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To: OMH Providers
From: OMH Central Office
Date: March 13, 2023
Subject: Impact of the end of the Federal Public Health Emergency (PHE) on the OMH System

Background

The Federal Government has announced that the PHE will expire at the end of the day on May 11, 2023. On the date the PHE ends, the flexibilities afforded providers regarding minimum billing standards and documentation requirements will end, unless otherwise specified by OMH through formal regulatory waivers. The current OMH Commissioner's waiver, which was last renewed on February 1, 2023 and contains the COVID-19-related flexibilities, will terminate on the same date as the PHE ends.

Below is a summary of the areas impacted by the end of the PHE. Providers will be immediately required to resume appropriate service provision for billing purposes and documentation activities pursuant to OMH regulations and the approved Medicaid State Plan for services reimbursed by Medicaid.

OMH strongly encourages providers to utilize the available lead time and begin resuming and completing outstanding documentation, such as treatment or service planning documentation, and utilization review activities to ensure services rendered on and after the end date of the PHE meet all regulatory requirements.

Telehealth

OMH has adopted regulatory changes to Part 596 which made permanent many of the flexibilities put in place during the NYS Executive Order and continued with the OMH Commissioner's Waiver. These revised regulations were effective September 12, 2022 and published in issue #39 of the State Register dated September 28, 2022. OMH will soon release Telehealth Guidance to further clarify expectations for OMH licensed and funded programs.

OMH licensed providers are required to add the optional/additional service "Telehealth" to the operating certificate. Providers requesting to utilize this practice may simply submit an "Administrative Action" via the Mental Health Provider Data Exchange (MHPD). Outpatient clinics should choose a "change in optional services offered" and all other program types should choose a "change in additional services offered". OMH designated providers are required to receive approval for telehealth services. Further guidance for all providers is available at [Streamlined Process to Permanently Add Telemental Health](#). Programs that have not received permanent approval for telehealth by the end of the PHE must cease offering services by telehealth until such time as they receive permanent approval. Approval for telehealth services is specific to each site and satellite site.

CMS has also extended the Medicare telehealth flexibilities until the end of 2024. This means the new rules requiring an in-person visit six months before an initial telehealth visit and every

12 months thereafter for telehealth visits for the treatment of a mental health condition will not take effect until January 1, 2025.¹ Note these new in-person visit requirements do not apply to telehealth services for the treatment of substance use disorder conditions or co-occurring mental health and substance use disorder conditions.

OMH programs must continue to use applicable modifiers to denote the provision of telehealth services on Medicaid claims. For more information about Medicare claiming for telehealth services, please visit the federal [Health and Human Services website for billing and coding Medicare Fee-for-Service claims](#).

OMH has also issued an [Informational Bulletin from the OMH Chief Medical Officer \(03/03/2023\)](#) with guidance for providers regarding prescribing controlled substances by telehealth after the end of the PHE.

Documentation

For all program types, effective May 11, 2023, all medically necessary services must be documented in a treatment, recovery, or service plan which was either initially completed or has been reviewed (in the past) within the timeframes required by OMH regulations.

Such plans must also comply with regulatory requirements regarding appropriate signatures.

Utilization Review

All programs must resume utilization review requirements pursuant to OMH regulations.

Billing Standards

Programs shall not submit Medicaid claims using the modifier code CR (Catastrophe/Disaster related) for any date of service on or after May 11, 2023. OMH programs must continue to use applicable modifiers to denote the provision of telehealth services on Medicaid claims. See Program-Specific Guidance below for more information.

HIPAA Enforcement

The federal Department of Health and Human Services (HHS) has deferred HIPAA enforcement for the good faith provision of telehealth services during the PHE. HIPAA enforcement in this area will resume. Providers must ensure their telehealth platforms and practices comply with the HIPAA privacy and security rules, if they have not done so already.

Hospital Conditions of Participations

Hospital conditions of participation are applicable to all Medicare certified hospitals. During the PHE, numerous federal regulations were waived to permit hospitals flexibility to handle the COVID-19 surge/staffing crisis, including waivers related to physician privileging, physical environment, temporary locations, nursing care planning, and Medicare billing for hospitals with inpatient PPS-excluded “distinct” psychiatric units. These waivers, available at

¹ Consolidated Appropriations Act of 2023, P.L. 117-328, § 4113(d).

<https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf>, will expire at the end of the PHE.

