New York State Office of Mental Health
COVID-19 Disaster Emergency FAQ

Issued: July 13, 2020

OMH will be updating this document as answers become available. New York State is in the midst of a rapidly evolving public health crisis. Some of the federal and state COVID-19 emergency flexibilities outlined in this FAQ document are in effect on a time limited basis, and are subject to expiration, revocation, or continuation. This FAQ document is accurate as of the date issued.

OMH Guidance on COVID-19 can be found here: https://omh.ny.gov/omhweb/guidance/

DOH Guidance on COVID-19 can be found here: https://coronavirus.health.ny.gov/home

- **New Questions (color coded purple):** 107, 115, 147, 167, 171-176, 223-225

FAQ Topics

General

Q#	Topic	Question	Answer
1.	Altering Office Hours	Do agencies need to submit an E-Z PAR to alter office hours during the disaster emergency?	An E-Z PAR is not needed for changing hours for the duration of the disaster emergency, but agencies should notify the local Field Office of any reduction in hours. OMH Field Office contact information can be found here: https://omh.ny.gov/omhweb/aboutomh/fieldoffices.html
2.	Consolidated Fiscal Report	Will there be an extension of the Consolidated Fiscal Report (CFR) deadline if the disaster emergency poses an impact on timely submission?	OMH understands agencies face an increased administrative burden at this time. OMH issued a letter on March 18, 2020 stating the January 1, 2019-December 31, 2019 CFR due date has been extended to August 1, 2020 for all OMH providers. OMH will continue to assess the need for additional extensions based on situational impacts. The 2019 CFR Extension Memo can be found here: https://omh.ny.gov/omhweb/guidance/cfr-due-date-extension-memo.pdf
3.	Essential Businesses	Are OMH licensed/designated/funded providers considered essential businesses exempt from the Governor's Executive Order (202.7) requiring in-person work restrictions?	Yes. Agencies providing services to individuals with mental illness and operated, licensed, designated, funded, or authorized by the Office of Mental Health, qualify as an essential business and should remain in operation to the extent necessary to provide those services. This includes administrative offices and employees necessary to support the essential functions of an agency's mission. Agencies have the discretion to allow staff to work remotely as long as essential functions are maintained.
4.	New Referrals	How should community-based behavioral health providers handle new referrals at this time? Can admissions be closed?	Community-based behavioral health providers should not close admissions to existing programs and services. Intakes may be conducted using telemental health services, if necessary. At this time, hospitals, jails and prisons need support and partnership in discharging individuals to appropriate levels of care/support in the community.
5.	NIMRS Reporting	Do agencies need to report COVID-19 cases in NIMRS?	The New York State Incident Management and Reporting System (NIMRS) has been updated to include a new subtype when reporting Death incidents. Please choose the subtype "COVID-19 Related" for any client death which can be attributed to, or is suspected to be related to, COVID-19. Please review any reportable deaths that have occurred since March 1, 2020 and update the final incident subtype as necessary.

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			OMH is not requiring providers to report in NIMRS when clients have been tested for COVID-19 and are awaiting results or when a client tests positive for COVID-19. Please see the Incident Reporting and NIMRS Update Guidance for more information, posted here: https://omh.ny.gov/omhweb/guidance/covid-19-guidance-nimrs-incident-reporting-updates.pdf
6.	Building Closures	Are agencies allowed to close the physical building of an OMH licensed/funded/operated outpatient program if they are using telehealth to provide existing services?	OMH licensed/funded/operated programs should continue to have on-site capacity to address the needs of recipients who may require face-to-face contact using infection control guidelines outlined by the NYS DOH and the CDC. Programs that provide long acting injectable medications, obtain samples for lab testing, and other services that must be done in-person, must make provisions for continuity of these services. OMH is allowing the use of telehealth and telephonic intervention across much of the provider system to allow maximum flexibility in service delivery. Agencies should continue to prioritize the health and safety of individuals served.
7.	Building Closures	Is there an expectation clinics will remain open for those patients who cannot or will not participate in telemental health services?	Yes. Providers should be aware of, and in compliance with, any state and local advisories, including appropriate patient screening.
8.	Building Closures	Does OMH have guidance on how agencies transitioning entirely to telemental health can move all clients on long-acting injectables to oral formulations of the medications?	OMH licensed/funded/operated programs should continue to have on-site capacity to address the needs of recipients who may require face-to-face contact using infection control guidelines outlined by the NYS DOH and the CDC. Programs that provide long-acting injectable medications must make provisions for continuity of these services. OMH is strongly against transitioning individuals from long-acting injectable medications to oral formulations if there is a risk the individual cannot adhere to treatment, may decompensate, and need hospitalization. This would significantly increase the risk to that individual. Outpatient programs should transfer as many visits as possible to telemental health, but must maintain capacity to care for patients who cannot tolerate virtual visits, require administration of long-acting antipsychotics, and to obtain laboratory testing samples, to ensure high quality care of their patients. Clinic physicians and

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			nurses are also authorized to visit patients in their place of residence to administer injectable medications.
9.	Service Provision	Should agency staff enter an area where COVID-19 infections have been reported, even if personal protective equipment (PPE) is available?	In congregate locations where individuals have tested positive for COVID-19, healthcare workers must continue to provide care, including in hospital units or housing programs. If available, staff should use surgical masks in these settings. Staff who are obtaining samples for COVID-19 tests should wear N95 respirators.
10.	COVID-19 Infection Notification	When should residential programs or clinics inform patients if a staff member develops COVID-19 symptoms?	If a program learns that a client or staff member developed symptoms or tested positive for COVID-19, they should inform all individuals who had close contact with that person. Programs should advise potentially exposed clients to self-quarantine for 14 days. Potentially exposed staff members can report for work as long as they are asymptomatic, wear a mask, and check their temperature twice per day. If staff members are unable to wear a mask or check their temperature, they cannot report to work and must self-quarantine for 14 days.
11.	Transporting COVID-19 Patients	If an agency is moving COVID-19 positive residents to a consolidated space to protect others (such as a community residence or apartment), is there guidance about how to transport residents without exposing the transporting staff member?	When staff are transporting COVID-19 positive or symptomatic clients, both the staff and client should wear masks, if available. The client should sit in the farthest possible position from the driver or other staff, taking safety into consideration. If the driver or other staff cannot sit more than 6 feet away from the client, they should wear N95 respirators, if available. Eye protection, such as goggles, is advisable if it does not impede driving safety. It is also recommended that while the car is going less than 30mph, the windows of the vehicle be left open to maximize ventilation. At higher speeds, the car climate settings should be set to allow ventilation from outside the car (do not recirculate the air) and the fans should be set at maximum level. After the client has been transported, the portions of the vehicle that the client may have come into contact with should be wiped down. Both staff and client should be instructed to avoid touching their faces and to wash their hands upon arrival.

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12.	Residential Treatment Facility Restraint Training	How should providers train new hires and current staff for in-person restraint application to ensure they demonstrate competence while practicing social distancing?	Training in the proper and safe use of restraint application and techniques, as well as alternative methods for handling behavior, symptoms, and situations that traditionally have been treated using restraints, is still required for all new Residential Treatment Facility staff. It is at the discretion of the provider to determine the appropriate approach to training during the emergency period. However, contact training should **not** be conducted during this emergency period. Providers should consider the use of videos and/or demonstrations on mannequins. For staff to demonstrate competence, they must confirm they understand the techniques and should be paired initially with experienced staff to observe and understand how to do restraints, if necessary.
13.	Long-Acting Injectable Administration	What is the guidance for nurses administering anti-psychotic long-acting injectable medications in home or shelter settings, given the lack of personal protective equipment (PPE) and in light of the Center for Disease Control's guidance that full PPE should be used by public health professionals when in contact with individuals who are either COVID-19 positive, symptomatic and presumed positive, persons under investigation (PUI), or individuals asymptomatic but in close contact with people presumed or confirmed COVID-19 positive?	When administering long-acting injectable medications (LAIs) to clients, staff should follow droplet precautions. As always, staff should wear gloves when administering injections. This is not only for protection against COVID-19, but is universal protocol for protection against blood-borne pathogens. While there is community spread of COVID-19, staff should also wear surgical masks. If enough masks are available, the patient can also wear one. This will reduce the risk of droplet contamination. N95 respirators are not appropriate for LAIs and are only needed for procedures that result in aerosolizing of sputum, such as intubation. Frequent-contact surfaces in the examination room should be disinfected after every patient encounter. Given the national shortage of PPE, if masks are unavailable, outpatient programs can consider administering injections outdoors, particularly if the client is a PUI or has tested positive for COVID-19. Whenever possible, staff can provide gluteal injections instead of deltoid injections to increase distance from the client's face. An eye shield is recommended, if available.
14.	Clozapine- ANC Monitoring	How should practitioners handle Absolute Neutrophil Count (ANC) monitoring for patients on Clozapine via telemental health?	According to the Clozapine Risk Evaluation and Mitigation Strategy (REMS) website, Absolute Neutrophil Count not current (i.e., within 7, 15, or 31 days of the lab draw date) based on the patient's monitoring

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			frequency (MF) will not prevent a patient from receiving Clozapine from the pharmacy. Outpatient programs must continue to provide capacity for laboratory testing when clinically indicated. The clinician can continue to report the latest ANC available to the Clozapine REMS registry, and make a note to the pharmacist in the prescription that in your opinion, it is appropriate to dispense Clozapine in the absence of a more recent ANC. Please see OMH's Clozapine Guidance here: https://omh.ny.gov/omhweb/guidance/omh-covid-19-guidance-clozapine-blood-test-monitoring.pdf
15.	NYS COVID-19 Emotional Support Line	Will there be any State-provided emotional support for clinicians responding to the COVID-19 emergency?	The Emotional Support Helpline provides free and confidential support. Clinicians on the front lines can select the option on the Helpline developed for "essential healthcare workers and first responders" and speak with a volunteer who has been specially trained in the unique challenges and strengths of professional care providers. Please call 1-844-863-9314 between 8am and 10pm, 7 days per week.

OMH Licensed Programs/Designated Services

Q#	Topic	Question	Answer
16.	AOT	What is the impact of the disaster emergency on required AOT visits?	Teams should be in continuous contact with local government units related to AOT court orders. For more information, refer to the telemental health AOT question below (#83).
17.	AOT	What is the procedure for when an individual with an active AOT (Assisted Outpatient Treatment) order wishes to leave their current living environment in order to protect a COVID-19 vulnerable person living in that home and their new residence happens to be in a new county?	Where geographically possible and in coordination with the individual, the county servicing the recipient should maintain the relationship and oversight of the individual, while notifying the new county of residence. If continuing to provide services to the individual is not possible, the county should follow the OMH County Transfer Guidance to ensure the individual receives all necessary services. Guidance is available here: https://my.omh.ny.gov/analyticsRes1/files/aot/AOTCountyTransfersGuidanceFinal.pdf

18.	CCBHC	Can CCBHCs use a Licensed Practical Nurse (LPN) in lieu of a Registered Nurse (RN) to staff the Crisis Recovery Center to fulfill the required nursing duties for CCBHC during the emergency response to COVID-19?	Yes. The CCBHC demonstration requirement to have a Registered Nurse (RN) onsite to perform nursing duties will be temporarily relaxed during the emergency response to COVID-19, to allow a Licensed Practical Nurse (LPN) to perform nursing duties onsite within the LPN scope of practice. The LPN must have access to supervision by an RN. The LPN may not perform any nursing duties outside of the LPN scope of practice.
19.	Children's Residences	Is there any guidance regarding whether Children's Community Residences are allowed to bill for children who are on "home time leave," because they were home when the pandemic began and could not come back?	As outlined in 14 CRR-NY 593 Medical Assistance Payments for Community Rehabilitation Services Within Residential Programs For Adults and Children and Adolescents regulations, in residence is defined as currently admitted to and residing in a program governed by Part 593 and not on leave as an inpatient of any hospital for any reason or temporarily residing in any other licensed residential facility. Children are considered "in residence" as long as they continue to be admitted to the Community Residence and receive services while in the home, in accordance with required services and contacts for reimbursement. Agencies can bill for the child as long as all required services are provided, either in-person or via telemental health.
20.	Clinic Outreach	Can clinics request welfare checks by Comprehensive Psychiatric Emergency Program (CPEP) mobile outreach or mobile crisis teams for clients who miss scheduled outpatient appointments?	As Mobile Crisis Teams are operating largely telephonically and reserving in-person response for the most high-risk referrals, OMH requests community providers conduct telephonic outreach internally and only refer high-risk individuals with a clear need for in-person evaluation.
21.	Mobile Crisis	Are Mobile Crisis services available during the COVID-19 disaster emergency?	Mobile Crisis services remain available across the State and Mobile Crisis providers are using all available tools to respond as needed.
22.	Mobile Crisis	Can Comprehensive Psychiatric Emergency Program (CPEP) mobile outreach and Designated Crisis Intervention Mobile Crisis teams provide services to individuals being discharged from an inpatient psychiatric admission?	During this disaster emergency, CPEP Crisis Outreach services, including Interim Services, may be provided to individuals released from the emergency room of the CPEP as well as discharged from the psychiatric inpatient program. Additionally, Crisis Intervention Mobile Crisis providers can assist individuals being discharged from inpatient settings. This can be provided face-to-face or through telemental health.

