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**Telehealth Services Guidance
for OMH Providers**



**Office of
Mental Health**

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SECTION 1: Introduction

The purpose of this document is to provide implementation guidance to providers licensed pursuant to Article 31 of New York State (NYS) Mental Hygiene Law, as well as providers designated or otherwise authorized by the NYS Office of Mental Health (OMH) to provide services that are approved to utilize telehealth pursuant to Part 596.

The use of telehealth provides increased access to mental health services and enhances service engagement for adults, children and families. OMH has updated Part 596 of Title 14 NYCRR to allow for greater flexibility and capacity for the utilization of Telehealth Services in NYS. Providers should review Part 596 in addition to this guidance to inform necessary policy changes, as applicable. Regulatory changes include: changing the title from “Telemental Health” to “Telehealth”; allowing for the use of Audio-only; expanding the definition of Telehealth Practitioner; allowing all Telehealth Practitioners the option to deliver services from locations located outside of NYS, but within the United States or its territories; and allowing for the use of Audio-visual technologies for Article 9 examination, evaluation, or assessment.

The regulations prescribe that, when approved by OMH, Telehealth Services may be utilized for licensed, designated, and authorized services provided from a site distant from the location of an individual receiving services, where the individual is physically located at a provider site licensed by the Office, or the individual’s place of residence located in NYS, other identified NYS location, or temporary location out of State. Generally speaking, Telehealth Services are considered to be provided where the individual is located. Therefore, practitioners must ensure any services provided to individuals out of state also comply with local law. OMH’s regulations do not govern the provision of Telehealth Services to individuals who have permanently relocated outside of NYS.

OMH supports the implementation of telehealth in order to:

- Increase access to care and reduce barriers to participation
- Expand individualized service delivery options to prioritize person-centered care and recognize voice and choice
- Increase capacity and flexibility for family and network-oriented treatment approaches
- Facilitate continuity of care in response to a clinical need or circumstance that would otherwise result in an interruption in program or service participation
- Promote opportunity for planned interventions in settings, situations or activities that are particularly challenging
- Increase real time responsiveness to help decrease the utilization of crisis and emergency interventions

This document offers broad guidance that applies to all OMH providers approved to deliver telehealth as well as specific programmatic guidance that will support the implementation of telehealth in different program types, while maintaining fidelity to program-specific regulations and standards. This guidance affirms OMH’s position that in-person and Audio-visual telehealth are the preferred methods for service delivery, while recognizing that Audio-only service delivery, where appropriate, has an important role to play in increasing access to care. OMH expects providers to use their judgment and respect individual and, as applicable, family preference in deciding which services and in which circumstances to utilize the appropriate telehealth modality to best meet the individual’s needs.

SECTION 2: Definitions

- A. *Audio-only* means the use of telephone and other Audio-only technologies to deliver services synchronously.
- B. *Audio-visual* means the use of both audio and video technologies to deliver services synchronously, through programs, platforms, or technologies that enable synchronous transmission of audio and video data.
- C. *Distant or “hub” site* means the distant secure location at which the Telehealth Practitioner rendering the service using Telehealth Services is located.
- D. *In-person* means being present physically in the same location when a service is delivered.
- E. *Originating or “spoke” site* means a site where the individual receiving services is physically located at the time mental health services are delivered to them by means of Telehealth Services, which may include the individual’s place of residence, other identified location in state, or other temporary location out-of-state.
- F. *Provider* refers to a provider agency that may operate one (1) or multiple OMH licensed, designated, or authorized programs or services.
- G. *Telehealth Practitioner* means:
 - 1. A prescribing professional eligible to prescribe medications pursuant to federal regulations; or
 - 2. Any other staff authorized to provide in-person services within a program or services licensed, designated, or authorized by OMH who are authorized to provide such services utilizing telehealth, consistent with their scope of practice and in accordance with guidelines established by the Office.
- H. *Telehealth Services* means the use of Telehealth Technologies by Telehealth Practitioners to provide mental health services at a distance. Such services do not currently include an electronic mail message, text message, or facsimile transmission between a practitioner and an individual receiving services, services provided where the originating and distant sites are the same location, or a consultation between two (2) physicians or nurse practitioners, or other staff, although these activities may support Telehealth Services. Telehealth Services must be synchronous. Where program regulations or guidance define an individual’s service provider as a collateral, a discussion or consultation between the Telehealth Practitioner and the individual’s other provider is considered a collateral contact, therefore is considered a Telehealth Service.
- I. *Telehealth Technologies* means a dedicated, secure, and interactive Audio-only or Audio-visual linkage system approved by the Office to transmit data between an originating/spoke site and distant/hub site for purposes of providing Telehealth Services.

SECTION 3: General Implementation Guidance

Considerations for the use of Telehealth Services

General Standards for Telehealth Services

The following standards apply to all programs approved to provide Telehealth Services. Programs approved to provide Telehealth Services must ensure that services are provided consistent with both the following general and program-specific standards (see Section four (4)), as applicable for each program.

1. ***Maintain compliance with regulatory requirements.*** All regulatory requirements applicable to mental health services (e.g., development and periodic review of treatment plans, entry of progress notes, timeliness of documentation, etc.), apply to Telehealth Services to the same extent as they apply to in-person services.
2. ***Maintain capacity for in-person services.*** A program may not refuse to provide services to an individual who expresses a preference for in-person service delivery. No program can offer only Telehealth Services. Providers must maintain capacity to deliver in-person services in accordance with applicable OMH regulations. In-person operations must be readily available to individuals and families without significant disruption in care, including through continuity with the treating clinician when possible. Provider must have a process to provide emergency in-person evaluations as required.
3. ***Be person-centered.*** Telehealth Services are delivered at an intensity and quality that meet the needs of the individuals and families being served, consistent with their treatment, service, or recovery plan goals and the intended outcomes of the program. Telehealth Services are utilized to meet individual and family needs and preferences, as applicable, rather than to address primarily administrative or cost saving purposes. Providers should continually assess the individual's and family's appropriateness for telehealth and adjust service delivery accordingly.
4. ***Be culturally and linguistically competent.*** Telehealth Services must be culturally responsive, respecting the individual's and, as applicable, their family's cultural norms, acceptability around service provision and impact on participation. It is the expectation of OMH and required by the Americans with Disabilities Act that Deaf or hard of hearing individuals seeking Telehealth Services are accommodated with appropriate interpreter or communication access services. Programs must also ensure language needs are met for individuals with Limited English Proficiency when delivering Telehealth Services.
5. ***Ensure that all components of services can be effectively delivered using Telehealth Technologies.*** Telehealth Services must include all elements of the billable procedure code or rate codes and all required documentation, and the provider must decide that services can be effective using Telehealth Technologies and without an in-person component. Additionally, for Audio-only Telehealth Services, pursuant to Department of Health (DOH) regulation 18 NYCRR § 538.2, providers must decide that services can be effectively delivered without a visual or in-person component.

Considerations for Use of Telehealth – General Services

The use of telehealth is part of a broader approach to care based on assessment of the unique, individualized needs and preferences of the individuals and families being served, as well as the design and intent of services within a program (see Section four (4) for additional Program-

Specific Considerations). Since the needs, preferences, appropriateness for, and clinical effectiveness of telehealth service delivery may change during treatment, Telehealth Practitioners are expected to continuously assess effectiveness and appropriateness and to adjust the mode of service delivery accordingly.

The following are key factors Telehealth Practitioners need to consider when making determinations concerning telehealth appropriateness with individuals receiving services.

1. Individual and, as applicable, family preference. Access to in-person services for individuals receiving Telehealth Services should be provided in as seamless a manner as possible to minimize disruption in care as their preferences or needs change. Provider protocols must describe this requirement and process.
2. Ability of the distant site Telehealth Practitioner to communicate and work with program staff as a collective treatment team, regardless of service modality.
3. Ability of individual and, as applicable, family, to participate in and benefit from the critical components of the service or program model via telehealth, considering the following:
 - a. Need for in-person services, including but not limited to laboratory testing, physical examination, or long-acting injectable medications.
 - b. Need to engage in the physical structure or immersive nature of a program
 - c. Ability to maintain continuous engagement in services.
 - d. Need for engagement in home or community setting to address specific goals.
 - e. Need for physical co-location to address specific goals.
 - f. Consultation from other programs or services in which the individual is participating in-person regarding the individual's ability to participate in and benefit from Telehealth Services.
 - g. Other individual-specific factors.
4. Clinical factors, including but not limited to the below, should be considered in balancing the need for in-person and Telehealth Services:
 - a. The individual's capacity to safely engage in Telehealth Services, including the ability to implement an individualized safety plan or respond to urgent/emergent situations. Telehealth Services should be avoided when there is concern for safety that cannot be addressed through the modality, or when an individual or family, as applicable, does not consent to developing or adhering to a needed safety plan. Telehealth Services are contraindicated when severity of the risk increases, or telehealth does not allow for an adequate assessment of risk. In such high-risk situations, risk related to providing Telehealth Services instead of in-person services must be balanced, with a strong preference for in-person services where possible.
 - b. Type or complexity of the individual's presentation, symptoms or conditions that may impede their ability to tolerate or adequately respond to Telehealth Services, including:
 - i. Risk factors, such as risk for suicide or self-injurious behavior, substance use disorder relapse, housing stability, violence, use of emergency services or hospital admissions, etc.

