Attestation of Compliance for OMH Approval to Offer Telemental Health Services

14 NYCRR Section 596

Part 596 of Title 14 NYCRR permits the provision of Telemental Health Services by OMH programs licensed or designated pursuant to Article 31 of the NYS Mental Hygiene Law, if approved to do so by the Office of Mental Health (OMH). Approval shall be based upon acceptance of a written plan that addresses a series of standards and procedures. The following Attestation of Compliance must be completed and submitted with the written plan to verify compliance with such required standards and procedures.

Instructions for Applicant:
For each required standard or procedure, place your initials to verify compliance and include the page or section number(s) of the plan that addresses same. **(*This Attestation consists of four pages.)***

For all provider types:

1. The plan confirms the Telemental Health Practitioner is being requested because they are necessary to improve the quality of care of individuals receiving services, or because they are necessary to address workforce shortages.

Initials: _____ Page/Section Number(s): _____

2. The plan confirms the practitioner meets standards established in Part 596.6(a)(1), including a current, valid license, permit, or limited permit to practice in NYS.

Initials: _____ Page/Section Number(s): _____

3. The plan identifies the transmission linkages on which Telemental Health Services will be performed, which are dedicated, secure, meet minimum federal and New York State requirements (e.g., HIPAA Security Rules) and are consistent with guidelines issued by the Office of Mental Health.

Initials: _____ Page/Section Number(s): _____

4. The plan identifies acceptable authentication and identification procedures which will be employed by both the sender and the receiver.

Initials: _____ Page/Section Number(s): _____

5. The plan includes procedures and protocols designed to ensure that confidentiality is maintained as required by NYS Mental Hygiene Law Section 33.13 and 45 CFR Parts 160 and 164 (HIPAA Privacy Rules).

Initials: _____ Page/Section Number(s): _____

6. The plan confirms that the spaces occupied by the recipient and the distant Telemental Health Practitioner meet the minimum standards for privacy expected for recipient-clinician interaction.

Initials: _____ Page/Section Number(s): _____

7. The plan confirms that culturally competent interpreter services will be provided when the recipient and Telemental Health Practitioner do not speak the same language and identifies methods by which this will be fulfilled.

Initials: _____ Page/Section Number(s): _____

8. The plan contemplates the provision of Telemental Health Services to recipients under age 18 and describes how clinically-based decisions will be made with respect to whether to include clinical staff in the room with the recipient consistent with OMH clinical guidelines.

Initials: _____ Page/Section Number(s): _____

9. There is a written procedure at each site which describes the availability of an alternative to the Telemental Health Practitioner if requested by the recipient. For recipients who do not want to receive services via telemental health, the program will make a referral to an in-person practitioner or provide a practitioner for in-person assessment if requested.

Initials: _____ Page/Section Number(s): _____

10. The plan includes procedures for prescribing medications.

Initials: _____ Page/Section Number(s): _____

11. The plan describes how progress notes and treatment plans will be developed and maintained.

Initials: _____ Page/Section Number(s): _____

12. The plan identifies procedures for assessing recipients to determine whether a recipient is appropriate for Telemental Health Services.

Initials: _____ Page/Section Number(s): _____

13. The plan describes how recipients will be informed about Telemental Health Services and how consent to participate will be obtained.

Initials: _____ Page/Section Number(s): _____

14. The plan includes procedures in the event that emergency hospitalization becomes necessary, including specifics for situations in which the recipient's place of residence may be considered the originating/spoke site.

Initials: _____ Page/Section Number(s): _____

15. The plan includes a procedure describing the contingency plan when there is a failure of transmission or other technical difficulties that render the service undeliverable.

Initials: _____ Page/Section Number(s): _____

16. The plan confirms that a review of Telemental Health Services is incorporated within the provider's quality management process.

Initials: _____ Page/Section Number(s): _____

17. The plan confirms that claim modifiers "95" or "GT" will be used on each claim line that represents a service via telemental health.

Initials: _____ Page/Section Number(s): _____

Specific to ACT:

18. The plan confirms the practitioner meets the following:
    a. Psychiatrists and Psychiatric Nurse Practitioners meet NYS ACT standards for Psychiatric Prescriber (PP), including training requirements through the ACT Institute.
    b. The practitioner is familiar with NYS ACT Program Guidelines, Standards of Care, Part 508, and Part 596.
    c. The practitioner received training and information on systems within the ACT Team's service area/community.

Initials: _____ Page/Section Number(s): _____

19. The plan includes ACT team developed protocols and procedures to address the following:
    a. Emergencies and crisis response, specifically a plan for availability/accessibility of the practitioner by the ACT Team.
    b. Presence of ACT staff during the delivery of telemental health services.
    c. Ownership and maintenance of records, including documentation of service delivery/appointment is entered into the case record within 1-2 business days.
    d. Practitioner access to the recipient's case record.
    e. Active involvement of the practitioner in the ACT Team, including:
        i. Practitioner participation routinely and regularly in the daily meeting (via VTC or another teleconferencing vehicle), and
        ii. Communication with the nurse within 24 hours of service delivery/ appointment to communicate updates or medication changes.

Initials: _____ Page/Section Number(s): _____

20. The plan confirms the ACT team understands that telemental health may only be delivered for a limited period, not to exceed one year. Upon demonstration of a continued shortage or need beyond one year, a request can be made to extend for a period not to exceed one additional year.

Initials: _____ Page/Section Number(s): _____

Specific to PROS:

21. The plan includes protocols and procedures to address the following:
    a. Availability of PROS staff during the delivery of Telemental Health Services as needed, and in the case of an emergency.
    b. Ownership and maintenance of records, including documentation of service delivery/appointment is entered into the case record within 1-2 business days.
    c. Practitioner access to the recipient's case record.
    d. Active involvement of the practitioner with PROS staff, including:
    i. Practitioner participation in staff meetings or participant-specific meetings, as necessary, and
    ii. Communication with the PROS program staff within 24 hours of service delivery/ appointment to communicate updates or medication changes.

Initials: _____ Page/Section Number(s): _____

22. The plan confirms the PROS program understands telemental health may only be delivered for a limited period, not to exceed one year. Upon demonstration of a continued shortage or need beyond one year, a request can be made to extend for a period not to exceed one additional year

Initials: _____ Page/Section Number(s): _____

Statement of Compliance and Signature:

I, [Print full name and title of the applicant]_____hereby attest that the representations made on this attestation form are true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may result in revocation of approval to provide Telemental Health Services at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability."

Agency Name: _____

Applicant Signature: _____ Date: _____

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For OMH Field Office:

This Attestation of Compliance has been reviewed for completeness. The Field Office is accepting the written plan of this Applicant based upon the representations made in this Attestation.

Field Office Signature: _____ Date: _____

Revised 8/27/20