Program Specific Guidance for Community-Based Services

Adult Behavioral Health Home and Community Based Services (Adult BH HCBS) & Recovery Coordination Services

The Program and Billing Guidance for Designated Providers of Adult BH HCBS and Recovery Coordination regarding Emergency Response to Covid-19 (issued 04/16/2020, revised 05/08/2020) is no longer effective. There is no longer a reduction of billing minimum requirements, which allowed for the rounding of units. For more information on billing and claiming for BH HCBS, please refer to the [HARP and Mainstream Behavioral Health Billing and Coding Manual](#). For more information on billing and claiming for Recovery Coordination services, please refer to the [Guidance on Documentation and Claiming for Recovery Coordination](#) (07/02/2018). All other service and documentation standards will resume on May 11, 2023.

Article 31 Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)

The OMH Commissioner's Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR § 599 will no longer be waived:

- 14 NYCRR § 599.13(m)(3); (d)(1)(i)(b)-(c); (d)(1)(ii)(b)-(c); (d)(3)(ii)(a); (d)(4)(ii); (d)(5); (d)(6)(i)(a)(1)-(2); (d)(6)(i)(b)(1)-(2); (d)(6)(iii)-(iv); (e) and 14 NYCRR § 599.14 (relating to the Medical assistance reimbursement system and Medical Assistance billing standards.) **Note recent amendments to Part 599 regulations permit rounding for service durations.**
- 14 NYCRR § 599.10(g) and (i), and 14 NYCRR § 599.11(b)(7) and (11) (relating to documentation requirements and timeframes associated with initial treatment plan development and treatment plan reviews.) **Note recent amendments to Part 599 regulations change treatment plan review timeframes.**
- 14 NYCRR § 599.6(l) (relating to provider internal, written utilization review procedures.)

Assertive Community Treatment (ACT) (Adult ACT, Young Adult ACT, Youth ACT)

The OMH Commissioner's Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR § 508 will no longer be waived:

- 14 NYCRR § 508.4(i) (relating to the definition of "contact"); 14 NYCRR § 508.5(c)(1)-(3) (relating to reimbursement rates); and 14 NYCRR § 508.7(b) (relating to minimum billing standards for services provided to hospital inpatients), to reduce minimum service duration standards, to permit providers to bill for providing services to individuals or collaterals for at least 5 minutes and for fewer than 3 or 6 contacts per month, as applicable, if providers perform and document sustained outreach to clients.

- 14 NYCRR § 508.5(b)(8) (relating to reimbursement standards), to waive requirements related to reimbursement for services contained in a recipient's formal treatment plan.

ACT Programs must resume compliance with Program regulations and guidance regarding documentation:

- Any assessments, service plans, physician authorization and service plan reviews that are past their 6-month due date must be completed on or before May 11, 2023.
- All new admissions to ACT programs should resume following regulations relevant to documentation requirements, including signature requirements.
- ACT billing requirements will be resumed to meet the following minimum standards. As PHE ends mid-month and claims for ACT services are billed monthly and not based on the dates of contacts provided, ACT programs must resume compliance with regulatory billing standards as of May 12, 2023.
 - All billable telehealth/telephonic and face-to-face individual contacts (any service) shall be a minimum of 15 minutes in duration.
 - Reimbursement shall be made at the full payment rate (rate code 4508) for services provided to active clients who receive a minimum six contacts in a month, three of which may be collateral contacts.
 - Reimbursement shall be made at the partial step-down payment rate (rate code 4509) for services provided to active clients who receive a minimum of two, but fewer than six contacts in a month.
 - Reimbursement for services to ACT clients who are admitted for treatment to an inpatient facility and are anticipated to be discharged within 180 days of admission shall be made in accordance with section 508.7 of New York State regulations pertaining to the Assertive Community Treatment program.
- The ACT program may choose to bill under the COVID-19 billing flexibilities in effect through May 11, 2023, as follows:
 - If an individual receives three (3) 5-minute telehealth/telephonic or face-to-face contacts occurring on May 1-11, the ACT program may choose to use the disaster emergency billing standard and bill a full month (rate code 4508) instead of billing under Part 508 regulations.
 - If an individual receives one (1) 5-minute telehealth/telephone or face-to-face contact occurring on May 1-11, the ACT program may choose to use the disaster emergency billing standard and bill a partial month (rate code 4509) instead of billing under Part 508 regulations.
 - If an individual receives one (1) 5-minute telehealth/telephonic or face-to-face contact occurring on May 1-11 in an inpatient setting, the ACT program may choose to bill an ACT inpatient claim (rate code 4511) instead of billing under Part 508 regulations.
 - Additionally, if the ACT program chooses to bill for the month of May under Part 508 regulations, telehealth/telephonic or face-to-face contacts made prior to May 12, provided under PHE guidelines, may be counted toward a standard Part 508 claim.
 - All claims submitted under PHE guidelines must include the disaster relief Medicaid billing modifier (CR).