- ii. Whether current symptoms or behaviors, including co-occurring conditions or medication side effects, warrant visual assessment (e.g., disordered eating, self-injurious behaviors, non-verbal cues) that cannot be reasonably assessed via telehealth.
 - iii. Use of medications that could result in extrapyramidal symptoms or tardive dyskinesia (i.e., the need to conduct an abnormal involuntary movement scale (AIMS) assessment).
 - iv. Symptoms or comorbidities that could preclude the use of telehealth (e.g., impairment of vision or hearing, delusions related to technology, etc.).
 - v. Cognitive and developmental functioning including motor and communication skills.
 - c. Response to treatment, including whether presenting or co-occurring conditions are worsening.
 - i. Appropriateness for telehealth should be reassessed after a clinically significant event, including but not limited to hospitalization or ED/CPEP visit.
 - d. Engagement with treatment and strength of therapeutic relationship, including previous engagement through Telehealth Services delivery.
 - e. Continuity of care, specifically the consideration for in-person engagement or warm hand-off at critical transitions, including but not limited to recent hospital or CPEP/ER discharge and recent re-entry from incarceration.
 - f. For individuals who may require additional assistance, the individual's capacity to engage in telehealth alone or jointly with staff or parent/guardian, and their ability to engage with the Telehealth Technology.
- 5. Factors related to the appropriateness of Audio-only Telehealth Services:
 - a. For individuals without the developmental capacity to participate meaningfully telephonically, the Audio-only modality is not recommended.
 - i. Children 0-5 do not have the developmental capacity to participate meaningfully telephonically. Audio-only telehealth is not permissible for individual sessions with children 0-5 or dyadic sessions with a child 0-5 and parent. Audio-only telehealth is permissible for collateral sessions with parent/guardian of a child 0-5.
 - b. For all Telehealth Services including children/youth, Audio-visual is strongly encouraged.
 - i. All services for children/youth (up to age 18 or 21, based on regulation and program guidance) must include visualization of the individual (using Audio-visual Telehealth Services or in-person) in the initial assessment period and every 12 months thereafter at minimum. When this does not occur, reasons should be documented.
 - ii. Audio-visual options should be fully explored with parents/guardians prior to considering Audio-only services.
- 6. Presence of a new or worsening declared public health emergency or other significant occurrence, such as a natural disaster, which impacts all or a specific segment of the population's ability to receive services in person, including the Telehealth Practitioner's ability to mitigate the specific health risks, such as through the use of personal protective equipment or other environmental accommodations at the site of care.

7. Factors related to accessibility of the Telehealth Technologies, including:
 - a. The individual's and, as applicable, family's familiarity and comfort with the available technology.
 - b. Technological capability within the home or community setting and its accessibility to the individual or family, as applicable.
 - c. For interventions in which multiple individuals are required, the ability of the technology platform to support concurrent communication and each individual's ability to access technology, e.g., if family members or other identified supports residing in different locations are needed to jointly participate in sessions.
 - d. Issues related to access (device ownership, privacy, data plan, minutes, broadband access, etc.).
 - e. Issues related to incorporating additional assistive technologies (i.e., captioning) or individuals (i.e., language interpreters).
 - f. For information about how to support individuals and families with limited or lack of access to devices and services, please see Section VIII of the NYS DOH's [Medicaid Update Special Edition: Comprehensive Guidance Regarding Use of Telehealth & Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency \(health.ny.gov\)](https://www.health.ny.gov/publications/docs/section8.htm).

8. Factors related to the setting in which the individual is located at the time of service:
 - a. The availability of an adequate, safe, and private space for the individual to receive Telehealth Services, including adequacy to maintain confidentiality.
 - b. When delivering in community-based settings (e.g., community residence, shelter), Telehealth Practitioners should collaborate with staff within those settings (with consent, where required) to ensure access and that appropriate accommodations are made.
 - c. The degree to which consistency of location may impact treatment.

9. Cultural and linguistic factors, including, but not limited to:
 - a. Individual and, as applicable, family's cultural norms and acceptability around service provision, including Telehealth Services, and impact on participation.
 - b. The individual's comfort receiving Telehealth Services using required accommodations to meet the language needs of individuals with Limited English Proficiency and individuals with hearing loss or who are deaf.

Considerations for the Use of Telehealth - Specific Services

The use of telehealth for certain specific services requires additional considerations.

1. Considerations for prescribing controlled medications using Telehealth Services. Note that the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which amended the Controlled Substances Act, requires at least one (1) in-person medical evaluation prior to issuing a prescription for controlled substances that is facilitated by the internet, unless an exception applies. For the most updated information about this requirement, including NYS requirements, please review OMH's guidance available at <https://omh.ny.gov/omhweb/guidance/>.

2. Considerations for Health Monitoring related to Medication Management.
In programs where practitioners prescribe medications, the standard of care requires that individuals receive a thorough mental status exam and appropriate laboratory testing.
 - a. Audio-visual Telehealth Services can be used to examine appearance, behavior, affect, involuntary movements, gait, or conduct an AIMS using an adequate video connection. If practitioners determine that a thorough exam is not feasible by Telehealth Services (e.g., the individual is unable to cooperate or the video connection is not sufficient to allow an exam), an in-person evaluation should be conducted.
 - b. To ensure safety and quality, laboratory testing should be conducted in-person.
 - c. When Medication Management can be safely conducted without the need for Health Monitoring, program-specific guidance should be followed regarding the use of Audio-only Telehealth Services.

3. Considerations for Hybrid Groups or Classes.
In programs that include group-based services, groups or classes may be provided using telehealth.
 - a. Groups may also be offered as a hybrid, wherein some individuals attend in-person and others using Telehealth Technologies. If any individual is participating in-person, a member of the program staff must also be present in-person to facilitate or co-facilitate the session or class.
 - b. It is recommended that at the start of each group session, the facilitator should review etiquette and group rules. This may include, but is not limited to:
 - i. Verifying participant location at the beginning of each telehealth service to ensure safety and wellbeing.
 - ii. Reminding participants of what to do if any participant, or the entire group, gets disconnected.
 - iii. Discussion around privacy expectations and use of private space.
 - iv. Review of phone or web-conferencing features, including the mute button and raise hand buttons.
 - v. Identifying the speaker when any participant is using Audio-only Telehealth Services.

4. Considerations for Developmental and Psychological Testing.
 - a. Testing administration is restricted to Audio-visual, except for tests that are expected to be completed independently without monitoring.
 - b. Use of telehealth for individual tests should be informed by guidelines from test developers.
 - c. As clinically indicated, a staff member should be present in-person with the individual during the testing in order to present stimuli or perform other testing functions that cannot be accomplished using telehealth. The staff member should be familiar with the testing materials and have experience with individuals with similar developmental and clinical presentations to the individual being tested.
 - d. For children/youth: as children/youth are more likely to leave the prescribed testing area, either due to developmental considerations or due to the design of the assessment, Audio-visual technology must be capable of capturing a wide field.

Informed Consent

1. Informed consent means that Telehealth Practitioners provide individuals with sufficient information and education about telehealth to assist them in making an informed choice to receive Telehealth Services. This must include the following:
 - a. The Telehealth Practitioner must confirm that the individual is aware of the potential advantages and disadvantages of telehealth, be given the option of not participating in Telehealth Services and information regarding their right to request a change in service delivery mode at any time.
 - b. The Telehealth Practitioner must inform individuals that they will not be denied services if they do not consent to Telehealth Services or request to receive services in-person.
 - c. Where the individual is a minor, consent shall be provided by the parent/guardian or other person who has legal authority to consent to health care on behalf of the minor.
2. Informed consent shall be obtained through a process of communication between the Telehealth Practitioner and individual receiving services. Although some Providers may choose to document informed consent to receive Telehealth Services using a form, it is not necessary to use a specific form. Informed consent processes should be specified in Providers' policies and procedures.
3. Informed consent must be obtained before or during the first visit in which Telehealth Services are provided and documented in the case record.
4. Individuals, or a minor individual's parent or guardian, should be informed how to verify a Telehealth Practitioner's professional license.

Confidentiality and Privacy of Health Information

1. Providers must have policies and procedures regarding compliance with all relevant state and federal confidentiality laws, regulations, and guidance, including, but not limited to NYS Mental Hygiene Law Section 33.13 and HIPAA Privacy and Security regulations codified at 45 C.F.R. Parts 160 and 164, including Health Information Technology for Economic and Clinical Health (HITECH) breach notification procedures.
2. Provider must ensure the privacy and security of all records containing identifiable health information is maintained at all times, including when practitioners transmit documents to individuals receiving services at an originating site or remove records from the program site or create records off-site while providing Telehealth Services.
3. The Telehealth Practitioner must have access to HIPAA-compliant Audio-visual and telephonic Telehealth Technology at all times while providing Telehealth Services.
4. The Telehealth Practitioner's and individual's location should be assessed for privacy and confidentiality during each encounter. Where there are concerns about the individual's location, the Telehealth Practitioner should discuss with the individual options for relocating, rescheduling, or continuing despite the concerns with appropriate mitigation.

Staff Qualifications, Supervision, and Training

1. Staff qualifications remain the same whether a service is delivered in-person or using telehealth. Telehealth Practitioners are subject to all applicable pre-employment checks prior to the provision of service.
2. Supervisory requirements remain the same whether a service is delivered in-person or using telehealth.
3. Providers must ensure that staff providing Telehealth Services, whether employed directly by the provider or contracted, are trained in best practices, applicable OMH guidance, other available guidance related to specific payer policies (e.g., Medicaid, Medicare), how to use the Telehealth Technologies, and other provider policies and procedures for communication, emergency response, incident reporting, and other operations.

Documentation and the Electronic Health Record

1. All care provided by distant/hub site Telehealth Practitioners must conform to the Provider's policies and procedures related to the provision of care, including but not limited to documentation of initial evaluation, diagnoses, treatment planning, ongoing encounters, and discharge summaries.
2. Providers must ensure program specific documentation reflects that a Telehealth Service was delivered.
 - a. The use of telehealth must be documented in each progress note, including the time the service was started and the time it ended.
 - b. The individual's location should be confirmed at the start of each encounter and documented in the record.
 - c. Treatment plan/service plan/individual recovery plan reviews shall document appropriateness of Telehealth Services, including through a person-centered discussion on the use of telehealth as a service modality.
3. For Audio-only Telehealth Services, DOH Medicaid guidance requires that providers document why Audio-only services were used for each encounter, i.e., Audio-only Telehealth Services are the individual's preference or Audio-visual Telehealth Services are not available due to lack of equipment or connectivity.
4. The Telehealth Practitioner must have real-time access to the full electronic health record.
5. Centers for Medicare & Medicaid Services (CMS) has provided additional guidance regarding documentation standards for Telehealth Services, available at <https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf>.