23.	Residential	Can an OMH licensed housing program work with an outpatient program (clinic, PROS, ACT, etc.) to provide injectable medications to reduce risk of infection by having an outside staff come into the residential program?	Yes. OMH encourages collaboration between residential and treatment providers.
24.	Residential	Does OMH have guidance on how agencies should proceed with completing self-preservation tests and fire drills during the COVID-19 disaster emergency?	In NYS regions that have met the Phase 1 reopening metrics, the OMH congregate and Single Room Occupancy (SRO) program regulation requiring monthly fire drills are reinstated. Individuals in residence that are in quarantine or isolation should not participate with the rest of the program's residents. If necessary, providers should contact their local Field Office to discuss an additional extension. In NYS regions that have not met Phase 1 reopening metrics, the OMH congregate and Single Room Occupancy (SRO) program regulation requiring monthly fire drills will continue to be suspended, with the exceptions listed below: 1. New admissions with an unclear self-preservation assessment, requiring a fire drill to confirm assessment for that one person. 2. When an individual's physical or psychiatric status has changed and it's no longer clear if the home's maximum evacuation time requirement could be maintained (i.e. an individual returning from a psychiatric or medical hospitalization). Fire drills should continue to be conducted based on the most recent CDC and NYS DOH infection control guidelines.
25.	Housing Programs	Are OMH licensed or contracted housing programs, including Single Room Occupancy (SRO) programs, allowed to admit individuals during the COVID-19 disaster emergency?	Guidance was issued by OMH on the importance of continuing admissions in mental health programs, including housing programs such as Single Room Occupancy (SRO) programs. There may be circumstances in congregate settings where clients have tested positive or are displaying symptoms, where the risks and benefits of continuing admissions will need to be assessed. In these situations, providers have been directed to contact their local OMH Field Office to discuss the particular circumstances.

			In no case has OMH issued any guidance directing providers of any housing program type to stop admissions universally. Previously issued guidance regarding admissions can be found at the following link: https://omh.ny.gov/omhweb/guidance/omh-covid-19-admissions-continuity-of-care.pdf.
26.	Supported Housing	How can individuals living in supportive housing pay their portion of rental costs if they had to stop working because of COVID-19-related issues?	If an individual stops working due to the COVID-19 crisis, rent should be recalculated to ensure it does not exceed 30% of their income. Individuals should be encouraged to file for unemployment or any other benefits for which they may be eligible. OMH has granted State Aid flexibility and waiver of occupancy standards for supportive housing providers to help manage loss of revenue during this emergency period.
27.	Graduate Student Trainees	Graduate programs are terminating clinical affiliation agreements with our OMH-licensed training site early due to COVID-19 related concerns. Can student trainees continue to work in OMH-licensed programs under these circumstances? We would like for students to continue to maintain continuity of care, and to hire them after graduation.	Student trainees who are enrolled in programs to become licensed healthcare professionals, may continue to provide services under appropriate supervision in OMH licensed programs pursuant to various exemptions in the NYS Education Law applicable to various professions. In addition, students can continue to work and get educational credit pursuant to Executive Order (EO) 202.10 notwithstanding the lack of a clinical affiliation agreement between their program of study and their field work placement. NYS Office of the Professions in the State Education Department (OPSED) has compiled all of the relevant sections of the EOs here: http://www.op.nysed.gov/COVID-19_EO.html
28.	Provider Licensure	Can a provider licensed in another state render services at an OMH licensed/designated/funded program for clients in NY?	Numerous Executive Orders have permitted out of state licensed healthcare practitioners to provide services in NYS within their scope of practice during the COVID-19 disaster emergency. For a current list refer to the COVID-19 Executive Orders on the State Education Department (SED) website: http://www.op.nysed.gov/COVID-19_EO.html
29.	Utilization Review	Are OMH-licensed programs required to comply with internal utilization review requirements included in program regulations during the COVID-19 disaster emergency?	OMH issued COVID-19 documentation, and program and billing guidance for several OMH licensed programs. These guidance documents include a section on utilization review. These guidance documents can be found on the OMH guidance webpage: https://omh.ny.gov/omhweb/guidance/.

Background Check and Fingerprinting Requirements

Q#	Topic	Question	Answer
30.	Criminal Background Checks	Is there any temporary relief to the background check or fingerprinting requirements to allow providers to recruit and deploy new staff quickly during the COVID-19 disaster emergency?	Yes. Executive Order 202.13 provides relief to programs requiring background checks. It allows current employees of an OMH, OPWDD, OCFS or OASAS program who have completed the necessary background checks for their current employment to work at a different OMH program without additional background checks. Guidance issued by OMH on April 11, 2020 includes a process for verifying if a potential employee has already been cleared. The Executive Order also created an expedited process for the deployment of potential employees not currently employed by a program for which they completed a background check. Providers should review the April 11, 2020 guidance with respect to the timeframes and requirements of the expedited process. The emergency flexibilities outlined in this Executive Order are in effect on a time limited basis. Please refer to the Governor's Executive Orders for the most updated information: https://www.governor.ny.gov/executiveorders For more information, please see the OMH COVID-19 Guidance- Interim Background Check posted here: https://omh.ny.gov/omhweb/guidance/covid-19-interim-background-check.pdf.
31.	Background Checks for Telemental Health Services	Do background check and fingerprinting requirements apply to practitioners delivering care only via telehealth?	Yes. Background check and fingerprinting requirements (as modified by Executive Order 202.13) apply to practitioners using telehealth. In determining whether the requirements apply in a specific situation, providers should treat the telehealth contact as the equivalent of a face-to-face contact. Where such face-to-face contact would require background checks, the delivery of the same service via telehealth would also require background checks.
32.	Background Checks	Can an individual employed by a program with DOH oversight work at an OMH licensed or designated program without a Justice Center background check?	No. Programs under the auspices of the Department of Health are not covered by Executive Order 202.13. Therefore, these individuals must follow the "New Staff Members Not Otherwise Employed by an Approved Provider" section in the OMH COVID-19 Guidance- Interim

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			Background Check to work in an OMH licensed or designated program. For more information, please see the OMH COVID-19 Guidance-Interim Background Check posted here: https://omh.ny.gov/omhweb/guidance/covid-19-interim-background-check.pdf.
33.	Applicability	Does the OMH Guidance for Implementation of Executive Order 202.13 Provisions Regarding Background Checks also apply to volunteers?	Yes.
34.	Attestation Witness	The Executive 202.13 Criminal History Information Attestation requires a witness' signature. Are there requirements about who the witness must be?	No. Anyone at least 18 years old can witness the applicant's signature.
35.	New Staff	Under the Executive Order 202.13 can a new employee of an OMH licensed, funded, or approved program begin working prior to completing their background check?	Yes. A new employee may work in an OMH licensed, funded, or approved program prior to the completion of their background check if the individual: • Does not appear on the Staff Exclusion List (SEL). • Completed the OMH Executive Order 202.13 Criminal History Information Attestation form. • Initiated the Criminal Background Check (CBC) and Statewide Central Register (SCR) check. • Scheduled a fingerprinting appointment to occur no later than 5 business days after their first day of work. In addition, the program should limit the unsupervised contact of such employee to the extent practicable while checks are pending. The requirements outlined in the Guidance for Implementation of Executive Order 202.13 Provisions Regarding Background Checks must be followed. The Guidance is posted here: https://omh.ny.gov/omhweb/guidance/covid-19-interim-background-check.pdf

36.	Fingerprinting Appointment	What should OMH licensed, designated, funded or approved programs do if they want to hire a new individual who has not gone through a background check yet, but for whom the program is having difficulty trying to schedule a fingerprinting appointment for?	Where efforts to secure a fingerprinting appointment within five business days after the prospective employee's first scheduled day of work are unsuccessful, the Authorized Program should contact the OMH contact person at cbc@omh.ny.gov for assistance in securing such appointment, as soon as practicable.

Telemental Health

Q#	Topic	Question	Answer
37.	High-Risk Populations	Can providers use telemental health to provide services to high-risk individuals?	Providers must use their clinical discretion to determine the needs and appropriate response to individual circumstances. At this time, OMH is allowing telephonic intervention across much of the provider system to allow maximum flexibility in service delivery. Agencies should continue to prioritize the health and safety of individuals served.
38.	Prescribing Controlled Substances	Can controlled substances be prescribed via telemental health services?	Yes. CMS has temporarily waived provisions of the Ryan-Haight Act to allow practitioners to prescribe Schedule II-V controlled substances via telemedicine without an in-person medical evaluation provided: 1. The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; 2. The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; & 3. The practitioner is acting in accordance with applicable Federal and State laws.* For patients who have had an in-person medical evaluation previously, CMS is allowing practitioners to issue a prescription for a schedule II - V controlled substance after communicating with the patient via telemedicine, or any other means (including by telephone) so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his or her professional practice. *When prescribing via telemedicine, practitioners shall comply with all existing State laws and regulations pertaining to prescribing, including but not limited to: Education law 6902(3)(a)(ii), 7606, 7708,

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			and 8407; Public Health Law 281, 3331, and 3343-a; and regulations of the New York State Department of Health at 10 NYCRR Part 80 unless waived by Executive Order. As of 3/23/20, none of these provisions have been waived. For more information consult the federal guidance at https://www.deadiversion.usdoj.gov/coronavirus.html.
39.	Controlled Substance Prescriptions	While federal Drug Enforcement Agency (DEA) regulations allow for initiating a prescription for some controlled substances (benzodiazepines or stimulants) via telemental health, we are concerned the requirement for a video connection will seriously complicate prescribing these drugs, as many of our clients do not have access to a smart phone or computer allowing for a video evaluation. Do you have any guidance on this?	1. OMH expects ambulatory treatment providers to maintain in-person capacity to meet the needs of clients which cannot be met by telemental health or telephonic contact. This includes injectable medications, lab tests, and would also include in-person evaluations for initiating prescriptions of controlled substances. For more information, please see the OMH Admissions and Continuity of Care memo: https://omh.ny.gov/omhweb/guidance/omh-covid-19-admissions-continuity-of-care.pdf. 2. If new referrals are coming from psychiatric inpatient services OMH expects video evaluations be scheduled with the ambulatory care provider prior to discharge to ensure continuity of treatment. If this is not possible, OMH has already issued guidance to inpatient services stating they are responsible for maintaining continuity of prescriptions during transitions to community care, and which applies here as well. The Treatment planning and documentation standards for article 28/31 hospital psychiatry providers during emergency period guidance are posted here: https://omh.ny.gov/omhweb/guidance/covid-19-article28-31-hospital-psych-providers-treatment-planning-documentation.pdf 3. If there is a risk of acute withdrawal due to discontinuation of a benzodiazepine, the existing standard of care is to continue such prescriptions on a short-term basis to ensure client safety.