Children and Family Treatment Supports and Services (CFTSS)

No regulatory requirements were waived for CFTSS during the PHE and as such the ending of the PHE does not impact the applicability of CFTSS regulations. The ending of PHE does not impact the waiver in place for 14 NYCRR Section 511-2.5. This waiver applies to all OMH-licensed CMHRS programs and is effective through July 17, 2023, at which time OMH will reevaluate the need for the waiver.

During the PHE, flexibilities were permitted regarding billing allowances to provide Other Licensed Practitioner (OLP) Crisis Off-site (In-Person) via telehealth. Post-PHE, OLP Crisis Off-site must be provided off-site and in-person in accordance with program guidance. During the PHE, flexibilities were permitted regarding rounding allowances. Post-PHE, rounding allowance must adhere to timeframes as currently outlined in program billing guidance.

As CFTSS are community-based services intended to engage youth and families in their natural environments, services should primarily be delivered off-site and in person in accordance with state-issued guidance. Providers should begin efforts to transition to in-person service delivery, as appropriate, and in accordance with youth and family preference.

Continuing Day Treatment (Adult) and Day Treatment for Children and Adolescents Programs

During the PHE, NYS obtained a waiver of federal regulations which require Medicaid “Clinic option” services to be provided within the four walls of the facility. OMH Continuing Day Treatment and Day Treatment for Children and Adolescents Programs are authorized under the Medicaid “Clinic Option.” Once the PHE expires and federal regulations resume for these programs, either the telehealth recipient or the telehealth practitioner or both must be in-person at the program site in order to bill Medicaid.

The OMH Commissioner’s Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR §§ 587 and 588 will no longer be waived:

- 14 NYCRR § 588.8(a) (relating to reimbursement standards for day treatment programs service children), to provide for the reduction in minimum service duration standards to permit providers to bill for providing services to individuals or collaterals for at least 5 minutes or for fewer than 5 minutes, if providers perform and document sustained outreach to clients.
- 14 NYCRR § 588.8(d) and 14 NYCRR § 587.16 (relating to timeframes associated with initial treatment plan development and treatment plan reviews for day treatment programs services children.)
- 14 NYCRR § 588.7 (relating to reduced minimum service timeframes), to permit providers to bill for providing services to individuals or collaterals for at least 5 minutes or for fewer than 5 minutes if providers perform and document sustained outreach to clients.
- 14 NYCRR § 588.7(i) (relating to provider internal, written utilization review procedures.)
- 14 NYCRR § 588.7(k) (relating to timeframes associated with initial treatment plan development and treatment plan reviews.)

Community Oriented Recovery and Empowerment (CORE) Services

There is no longer a reduction of billing minimum requirements, which allowed for the rounding of units. For more information on billing and claiming for CORE Services, please refer to the [CORE Benefit and Billing Guidance](#) (issued 10/06/2021, updated 04/01/2022).

Partial Hospitalization Programs

During the PHE, NYS obtained a waiver of federal regulations which require Medicaid “Clinic option” services to be provided within the four-walls of the facility. OMH Partial Hospital Programs are authorized under the Medicaid “Clinic Option.” Once the PHE expires and federal regulations resume for these programs, either the telehealth recipient or the telehealth practitioner or both must be in-person at the program site in order to bill Medicaid.

The OMH Commissioner’s Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following section of 14 NYCRR §§ 587 and 588 will no longer be waived:

- 14 NYCRR § 587.16 (relating to requirements related to treatment plans, timeframes associated with initial treatment plan development and treatment plan reviews.)
- 14 NYCRR § 588.9(a) (relating to minimum service duration timeframes), to permit providers to bill for providing services to individuals or collaterals for at least 5 minutes if providers perform and document sustained outreach to clients.
- 14 NYCRR § 588.9(a)(1)-(4)(5); and 588.9(d) (relating to timeframes associated with initial treatment plan development and treatment plan reviews.)
- 14 NYCRR § 588.9(b) (relating to provider internal, written utilization review procedures.)