Prescriptions, Labs, and Orders

1. Lab results must be delivered to the ordering or treating practitioner in a timely manner (e.g., lab results that arrive to a clinic via fax must be uploaded to the electronic health record and flagged for the ordering or treating practitioners.).

2. Prescribers and other Telehealth Practitioners who work remotely must proactively communicate to other program staff completion of new or renewed prescriptions, prior authorizations, ordering labs, reviewing labs, and other critical information.
3. All Providers must adhere to Federal and State laws and regulations that govern prescription of medications using telehealth (e.g., the Ryan Haight Act).

SECTION 4: Program-Specific Implementation Guidance

All Program-Specific Implementation Guidance is supplemental to Section three (3): General Implementation Guidance. As such, programs should ensure that policies and procedures are aligned with both Section three (3) and the applicable sections in Section four (4).

Outpatient Programs

Article 31 Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Programs for Adults and Children

Note: For the purpose of telehealth allowances, all references to “face-to-face” in 14 NYCRR 599 includes allowable Telehealth Services, both Audio-visual and Audio-only, in accordance with Part 596 and this guidance.

Considerations for Use of Telehealth

MHOTRS programs are designed to serve individuals with a range of needs. The modality of service delivery should be determined by the individual’s and, as applicable, family’s needs and preferences. In-person service delivery must be available when there is a need or preference.

Program Guidelines

Admission to and services provided by MHOTRS programs should not be denied based on lack of in-person assessment or availability.

1. Assessment/Screening:
 - a. Any session requiring a full mental status exam must include visualization of the individual, either in-person or using Audio-visual telehealth. MHOTRS programs can conduct in-person assessments in the home or community.
2. Initial Assessment:
 - a. At least one (1) initial assessment should be conducted in-person or using Audio-visual telehealth. If the assessing clinician determines that the Audio-visual or Audio-only platform is insufficient to assess the individual, at least one (1) in-person assessment session should be conducted. However, ongoing engagement and initiations of services as clinically appropriate should not be denied based on lack of in-person assessment.
 - b. Audio-only telehealth may be used for conducting initial assessments when an individual does not have access to or is uncomfortable using Audio-visual technology or is unable to attend an in-person service. When this occurs, reasons for conducting the intake assessment using Audio-only should be documented.
 - i. Audio-only telehealth shall not be utilized to provide initial assessment for children aged 0-5.
 - ii. Audio-only telehealth is permissible for collateral contact with parent/guardian of a child 0-5.
 - iii. For children/youth, if Audio-only telehealth was used for all initial assessment sessions, an in-person or Audio-visual telehealth should be conducted as soon as possible after admission. Clinics can conduct in-person assessments in the home or community.

3. Psychiatric Assessments:

- a. Psychiatric Assessment services should be performed in-person or using Audio-visual telehealth where, in order to provide services, the clinician must observe physical, nonverbal aspects of an individual's presentation, including appearance, hygiene, facial expression, eye contact, movement in the environment, etc., as well as interactions between the individual and any others participating in the assessment (e.g., parent, if applicable).
- b. Any initiation or continuation of a medication that requires a full mental status exam must include visualization of the individual, either in-person or using Audio-visual telehealth.

4. Medication Treatment:

- a. Medication treatment services performed subsequent to admission to the clinic should be performed in-person or using Audio-visual telehealth where the clinician, in order to provide services, must observe physical, nonverbal aspects of an individual's presentation, including appearance, hygiene, facial expression, eye contact, movement in the environment, etc., as well as interactions between the individual and any others participating in the assessment (e.g., parent, if applicable).
- b. However, the provision of medication treatment should not be delayed or prevented by the inability to provide timely in-person or Audio-visual services. When clinically appropriate, prescribers may provide medication treatment services using Audio-only telehealth. Clinics can also conduct in-person medication treatment in the home or community.

Billing Standards

MHOTRS programs cannot use the off-site billing codes when providing Telehealth Services.

Licensed programs may use Telehealth Technologies, including Audio-visual or Audio-only modalities for the provision of all Clinic CPT procedure codes, except:

- Injectable Medication Administration with Monitoring and Education (H2010) and Injection Only (96372) is restricted to in-person only.
- Health Physical (99382-99387) (New Patient) and 99392-99397 (Established Patient) – is restricted to in-person or Audio-visual only.
- Developmental (96110, 96111) and Psychological Testing (96101, 96116, 96118) is restricted to in-person or Audio-visual for testing administration.

Article 31 Satellite, School-based Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Programs

The above guidelines for Article 31 MHOTRS programs also apply to satellite, school-based MHOTRS programs. Additional considerations and guidelines are below.

Considerations for Use of Telehealth

School-based satellite MHOTRS programs are designed to be site-based programs with in-person service delivery. Benefits of school-based satellites include increased access to care for children/youth and families within a natural environment, increased opportunity for early identification of mental health concerns, and well-coordinated treatment through partnership among staff and families to address clinical needs. Services must be delivered in-person and on-site, with exceptions as noted below, unless there is a clinical rationale for delivering services via telehealth for a limited term basis (e.g., a crisis prevention session in response to an acute increase in stress or symptoms, an infection risk). This clinical rationale must be documented in a progress note.

Where limited-term services are provided using telehealth, Audio-visual telehealth modalities are strongly encouraged. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. If an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or transition to alternate outpatient services, which can be effectively delivered through Audio-only telehealth.

Telehealth may also be used as an adjunct to in-person operations to engage others in the individual's care, such as for family therapy sessions, collateral contacts, etc.

Program Guidelines

Telehealth Services may be provided by a school-based satellite to augment service delivery by expanding capacity for parent or family participation, or to enable continuity of care for enrolled children/youth when in-person services cannot be provided. For example, Telehealth Services may be used from the school site or from another location operated by the Provider (distant/hub site):

- To provide a treatment service for a child/youth or family outside the hours of operation or school day, when the child/youth is no longer at school (e.g., "by appointment" for family therapy, collateral session, medication treatment, etc.).
- To provide a treatment service for a child/youth who is not at school during hours of operation, including during school breaks.
- To provide specialized assessment, treatment including medication treatment by a prescriber, or support not otherwise accessed directly via school-based satellite.

Telehealth Services may also be provided to a youth located at school in circumstances where if care is not delivered remotely, the youth may experience an increase in symptoms or risk, e.g., a session to prevent crisis. Providers should establish protocols with host schools for these circumstances. Policies and procedures should include:

- Method for immediate communication between the Telehealth Practitioner and the host school should an emergent need arise.
- Identification of appropriate school staff to accompany the youth or have a nearby presence during telehealth delivery.
- Standards and processes for determining the youth's capacity to participate in Telehealth Services without the on-site presence of the school-based satellite Telehealth Practitioner.
- Ensuring confidentiality and safety within the identified space (e.g., no access to confidential material; removal of objects that may present a danger).

Assertive Community Treatment (ACT)

Considerations for Use of Telehealth

ACT (Adult, Young Adult, and Youth ACT) teams are specifically designed to serve vulnerable, high-risk individuals who have not been able to engage in traditional outpatient services. Individuals receiving ACT services are at high risk of disengaging from care absent assertive in-person interventions. Therefore, providers should prioritize in-person service delivery. Telehealth must not replace in-person program requirements. Telehealth may be used to supplement in-person services to optimize engagement (e.g., for screening so that the individual can learn about choices in services), to temporarily provide care in circumstances where in-person engagement is not possible (e.g., risk of infection), or to engage others in the individual's care (e.g., family therapy sessions, collateral contacts, etc.).

Where limited-term services are provided using telehealth, Audio-visual telehealth modalities are strongly encouraged. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. If an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or transition to alternate outpatient services for which services can be effectively delivered through Audio-only telehealth.

Clinical factors such as critical points of transition should be heavily weighed when determining the use of telehealth. For example:

- For individuals returning to the community from incarceration, it is recommended that in-person warm hand-offs be facilitated on the day of release to ensure safe transition to housing and access to psychiatric medication, food, clothing, and a telephone for Telehealth Services, as applicable. Community re-entry is a critical juncture, and many individuals will require in-person assistance to reconnect to services as they readjust to the community environment.
- For individuals who are recently discharged from hospital or CPEP/ER or have a recent increase in hospital/ER admissions, in-person services should be provided to support a warm hand-off during this critical time.
- For youth who are discharged from residential care, in-person services should be provided to support a warm hand-off.

Program Guidelines

ACT Providers must have a plan for in-person availability and accessibility 24/7, as required by ACT Program Guidelines. If an individual is experiencing a possible emergency or crisis episode and cannot be engaged through Telehealth Technologies, ACT teams must determine need for in-person contact, and if appropriate, engage in-person or work with local emergency personnel to address the crisis in a timely manner.

When providing Telehealth Services, ACT teams should always ascertain the location of the individual to ensure appropriate mobilization of services or available resources in an emergency or crisis episode.

For individuals receiving ACT services pursuant to Assisted Outpatient Treatment (AOT) orders, requirements for in-person service delivery may be more intensive based on individual case considerations. ACT teams must collaborate with the Local Governmental Unit(s) responsible for AOT monitoring to ascertain whether Telehealth Services may be used on a case-by-case basis.

Staffing Requirements

ACT teams shall continue to comply with all ACT Program Guidelines regarding team staffing, treatment, and team communication.

ACT team staff must be in sufficient proximity to be able to provide in-person services, as indicated, with the exception of prescribers as noted below. All staff, regardless of location, must maintain active involvement in ACT team operations, including participation in the daily meeting, in-person or virtually.