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40.	Mental Status Examinations	How should organizations handle mental status examination requirements in psychosocial or psychiatric evaluations while completing a telephonic intake?	Practitioners should document the elements of the mental status exam that can be completed telephonically (i.e. behavior, speech, mood, thought process, thought content, cognition, memory, insight, and judgement). On video, practitioners are also able to do a limited motor exam, note appearance, and evaluate affect. When possible and if necessary, practitioners can attempt to complete missing elements of the mental status exam by speaking with corroborative sources such as family members, residential program staff, or roommates.
41.	Vital Sign Information	How should practitioners collect vital sign information while completing psychiatric evaluations over the telephone or using video technology?	Clients can be encouraged to purchase home electronic sphygmomanometers if they can afford it and report to the practitioner their blood pressure and pulse. If this is not an option, then practitioners should evaluate the risks and benefits of starting, continuing, or changing a medication in the absence of the information. When regular vital signs are not an option, it is even more critical for practitioners to explain to clients, family members or residential program staff possible adverse reactions to medications. Clients should be carefully counseled to call with any concerns about side effects. Practitioners may need to prescribe different medications or second-line agents that are safer to use without vital sign monitoring.
42.	Self-Attestation	Who is responsible to submit the Self-Attestation of Compliance to Offer Telemental Health Services?	One Self-Attestation needs to be submitted per agency for all applicable programs. Individual practitioners do not need to submit Self-Attestations.
43.	Self-Attestation	Can I begin providing services via telemental health as soon as I submit my attestation?	Yes. All Self-Attestations of Compliance to Offer Telemental Health Services are approved once submitted. This includes all attestations submitted since March 11, 2020. This applies to OMH licensed programs and designated services that meet the requirements outlined in the OMH Consolidated Telemental Health Guidance. Keep a copy of what you submitted for your records.
44.	Self-Attestation	Do organizations need to submit a new Self-Attestation if, when they submitted initially, it only included the agency name without listing all affected programs/services?	No. A new Self-Attestation is not necessary. Agencies may submit a follow-up email to amy.smith@omh.ny.gov identifying the agency name and the particular programs/services that will be utilizing telemental health. Keep a copy of this email for your records.

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45.	Self-Attestation	Does the Self-Attestation form need to be signed by the Executive Director/CEO or a Licensed practitioner?	No. The Self-Attestation form needs to be signed by anyone appropriately authorized or designated by the provider agency seeking approval.
46.	Self-Attestation	Do agencies with both OMH and OASAS programs need to submit separate Self-Attestations to each Office?	Yes.
47.	Telemental Health	Does the OMH Consolidated Telemental Health Guidance allow for audio only/phone encounters while we build up video capacity?	Yes. The OMH Consolidated Telemental Health Guidance allows for telephonic service provision.
48.	Telemental Health	Are services provided only via text message or email included in the telemental health waiver?	No.
49.	Telemental Health	Is the use of telephone allowed or is it reserved only for video?	Yes. See OMH Consolidated Telemental Health Guidance for more information.
50.	Telemental Health	Are text messaging or text chats allowed as part of services delivered using the expanded telemental health waiver?	There are many ways in which text or chat can be beneficial, however, under current regulations, neither text nor chat is a billable service, with one exception. Time spent texting can be incorporated into services provided via two-way synchronous video. During the COVID-19 disaster emergency period, providers delivering telehealth services through two-way synchronous video may permit their clients to use a chat/text function, if a client is concerned their space is not private enough to participate in services verbally. Additionally, text or chat can be used to augment other forms of communication during a telephonic session. For example, a provider could conduct a session primarily by phone, but could allow the recipient to end the session by texting or chatting feelings or thoughts they might find hard or embarrassing to verbalize, or they don't want overheard. However, the time spent texting would not be part of the duration of services used for billing purposes. Text or chat can also be used for brief check-in contacts, to confirm informed consent and other similar brief communications, and these services would not be billable. For text or chat to be used, the role text or chat can play would need to be clearly communicated, agreed upon by the provider and the

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			recipient, and documented in the record. This would include but not be limited to areas such as how the provider will ensure availability to respond to texts or chats, or the role (if any) of text/chat in crisis situations. Additionally, minors would require parental consent to text or chat.
51.	Telemental Health	Are we able to do group sessions via a phone teleconference number?	Yes. See OMH Consolidated Telemental Health Guidance for more information.
52.	Telemental Health	Can mailed materials (e.g., exercise sheets, etc.) be considered a telemental health service?	No.
53.	Applicability	To which service providers does the OMH telemental health waiver apply?	The OMH telemental health waiver applies to programs licensed, funded or designated by the NYS Office of Mental Health (OMH) defined in the applicability section of the OMH COVID-19 Consolidated Telemental Health Guidance. The guidance is posted here: https://omh.ny.gov/omhweb/guidance/
54.	Applicability	Does the OMH telemental health waiver apply to school-based health clinics?	No. The guidance issued by OMH for telemental health applies only to OMH programs and services. School based health providers should follow guidance from DOH. Article 31 School Based Mental Health Clinics should follow guidance issued by OMH.
55.	Applicability	Does the OMH telemental health waiver apply to private practitioners?	No. The OMH guidance applies only to OMH licensed, funded, or approved programs/agencies. For further information follow up with your licensing authority, if applicable, or more generally visit the DOH website at: https://coronavirus.health.ny.gov/home. Private practitioners should review the Circular Letter issued by the NYS Department of Financial Services (DFS) on 3/15/2020 for information on commercial insurance reimbursement for telehealth, and follow any additional guidance from DFS. The circular letter is available here: https://www.dfs.ny.gov/industry_guidance/circular_letters

56.	Applicability	Does the OMH telemental health waiver apply to practitioners from other states providing mental health services to individuals living in New York because of the COVID-19 crisis (e.g. services provided to a college student who attends school out of state, but is home in NY)?	No. The NYS OMH telemental health regulations do not apply to this situation. Mental health services provided and billed in other states are subject to regulatory relief to the extent available in that state. Please follow up with the state regulatory authority where you are providing services and billing.
57.	Documentation	Are providers delivering services through telemental health required to record sessions and save those for documentation?	No. Providers must document informed consent from a client in order to record services.
58.	Telemental Health Equipment	Can providers use personal phones to conduct services telephonically?	Yes.
59.	Telemental Health Equipment	Can providers bill for telemental health services if they block the phone number the call originated from?	Yes.
60.	Telemental Health Equipment	Are there any waivers available for organizations that do not currently have the required infrastructure (hardware and software) to provide telemental health?	Telemental health for Medicaid-reimbursable services is temporarily expanded to include telephonic and/or video, including technology commonly available on smart phones and other devices. Please see OMH Consolidated Telemental Health Guidance.
61.	Telemental Health Equipment	How can I help clients obtain mobile phones, additional data or minutes, and/or Wi-Fi for telemental health services?	Please refer to the DOH issued Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-19 State of Emergency. **Options to Support Members with Limited or Lack of Access to Devices and Services** The following is a listing of helpful resources compiled for emergency assistance: **1. Free Wi-Fi/internet** • Charter Communications (Spectrum) and Comcast are giving households with K-12 and college students, and those who qualify as low-income complimentary Wi-Fi for 60 days • Families who do not have the service will also receive free installation of the service • Both companies are expanding Wi-Fi hotspots to the public within the company's available regions

			• Call **(844) 488-8395** (Charter) or **(855) 846-8376** (Comcast) to enroll • Individuals must call company after 60 days, or they will be automatically billed **2. Unlimited data** • Charter, Comcast, AT&T, and Verizon are offering unlimited data plans to customers until May 13 for no additional charge **3. SafeLink Wireless** • Eligibility requirements must be met, which are set by each State where the service is provided • To qualify for Lifeline, subscribers must either have an income that is at or below 135% of the federal Poverty Guidelines, or participate in one of the following assistance programs: o Medicaid o Supplemental Nutrition Assistance Program (SNAP) Food Stamps o Supplemental Security Income (SSI) o Federal Public Housing Assistance (Section 8) o Veterans and Survivors Pension Benefit • Service is limited to one person per household • Call **1-800-SafeLink (723-3546)** for enrollment and plan changes support • Subscribers can use their own phones: o SafeLink Keep Your Own Smartphone plan requires a compatible or unlocked Smartphone. Most GSM Smartphones are compatible. o Subscribers can get up to 350 minutes and 3GB of data, which includes voice minutes and unlimited texts, voicemail, nationwide coverage and 4G LTE on 4G LTE compatible devices
62.	Telemental Health Equipment	What resources are available to help clients access home telephone or mobile phone services during the COVID-19 disaster emergency?	Lifeline is a federal program providing discounted phone service for qualifying low-income consumers to ensure all Americans have the opportunities and security phone service brings, including being able to connect to jobs, family and emergency services. Supported by the

			Federal Communications Commission (FCC), the Lifeline program provides subscribers monthly telephone service, broadband Internet access service, or voice-broadband bundled service from participating carriers. For more information, please visit the Lifeline website: https://www.fcc.gov/consumers/guides/lifeline-support-affordable-communications Subscribers may receive a Lifeline account on either a landline or a wireless service, but they may not receive an account on both services at the same time. Lifeline also supports broadband Internet access service and broadband-voice bundles. FCC rules prohibit more than one Lifeline service per household. Lifeline guidance includes information on: • Eligibility • How to apply for services • Lifeline Providers The Lifeline guidance is posted here: https://www.fcc.gov/sites/default/files/lifeline_support_for_affordable_communications.pdf There are 32 Lifeline Providers in New York State, 27 provide landline services and 5 provide mobile services. The below link includes information for all these providers: https://data.usac.org/publicreports/CompaniesNearMe/State/StateOption/NY Individuals or providers should visit webpages, or contact Lifeline service providers, to inquire about any special service provision during the COVID-19 Disaster Emergency.

63.	Telemental Health Equipment	Many of our clients have limited connectivity via phone and internet, which is necessary for telemental health services. Can our agency/organization buy phones, minutes, or data for clients using Service Dollars or other discretionary funds? Will the State reimburse agencies for this expense?	Organizations should first explore the options listed in the two questions above, but may buy phones, minutes, and/or data for clients in order to support the provision of telemental health services. This may be done using OMH Service Dollars or other agency funds, using contract flexibility already outlined by OMH. For more information, see OMH COVID-19 Guidance- State Aid Funded Contracts: https://omh.ny.gov/omhweb/guidance/omh-covid-19-guidance-state-aid-funded-contracts.pdf
64.	Telemental Health Equipment	Are there any pre-approved platforms to deliver telemental health services?	There are no OMH pre-approved telemental health platforms. As of March 19, 2020, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) will not enforce HIPAA with telehealth during this emergency. Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Also, HHS provided the list below of vendors that represent that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA business associates agreement (BAA). These vendors are: • Skype for Business • Updox • VSee • Zoom for Healthcare • Doxy.me • Google G Suite Hangouts Meet See OCR notice here: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

65.	Telemental Health	Can providers consider time spent meeting with clients distributing telemental health equipment and explaining how to operate the equipment as part of a service session?	Yes. Providers may bill for time spent assisting clients, caregivers, and/or family with the set-up of telemental health equipment and/or an activity, demonstrating the equipment and/or activity, and for time spent actively engaging in the activity with the individual. For more information, please see: • OMH COVID-19 Consolidated Telemental Health Guidance- https://omh.ny.gov/omhweb/guidance/covid-19-consolidated-telemental-health-guidance.pdf • Telehealth Modifier Use for OMH-licensed/Designated Programs During COVID-19 Emergency: https://omh.ny.gov/omhweb/guidance/covid-19-telehealth-modifiers.xlsx
66.	HIPAA/ Confidentiality	Can agencies email documents containing protected health information (PHI) to outside entities?	During the COVID-19 disaster emergency, providers must still comply with the NYS Mental Hygiene Law and put forth a good faith effort to comply with HIPAA. Encrypted email is HIPAA compliant. Agencies should check with their HIPAA Compliance Officer about their internal HIPAA compliance policies and procedures.
67.	HIPAA/ Confidentiality	Do confidentiality and HIPAA requirements apply when providing mental health services via telemental health and telephonically?	During the COVID-19 national emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

			See OCR guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html NYS confidentiality requirements found in Mental Hygiene Law 33.13 remain in effect and apply to all programs and services regulated by OMH, but do not prohibit telemental health service delivery.
68.	HIPAA/ Confidentiality	Is there any available guidance for OMH providers on parameters to maintain HIPAA compliance at home, including but not limited to, secure internet and space guidelines?	As of March 19, 2020, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) will not enforce HIPAA with telehealth during the federally declared COVID-19 nationwide public health emergency. See OCR guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html OMH recognizes that during the COVID-19 disaster many practitioners who would not normally be working from home are doing so. OMH asks practitioners delivering services from their home to make every effort to deliver services from a dedicated space that looks professional, is secure, and free of interruptions. Efforts should be made to ensure conversations (via video/phone) cannot be heard by others. The Adirondack Health Institute has a number of resource documents which can be found here: https://ahihealth.org/what-we-do/telemedicine/. Additional references include: • American Telemedicine Association (https://www.americantelemed.org/) • Northeast Telehealth Resource Center (https://netrc.org/index.php)
69.	Practitioner Type	Which practitioner types are eligible to provide telemental health services?	Telemental health is a service delivery mechanism. Anyone who can deliver a service in-person for an OMH licensed, funded, or designated program can deliver the service through telemental health.