Personalized Recovery Oriented Services (PROS) Programs

The OMH Commissioner’s Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR § 512 will no longer be waived:

- 14 NYCRR § 512.11(b)(5); (11)(i) and (ii); (13) and (14) (relating to reimbursement for Personalized Recovery Oriented Services (PROS), to waive provisions which refer to minimum service duration timeframes and contacts to permit providers to bill for providing services to individuals or collaterals for at least 5 minutes or for fewer than 5 minutes, if providers perform and document sustained outreach to clients.)
- 14 NYCRR § 512.7(e) (relating to PROS recovery planning process); 512.8(b) (relating to PROS individualized recovery plans); and 512.11(b)(6)(iv) (relating to medically necessary PROS services, to waive requirements related to recovery planning, including timeframes associated with initial recovery plan development and recovery plan reviews.)
- 14 NYCRR § 512.9(h) (relating to PROS organization and administration); and 512.7(e)(5)(ii) (relating to PROS individualized recovery planning process to suspended provider internal, written utilization review procedures.)

PROS Programs must resume compliance with all programmatic, documentation, and billing requirements as defined in Part 512 regulations:

- Any assessments, initial Individual Recovery Plans (IRP), and IRP reviews that are past their 6-month due date must be completed on or before May 11, 2023.

- Signature requirements, including participant signature requirements, as defined in regulations must be resumed on or before May 11, 2023.
- All billable services must meet regulatory service definitions and must be provided in accordance with the participant's IRP.
- PROS programs must maintain supporting documentation for each participant's on- and off-site program participation time (PPT), including PPT accrued through telehealth.
- PROS billing requirements will be resumed to meet the following minimum standards:
 - All billable telehealth/telephonic and in-person individual services shall be a minimum of 15 minutes in duration
 - All billable telehealth/telephonic and in-person group services shall be a minimum of 30 minutes in duration
 - Claims will be submitted for appropriate Tiers and add-ons based on program participation time and service delivery, as defined in Part 512.11

PROS Billing guidelines for the month of May 2023 (or month that the PHE ends):

- When the reduced billing minimums to bill Tier 1 or Tier 3 are met for an individual prior to the date the PHE ends, the PROS program may choose to bill under the COVID-19 billing flexibilities in effect until that date. For example, if an individual receives four (4) 5-minute contacts between May 1 and May 11, the PROS program may choose to use the PHE billing standard and bill at a Tier 3 (rate code 4522), instead of billing under Part 512 regulations using program participation time to determine the tier. Providers choosing to bill under the PHE standards are subject to the full scope and limitations of PHE billing guidance.
- If a PROS program submits a claim under the reduced billing minimums, the date of service on the claim should be entered as the last date of the federal PHE (i.e., 05/11/2023) and they must include the modifier code CR (Catastrophe/Disaster related).
- All services provided after the federal PHE must meet standard billing requirements as described above and in Part 512.11.

Program Specific Guidance for Residential Services

Children's Community Residence

The OMH Commissioner's Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR § 594 will no longer be waived:

- 14 NYCRR § 594.10(a), (b), (d), and (f) (relating to the operation of licensed housing programs for children and adolescents with serious emotional disturbances.)
- 14 NYCRR § 594.14(a) (relating to provider internal, written utilization review procedures.)

Community Rehabilitation Services within Residential Programs for Adults and Children and Adolescents

The OMH Commissioner's Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR §§ 593 and 595 will no longer be waived:

- 14 NYCRR § 593.6(c) and (f) (relating to payments for community rehabilitation services within residential treatment programs for adults and children and adolescents, to waive regulatory timeframes associated with initial treatment plan development and treatment plan reviews.)
- 14 NYCRR § 593.6(b) and 14 NYCRR § 595.11(f) (relating to the physician's authorization renewal requirement for residential programs, to permit housing providers to continue to bill Medicaid if circumstances related to the crisis prevent the renewal of a physician's authorization within required the timeframes.)

Residential Treatment Facilities (RTF)

Documentation requirements and utilization review procedure requirements for RTFs were reinstated on 10/31/2021. COVID-19 emergency period allowances regarding use of restraint in RTFs were rescinded 6/24/2021. No other regulatory requirements were waived for RTFs during the PHE and as such, the ending of the PHE does not impact the applicability of any RTF regulations.

Residential Treatment Programs for Adults

The OMH Commissioner's Waiver, including the following regulatory waivers, will terminate on May 11, 2023. The following sections of 14 NYCRR § 595 will no longer be waived:

- 14 NYCRR § 595.11(a), (c), and (d) (relating to timeframes associated with initial treatment plan development and treatment plan reviews.)
- 14 NYCRR § 595.13(a)(1) (relating to provider internal, written utilization review procedures.)