In exceptional circumstances, in areas with low access to prescribers, psychiatrists or psychiatric nurse practitioners may provide Telehealth Services. In these circumstances, the Telehealth Practitioners must be located within the United States. When providing Telehealth Services, the psychiatrist or psychiatric nurse practitioner must alert the nurse within 24 hours of making any medication changes.

Billing Requirements

ACT teams may not use Telehealth Services to provide all of the minimum contacts required for ACT billing. A contact is defined as a minimum of a 15-minute interaction for both in-person and Telehealth Services, with the individual or collateral. The following standards will continue to apply for ACT billing:

For full billing (rate code 4508), which requires at least six (6) contacts per month, three (3) of which may be with the collateral:

- At least three (3) contacts must be provided in-person with the individual;
- A maximum of three (3) contacts may be provided using Telehealth Services; and
- Where collateral contacts are provided, a maximum of two (2) collateral contacts may be provided using Telehealth Services.

For partial billing (rate code 4509), which requires a minimum of two (2) contacts per month, which must be with the individual:

- At least two (2) contacts must be provided in-person with the individual; and
- Any additional contacts with the individual may be provided using Telehealth Services.

For inpatient billing (rate code 4511), which requires a minimum of two (2) contacts per month, which must be with the individual:

- At least one (1) contact must be provided in-person and the other contact may be provided using Telehealth Services;
- In the month of admission or discharge, the full payment rate reimbursement is permitted for any month in which at least six (6) contacts are provided, including four (4) or more community-based contacts, consistent with the standards stated above for full billing, combined with a minimum of two (2) inpatient contacts, consistent with the standards in this paragraph; and

- In the month of admission or discharge, the partial payment rate reimbursement is permitted when a minimum of one (1) in-person community contact, combined with a minimum of one (1) in-person inpatient contact, is provided.

Behavioral Health Home and Community Based Services (BH HCBS) and Community Oriented Recovery and Empowerment (CORE) Services (Adult)

This guidance is intended to outline the program-specific rules, restrictions, and recommendations for use of telehealth by OMH-Hosted Adult BH HCBS and CORE Services Providers under OMH's Part 596 regulations. OASAS-hosted Providers must also follow any applicable OASAS telehealth guidance.

Considerations for Use of Telehealth

Adult BH HCBS and CORE Services are designed to provide rehabilitative and supportive services in home and community-based settings where people live, work, learn, and socialize. As rehabilitative services, BH HCBS and CORE Services include skill building components and interventions, such as role playing, modeling and demonstrations, coaching, and opportunities for practice. Telehealth Practitioners must make person-centered determinations regarding the extent to which rehabilitative services can be effectively provided using telehealth based on each individual's needs, each staff person's skills and training, and the specific skill being addressed. In making these determinations, Telehealth Practitioners must consider their ability to maintain fidelity to the service design.

Telehealth may be used to supplement in-person services, to optimize engagement (e.g., for screening so that the individual can learn about choices in services), to provide care in circumstances where in-person engagement is not possible (e.g., risk of infection), in-person access is challenging due to distance, e.g., in rural areas, or routine in-person care is not the individual's preference. Telehealth can be helpful to engage others in the individual's care, such as for family therapy sessions, collateral contacts, etc.

Where services are provided using telehealth, Audio-visual telehealth modalities are strongly encouraged. Due to the rehabilitative nature of these services, there are significant limitations to the type and quality of interventions that can be delivered via Audio-only telehealth. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. If an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. If despite assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or transition to alternate outpatient services which can be effectively delivered through Audio-only telehealth.

Program Guidelines

BH HCBS and CORE Services are intended to promote and facilitate community participation and independence. Providers must have capacity to deliver services with respect to each individual's preferences regarding modalities and locations that are convenient for them and best suited for their desired outcomes. This also includes the capacity to provide in-person services in the community in all counties the provider is designated in.

BH HCBS and CORE Services are often provided by unlicensed behavioral health staff, and professional/clinical supervision is critical to the success and quality of these services. Any assessments related to the appropriate use of telehealth must involve consultation with the qualified supervisor, which must be documented in the case record.

At least one (1) initial intake & evaluation (I&E) session should be conducted in-person or by Audio-visual telehealth. If Audio-only telehealth was used for the preliminary initial I&E sessions, an in-person or Audio-visual telehealth evaluation session must be conducted prior to the completion of the initial service plan. This evaluation session must be conducted in-person if the assessing clinician determines Audio-visual Telehealth Services are insufficient to assess the individual. However, ongoing engagement and initiation of services as clinically appropriate should not be delayed pending an in-person assessment, and admission should not be denied based on lack of in-person assessment.

CORE Community Psychiatric Support & Treatment (CPST) should be delivered in-person unless there is a clinical rationale for delivering services via telehealth for a limited term basis (e.g., a crisis prevention session in response to an acute increase in stress or symptoms) or strong individual preference for Telehealth Services. This clinical rationale or personal preference must be documented in a progress note. Where an individual expresses a preference for ongoing or long-term clinical services via telehealth, based on clinical judgment, CORE CPST may not be the appropriate level of service for that individual. The Telehealth Practitioner may need to support the individual in transitioning their clinical services to an outpatient clinical treatment provider.

Billing Standards

Telehealth Technologies, including Audio-visual or Audio-only modalities may be used for the provision of all CORE rate codes, except Psychosocial Rehabilitation (PSR) – Individual – Off-Site (7785). When a PSR service is delivered using telehealth, the off-site service rate code does not apply.

Children's Day Treatment

Consideration for Use of Telehealth

Children's Day Treatment is designed to be a site-based program with in-person service delivery. Services must be delivered in-person and on-site unless there is a clinical rationale for delivering services via telehealth for a limited-term basis (e.g., a crisis prevention session in response to an acute increase in stress or symptoms, an infection risk). This clinical rationale must be documented in a progress note.

Where limited-term Day Treatment services are provided to children/youth using telehealth, Audio-visual Telehealth Services should be used. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. However, if an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. Such activities and justification for using Audio-only must be documented. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or alternate outpatient services which can be effectively delivered through Audio-only telehealth.

Telehealth may be used as an adjunct to in-person operations to engage others in the individual's care, such as for family therapy sessions, collateral contacts, etc. Collateral contacts can be made using Audio-only Telehealth Services both for Pre-admission and Full Day, Half Day, or Brief Day services.

Program Guidelines

As specified in Part 587.11, admission to a Children's Day Treatment Program must occur within the first three (3) visits. At least one (1) preadmission visit must be conducted in-person prior to admission. When this does not occur, reasons for use of Telehealth Services must be documented. Preadmission visits with children cannot be conducted using Audio-only Telehealth Services.

Telehealth may not be used to routinely deliver Full Day, Half Day, or Brief Day Treatment services and should only occur under rare and time-limited circumstances for individuals who are not on site. High-needs individuals served in this program benefit from in-person care and the acuity of symptomatology makes participation in extended hours of Telehealth Services challenging. All of the following conditions must be met for the temporary provision of Full Day, Half Day, or Brief Day Telehealth Services:

- There is a specific need identified, in accordance with provider policies and procedures, preventing in-person participation that is clearly documented, and
- The program has the means to accommodate the range of service delivery through Telehealth Services, and
- The enrolled individual has capacity for continuous, meaningful participation for the required duration.

Audio-only Telehealth Services may not be used for young children served in Therapeutic Nursery or Early Childhood programs.

Day Treatment Providers may use Telehealth Services to provide:

- A treatment service for a child/youth or family outside the hours of operation or school day, when the child/youth is no longer at school (e.g., “by appointment” for family therapy, collateral session, medication treatment, etc.).
- A treatment service for a child/youth who is not at school during hours of operation, including on school breaks, when the Telehealth Practitioner has continued access to the site, subject to the limitations provided above on routine use.
- To provide specialized assessment, treatment including medication treatment by a prescriber, or support not otherwise accessed directly via the in-person Day Treatment program.

Billing Standards

OMH Day Treatment for Children and Adolescents Programs are authorized under the Medicaid “Clinic Option,” which requires that either the individual receiving services, the Practitioner, or both, must be in-person at the program site in order to bill Medicaid. When the individual is off-site and the program site is also inaccessible to the Telehealth Practitioner, a Provider-controlled office can be made available and considered a temporary program site from which Day Treatment Services may be provided using Telehealth Technologies.

Children and Family Treatment and Support Services (CFTSS)

This guidance is intended to outline the program-specific rules, restrictions, and recommendations for the use of telehealth by OMH designated or licensed CFTSS providers that have obtained approval to provide Telehealth Services pursuant to Part 596. Providers designated for CFTSS must also follow any applicable telehealth guidance from DOH as the State Medicaid Agency and any/all other designating State agency under which they are authorized.

Consideration for Use of Telehealth

CFTSS are designed to be delivered in the natural environment, specifically the home and community-based settings where individuals live, work, learn, attend school, and socialize or participate in their community. Therefore, providers should prioritize in-person service delivery. Telehealth must not replace in-person program requirements. Telehealth may be used to supplement in-person services, to optimize engagement (e.g., for screening so that the individual can learn about choices in services), to temporarily provide care in circumstances where in-person engagement is not possible (e.g., risk of infection), or to engage others in the individual's care, such as for family therapy sessions, collateral contacts, etc.

Where services are provided using telehealth, Audio-visual telehealth modalities are strongly encouraged. Due to the rehabilitative nature of these services, there are significant limitations to the type and quality of interventions that can be delivered using Audio-only telehealth. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. If an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or alternate outpatient services which can be effectively delivered through Audio-only telehealth.

Program Guidelines

Every OMH-designated CFTSS Provider must obtain OMH approval pursuant to Part 596 to provide Telehealth Services. Such approval does not apply to and cannot be transferred to another program operated by the provider or entity with which the provider contracts. For example, in the case of Children's Mental Health Rehabilitation Services (CMHRS) Programs, which may have formal agreements with other CFTSS agencies, both the Program and the other agencies must obtain OMH approval to provide Telehealth Services.