70.	Practitioner Location	Do telemental health services need to be provided onsite by the clinician?	No. Any limitations and restrictions pertaining to the location of the telemental health practitioner while providing service via telemental health are waived.
71.	Practitioner Location	Can practitioners other than prescribers be physically located outside NYS while delivering services via telemental health?	Yes. Telemental health practitioner includes any professional, paraprofessional, or unlicensed behavioral health staff who deliver a qualified service via telemental health. Any limitations and restrictions pertaining to the location of the telemental health practitioner while providing service via telemental health are waived.
72.	Consent	Is verbal consent allowable to begin telemental health services?	Yes. Verbal consent is allowable during the COVID-19 disaster emergency period. Providers of telemental health services can collect consent for services verbally so long as the consent is informed (i.e. providers are informing patients about the services provided, their right to refuse, right to revoke consent at any time, etc.), and the verbal consent is recorded by the provider in the patient's treatment record. Providers should also be advised that in subsequent in-person appointments that occur at a later date, written consent from the patient should be obtained. The HIPAA privacy rules and Mental Hygiene Law (MHL) do not specifically require written consent. Moreover, the federal Department of Health and Human Services (HHS) Office of Civil Rights will not impose penalties for noncompliance with the HIPAA privacy rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 public health emergency. Given that the HIPAA rules and MHL do not prohibit verbal consent for the release of Protected Health Information (PHI) and that HHS is temporarily relaxing enforcement of HIPAA penalties, practitioners may obtain verbal consent for the provision of telemental health services so long as the consent is informed and documented in the patient's treatment record.

73.	Consent	Can consent be obtained in the same interaction that the service itself is being delivered?	Yes.
74.	Consent for PSYCKES	Can providers delivering services through telemental health verbally obtain consent for PSYCKES?	Yes. During the COVID-19 disaster emergency, it is acceptable to verbally obtain patient consent for PSYCKES so long as: 1. The consent is informed (i.e. you explain to the patient what PSYCKES is and what information is available, their right to not give consent, and their right to withdraw consent at any time); 2. Staff obtaining verbal consent complete the PSYCKES consent form: • Check the "I give consent" check box • Enter the patient's name in the "Name of Patient" line • Enter "Verbal consent with (*staff name*)" in the "Signature of Patient" line • Enter the date verbal consent was obtained in the "Date" line • Save the form in the patient's file 3. A copy of the completed PSYCKES consent form with the date of verbal consent is provided to the patient via mail, email, or after the emergency is over, in person If you have any questions, please contact the PSYCKES team at PSYCKES-Help@omh.ny.gov.
75.	Admission	Can we admit someone to an OMH licensed, designated, or funded outpatient program without a face-to-face contact including signatures and completion of admission paperwork?	Yes, we strongly encourage providers to implement admissions procedures using telemental health. Please document consent, including verbal consent, in the client record. Please refer to the OMH Admissions and Continuity of Care guidance: https://omh.ny.gov/omhweb/guidance/omh-covid-19-admissions-continuity-of-care.pdf
76.	Intakes	Are providers able to conduct intake for new clients using telehealth?	Yes.
77.	Initial Evaluations	Are initial evaluations permitted via emergency telehealth procedures?	Yes.
78.	Treatment Plans	Can clinics manage treatment plans remotely when a client cannot provide a signature?	Yes. The provider must document the verbal approval in the client's record.

79.	Documentation	Throughout the treatment and rehabilitation process, signatures by staff and clients are frequently required on service/treatment plans and other program documentation. Can we modify our procedures for completing and signing off on such documentation at this time?	Yes. Whenever possible, staff completing any documentation should sign-off at the time it's written. If signatures (including client or staff) cannot be obtained during the disaster emergency, the record should be updated to include evidence the document was discussed with and agreed upon by the individual.
80.	Documentation	Do providers need to document in the record the physical location of the provider and client?	No. During the disaster emergency period, OMH will not require this information.
81.	ACT/PROS	For ACT and PROS, may providers other than doctors and psychiatric nurse practitioners provide services using telemental health?	Yes. See the OMH Consolidated Telemental Health Guidance.
82.	ACT/PROS/ Adult BH HCBS	Does the telehealth guidance issued during the disaster emergency period include Adult BH HCBS, ACT, and PROS providers?	Yes. All practitioners (professional or licensed staff as well as paraprofessional or non-licensed staff) providing Adult BH HCBS, ACT, and PROS are included in the OMH Consolidated Telemental Health Guidance. Services delivered via the expanded telemental health allowances must comply with existing program regulations and guidance.
83.	AOT	Are face-to-face requirements waived for individuals receiving AOT care management including ACT and Health Home Plus?	Yes, as clinically indicated.
84.	CCBHC	How can CCBHCs provide and bill for Targeted Case Management (TCM) through telemental health services during the disaster emergency?	For the duration of the declared disaster emergency, the threshold visit for CCBHC Targeted Case Management services can generate a Prospective Payment System (PPS) payment in one of three ways: 1. A single face-to-face meeting with the individual (or collateral for a child or adolescent) of at least 15 minutes. 2. A single Telehealth meeting with the individual (or collateral for a child or adolescent) of at least 15 minutes. 3. A single telephonic meeting with the individual (or collateral for a child or adolescent) of at least 15 minutes.
85.	CFTSS	Can providers delivering CFTSS designated services provide and bill for telephonic services?	Yes.
86.	CFTSS	Can CFTSS be provided daily in 15-minute services instead of weekly for 1 hour?	Children and Family Treatment and Support Services (CFTSS) are all billable in 15-minute increments. Providers can make necessary changes to a treatment plan with documented verbal consent from the child and guardian. Rates can be found here: https://www.health.ny.gov/health_care

			/Medicaid/redesign/behavioral health /children/proposed_spa.htm.
87.	Children's HCBS	How are telephonic Children's HCBS services billed?	Refer to DOH for information on telehealth for Children's HCBS.
88.	Clinic Services for Children	How can clinics provide telephonic services for young children, as some young children are unable to participate in 30-minute telephone sessions?	During the emergency period beginning 3/7/2020, OMH is relaxing current time requirements for mental health Clinics to allow for billing flexibility under State regulations and to conform with American Medical Association time standards. For example, psychotherapy with an original minimum time of 30 minutes can be temporarily reduced to a minimum of 16 minutes for rounding allowance. For a comprehensive list of affected OMH-licensed clinic services, please refer to the COVID-19 Billing Guidance for OMH-Licensed Clinic Programs posted here: https://omh.ny.gov/omhweb/guidance/covid-19-guidance-clinic-treatment-billing.pdf.
89.	Residential Programs	Does the Physician's Authorization for residential programs still require a face-to-face visit? If an authorization is due for renewal and we can't get it completed during the crisis, can we still bill Medicaid for restorative services?	Existing telemental health guidance extends to Physician's Authorization for residential programs. For the duration of the COVID-19 disaster emergency period, these authorizations may be completed via telemental health. Housing providers may continue to bill Medicaid if circumstances of the crisis prevent renewal in the timeframe dictated by regulation.
90.	Community Residence Billing	How should Community Residence services be billed if some of the services were provided through telemental health?	Community Residences should bill using the following parameters during the COVID-19 disaster emergency: • If no contacts/services were provided through telemental health, claims should be submitted using the standard billing procedures. • If at least one contact/service was delivered via telemental health, and where modifiers are not used for billing, the telemental health revenue code 0780 should be used. • If at least one contact/service was delivered via telemental health, and where modifiers are used for billing, the telemental health modifier should be used. See the *Telehealth Modifier Use for OMH-licensed/Designated Programs During COVID-19 Emergency* to determine the appropriate modifier.
91.	Residential Treatment Facilities	Can clinicians in residential treatment facilities (RTFs) use telemental health to deliver services?	Residential Treatment Facilities can provide telemental health in accordance with the OMH Consolidated Telemental Health Guidance.

92.	Mobile Crisis	Are Mobile Crisis Services included in the OMH telemental health waiver?	Yes. State-approved Mobile Crisis providers through the NYS 1115 Waiver Crisis Intervention Benefit, CFTSS, and mobile crisis services operated by CPEPs, are included in the OMH telemental health waiver and can deliver services via telemental health and be reimbursed.
93.	Single Point of Access (SPOA) Referrals	Can an agency accept telephonic verbal consent to initiate a referral to a Single Point of Access (SPOA) or Children's SPOA (CSPOA)?	Yes. The agency should document that the individual (or caregiver) understood the referral process and provided verbal consent. Providers of telemental health services can collect consent for services verbally so long as the consent is informed (i.e. providers are informing patients about the services provided, their right to refuse, right to revoke consent at any time, etc.), and the verbal consent is recorded by the provider in the patient's treatment record. Providers should also be advised that in subsequent in-person appointments that occur at a later date, written consent from the patient should be obtained. The HIPAA privacy rules and MHL do not specifically require written consent. Moreover, the federal Department of Health and Human Services Office of Civil Rights will not impose penalties for noncompliance with the HIPAA privacy rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 public health emergency. Given that the HIPAA rules and MHL do not prohibit verbal consent for the release of PHI and that HHS is temporarily relaxing enforcement of HIPAA penalties, we believe that practitioners may obtain verbal consent for the provision of telemental health services so long as the consent is informed and documented in the patient's treatment record.
94.	Single Point of Access (SPOA) Referrals	Can a SPOA or Children's SPOA (CSPOA) accept and process a referral based upon confirmation from an agency that verbal consent was provided?	Yes. Verbal consent of the client and/or parent should be documented in the referral packet.
95.	Single Point of Access (SPOA) Meetings	Can SPOA meetings be held using telephonic or video technology in lieu of face-to-face meetings?	Yes. SPOA meetings can take place telephonically or via other tele-platforms.

			The agency should document that the individual (or caregiver) understood the referral process and provided verbal consent.
96.	Telemental Health Effective Date	What is the effective date of the OMH telemental health guidance?	The effective date for COVID-19-related disaster emergency relief issued by the New York State Office of Mental Health is March 7, 2020, the date of New York State's declaration of a disaster emergency. All telemental health guidance, including the Self-Attestation of Compliance to Offer Telemental Health Services, may be operationalized retroactive to March 7, 2020.
97.	Documentation Relief	What is the effective date for the documentation relief components contained in the OMH Program and Billing guidance documents for Adult and Children's Residential Programs, Children's Residential Treatment Facilities, and Clinic Treatment Programs?	The documentation relief components contained in the Program Documentation Guidance are effective as of March 7th, 2020. This applies to the following OMH licensed and designated programs: • Adult and Children's Residential Programs • Children's Residential Treatment Facilities Guidance for each OMH program is posted here: https://omh.ny.gov/omhweb/guidance/
98.	Billing and Documentation Relief	What is the effective date for the documentation and billing relief components contained in the OMH Program and Billing Guidance documents?	The documentation and billing relief components contained in the Program and Billing Guidance documents are effective as of March 7th, 2020. Providers may bill using the revised billing guidance retroactively, starting March 7th, as long as it is supported with corresponding documentation. It is up to providers/agencies to determine how to implement the billing relief guidance. This applies to the following OMH licensed and designated programs: • Adult BH HCBS (BH HCBS) and Recovery Coordination (RCA) • Assertive Community Treatment (ACT) • Children's Day Treatment (DTx) • Clinic Treatment Programs • Continuing Day Treatment (CDT) • Partial Hospitalization (PH) • Personalized Recovery Oriented Services (PROS)

