation will roll-out statewide using the current NYSCRI form set. However, we recognize that no clinical records form set should remain static for long as clinical standards can change and clinician experience with NYSCRI will suggest further enhancements and improvements. Our staff will set up a collaborative stakeholder workgroup to keep NYSCRI current and relevant. Each participating organization will also have the opportunity to suggest revisions and modifications over time. We expect to re-visit the NYSCRI form set about a year after implementation to review necessary and recommended revisions.

We look forward to your consideration of, and participation in, implementation of this NYSCRI form set.

Sincerely,

Michael F. Hogan, Ph.D. Karen M. Carpenter-Palumbo, MSSW
Commissioner, OMH Commissioner, OASAS

Statewide Roll-Out: Although adoption of the NYSCRI format is **voluntary**, the records system is new and requires training and support for providers and clinicians in order to be successfully implemented within a program. OMH and OASAS are committed to assuring this training and support. Following the Long Island pilot project, the NYSCRI will roll-out statewide one region at a time on a schedule to be determined after considering advice from agencies, providers, and provider organizations as well as consumers and families.

The 2011 Statewide One-Day Train-the Trainer Regional Seminars Schedule is as follows:

City/Region	Training Days	Location
Long Island	January 11th	Pilgrim PC
Long Island	January 12th	Pilgrim PC
Poughkeepsie	February 1st	Dutchess County DMH
Orangeburg	February 2nd	Nathan Kline Institute
Albany	February 17th	Albany Medical Center
New York City	March 1st	Pending
New York City	March 2nd	Metropolitan Hospital
New York City	March 3rd	Metropolitan Hospital
Syracuse	March 10th	Hutchings PC
Buffalo	March 22nd	Buffalo PC
Rochester	March 23rd	Rochester General Hospital
Northern Central NY Region	April (tent.)	TBD

For further information, go to:

<http://www.omh.ny.gov/omhweb/nyscri/overview/pdf>
[http://www.omh.ny.gov/omhweb/clinic_restructuring/training materials/nys_clinical_record](http://www.omh.ny.gov/omhweb/clinic_restructuring/training_materials/nys_clinical_record)