Audio-only telehealth is not permissible for assessment or ongoing services for children aged 0-5 (i.e., individual sessions with children or dyadic sessions with the child and parent). Audio-only telehealth is permissible for collateral sessions with parent/guardian of a child 0-5.

At least one (1) initial assessment should be conducted in-person or by Audio-visual telehealth to determine medical necessity for services. If Audio-only telehealth was used for the preliminary initial assessment sessions, an in-person or Audio-visual telehealth evaluation session must be conducted prior to the completion of the initial treatment plan. This evaluation session must be conducted in-person if the assessing clinician determines Audio-visual Telehealth Services are insufficient to assess the individual. However, ongoing engagement and initiation of services as

clinically appropriate should not be delayed pending an in-person assessment, and admission should not be denied based on lack of in-person assessment.

Providers may not use Audio-only Telehealth Services to conduct Other Licensed Practitioner (OLP) Evaluations for children/youth for the sole purpose of informing eligibility for alternative programming (e.g., Licensed Practitioner of the Healing Arts Recommendation), unless the child/youth is admitted to ongoing OLP services.

OLP Crisis Off-site (7902) is restricted to in-person services only.

Billing Standards

When a service is delivered via telehealth, the off-site service rate code does not apply (7920, 7927, 7921, 7928, 7922, 7929, 7923, 7930).

Continuing Day Treatment

Considerations for Use of Telehealth

Continuing Day Treatment programs are designed to serve individuals with a range of needs. The modality of service delivery should be determined by the individual's needs and preferences. In-person service delivery must be available for when there is a need or preference.

Program Guidelines

All CDT services, including those provided individually and in groups, may be delivered using Telehealth Services when existing service definitions and standards are met. This includes minimum staff qualifications, supervision and training requirements, minimum service durations, and group sizes, as defined in 14 NYCRR Parts 587 and 588. CDT programs must maintain a dynamic program schedule that includes daily opportunities for in-person group participation. The CDT program schedule must clearly identify the modality in which a group is offered (in-person, telehealth, or hybrid).

It is recommended, but not required, that individuals who are being evaluated for CDT services are seen in-person prior to admission. Pre-admission and intake sessions should be completed in-person whenever feasible to promote engagement. When not feasible, Audio-visual Telehealth Services may be used for assessment and admission purposes. Audio-only Telehealth Services should only be used as a last resort.

If during the admission and intake process, an individual is unable to engage in-person and telehealth is deemed appropriate and necessary, the program must deliver these services via Audio-visual telehealth. Only when an individual is unable to engage through in-person or Audio-visual telehealth may a CDT program deliver pre-admission, initial screening, and assessment services using Audio-only telehealth.

When an individual attends a CDT program in-person, services must be provided in-person, except remote psychiatrists or psychiatric nurse practitioners may provide services to an individual who is attending in-person. When this occurs, the CDT program must ensure the availability of onsite CDT staff during the delivery of Telehealth Services.

Telehealth Services may be used to enhance coordination among the extended treatment team involved in the care of the individual (e.g., Health Home Care Manager, primary care physician, other external service providers, etc.), with the individual's consent and in support of their treatment plan goals.

Billing Requirements

OMH Continuing Day Treatment Programs are authorized under the Medicaid "Clinic Option," which requires that either the individual receiving services, the Practitioner, or both, must be in-person at the program site in order to bill Medicaid.

Partial Hospitalization Programs (PHP)

Considerations for Use of Telehealth

The purpose of a PHP is to provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Services must be delivered in-person and on-site unless there is a clinical rationale for delivering services via telehealth for a limited-term basis (e.g., a crisis prevention session in response to an acute increase in stress or symptoms, an infection risk). This clinical rationale must be documented in a progress note.

Where limited-term services are provided using telehealth, Audio-visual Telehealth Services should be used. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment and conduct a mental status exam. However, if an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. Such activities and justification must be documented. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, depending on clinical determinations and the individual's or family's preference, the provider should work to transition the individual and the family to in-person services or to alternate outpatient services which can be effectively delivered through Audio-only telehealth.

Telehealth may be used as an adjunct to in-person operations to engage others in the individual's care, such as for family therapy sessions, collateral contacts, etc.

Program Guidelines

At least one (1) preadmission must be conducted in-person. When this does not occur, reasons for use of Telehealth Services must be documented. Preadmission visits cannot be conducted using Audio-only Telehealth Services. Collateral contacts can be made using Audio-only Telehealth Services.

PHPs may not use telehealth to routinely deliver PHP services and should only occur under rare and time-limited circumstances for individuals who are not on site. High-needs individuals served in this program benefit from in-person care and the acuity of symptomatology for individuals in this program makes participation in extended durations of Telehealth Services challenging. All of the following conditions must be met for temporary provision of Telehealth Services:

- There is a specific need identified, in accordance with provider policies and procedures, preventing in-person participation that is clearly documented;
- The program has the means to accommodate the range of service delivery through Telehealth Services; and
- The enrolled individual has capacity for continuous, meaningful participation for the required duration.

Staffing Requirements

Consistent with requirements in Section 587.15(d)(3), programs must have one (1) clinical staff member on site for every five (5) recipients on site. Staff providing Telehealth Services may not count towards this minimum requirement.

Billing Standards

OMH Partial Hospitalization Programs are authorized under the Medicaid "Clinic Option," which

requires that either the individual receiving services, the Practitioner, or both must be in-person at the program site in order to bill Medicaid.

Personalized Recovery Oriented Services (PROS)

Considerations for Use of Telehealth

PROS programs are designed to serve individuals with a range of needs. The modality of service delivery should be determined by the individual's needs and preferences. In-person service delivery must be available for when there is a need or preference.

As a rehabilitative services program, PROS provides primarily skill building services that include exercises such as role playing, modeling and demonstrations, coaching, and opportunities for recipients to practice their skills. Due to the nature of these rehabilitative services, it is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment and for individuals to visualize their provider demonstrating a skill. There are significant limitations to the type and quality of rehabilitative interventions that can be delivered via Audio-only telehealth. However, if an individual does not have access to Audio-visual technology, then Audio-only may be used temporarily while assisting the individual to obtain Audio-visual technology, or training or otherwise helping them become comfortable using Audio-visual technology. Such activities and justification must be documented. If despite this assistance, the individual is unable to use Audio-visual technology, then the appropriateness of telehealth as a modality should be reconsidered. In such situations, PROS programs must make person-centered determinations regarding whether rehabilitative services can be effectively provided using telehealth, while maintaining fidelity to the program design and intent. PROS should be delivered in the modality best suited to the individual's goals and consistent with how the individual chooses to receive services.

Program Guidelines

All PROS components, including Ongoing Rehabilitation and Support, may be delivered using telehealth only when existing service definitions and standards are met. This includes minimum staff qualifications, supervision and training requirements, minimum service durations, and group sizes, as defined in Part 512 regulations. Telehealth Services must be delivered in accordance with each individual's Individualized Recovery Plan (IRP). For individuals receiving Telehealth Services, each IRP review must include a discussion of the individual's telehealth access, skills, preferences, or needs moving forward.

Programs must maintain a dynamic program schedule that includes daily opportunities for in-person group participation. The PROS program schedule must clearly identify the modality in which a group is offered (in-person, telehealth, or hybrid).

Pre-Admission, Admission, and Assessment Services: Prospective service recipients do not need to be seen in-person prior to admission to the PROS Program. However, pre-admission and intake sessions should be completed in-person whenever feasible to promote engagement and facilitate informed choice. PROS is a model that is not easily described without the opportunity to see the program space. An in-person, on-site admission allows the individual to tour the space and see the program in action.

When an individual attends a PROS program in-person, services must be provided in-person, except:

- Remote psychiatrists or psychiatric nurse practitioners may provide services to an individual who is attending in-person. When this occurs, the PROS program must ensure the availability of onsite PROS staff during the delivery of Telehealth Services; and
- Psychiatric consultations in which the PROS program obtains a consult from another mental health program or consultative expert as needed for a specific participant. These

consultations can be done remotely, preferably through Audio-visual telehealth modalities.

In PROS, a discussion or consultation between the Telehealth Practitioner and the individual's other provider is considered a collateral contact, and therefore is considered a Telehealth Service.

Billing Standards

The Intensive Rehabilitation (IR) component is distinguished for its intensity and targeted interventions, and it is reimbursed at a higher rate than other PROS services components. The IR add-on (rate code 4526) may *only* be claimed if the individual has received at least one (1) service in-person or through Audio-visual telehealth over the course of the calendar month. Services provided in-person may be provided onsite or offsite. This requirement is in addition to the existing IR billing requirements in 14 NYCRR § 512.11(c)(2).

Telehealth & Program Participation Time: Medically necessary PROS services delivered using telehealth shall be counted toward the duration of program participation time. PROS programs must maintain accurate documentation for each individual indicating the duration of program participation time per day. In order to accumulate any PROS units for a day, a PROS program must deliver a minimum of one (1) medically necessary PROS service to an individual or collateral during the course of the day. As a reminder, planned recreational activities that are not specifically designated as medically necessary in an individual's individualized recovery plan are excluded from the calculation of program participation time pursuant to 14 NYCRR § 512.4.

Crisis Services

Crisis Intervention – Crisis Residential Programs (Adult Residential Crisis Support, Adult Intensive Crisis Residence, and Children’s Crisis Residence Services)

Considerations for Use of Telehealth

Crisis Residential services, which include Adult Residential Crisis Support, Adult Intensive Crisis Residence, and Children’s Crisis Residence Services are designed to be a site-based program with in-person service delivery. These services rely on the implementation of a therapeutic milieu and in-person service delivery to effectively address crisis situations that cannot be managed in the community. Services must be delivered in-person and on-site, with exceptions noted below.