			Guidance for each OMH program is posted here: https://omh.ny.gov/omhweb/guidance/
99.	Billing	Does the March 2020 DOH Medicaid Update (Volume 36, Number 5) about telehealth apply to OMH licensed or designated providers?	OMH licensed programs and designated services should follow the OMH telemental health guidance for Medicaid billing procedures available here: https://omh.ny.gov/omhweb/guidance/
100.	Billing	If our service is normally delivered face-to-face but is delivered telephonically, do we still use the same billing codes?	Yes. Providers should use the same billing procedures and add the telemental health modifiers GT or 95. Providers should document the modality with which services were provided.
101.	Billing	Should the telemental health service be billed as an "on-site" visit or “off-site” visit?	It is considered an “on-site” visit.
102.	Billing	Should providers use the GT or 95 modifiers for services delivered telephonically and/or via video?	Yes.
103.	Billing	Is there a difference between the GT and 95 modifiers, and when should each be used?	Modifier 95 is used for specific synchronous telemedicine services. There are over 70 CPT codes that may be coded with the 95 modifier. They are outlined in Appendix P of the AMA CPT Coding Manual. All other procedure codes, including all HCPCS codes, will need to use Modifier GT. Refer to the *Telehealth Modifier Use for OMH-licensed/Designated Programs During COVID-19 Emergency* document posted here: https://omh.ny.gov/omhweb/guidance/
104.	Billing	Should the GT or 95 modifiers be included in addition to, or replace, the existing modifiers for services delivered via telemental health?	The GT and 95 modifiers should be used in addition to the usual service modifiers when services are delivered via telemental health. They are not meant to supersede the regular modifiers outlined in previously issued Medicaid billing rules.
105.	Billing	Should providers billing for monthly services (ACT, PROS, etc.) use the telemental health modifiers if only some of the services delivered were provided via telemental health?	Yes. If any services were delivered through telemental health, providers should add the appropriate telemental health modifier when submitting their claim. This will not affect payment.
106.	Billing	Should clinical and medical staff use different CPT codes and add-ons for services provided through telemental health?	The same procedure codes should continue to be used for both clinical and medical staff. Use the appropriate telemedicine modifier for the service provided.
107.	Billing	Can off-site Adult BH HCBS or CFTSS rates be billed when using telehealth?	If staff travel to an individual’s home or community location of preference to provide a service, the off-site rates may be used. If staff are at the agency’s business location, the staff person’s own home, or any other location not in the home or community location of

			preference for the client, and use telehealth (currently phone or video) to provide a service to the individual, the on-site rates must be used with appropriate telehealth modifiers.
108.	Treatment Plan	Can providers deliver services that depart from a client's treatment plan during the COVID-19 disaster emergency?	Yes. Providers should make notes in case records to indicate what they are doing is necessary to ensure continuity of care during the COVID-19 disaster emergency.
109.	Medicaid Managed Care Plans	Are Medicaid Managed Care Plans (MMCPs) required to accept these emergency procedures without adding criteria or additional requirements?	Yes. OMH issued communication to MMCPs stating no additional paperwork or criteria may be requested from providers to allow for telemental health billing and reimbursement, as this would delay service access during a time when rapid response is critical. Providers should contact the at OMH-Managed-Care@omh.ny.gov if they are asked by MMCPs to complete additional requirements in order to be paid for telemental health services provided.
110.	Medicaid Managed Care Plans	Will there be technical issues with the managed care companies and the new billing rules?	The billing guidance effective during the COVID-19 disaster emergency does not change billing procedures, except for requiring the use of the additional CR modifier (defined as catastrophe/disaster related). The CR modifier does not impact reimbursement amounts. Providers experiencing issues with Medicaid Managed Care billing should contact the managed care plan directly. Medicaid Managed Care contact information can be found using the MCTAC MCO Plan Matrix posted here: https://matrix.ctacny.org/. If the issue is not resolved satisfactorily, contact the OMH Managed Care Mailbox at: OMH-Managed-Care@omh.ny.gov.
111.	CHP and Essential Plan	Does the OMH telemental health billing guidance apply to CHP and the Essential Plan?	No. Refer to DOH guidance for information related to CHP and the Essential Plan. DOH guidance is available here: https://health.ny.gov/health_care/medicaid/covid19/index.htm
112.	Copayments	Are copayments waived for any services delivered by telehealth during the COVID-19 disaster emergency period?	The NYS Department of Financial Services (DFS) issued emergency regulations providing that, during the state of emergency for COVID-19, no policy or contract delivered or issued for delivery in New York that provides comprehensive coverage for hospital, surgical, or medical care may impose, and no insured is required to pay, copayments, coinsurance, or annual deductibles for an in-network service delivered via telehealth when such service would have been covered under the policy if it had been delivered in person.

			DFS circular here: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_06 DFS Telehealth FAQs (see Q-5 for link to emergency regs) here: https://www.dfs.ny.gov/industry_guidance/coronavirus/telehealth_ins_prov_info
113.	Commercial Insurers	Does the OMH telemental health billing guidance apply to commercial health insurance plans?	No. Refer to NYS Department of Financial Services (DFS) Insurance Circular Letter regarding Coronavirus and Telehealth Services: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_06
114.	Medicare	Does the OMH telemental health billing guidance apply to Medicare?	No. Refer to Medicare guidance posted here: https://www.medicare.gov/medicare-coronavirus.
115.	Telehealth Flexibilities Continuation	Will Executive Order 202.1 regarding telehealth and telephonic practice be extended further?	Executive Orders are issued by the Governor, and the Executive Order authorizing expanded telehealth services has only been issued and extended in thirty-day increments. Updates on additional Executive Orders and/or extensions can be found here. Agencies or programs with questions on applicability of any of these provisions to their particular programs or services may consult the OMH Guidance website and/or their own legal counsel.

Adult BH HCBS and RCA Program and Billing

Q#	Topic	Question	Answer
116.	Adult BH HCBS Eligibility Assessments	Can the NYS Eligibility Assessment be conducted via telemental health, including both the initial and re-assessment?	Yes, the NYS Eligibility Assessment may be conducted via telemental health. This includes both the initial assessment and re-assessments.
117.	Adult BH HCBS Eligibility Assessments	An individual's consent is required to administer the Adult BH Eligibility Assessment in the UAS, and Recovery Coordination Agency (RCA) assessors are using the DOH 5230. Can the assessor obtain verbal consent to conduct the assessment?	Yes. Verbal consent is allowable for the DOH 5230, with the expectation that this is documented in a note in the member's record, and that written consent is obtained following the disaster emergency.
118.	Adult BH HCBS and Recovery Coordination Agencies	Are signatures still needed to complete the Adult BH HCBS Plan of Care and Individual Service Plans during the COVID-19 disaster emergency?	For Recovery Coordination Agencies: During the disaster emergency period, in lieu of the client's signature, the Recovery Coordinator may update the client's record to reflect evidence that the document was discussed and agreed upon by the individual.

Q#	Topic	Question	Answer
			For BH HCBS Designated Providers: If a BH HCBS provider updates or revises the ISP, then the client's record should be updated to include evidence that the document was discussed with and agreed upon by the individual.
119.	Documentation	What should Adult BH HCBS providers do to ensure their documentation and charts are in compliance for future oversight and monitoring reviews covering the COVID-19 disaster emergency period?	The COVID-19 Program & Billing Guidance for Adult BH HCBS & RCA includes specific changes to documentation requirements, which will be considered during future Oversight and Monitoring Reviews. Providers should ensure each claim has the appropriate supporting documentation including all required elements (see Provider Manual, pg. 32).
120.	Outreach Documentation	Are Adult BH HCBS providers required to document outreach efforts/attempts (e.g. voicemails, emails, text messages)?	Yes. Providers should document all outreach attempts, even if unsuccessful. Providers have discretion in how these attempts are documented, including in a progress note, non-billable case note, or contact log.
121.	Authorizations	Do Adult BH HCBS providers need to obtain new authorizations from each MMCP to include telehealth modifiers GT/95 and CR on claims?	No. Providers do not need to request a new authorization to submit claims using the telehealth and catastrophe/disaster modifier codes.
122.	Authorizations	Do providers have to get authorization from the MMCP before changing service frequency and duration for a BH HCBS participant?	Providers are encouraged to contact the recipient's Medicaid Managed Care Plan to determine if a new authorization is needed to increase BH HCBS frequency or duration. Medicaid Managed Care contact information can be found using the MCTAC MCO Plan Matrix: https://matrix.ctacny.org/.
123.	Authorizations	What should Adult BH HCBS providers do if an individual needs more support than offered by the number of service units an MMCP previously authorized?	If an Adult BH HCBS provider expects to exceed the total number of authorized units, they should contact the MMCP to request a concurrent review.
124.	Billing/ Relief Effective Date	Can Adult BH HCBS providers submit claims retroactively back to when the emergency was originally declared on March 7, 2020?	Yes. Providers may bill retroactively for services provided during the COVID-19 disaster emergency, with dates of service beginning March 7, 2020.
125.	Billing/ Collaterals	Are collateral contacts billable for Peer Empowerment Support services?	No. Collateral contact is not an Adult BH HCBS billable service.
126.	Billing/ Unit Limits	Have the daily unit limits for Adult BH HCBS been increased under the disaster emergency?	The daily unit limits indicated on the HARP BH HCBS Fee Schedule have not changed and remain in effect during the disaster emergency. The HARP BH HCBS Fee Schedules are posted here: https://omh.ny.gov/omhweb/bho/billing-services.html

Q#	Topic	Question	Answer
			The updated Adult BH HCBS & RCA COVID-19 Program and Billing Guidance (05/08/2020) includes an addendum with unit conversion tables, which shows how many additional units, up to the maximum, may be billed. Adult BH HCBS &RCA COVID-19 Program and Billing resources: • April 22nd webinar (recording and slides)- https://ctacny.org/training/omh-oasas-adult-bh-hcbs-rca-program-and-billing-guidance-regarding-covid-19-emergency • Guidance- https://omh.ny.gov/omhweb/guidance/omh-oasas-covid-19-guidance-bh-hcbs-rca-program-billing.pdf
127.	Billing/ Modifiers	Can you clarify whether providers should use the GT or 95 telehealth modifier for Adult BH HCBS claims?	Please refer to this *Telehealth Modifier Use for OMH-licensed/designated Programs during COVID-19 Emergency* document to determine which telehealth modifier to use for each Adult BH HCBS: https://omh.ny.gov/omhweb/guidance/covid-19-telehealth-modifiers.xlsx
128.	Billing/ Modifiers	When should the CR modifier be used for Adult BH HCBS and where is it included on the claim form?	The CR (Catastrophe/Disaster related) modifier is used when the minimum time frame of the service does not meet original requirements (e.g. providing five minutes of service for one unit of service instead of 15 minutes). The CR modifier is placed on the line level of the claim. Example: Psychosocial Rehab Individual – spent 5 minutes on a call with the client. Bill H2017 with modifiers U1 (already required), GT (telephonic modifier), CR (use when 15-minute unit has not been met). There should be supporting documentation in the client's case record, such as a progress note, including duration of service, and start and end times.
129.	Billing/ Managed Care Organizations	Are MMCP billing systems ready to accept the procedure code and modifier combinations required to reimburse Adult BH HCBS services delivered via telehealth?	MMCPs are making adjustments to accommodate the billing changes due to COVID-19. MMCPs have been instructed to configure systems to accept telehealth modifiers. Providers experiencing difficulty with this should reach out to the MMCP, and if needed, to the contacts listed below: OASAS mailbox:PICM@OASAS.ny.gov; OMH mailbox: OMH-Managed-Care@omh.ny.gov

Q#	Topic	Question	Answer
130.	Claim Submissions	Will there be an extension on Adult BH HCBS claim submissions?	The State has not issued extensions for Medicaid Managed Care claim submissions. Providers are encouraged to reach out to their contracted Medicaid Managed Care Plans to discuss the need for an extension. Providers should regularly check State-issued guidance and resources for updates. Medicaid Managed Care contact information can be found using the MCTAC MCO Plan Matrix posted here: https://matrix.ctacny.org/.

Assertive Community Treatment (ACT) COVID-19 Program and Billing

Q#	Topic	Question	Answer
131.	ACT	Will ACT Teams continue to receive referrals?	Yes.
132.	ACT	Are providers allowed to bill for ACT services provided by telephone? What is the length of time a phone session should be for telemental health?	Yes, ACT services may be provided via telemental health, including telephonic service delivery. Under the 04/13/20 COVID-19 Program & Billing Guidance for ACT Programs, ACT providers may count any contact lasting at least 5 minutes in duration. If any sessions with the recipient or collateral did not meet existing requirements for duration, but did meet the reduced billing standard, then the modifier CR should be added to the claim.
133.	ACT	Can ACT teams bill for collateral telephone contact?	Yes. See the COVID-19 Program & Billing Guidance for ACT Programs for more details.
134.	Billing and Documentation Relief	Can ACT providers retroactively bill for services provided since the COVID-19 Program & Billing Guidance for ACT Programs is effective date of March 7, 2020?	Providers may bill for the month of March or void previously submitted claims and resubmit for the month of March, so long as the revised emergency minimum standards are met for the month. It is important to note that the emergency contact minimum standards apply only to contacts made on or after March 7, contacts made before March 7 must meet the standards set forth in 14 NYCRR Part 508.
135.	Billing and Documentation Relief	The COVID-19 Program & Billing Guidance for ACT Programs is retroactive to 3/7/20. Initial guidance about telemental health was issued 3/13/20 allowing providers to start billing for telemental health based on the date of attestation submission. If we submitted our attestation for telemental health at that time, can	The effective date for COVID-19 related disaster emergency relief issued by the NYS OMH is March 7, 2020, the date of New York's declaration of a disaster emergency. All telemental health guidance and program guidance listed in the *Effective Date of OMH COVID-19 Disaster Emergency Telemental Health and Program Guidance* document may be operationalized retroactive to March 7, 2020.

Q#	Topic	Question	Answer
		we still apply the updated standards as of 3/7/20 if minimum standards via telemental health were met during that time?	
136.	Service Plans	Will a progress note indicating the review and agreement of an ACT service plan count after the COVID-19 disaster emergency is lifted?	The COVID-19 Program & Billing Guidance for ACT Programs is specifically written for the duration of the NYS COVID-19 disaster emergency.
137.	Service Plans	Contacts with ACT recipients have often been limited to discussion of COVID-19 related topic/needs only. For recipients who don't have an applicable health goal or objective on their existing service plans, should we be adding goals specific to COVID-19 so we can link these sessions to billable goals?	ACT providers may work under existing service plans and provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency. Providers do not need to add goals specific to COVID-19 to link sessions to billable goals.
138.	Service Plans	If we need to postpone an ACT service plan, is it due as soon as the disaster emergency period ends or is there time to catch up?	OMH will issue further guidance for when the COVID-19 disaster emergency is lifted. Service Plans will likely be due sometime near the lifting of the emergency disaster, with a grace period for agencies to implement.
139.	Staff Engagement	Is the existing standard requiring three separate staff members engage with an ACT recipient per month still in effect during the COVID-19 disaster emergency?	During the COVID-19 disaster emergency, OMH expects providers to do their best to adhere to program guidelines, but OMH is aware that there may be challenges in doing so.
140.	Collateral	Will there be a change in the definition of an ACT collateral contact, such as including residential staff?	No. The ACT COVID-19 emergency billing and program guidance does not include a change to the definition of collateral.
141.	Billing/ Collateral	Are ACT providers able to bill for a partial payment if the only visit/contact for the month is with a collateral?	If a single, collateral contact is made in a month, the ACT provider may bill for a partial month (rate code 4509).
142.	Billing/ Collateral	If an ACT recipient has 2 collateral contacts, but only 1 telemental health contact with the recipient in a month, we would be able to bill the partial rate, not the full rate?	Yes, the ACT provider would bill the partial rate. To bill a full month rate, a minimum of three contacts must be made, two of which must be with the client.
143.	Billing/ Partial Month	If a client receives enough ACT services to bill for a partial month using the regular rules, but they can bill a full month under the emergency rules, can they bill the higher rate?	Yes. If a provider meets the revised ACT COVID-19 emergency minimum standards for billing (three five-minute contacts, one of which may be with a collateral), they may bill the full month rate (rate code 4508).

Q#	Topic	Question	Answer
144.	Billing/ Partial and Full Month	Please clarify when partial and full months may be billed using the reduced billing standards in the ACT COVID-19 Program and Billing Guidance.	To bill the partial month, one or two contacts must be made, one of which may be with a collateral. To bill the full month, three or more contacts must be made, one of which may be with a collateral, two must be with the client. In any case, only one collateral contact can be counted toward the monthly bill. In the example given, the client contact plus one collateral contact may be counted, giving a total of two contacts for the month, and therefore, only a partial month bill is allowed. Regardless of billing, individuals should be served at the level needed, these are just minimum standards for billing purposes.
145.	Billing/ Inpatient	Can an ACT collateral contact while a client is in an inpatient setting count as a billable contact?	Reimbursement for services provided to ACT clients who are admitted for treatment to an inpatient facility and are anticipated to be discharged within 180 days of admission shall be made in accordance with section 508.7 of New York State regulations pertaining to the Assertive Community Treatment program, with adjusted minimum contact requirements as set forth herein. 1.In the month of admission and/or month of discharge, full payment rate reimbursement (rate code 4508) is permitted for any month in which three or more telehealth/telephonic and/or community-based contacts combined with inpatient telehealth/telephonic and or face-to-face contacts equals three or more total contacts in the month, one of which may be collateral. 2.In the month of admission and/or month of discharge, stepdown/partial payment rate reimbursement (rate code 4509) is permitted when a minimum of one telehealth/telephonic and/or community-based and/or inpatient contact is provided in a month. This contact may be with a collateral. 3.Inpatient payment rate reimbursement (rate code 4511) is permitted when a minimum of one inpatient telehealth/telephonic or face-to-face contact is provided in a month, regardless of the number of community contacts. This contact may be with a collateral.

Q#	Topic	Question	Answer
146.	Billing/ Modifier	When should ACT providers use the GT and/or 95 modifiers for services delivered through telemental health?	For ACT providers, if one or more client contacts in the billed month was achieved through use of Telemental Health, the claim should include the modifier 'GT'. If no client contacts in the billed month were achieved through use of Telemental Health, the 'GT' modifier should not be used. For more information please see the *Telehealth Modifier Use for OMH licensed/Designated Programs,* posted here: https://omh.ny.gov/omhweb/guidance/covid-19-telehealth-modifiers.xlsx
147.	Billing/ Historical Revenues	The ACT COVID-19 Program and Billing Guidance states, "OMH will review claims submitted during the emergency period and may recoup any funding received that is found to be in excess of historical revenues or actual cost." What is seen as an appropriate change in revenue?	OMH constructed these revised ACT emergency billing standards in an effort to help stabilize program revenue and preserve historic levels of reimbursement. The intent of these changes is to allow providers to continue providing critical community mental health services and to maintain existing staffing and salary levels. It is not anticipated that providers will generate substantial revenue in excess of operational expenses or in excess of historical program revenues. OMH reserves the right to recover funds if reimbursement is in excess of these levels.

Children's Day Treatment COVID-19 Program and Billing

Q#	Topic	Question	Answer
148.	New Admissions	Are Children's Day Treatment programs able to accept new admissions during the emergency period?	Yes. Children's Day Treatment programs are not prohibited from accepting new admissions, if they choose to, during the COVID-19 emergency period.
149.	Telemental Health Billing	Can email or texting be counted as billable contact for Children's Day Treatment?	No. Email or texting can be used in order to schedule a call or telehealth meeting but is not itself considered a contact and cannot be counted as billable time.
150.	Telemental Health Billing	Can Google Classroom be used as billable Children's Day Treatment contact?	In order for Google Classroom to be a billable contact, real time audio and/or video must be used. Without real-time audio and or/video communication, Google Classroom is not considered billable contact.
151.	Contact	How can Children's Day Treatment providers handle families who have asked not to be contacted daily?	Providers can address this issue clinically. Engage the parent/caregiver in exploring how therapeutic support can help with managing day to day stressors, and how therapeutic contacts can be scheduled in such a way that they do not become intrusive or burdensome.

Q#	Topic	Question	Answer
152.	Outreach	The Children's Day Treatment COVID-19 Program and Billing guidance says programs must make a minimum of 5 outreach efforts (telephone contact) to every enrolled participant each week. If only 4 contacts are made in any given week, are there any billing implications for not achieving the minimum expected outreach?	The guidance recommends at least 5 outreach efforts because children enrolled in Day Treatment programs require extensive therapeutic and educational services 5 days per week. However, providers can bill for any and every day in which a contact of at least a 5-minute duration is made or when a documented telephonic outreach effort is made.
153.	Educational Staff Services	What contact can be provided by educational staff, such as teachers, speech pathologists, occupational therapists in Children's Day Treatment Programs, and how is it billed?	The contact provided by a professional staff should be within their scope of practice and responsibility within the day treatment program. A contact delivered by professional staff can be billable as long as it is not specifically an educational activity and does not duplicate other/educational billing that would occur for that same contact.
154.	Documentation	Is a progress note required for a Children's Day Treatment 5-minute contact, or can a brief note be written?	A full psychotherapy progress note is required for contacts that result in full day billing. Collateral Sessions and Crisis interventions also require a full psychotherapy progress note. Outreach attempts may be documented in a general progress note.
155.	Service Hours	Are there any restrictions on the hours that Children's Day Treatment can be delivered?	No. Services can be provided any time of day or day of the week, based on mutual agreement between the family and provider.
156.	Service Hours	Is the Children's Day Treatment day rate code only applicable for traditional school hours?	No. services can be provided any time of day or day of the week, based on mutual agreement between the family and provider.
157.	Service Hours	Are school holidays billable for Children's Day Treatment?	Yes, as long as a reimbursable contact is provided on that day.
158.	Collaterals	Can a Children's Day Treatment provider bill the full-day rate for a 5-minute contact with a parent?	No. If providers do not speak directly to the enrolled youth, the collateral rate code (4066) must be used. Contact with collaterals is also reduced to a 5-minute minimum duration.
159.	Collaterals	Can unlicensed staff bill for collateral contact in Children's Day Treatment programs?	Yes, consistent with the staff's role and responsibilities within the program.
160.	Collaterals	Who can be considered a collateral for Children's Day Treatment programs?	14 NYCRR PART 587- Operation of Outpatient Programs regulations define collaterals for Children's Day Treatment programs. Collateral persons are defined as members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition and are identified in the treatment or psychiatric rehabilitation service plan as having a role in treatment and/or identified in the preadmission notes as being necessary for

Q#	Topic	Question	Answer
			participation in the evaluation and assessment of the recipient prior to admission. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.
161.	Collaterals	Are professional coworkers such as Nurse Practitioners or Primary Care Physicians considered collaterals for Children's Day Treatment programs?	No. Professional coworkers are not considered collaterals. Section 587.4 of the 14 NYCRR PART 587- Operation of Outpatient Programs regulations define collaterals for Children's Day Treatment programs.
162.	Collaterals	If a Children's Day Treatment program clinician holds a 30-minute video session with the parent but without the child, how is that billed?	A 30-minute contact with the parent will be billed using the collateral rate code (4066).
163.	Collaterals	If a Children's Day Treatment clinician holds a 30-minute telehealth session with the parent and the child participates for 5 minutes of the session, how is this billed?	This session will be billed at the full-day rate.
164.	Collaterals	How is the following Children's Day Treatment scenario billed: the clinician calls to speak with the enrolled youth and that youth is not able or willing to come to the phone, but the clinician is able to speak with the parent.	If a collateral contact was made of at least five minutes, bill the collateral rate code (4066). If a contact was made with the parent that does not meet the five-minute requirement, providers may bill the half-day rate code (4061) for the attempt at a contact. Providers may not bill both the collateral and half-day rate code in this scenario.
165.	Collaterals	Can Children's Day Treatment providers bill for full-day or half-day services and collateral services on the same day?	If a five-minute contact has been made with the child, providers may bill the full day (4060) rate code. If, in addition, another five minutes was spent with the parent, providers may bill the collateral rate code (4066) as well.
166.	Crisis Services	Can Children's Day Treatment crisis services be billed on the same day as half-day or full-day billing?	If a crisis service has taken place which meets the crisis definition, it could be used if the full-day service has already been billed (e.g., five-minute contact took place in the a.m., a crisis call comes in later in the day and a full 30 minutes of crisis service was provided). The full-day and crisis services must be separate and distinct (e.g., not arising from the same phone call).

167.	Summer Services	Can Children's Day Treatment providers continue to provide the program's mental health service component via telemental health if a child is not enrolled into a Children's Day Treatment program over the summer and is not receiving the educational component?	Children's Day Treatment providers may continue to bill for the program's mental health services component for any given participant, regardless of whether that child will be participating in the educational component during the summer. It is clinically appropriate that the therapeutic component continue to whatever extent is needed by a child and agreed upon by the parent/guardian. Billing for services provided to children participating in the mental health services component of Children's Day Treatment programs over the summer should continue to occur for the days in which these services have been provided, in accordance with the COVID-19 Program & Billing Guidance for Children's Day Treatment, posted here: https://omh.ny.gov/omhweb/guidance/covid-19-guidance-childrens-day-treatment-program-billing.pdf and this FAQ document.