Telehealth may be used as an adjunct to in-person operations to engage others in the individual’s care, such as for family therapy sessions, collateral contacts, etc.

Program Guidelines

In order to assist in facilitating a timely admission to the crisis residence, Telehealth Services may be used to conduct a screening for admission or to include family members and collaterals in the screening. In crisis situations, it is critical that the admission be facilitated as quickly as possible to allow the individual to be diverted or discharged from higher levels of care, create a plan with a crisis residence, and ensure that treatment is initiated as soon as possible.

With the exception of screening for admission, individuals receiving Telehealth Services must be on-site at the crisis residence. Where services are provided by Telehealth Practitioners to individuals on-site at the Crisis Residential Programs, Audio-visual Telehealth Services should be used. Engagement with supports may be delivered through Audio-only Telehealth Services. The use of Telehealth Services must be included in an individual’s service plan.

Allowable Telehealth Services include peer support, engagement with identified supports, safety planning, case management and coordination services for discharge planning, including collaboration with existing providers and referral. For Medication Therapy (available only in Intensive Crisis Residences) to be provided using telehealth, a medical staff must be present with the individual on-site. Group Counseling may not be delivered using Telehealth Services.

Staffing Requirements

Crisis Residential Programs must maintain onsite staffing ratios. With OMH approval, Crisis Residential Programs may implement staffing plans in which telehealth is used to supplement, but not replace, onsite staffing.

Crisis Intervention – Mobile Crisis

The Crisis Intervention Services array includes the following four (4) Mobile Crisis services: Mobile Crisis Response, Mobile Crisis Follow-up, Telephonic Triage and Response, and Telephonic Crisis Follow-up Services.

Considerations for the Use of Telehealth

Where services are provided using telehealth, Audio-visual telehealth modalities are strongly encouraged. Due to the crisis nature of these services, there are significant limitations to the type and quality of interventions that can be delivered via Audio-only telehealth. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment.

Program Guidelines

Mobile Crisis Response and Mobile Crisis Response Follow-up must have an in-person component. A one-person Mobile Crisis Response must be in-person and delivered by a licensed professional. A one-person Mobile Crisis Response Follow-Up must be in-person. When, through triage, a two-person response is determined to be required, one (1) member of the two-person response team may participate by telehealth. The team member participating by telehealth must be available through the entirety of the service. At least one (1) member of the two-person response team must be a licensed professional for Mobile Crisis Response.

Telephonic Triage and Response and Telephonic Crisis Follow-Up services may be provided using Audio-visual or Audio-only technology.

Billing Standards

When Mobile Crisis Response and Mobile Crisis Response Follow-up are delivered using Telehealth Services, the applicable telehealth modifier must be used.

Telephonic Triage and Response and Telephonic Crisis Follow-up services do not require a modifier, whether provided by Audio-only or by Audio-visual Telehealth Services. These services must be billed using Mobile Crisis Telephonic rates and billing codes, whether they are provided using Audio-visual or Audio-only.

Crisis Stabilization Centers

Crisis Stabilization Centers (CSCs) are jointly licensed by the New York State (NYS) Office of Mental Health (OMH) and the Office of Addiction and Support Services (OASAS). CSCs follow a separate and distinct OMH/OASAS telehealth regulation and guidance document that is under development.

Residential Programs

Adult Residential Programs (OMH Licensed)

Considerations for the Use of Telehealth

OMH-licensed adult residential programs are designed to serve individuals who are at higher risk and who present complex needs that often require in-person support and skill development. Housing Providers should deliver the majority of services in-person. Telehealth Services can be valuable to supplement in-person service delivery. Due to the nature of some of the rehabilitative services that Housing Providers deliver (e.g., daily living skills training or medication management training), where telehealth is used, Audio-visual telehealth should be used to allow practitioners to see the individual and their environment.

Program Guidelines

At least 50% of services provided in a calendar month must be delivered in-person. For Apartment Treatment programs, at least one (1) of the in-person visits must also occur in the individual's apartment.

Staffing Requirements

Residential programs must maintain capacity for in-person service delivery, and telehealth may never be used to replace required on-site staffing ratios.

Children’s Community Residences (CCRs)

Considerations for Use of Telehealth

CCRs are designed to serve individuals who are at higher risk and who present complex needs that often require in-person support and skill development. CCRs should deliver the majority of services in-person. Telehealth Services can be valuable to supplement in-person service delivery, particularly by reducing barriers to family participation, and augmenting capacity for engagement, treatment progress and continuity of care.

Where telehealth is used, Audio-visual Telehealth Services are strongly encouraged to allow practitioners to see the individual and their environment.

Program Guidelines

The use of Telehealth Services must be noted in the individual’s service plan.

To assist in facilitating a timely admission to a CCR, Telehealth Services may be utilized to conduct a screening for admission with an applicant and their caregiver(s) and collaterals. The CCR should make efforts to have the child/youth and family visit the residence to increase successful transition.

Telehealth Services can be used to provide services to individuals and their families when they are temporarily off-site, such as at the child’s home.

Staffing Requirements

CCRs must maintain capacity for in-person service delivery, and telehealth may never be used to replace required on-site staffing ratios.

Billing Standards

The minimum contacts CCRs are required to provide to bill for a half or full month of rehabilitative services must be delivered in-person.

Residential Treatment Facilities (RTFs)

Considerations for Use of Telehealth

RTFs are designed to serve children and adolescents who require 24/7 medical and clinical supervision, structure, and intensive treatment. As such, they are a site-based program with primarily in-person service delivery. Telehealth Services can be valuable to supplement in-person service delivery, particularly by reducing barriers to family participation, and augmenting capacity for engagement, treatment progress and continuity of care.

Where services are provided by Telehealth Practitioners to individuals who are on-site at the RTF, Audio-visual Telehealth Services should be used. It is always preferable to employ Audio-visual telehealth to allow practitioners to see the individual and their environment. Where services are provided to individuals who are not on-site at the RTF, such as individuals on a therapeutic leave, Audio-Visual Telehealth Services are also strongly encouraged.

Program Guidelines

The use of Telehealth Services must be included in an individual's service plan.

RTFs may supplement in-person service delivery with Telehealth Services to preserve or enhance access to care. These services may include but are not limited to the following:

- Screening for admission with an applicant as well as their caregiver(s) and collaterals.
- Family therapy and engagement with supports.
- A specialized service beyond the program's standard array (e.g., access to a contracted clinical specialist for assessment and/or consultation).
- Services to the youth and their caregiver while not onsite, such as while on therapeutic leave.
- Ad hoc medication treatment by an attending prescriber to a youth as long as nursing staff are on-site during the delivery of services. Medication treatment to youth in RTF cannot be solely through Telehealth Services.

Staffing Requirements

The program must be implemented by staff according to the RTF's clinical/direct care staff plan and Provider policies pertaining to staffing and supervision of individuals receiving services. RTFs must have in-person staff consistent with OMH staffing regulations codified in 14 NYCRR § 584.10.

OMH will not consider telehealth to supplement or replace clinical staffing requirements described in 14 NYCRR § 584.10(g)(1)-(4).

With OMH approval, RTF programs may implement staffing plans in which telehealth is used to supplement, but not replace, required in-person on site professional staffing described in 14 NYCRR § 584.10(e) and (f). For example, the psychiatrist may provide additional hours using telehealth beyond the minimum required FTEs specified in 14 NYCRR § 584.10(e)(2). RTFs are required to provide 24/7 physician coverage for on-site response for restraints. The evaluation required for restraint must be performed in-person.

Hospital-Based Programs

Comprehensive Psychiatric Emergency Programs (CPEP)

Considerations for Use of Telehealth

CPEP is designed to be a site-based program with in-person service delivery. Services must be delivered in-person. Telehealth may be used to supplement, but not replace CPEP services when the client is able to adequately engage using telehealth.

Program Guidelines

Policy and Procedures for implementation of Telehealth Services in CPEP must address:

- How telehealth will be used to supplement, but not replace in-person staffing requirements.
- Which disciplines, in addition to those required by regulation, are essential and must therefore have in-person capabilities.
- How the full array of treatment (including co-occurring substance use disorder treatment), psychosocial, rehabilitative, care coordination and discharge planning services will be provided either in-person or by telehealth. These services must be provided consistent with state and federal accreditation and certification requirements for hospitals, delivered by appropriately trained staff practicing within their scope of practice, and individualized to the needs of each client.
- What assessments, non-psychiatric treatment services, and other core CPEP services will be delivered in-person.
- Formal, structured mechanisms to allow for warm handoffs and transfer of patient information from Telehealth Practitioners to in-person staff, especially when information is obtained by Telehealth Practitioners during evening and overnight shifts.

Staffing Requirements

In order to provide the core clinical components of the service, CPEPs must provide in-person staff consistent with OMH Staffing regulations codified at 14 NYCRR § 590.10. With OMH approval, CPEPs may implement staffing plans in which Telehealth is used to supplement, but not replace, required in-person coverage. CPEPs must, at a minimum, employ the following types and numbers of staff, and where regulation specifies that the staff must be on duty, they cannot be replaced with Telehealth Practitioners:

- At least one (1) full-time equivalent psychiatrist who is a member of the psychiatric staff of the program shall be on duty and available at all times.
- At least one (1) full-time equivalent registered nurse shall be on duty at all times.
- At least one (1) full-time equivalent licensed master social worker or licensed clinical social worker shall be on duty and available, at a minimum, during the day and evening hours.
- A sufficient number of security personnel shall be on duty and available at all times.
- At least one (1) full-time equivalent credentialed alcoholism and substance abuse counselor or clinical staff person with experience in the counseling or treatment of individuals with a substance use disorder shall be available or on call 24 hours a day.
- The evaluation required for restraint and seclusion must be in-person.

OMH Licensed Inpatient Psychiatric Services

Considerations for Use of Telehealth

Inpatient psychiatry is designed to be a site-based program with in-person service delivery. Services must be delivered in-person. Telehealth may be used to supplement, but not replace inpatient psychiatric services.

Program Guidelines

Policy and Procedures for implementation of telehealth must address:

- How telehealth will be used to supplement, but not replace in-person staffing requirements.
- Which disciplines are essential, and must therefore have in-person capabilities, e.g., Nursing, Social Work, etc.
- How the full array of treatment (including co-occurring substance use disorder treatment), psychosocial, rehabilitative, care coordination and discharge planning services will be provided either in-person or by telehealth. These services must be provided consistent with state and federal accreditation and certification requirements for hospitals, delivered by appropriately trained staff practicing within their scope of practice, and individualized to the needs of each client.
- What assessments, non-psychiatric treatment services and other core inpatient services will be offered in-person.
- Formal, structured mechanisms to allow for warm handoffs and transfer of patient information from Telehealth Practitioners to in-person staff, especially when information is obtained by Telehealth Practitioners during evening and overnight shifts.

Staffing Requirements

In order to provide the core clinical components of the service, Inpatient Psychiatry Services must provide in-person staff consistent with OMH Staffing regulations codified at 14 NYCRR §§ 580.6 and 580.7 for Psychiatric Inpatient Units of General Hospitals and 14 NYCRR §§ 582.6 and 582.7 for Hospitals licensed solely by OMH. With OMH approval, Inpatient Psychiatry Services may implement staffing plans in which Telehealth is used to supplement, but not replace required in-person coverage.

Inpatient Psychiatry Services must, at a minimum, employ the following types and numbers of staff, and where regulation specifies that the staff must be on duty, they cannot be replaced with Telehealth Practitioners:

- Hospitals are required to provide 24/7 on-site physician coverage for inpatient services.
- The attending Psychiatrist or Psychiatric Nurse Practitioner of record must be onsite, at minimum, during regular business hours. The number of attending psychiatrists is dependent on the number and complexity of inpatients in the unit. Existing in-person staffing patterns for psychiatry must be maintained and may be enhanced but not replaced by telehealth.
- Each inpatient must be seen and assessed in-person, by the attending provider every day during the regular work week.
- The evaluation required for restraint and seclusion must be in-person.

Applications for approval that do not address all of the above will only be considered under a Part 501 waiver request.

SECTION 5: Guidance for Contracting with Telehealth Companies

OMH licensed or designated programs that plan to contract with a telehealth company must first obtain OMH approval to provide Telehealth Services. Prior to engaging in a contractual relationship with a telehealth company, the OMH provider must perform due diligence to ensure they are contracting with a reputable company and that the OMH provider will be able to meet all OMH requirements related to service provision, consistent with this guidance and Part 596. Providers must provide notice to the Field Office within 30 days of contract execution with a telehealth company.

Providers are responsible for ensuring that all Telehealth Practitioners meet standards in Part 596, including but not limited to appropriate credentialing and ensuring that the Telehealth Practitioner has access to the OMH provider's medical record and, if applicable, their electronic prescribing platform.

Additionally, providers are responsible for:

1. Monitoring third party vendor telehealth companies to ensure they comply with all applicable Federal and State laws and regulations and use all available evidence-based telehealth practice guidelines and standards of practice
2. Ensuring that the contracted Telehealth Practitioner is available for functions that support care beyond provision of direct services, such as team collaboration and consultation and emergency response
3. Making reasonable efforts to ensure continuity of care with Telehealth Practitioners, i.e., as possible the individual receiving services sees the same practitioner throughout their course of treatment.
4. Conducting formal, regular and ongoing quality reviews of contracted Telehealth Services, either through direct supervision or chart reviews. Such quality reviews shall include reviewing critical incidents for individuals receiving Telehealth Services through a contracted company in the same manner for all individuals receiving services.

OMH providers may not delegate to a contractor any quality management or quality improvement operational functions related to contracted Telehealth Services.

SECTION 6: Billing Guidelines

Medicaid Billing Guidelines

Providers should consult the latest DOH updates on Medicaid billing for Telehealth Services at https://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

Once the Provider has requested and received approval from OMH to utilize telehealth, claims may be submitted for Medicaid fee-for-service and Medicaid managed care reimbursement as long as the program meets the requirements outlined below.

All Telehealth Practitioners delivering Telehealth Services must be “affiliated” (the Medicaid term for “credentialed”) with the program submitting the claim for the telehealth service **BEFORE** the claim is submitted for payment. The process for affiliation for Telehealth Practitioners is the same as for all practitioners. If the originating/spoke site is a hospital, they must be credentialed and privileged at the originating/spoke site facility.

When billing Medicaid Fee-for-Service (FFS), Medicaid Managed Care, and Medicare, licensed and designated providers **MUST** use the claim modifiers “95” or “GT” to identify use of Telehealth Services, and “FQ” for Audio-only Behavioral Health Telehealth Services. Applicable modifiers must be on each claim line that represents a Telehealth Service. These modifiers may not be used until the program has approval to provide Telehealth Services. Other payors may require different coding for Telehealth Services. For further guidance on when to use 95 vs. GT, see <https://omh.ny.gov/omhweb/telehealth/telehealth-modifiers.xlsx>.

Telehealth Services that are **NOT** identified on Medicaid FFS claims or Medicaid Managed Care “paid encounter” claims with the telehealth 95, GT, or FQ modifier will be considered non-compliant and may lead to sanctions up to and including revocation of approval for telehealth. In addition, continued omission or inappropriate use of modifiers may lead to revocation of approval for telehealth.

Note: Medicaid Managed Care plans are currently required to reimburse outpatient behavioral health services, including Telehealth Services, in accordance with rates and fees established by the Office and approved by the Director of the Budget. Programs are required to submit managed care claims using the same codes and modifiers required by fee-for-service Medicaid claims, as outlined herein.

Medicare Billing Guidelines

Effective January 1, 2022, Medicare now permanently covers Telehealth Services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, including Audio-only Telehealth Services. See 42 C.F.R. § 410.78. CMS maintains a list of services that are approved Medicare Telehealth Services, including the current HCPCS codes that describe the services on the CMS website at <https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes>. Services must also be provided by Medicare-certified licensed physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers.

For mental health services, Medicare coverage is authorized without regard to the beneficiary's geographic location and the beneficiary's home can be the originating site. However, if a beneficiary receives Telehealth Services in their home, the following requirements apply:

- The practitioner must have provided an in-person service (whether or not Medicare paid for it), within six (6) months prior to first telehealth service. Note, this requirement does not apply to home Telehealth Services furnished to treat Substance Used Disorder (SUD) conditions or co-occurring SUD/MH.
- The practitioner must provide an in-person service at least once within 12 months of each subsequent, telehealth service unless, for a particular 12-month period, the practitioner and patient agree that the risks and burdens associated with an in-person service outweigh the benefits associated with furnishing the in-person service, and the practitioner documents the reason(s) for this decision in the patient's medical record.
 - Note, due to extensions granted by Congress, the in-person visit requirements do not apply to services rendered until January 1, 2025.
- For purposes of the in-person visit, CMS will permit practitioners of the same specialty or subspecialty within the same group as the Telehealth Services provider to perform the in-person visits if the Telehealth Services provider is not available.

For Audio-only services, Medicare coverage is available for services provided using interactive telecommunications including two-way, real-time Audio-only communication technology. The distant site practitioner must be technically capable of using an interactive telecommunications system including audio and video equipment, but the patient may not be capable of, or does not consent to, the use of video technology. CMS requires a specific modifier designated by CMS ("FQ") be appended claims for Audio-only services to verify that these conditions have been met.

SECTION 7: Applying to Use Telehealth Services

Application Pathways

Please note that approval for the use of Telehealth Services is program-specific and cannot transfer to other programs operated by the Provider.

OMH Licensed Providers may apply for the use of Telehealth Services through the Mental Health Provider Data Exchange (MHPD). Providers unfamiliar with the MHPD should consult with their local NYS OMH Field Office Licensing unit for assistance (<https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.html>).

- **Existing OMH licensed Providers** applying for use of Telehealth Services may submit an “Administrative Action” (AA) via MHPD. Providers who wish to apply for the use of telehealth in more than one (1) program may submit one (1) AA per agency, by choosing one (1) program in the program type to submit under. It must be clearly identified which program sites (including any satellites) are to be included for approval. A separate page/document listing out all the sites may be easiest and should be included as an attachment within the AA.
- **New Applicants to OMH program licensure** may include use of Telehealth Services in the Prior Approval Review (PAR) process, by submitting their telehealth policies and procedures and a completed Attestation.

OMH Designated (Unlicensed) Providers requesting to apply for use of Telehealth Services apply through program-specific pathways.

- For Adult BH HCBS and CORE, existing and new providers may submit a request by email to their regional OMH Field Office.
- For OMH CFTSS Providers (non-CMHRs), existing providers must contact Provider Designation to apply for the use of telehealth. New Unlicensed CFTSS applicants can incorporate Telehealth Services into the initial designation application.
- For Mobile Crisis Intervention Services Providers, existing and new providers may submit a request by email to their regional OMH Field Office.

Application Components

For all providers, the application for the use of Telehealth Services must include:

1. *Policies and Procedures*

Policies and procedures for the delivery of services through Telehealth Technologies must include all required elements as outlined in 14 NYCRR § 596.6(b) and in this guidance document, including Section four (4), which provides guidance regarding the delivery of Telehealth Services for each program type.

If a Provider is licensed for more than one (1) program type, the policies and procedures should reflect the use of telehealth within the different program types/settings, in accordance with applicable OMH Guidance and regulations.

Providers who received OMH approval to offer Telehealth Services prior to the

amendments to Part 596, effective September 12, 2022, should update their policies and procedures accordingly. OMH Field Office may request and review the updated policies and procedures as part of the routine licensing review of the approved program(s).