Continuing Day Treatment & Partial Hospitalization COVID-19 Program and Billing

Q#	Topic	Question	Answer
168.	Telemental Health	Is it the expectation that services will be provided over the phone now, or are providers able to continue to do on-site groups of 5 clients or less while maintaining proper social distancing?	Providers should continue to deliver services, while ensuring the safety of their staff and clients. Providers should follow the DOH COVID-19 guidance for healthcare workers posted here: https://coronavirus.health.ny.gov/information-healthcare-providers. In-person services should be provided only when necessary.
169.	Billing and Documentation Relief	What is the effective date of the flexibility provided by the COVID-19 Continuing Day Treatment (CDT) and Partial Hospitalization (PH) Program and Billing Guidance documents?	The effective date of the updated billing guidance is 3/7/2020, the effective date of the disaster emergency. Providers may bill for dates of service on or after 3/7/2020 following the emergency billing guidance if they have the appropriate documentation in the client's record.
170.	Billing/ Continuing Day Treatment	If someone usually comes to Continuing Day Treatment (CDT) three days per week, are providers only expected to outreach on normally scheduled days or should we be reaching out daily and billing each day for this service?	The "Program Expectations" outlined in the CDT emergency billing and documentation guidance are intended to set a minimum standard of service during the crisis period, and help programs to conceptualize how to outreach, engage and provide services in the current environment. Specific program expectations do not have to be met in order to bill for services. For minimum billing, please see Minimum Billing Standards section of the guidance.

Q#	Topic	Question	Answer
			If clients are effectively engaged and receiving services as they had been prior to the disaster emergency period, continued service schedules including frequency of contacts (i.e. 3 days/week) may be maintained. If it is in the client's interest to have more frequent contacts (i.e. 5 days/week) during the disaster emergency period, this is also allowable.
171.	Billing/ Continuing Day Treatment	When do Continuing Day Treatment (CDT) providers bill for full-day or half-day rates?	During the emergency period, CDT providers will bill the full day 41-64 cumulative hours rate code (4317) if a contact of at least 5 minutes has been made with the individual. If outreach attempts are unsuccessful and zero contacts have been made with the individual, the CDT program may bill the half day 41-64 cumulative hours rate code (4311).
172.	Billing/ Continuing Day Treatment	Are there any implications or concerns a Continuing Day Treatment provider must be aware of if they have 4 successful contacts of at least 5 minutes each in a week, but a 5th outreach attempt was not made?	During the emergency period, providers may bill for a full day (4317) if a minimum of five minutes has been spent with the client. In the example, the provider will bill four times for the four contacts.
173.	Billing/ Continuing Day Treatment	Are Continuing Day Treatment (CDT) providers able to bill for both individual therapy sessions and the full-day rate if an individual attends individual and several group therapy sessions in the same day?	CDT is not billed as individual or group sessions. During the emergency period, a contact of at least five minutes can be billed using the full-day rate code (4317). Only one full-day (4317) claim may be submitted per client, per day. Additionally, providers may not submit a full-day claim (4317) and a half-day claim (4311) for the same day for the same client.
174.	Billing/ Continuing Day Treatment	What rate code should a Continuing Day Treatment (CDT) provider bill if they make the minimum of five outreach attempts but are unable to reach the client?	If a CDT reaches out each day of the week and is unable to make contact, the CDT may bill the half-day rate code (4311) five times, for each day of that week a contact was attempted.
175.	Billing/ Continuing Day Treatment	When do providers use telehealth modifiers GT and 95 and the U2 and U5 modifiers?	Providers must continue to use the normally required modifiers (e.g., U2/U5) in addition to the appropriate telehealth modifier (either the GT or 95 modifiers based on the procedure code). See the Telehealth Modifier Use for OMH-licensed/Designated Programs during COVID-19 Emergency. If a provider uses the reduced billing flexibilities in the COVID-19 Program and Billing guidance, the CR modifier must also be used.

176.	Billing/ Historical Revenues	In order to avoid recoupment, what is the maximum amount that providers can bill for Continuing Day Treatment and Partial Hospitalization using the reduced billing standards?	OMH has constructed these revised emergency billing standards in an effort to help stabilize program revenue and preserve historic levels of reimbursement. The intent of these changes is to allow providers to continue providing critical community mental health services and to maintain existing staffing and salary levels. It is not anticipated that providers will generate substantial revenue in excess of operational expenses or in excess of historical program revenues. OMH reserves the right to recover funds if reimbursement is in excess of these levels.
177.	Billing/ Partial Hospitalization	For Partial Hospitalization Programs, if a patient meets the 4-hour minimum is the provider to bill the 4-hour rate code, or are you stating 6 hours can/should be billed?	For the duration of the COVID-19 emergency disaster, or until such time supplemental guidance is issued, NYS is reducing the minimum duration for submitting claims. PH providers may bill the six-hour rate code (4351) for any contact that is at least five minutes. This rate code may only be billed a maximum of once per day, even if multiple contacts are made in a single day. If the service provided does not meet the original regulatory requirements, providers must include modifier CR (Catastrophe/Disaster related) on the claim.
178.	Commercial Insurers	Are commercial payers/HMOs encouraged to follow the Medicaid guidance?	The information presented in the Continuing Day Treatment & Partial Hospitalization COVID-19 Program and Billing webinar applies to Medicaid fee-for-service and Medicaid Managed Care only.
179.	Authorizations	Are Partial Hospitalization Programs still required to obtain authorizations from insurers?	NYS has not changed Medicaid Managed Care prior authorization requirements at this time. Providers should check with each Medicaid Managed Care Plan about what kind of flexibility they are providing.

Personalized Recovery Oriented Services (PROS) COVID-19 Program and Billing

Q#	Topic	Question	Answer
180.	Telemental Health	What PROS services can be delivered via Telemental Health?	Any PROS service, including ORS, can be delivered via telemental health.
181.	Telemental Health	How do I document telemental health services for PROS?	A telemental health contact would be documented as you would any individual contact. You may verbally request and receive approval from participants in lieu of required signatures for PROS documentation (IRP, etc.).
182.	Participation Time	Can PROS programs bill when individuals are not on-site for PROS Program Participation time?	Program Participation time will be calculated based on the duration of the telehealth service or off-site service. When you reference the “PROS conversion chart”, the duration of the service (column to the

Q#	Topic	Question	Answer
			left of the chart) is the same as Program Participation time. For example, a 15-minute telephonic PROS service with a person is .25 hours and yields .25 PROS units based on the chart.
183.	PROS Attendance/Tiers	How can attendance-based tiers be billed in PROS when services are provided via telemental health?	PROS units will be generated from the telemental health or off-site services delivered, which will equate to a typical tier. Please see response above for additional detail.
184.	Billing and Documentation Relief	When does the PROS COVID-19 Program and Billing Guidance become effective?	The effective date of the COVID-19 Program & Billing Guidance for PROS Programs and adjusted billing standards is March 7, 2020.
185.	Billing and Documentation Relief	If PROS programs sent out March billing already, can it be resent it to capture all folks who meet the minimum billing requirements in the PROS COVID-19 Program and Billing Guidance?	PROS programs may re-submit billing for services which qualify for reimbursement under the emergency program and billing guidance. Please note the reduced frequency and duration standards only apply to contacts made on or after March 7, 2020.
186.	Billing and Documentation Relief	Are PROS providers able to claim billable services from March that may have been less than 15 minutes?	PROS programs may bill for services provided on or after March 7, 2020 that meet standards set forth in the COVID-19 Program & Billing Guidance for PROS Programs.
187.	Billing and Documentation Relief	If PROS services took place prior to 3/7/2020, would we be counting those services as well for the overall Tier range? e.g. We provided 2 services on 3/5/2020. Would we then be able to bill for Tier 1?	Yes, so long as the contacts meet the minimum standards set forth in 14 NYCRR Part 512. The PROS COVID-19 Program and Billing Guidance pertaining to contact frequency and duration apply to contacts taking place on or after March 7, 2020.
188.	Billing and Documentation Relief	For clients that did not meet any of the traditional minimum billing requirements, could PROS providers apply the emergency billing to those clients?	Yes, if the contacts met the minimum billing requirements set forth in the COVID-19 Program & Billing Guidance for PROS Programs. Please note the emergency billing standards only apply to contacts made on/after March 7, 2020.
189.	Outreach	Do PROS providers still have to outreach as outlined in the “Program Expectations” section in the COVID-19 Program & Billing Guidance for PROS Programs if the PROS participant is engaged in services?	Programs should aim to have at least weekly contact with every program participant, regardless of PROS Component enrollment. For participants with whom a program has not had successful contact, a minimum of two (2) outreach efforts (telephone contacts) should be made each week. For participants who have been contacted or engaged in an individual or group service in a given week, additional outreach efforts may not be necessary. PROS programs should use their clinical discretion to

Q#	Topic	Question	Answer
			determine if additional contacts may be necessary to ensure the safety and well-being of participants.
190.	Ongoing Rehabilitation and Support	Will there be a different guideline for PROS Ongoing Rehabilitation and Support (ORS) services?	If a client's monthly service record qualifies for billing under the standards set forth in 14 NYCRR Part 512, the regulatory standards for PROS Ongoing Rehabilitation and Support (ORS) service provision and claiming apply. Under the emergency programmatic and billing guidelines, ORS claims may not be submitted
191.	Clinic Treatment	For individuals enrolled in the PROS Clinic Treatment component, has the required timeframe of seeing the psychiatrist or psychiatric nurse practitioner at least once every three months changed?	Timeframes related to the Clinic Treatment component enrollment have not changed. The participant is required to see the psychiatrist or psychiatric nurse practitioner at least once every three months
192.	Utilization Review	Does the suspension of internal utilization review requirements include chart reviews for PROS providers?	The relaxation of Utilization Review policy includes chart reviews.
193.	Documentation/ Attendance	Is it necessary for PROS providers to record attendance for the participants they are using the CR modifier to bill for?	Yes. Documentation of attendance and duration of service in each of the participant's case record still important to ensure accurate record keeping and to support billing.
194.	Documentation	Do PROS providers need to do a plan amendment if providing relapse prevention services, or just document in a progress note?	Any change (adding services) to an Individualized Recovery Plan (IRP) can be documented in a progress note for the duration of the disaster emergency period.
195.	Documentation	Outreach attempts are marked as "Other" on PROS progress notes and face-to-face is "no". How should we write the note to enable us to bill for it?	Records must include outreach efforts and contacts to support PROS billing. PROS providers may need to work with their Electronic Health Record (EHR) vendor to modify documentation requirements to allow for billing.
196.	CAIRS	How can PROS providers receive assistance to access CAIRS, and will there be penalties if information is entered late into CAIRS (updates, new admissions, discharges, etc.)?	If your program is having difficulty accessing CAIRS remotely, please contact us at PROS@omh.ny.gov CAIRS follow-ups are not waived at this time. However, OMH recognizes the programmatic challenges at this time and encourages programs to update information, when possible.
197.	Maximum Group Sizes	Do the historical maximum group sizes for Community Rehabilitation and Support (CRS) and	Maximum group attendance rules still apply; a maximum of 12 individuals in a CRS group, and 8 individuals for an IR group.

Q#	Topic	Question	Answer
		Intensive Rehabilitation (IR) still apply during the crisis and for remote services?	
198.	IR Cap	Are PROS providers able to bill Intensive Rehabilitation (IR) for more than half their caseload, given the need for IR Relapse services for many clients during this crisis?	If billing under the standards set forth in 14 NYCRR Part 512, Intensive Rehabilitation (IR) add-on claims may be submitted for any clients the appropriate services were provided to. The 50% cap for IR billing remains in place. As a reminder, if billing under the standards set forth in the emergency program and billing guidelines, there is to be no separate billing for IR or Ongoing Rehabilitation and Support (ORS) add-ons.
199.	Program Capacity	Is there a relaxation of PROS program capacity in order to meet the needs of as many individuals who seek services?	At this time, there is no plan to modify the maximum PROS program census. If programs are interested in increasing the number of participants served beyond the approved program caseload, please contact your local OMH Field Office.
200.	Reimbursement Rates	What will the reimbursement rates be for Tier 1 and Tier 3 under the PROS COVID-19 Program and Billing Guidance?	PROS reimbursement will continue to be made at the approved amounts, available on the OMH website at https://omh.ny.gov/omhweb/medicaid_reimbursement/excel/pros.xlsx.
201.	Billing	Can providers bill for some participants using standard PROS billing practices and bill for others using the emergency billing guidelines?	The COVID-19 Program & Billing Guidance for PROS Programs is to be applied on a client-by-client basis. If a client's monthly service record qualifies for reimbursement under the standards set forth in 14 NYCRR Part 512, the provider may bill accordingly. If a client's monthly service record qualifies for reimbursement under the emergency guidelines, a bill may be submitted under the temporary authority.
202.	Billing	What if a PROS provider's March billing fits into the traditional billing for Tiers 4 or 5?	The COVID-19 Program & Billing Guidance for PROS Programs is to be applied on a client-by-client basis. If a client's monthly service record qualifies for reimbursement under the standards set forth in 14 NYCRR Part 512, the provider may bill accordingly. If a client's monthly service record qualifies for reimbursement under the emergency guidelines, a bill may be submitted under the temporary authority.
203.	Billing	Are Tiers other than 1 and 3 included in the PROS COVID-19 Program and Billing Guidance?	Emergency billing guidance pertains only to claims being submitted in accordance with the emergency guidelines. The emergency guidelines only allow for Tiers 1 or 3 to be billed.

Q#	Topic	Question	Answer
			If a client's monthly service is to be billed under standard practice, which includes all tiers, all standards set forth in 14 NYCRR Part 512 must be met.
204.	Billing/ Add-on Services	Can PROS providers still bill for add-on services?	If a client's monthly service record qualifies for reimbursement under the standards set forth in 14 NYCRR Part 512, the provider may bill for add-on services. A provider may not bill for the Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS) add-on if submitting a claim under the COVID-19 Program & Billing Guidance for PROS Programs. Clinic Treatment services may be billed under the COVID-19 Program and Billing Guidance.
205.	Billing/ Clinic Treatment	If a PROS participant has one Clinic Treatment service in the month, are providers able to bill for that service as a Tier 1 in addition to the Clinic Treatment add-on?	Yes. If a client receives one contact in a month, and that contact is a Clinic Treatment service, the provider may submit a Tier 1 claim and a Clinic add-on claim.
206.	Billing/ Clinic Treatment	Is there a minimum time duration for the clinic add-on?	Under the COVID-19 Program & Billing Guidance for PROS Programs, the minimum service duration for individual Clinic Treatment services is 5 minutes. It is 15 minutes for group Clinic Treatment services.
207.	Billing/ Collaterals	Can contact between a PROS provider and a pharmacy, collateral, or residential employee be a billable contact?	PROS contacts are billable with the participant only.
208.	Billing/ Collaterals	Are collateral contacts considered outreach, per the PROS Emergency Program and Billing Guidance? If a provider cannot reach an enrolled participant, is it acceptable to speak to their therapist or family member?	The program expectation is for providers to attempt to contact a PROS participant. Although communication with collaterals may be helpful to learn about the status of a participant, attempted outreach must be to the PROS participant in order to be billable.
209.	Billing/ Outreach	If a PROS provider documents 2 unsuccessful outreach attempts to a participant in a week, is this billable?	If two or more outreach attempts were made to a participant per week and appropriately documented in the client record, even if the provider was unable to speak to the participant, the provider may bill Tier 1.
210.	Billing/ Contacts	If during a conversation with a client, a PROS clinician provides two different services, and each has a duration of at least 15 minutes, can you count these as two contacts?	Yes.

Q#	Topic	Question	Answer
211.	Billing/ Contacts	Can PROS providers bill for services provided, even if they don't meet the "Program Expectations" outlined in the COVID-19 Program and Billing Guidance?	Specific program expectations do not have to be met in order to bill for services. As PROS is person-centered, respecting participant preference remains a priority. The "Program Expectations" outlined in the emergency billing and documentation guidance are intended to set a minimum standard of service during the crisis period, and help programs to conceptualize how to outreach, engage, and provide services in the current environment.
212.	Billing/ Medication Injection	If a PROS-enrolled client comes in-person for a medication injection, does that qualify for the emergency/CR billing?	If a client receives a minimum five-minute contact, and that contact is a clinic service, the provider may bill Tier 1 and clinic add-on.
213.	Billing/ Ongoing Rehabilitation and Support	Can PROS providers bill for Ongoing Rehabilitation and Support (ORS) services?	If a client's monthly service record qualifies for billing under the standards set forth in 14 NYCRR Part 512, the regulatory standards for ORS service provision and claiming apply. If providers are unable to bill for ORS under the existing regulations, the emergency program and billing guidance provides flexibility.
214.	Billing/ Ongoing Rehabilitation and Support	How can PROS programs bill for clients who only receive Ongoing Rehabilitation and Support (ORS) services?	If the services provided to a client meet the standards set forth under 14 NYCRR Part 512, claiming may be done using standard PROS billing practices, which includes the ORS add-on. Under the COVID-19 Program & Billing Guidance for PROS Programs there is no Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Support (ORS) add-on billing. The program expectation is for two outreach attempts per week, documented in the client record. If the outreach standard is met, the provider may bill for Tier 1. If one or two contacts are made, the provider may also bill for Tier 1. If three or more contacts are made, the provider may bill for Tier 3.
215.	Billing/ Modifiers	How do we calculate billing when a person attended PROS in person at a point in the month, and telephonically later in the month? Can these be utilized together, or do we need to pick one way of billing for each client?	Services provided by Telemental Health should be counted the same as if the service was provided face-to-face. If any service provided during a month utilizes Telemental Health, and all service and billing standards set forth in 14 NYCRR Part 512 are met, the submitted claim need only to include the 'GT' modifier. If any service provided during a month utilizes Telemental Health, and the client's monthly service record qualifies for claiming under the emergency programmatic and billing standards, both the 'GT' and 'CR' modifiers should be included.

Q#	Topic	Question	Answer
216.	Billing/ Modifiers	Will PROS providers still be required to bill using the U modifiers along with GT/95 and potentially CR modifiers?	GT and CR modifiers, when applicable, should be used in addition to any usually used modifiers.
217.	Billing/ Modifiers	Should the GT telemental health modifier be used if a PROS service is delivered in person (like an injectable medication) but all other services are delivered through telehealth, and existing minimum requirements are met?	Yes. If any services were delivered using Telemental Health in the month, the claim should include the 'GT' modifier.
218.	Billing/ Modifiers	If someone enrolled in PROS gets pushed into the Tier 3 disaster category through a combination of onsite services prior to closures and telehealth after agency closures, do providers submit claims with the GT AND CR modifiers?	Yes.
219.	Billing/ Electronic Health Record	How can a PROS provider use the COVID-19 Program and Billing relief if they have difficulty updating their Electronic Health Record (EHR)?	Providers using the minimum or reduced billing requirements in the emergency PROS Program and Billing Guidance must use the required modifiers and processes outlined in the guidance. Providers may continue to follow existing part 512 regulations for PROS program and billing, if services meet existing duration and frequency standards. Providers may choose to maintain supporting documentation outside of their Electronic Health Record (EHR) and submit paper/manual claims for services provided under the reduced billing standards. The billing and program guidance allows for flexibility in billing, but is not a requirement. Agencies may choose to continue to follow the Part 512 regulations for billing as they exist.
220.	Billing/ Sliding Fee Scale	Does the PROS COVID-19 Program and Billing Guidance affect participants who are billed via the sliding fee scale?	The billing portion of this guidance does not affect participants billed via the sliding fee scale as rates are determined by each provider agency. Service duration may be different due to the COVID-19 crisis.
221.	Authorizations	Are there any changes to PROS Medicaid Managed Care authorizations?	NYS has not changed Medicaid Managed Care prior authorization requirements at this time. Providers should check with each Medicaid Managed Care Plan about what kind of flexibility being provided.
222.	Authorizations	Have the MMCPs reconfigured their billing systems to accept the 95/GT telemental health and CR catastrophe/disaster modifiers?	The billing guidance effective during the COVID-19 disaster emergency does not change billing procedures, except for requiring

Q#	Topic	Question	Answer
			the use of the additional CR modifier (defined as catastrophe/disaster related). The CR modifier does not impact reimbursement amounts. Providers experiencing issues with Medicaid Managed Care billing should contact the managed care plan directly. Medicaid Managed Care contact information can be found using the MCTAC MCO Plan Matrix posted here: https://matrix.ctacny.org/. If the issue is not resolved satisfactorily, contact the OMH Managed Care Mailbox at: OMH-Managed-Care@omh.ny.gov.
223.	Billing/Telephonic	If a PROS Clinical service is provided by telephone only and the client's primary payer, such as Medicare, will not pay, can we zero fill the claim and bill Medicaid?	During the COVID-19 emergency, Medicare is now paying for a range of telephonic behavioral health codes. Please see the OMH guidance: https://omh.ny.gov/omhweb/guidance/covid-19-guidance-clinic-treatment-billing.pdf
224.	Billing/Dually Enrolled Individuals	We serve individuals dually enrolled in Medicare and Medicaid in our PROS clinic component. Does Medicare reimburse for telephonic contact to consumers?	During the COVID-19 emergency, Medicare is now paying for a range of telephonic behavioral health codes. Please see the OMH guidance: https://omh.ny.gov/omhweb/guidance/covid-19-guidance-clinic-treatment-billing.pdf
225.	Billing	Should providers who submitted PROS claims with the 95 modifier for services delivered through telemental health resubmit their claims using the correct GT telemental health modifier?	Medicaid Fee-for-service claims: New York State is not requiring resubmission of Medicaid fee-for-service claims which include the modifier '95'. Please note that the correct Telemental Health modifier for the PROS program is 'GT'. Medicaid Managed Care claims: If providers submitted PROS claims without any telehealth modifier or with the 95 modifier and the claim was rejected, the claims should be resubmitted using the modifier GT. If the claim was paid, then the provider does not need to resubmit the claim to the Medicaid Managed Care plan. If a provider would like to submit an adjustment to the paid claim to correct the modifier from 95 to GT, they should contact the Medicaid Managed Care plan about their claims adjustment policies and procedures. NYS does not require providers to do this.

Acronym Definitions

#	Acronym	Definition
1.	ACT	Assertive Community Treatment
2.	Adult BH HCBS	Adult Behavioral Health Home and Community Based Services
3.	ANC	Absolute Neutrophil Count
4.	AOT	Assisted Outpatient Treatment
5.	CCBHC	Certified Community Behavioral Health Clinics
6.	CBC	Criminal Background Check
7.	CDC	Centers for Disease Control and Prevention
8.	CDT	Continuing Day Treatment
9.	CFTSS	Children and Family Treatment and Support Services
10.	Children's HCBS	NYS Children's Medicaid Home and Community Based Services
11.	CHP	Child Health Plus
12.	CMS	Centers for Medicare & Medicaid Services
13.	COVID-19	Coronavirus Disease 2019
14.	CPEP	Comprehensive Psychiatric Emergency Program
15.	CPT	Current Procedural Terminology
16.	CRS	Community Rehabilitation and Support (PROS Component)
17.	CSPOA	Children's Single Point of Access
18.	DEA	Federal Drug Enforcement Agency
19.	DFS	NYS Department of Financial Services
20.	DOH	New York State Department of Health
21.	EHR	Electronic Health Record
22.	EO	Executive Order
23.	FCC	Federal Communications Commission
24.	FFCRA	Families First Coronavirus Response Act
25.	HHS	The United States Department of Health & Human Services
26.	HIPAA	Health Insurance Portability and Accountability Act
27.	IR	Intensive Rehabilitation (PROS Component)
28.	IRP	Individualized Recovery Plan
29.	ISP	Individual Service Plan

#	Acronym	Definition
30.	LAI	Long-acting Injectable Medication
31.	MHL	Mental Hygiene Law
32.	MMCP	Medicaid Managed Care Plan
33.	NIMRS	New York State Incident Management and Reporting System
34.	NYS	New York State
35.	OASAS	New York State Office of Addiction Services and Supports
36.	OCFS	New York State Office of Children and Family Services
37.	OCR	The Office for Civil Rights
38.	OMH	New York State Office of Mental Health
39.	OPSED	New York State Office of the Professions in the State Education Department
40.	OPWDD	New York State Office for People With Developmental Disabilities
41.	ORS	Ongoing Rehabilitation and Support (PROS Component)
42.	PH	Partial Hospitalization
43.	PHI	Protected Health Information
44.	PPE	Personal Protective Equipment
45.	PPS	Prospective Payment System
46.	PROS	Personalized Recovery Oriented Services
47.	PUI	Persons Under Investigation
48.	RTF	Residential Treatment Facility
49.	SCR	Statewide Central Register
50.	SED	New York State Education Department
51.	SEL	Staff Exclusion List
52.	SPOA	Single Point of Access
53.	SRO	Single Room Occupancy Housing
54.	TCM	Targeted Case Management