2. *Attestation*

A program applying for use of Telehealth Services must complete a “Telehealth Services Standards Compliance Attestation” form (Appendix A) and append it to the administrative action. The attestation assures OMH that the Provider’s plan for the use of telehealth conforms to the technological and clinical standards prescribed by 14 NYCRR Part 596 and applicable guidance. The “Technical Guidelines Checklist for Local Providers” (Appendix B) may be used as a guide to assist the program in purchasing equipment or choosing a telehealth platform.

Application Review and Approval

Upon receipt of the application for use of Telehealth Services, OMH Field Office licensing staff may conduct a remote readiness review to either or both the originating and/or distant sites to review the use of Telehealth Services as part of the routine certification process. This review may be achieved by having the Field Office licensing staff log on to the hub and/or spoke site’s telecommunication system to ascertain the quality of the transmission.

All applications for Telehealth Services for hospital-based Inpatient and CPEP services must be reviewed and approved by the OMH Chief Medical Officer or designee.

Upon final approval, Providers will receive either an amended Operating Certificate or a formal approval letter or email.

APPENDIX A: Attestation of Compliance for Approval for Telehealth Services

Part 596 of Title 14 NYCRR permits the provision of Telehealth Services by the New York State (NYS) Office of Mental Health (OMH) programs licensed or designated pursuant to Article 31 of the NYS Mental Hygiene Law, if approved to do so by OMH. Approval shall be based upon review of policies and procedures that satisfactorily address a series of standards and procedures. The following Attestation of Compliance must be completed and submitted with the application.

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 program’s Telehealth Policies and Procedures (P&P) that addresses same.

	Initials	Page or Section Number
1. The P&P confirms that the use of Telehealth Services is necessary to improve the quality of care of individuals receiving services or to address workforce shortages.		
2. The P&P confirms that Telehealth Practitioners meet standards established in Part 596.6(a)(1)(i), including that they possess a current, valid license, permit, or limited permit to practice in New York State, or are designated or approved by the Office to provide services.		
3. The P&P identifies the transmission linkages on which Telehealth 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.		
4. The P&P identifies acceptable authentication and identification procedures which will be employed by both the sender and the receiver.		
5. The P&P include provisions 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).		
6. The P&P confirms that the spaces occupied by the individual receiving services and the distant Telehealth Practitioner meet the minimum standards for privacy expected for delivery of services, consistent with guidance of the Office.		
7. The P&P confirms that individuals who are Deaf or hard of hearing seeking Telehealth Services are accommodated with appropriate interpreter or communication access services and that language access needs are met for individuals with Limited English Proficiency when delivering Telehealth Services. The P&P identifies methods by which this will be fulfilled.		
8. The P&P addresses the assessment of the appropriateness for Telehealth Services, including consideration of specific clinical and other factors, consistent with OMH clinical guidelines. The P&P		

includes specific considerations and supports for individuals under 18, if served by the program.		
9. The P&P addresses each site’s strategy for maintaining capacity for in-person services, including the procedures to ensure minimal disruption in care and continuity with the treating clinician when possible.		
10. The P&P describes how individuals receiving services will be informed about Telehealth Services and how consent to participate will be obtained.		
11. The P&P includes procedures for prescribing medications through Telehealth Services.		
12. The P&P describes how progress notes and treatment/ recovery/ service plans will be developed and maintained for Telehealth Services.		
13. The P&P includes procedures in the event that emergency in-person evaluation becomes necessary, including specifics for situations in which the individual’s place of residence may be considered the originating/spoke site.		
14. The P&P includes procedures describing the contingency plan when there is a failure of transmission or other technical difficulties that render the service undeliverable.		
15. The P&P confirms that a review of Telehealth Services is incorporated within the Provider's quality management process, including that incident review and other quality improvement activities are performed for Telehealth Services in the same manner as for in-person services.		
16. The P&P confirms that applicable telehealth modifiers will be used on each claim line that represents Telehealth Services.		

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 Telehealth Services at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability.

Signature: _____
 Date: _____
 Program/Site: _____
 Provider: _____

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 Representative: _____
 Field Office Signature: _____
 Date: _____

APPENDIX B: Technical Guidelines

Checklist for Providers

OMH regulations (14 NYCRR Part 596) provide that OMH approval of Telehealth Services in OMH licensed or designated programs will be based upon approval of a written plan that meets a variety of standards. These standards, as defined in Section 596.6(b)(4), include the following: “All Telehealth Services must be conducted via Telehealth Technologies that meet minimum federal and state requirements, including but not limited to 45 C.F.R. Parts 160 and 164 (HIPAA Security Rules), and which are consistent with guidelines of the Office. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.”

Audio-visual conferencing can be characterized by key features: the Audio-visual conferencing application, device characteristics, including their mobility, network, or connectivity features, and how privacy and security are maintained **This checklist can be used by providers to assist them in purchasing equipment or choosing a telehealth platform. It does not need to be submitted as part of the request for OMH approval.**

Telehealth Services Providers will ensure the confidentiality, integrity, and availability of recipient information, in accordance with Federal, State and NYS OMH regulations by:

- Developing and implementing policies and procedures to secure and control access to recipient data
- Minimally establishing HIPAA Business Associate Agreements (BAA) with any and all third-parties supporting Telehealth Services, including applicable conferencing service providers, where the party meets the legal definition of a HIPAA Business Associate
- Employing encryption in transit and at rest; leveraging multi-factor authentication technology and using strong passwords
- Developing and documenting policies and procedures for system/solution security and security/privacy of meeting recordings
- Obtaining appropriate consultation with technology experts to augment knowledge of the technologies in use and risks associated with those technologies to protect and maintain the confidentiality of recipient data
- Carefully assessing the remote environment to ensure efficacy, privacy and security of the services offered
- Developing mechanisms for secure configurations
- Developing policies and procedures to address what recipient data will be stored, how it will be accessed, the security of the information using given technology and any vulnerability to the confidentiality during the information lifecycle (creation, modification and timely destruction)
- Developing and documenting a retention and disposition plan for recipient data, including any images

Audio-visual Conferencing Applications:

- Applications include appropriate verification, confidentiality, and security parameters
- Audio-visual software platforms that include social media functions, interface with social media applications, or allow third parties to enter sessions at will should not be used for Telehealth Services

Security and Protection of Data Transmission and Information:

- Telehealth platforms must include security measures to protect data and information related to recipients from unintended access or disclosures
- When possible, all end points and all communications traversals should be managed through a managed network firewall and/or an Audio-visual-conferencing authentication server
- Confidential recipient data (including PHI) will be encrypted for storage or transmission, and other secure methods shall be used, such as safe hardware and software and robust passwords to protect electronically stored or transmitted data
- Protected Health Information (PHI) and other confidential data is encrypted, backed up to or stored on secure data storage locations. Cloud services unable to achieve compliance with HIPAA will not be used for PHI or confidential information. A HIPAA Business Associate Agreement (BAA) must be established and maintained with any cloud service supporting unsecured PHI associated with Telehealth Services which meets the definition of a HIPAA Business Associate
- It is strongly recommended that use of public WI-FI be avoided due to increased risk of exposure to malevolent activity that could compromise the session and gain unauthorized access to sensitive information
- Telehealth Practitioners and individuals receiving services will discuss any intention to record services and how this information is to be stored and how privacy will be protected
- Unauthorized users are not allowed to access sensitive information stored on the device or use the device to access sensitive applications or network resources
- Session logs that are stored by a third-party location are stored securely and access is granted only to authorized personnel
- Telehealth platform software does not allow multiple concurrent sessions to be opened by a single user. If this occurs first session will be logged off or second session blocked
- HIPAA and state privacy requirements will be followed at all times to protect the privacy of the individual receiving services
- Network and software security protocols to protect privacy and confidentiality are provided, as well as appropriate user accessibility and authentication protocols
- Measures to safeguard data against intentional and unintentional corruption are in place during storage and transmission
- Telehealth platform software capable of blocking Telehealth Practitioner's caller ID is utilized at the request of the Practitioner

Transmission Speed and Bandwidth:

- Transmission speed should provide smooth and natural communication pace for clinical encounters. Each end point uses bandwidth sufficient to achieve at least the minimum quality during normal operation
- The Audio-visual connection must be sufficient to allow for a thorough mental status exam
- Audio-visual conferencing software should be able to adapt to changes in bandwidth environments without losing connection
- When possible, each party should use the most reliable connection to access the Internet and use wired connections if available

Encryption:

- Encryption of data in transit and, if applicable, at rest: AES 256 bit or higher with Transport Layer Security (TLS 1.2 or higher)

- Use of validated digital certificates required
- Audio and Audio-visual transmission is secured by using point to point encryption that meets recognized standards. Federal Information Processing Standard (FIPS) 140-2 is the US Government security standard used to accredit encryption standards of software and list encryption such as AES as providing acceptable levels of security
- If data is stored on the hard drive, whole disk encryption to the FIPS standard is used to ensure security and privacy. Re-boot authentication shall also be used
- Recording of services is discussed with recipient and encrypted for maximum security. Access is available to authorized personnel only and stored in a secure location

Equipment:

- Equipment used is based on Telecommunication Standard (International Telecommunications Union (ITU)) which allow for successful conferencing regardless of platform or manufacturer. See H- Audio-visual; G-Audio T- Data Series
- Audio-visual conferencing with personal computers utilized for VTC complies with all facility, state and federal regulations applicable to both VTC and mental healthcare uses
- Personal computers, /laptops and /tablets have up to date antivirus software and a personal firewall appropriately configured to restrict inappropriate access
- Personal computers/ laptops and/ tablets have the latest security patches and updates applied to operating system and third-party applications that may be utilized for this purpose telehealth
- When feasible, personal computers/ laptops and/ tablets use professional grade or high-quality cameras and audio equipment
- In the event of equipment disruption, there is an appropriate equipment backup plan in place
- Processes are in place to ensure physical security of equipment and electronic security of data

Reference Material: American Telemedicine Association (<https://www.americantelemed.org/>)