Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
Frequently Asked Questions

This FAQ document is organized by the following topic areas.

- Billing-Related
- Off-Site Services
- Peer Support Services
- Documentation
- General regulations

Question	Answer
Billing-Related	
Are Peer Support Services billable pre-admission? Can they be billed during Open Access time? (Open Access refers to the time during which individuals can come to MHOTRS program to be seen without an appointment, predominantly used for initial appointments or crisis visits.) Do Peer Support Services pre-admission count toward the 3 initial assessment pre-admission visits?	Yes, Peer Support Services (PSS) are billable pre-admission. There is no limit on the number of PSSs pre-admission visits and they can be billed during Open Access time if applicable. All PSS provided pre-admission must have progress notes co-signed by an LPHA. Peer services pre-admission visits do not count toward clinical pre-admission visits. Pre-admission Peer Service contacts do not start the timeline for assessment completion or admission.
The Standards of Care and the Program Guidance do not match in the requirements for completing initial assessment during / after admission. Please clarify the requirements?	A discrepancy was identified in the required timeline for completion of the initial assessment in the MHOTRS Standards of Care (SOC). OMH will update/correct the SOC to match the Program Guidance, to require initial assessments to be completed within 30 days of admission. Program Guidance should be followed.

Does an individual have to be admitted to a MHOTRS Program, in order for the MHOTRS program to bill for peer support services?	Peer services pre-admission are billable and can be billed before an individual is admitted to the MHOTRS Program. However, pre-admission Peer Support Services are NOT intended to be stand-alone Peer Services. Ongoing Peer Support Services can only be provided to individuals enrolled in the MHOTRS. Peer Support Services may not continue if the individual declines treatment and is not admitted. It is recommended that MHOTRS programs review internal policies and procedures, and workflows, for this process.
Can we bill for a Peer Support Service if a Peer Specialist/Advocate attends a medication management or psychotherapy session with the individual and provider?	Peer Support Services may occur before or after psychiatry or psychotherapy sessions on the same day, but concurrent billing is NOT allowed for the same time.
Are there copays for Peer Support Services?	There are no copays for individuals receiving peer services under Medicaid Fee-for-Service or Managed Care Plans, similar to other MHOTRS services for individuals who have Medicaid. For commercial or other Plans, MHOTRS programs are encouraged to negotiate and discuss further with the relevant MCOs.
How does a MHOTRS Program bill if they are contracting out to a peer-run organization for Peer Support Services?	Peer Specialists/Advocates can work within the MHOTRS Program similar to other employees who are contracted. The MHOTRS Program can bill for the Peer Support Services and would work with the contracted organization for payment and contracts.
Do Peer Support Services count toward utilization thresholds, for example, is there a 25% reduction in payment for any visit excess of 30 visits, and 50% reduction in excess of 50 visits?	Peer Support Services do not count towards utilization threshold, so long as the appropriate rate codes are billed for these services.

Do Intensive Outpatient Program (IOP) services count toward utilization thresholds, for example, is there a 25% reduction in payment for any visit excess of 30 visits, and 50% reduction in excess of 50 visits?	Intensive Outpatient Program (IOP) Services do not count towards utilization threshold, so long as the appropriate rate codes are billed for these services.
Is there a document explaining the CPT Revenue Calculator that indicates which services are not part of off-site provision?	The CPT Weight and Rate Schedule in addition to the CPT Revenue Calculator can be found here.
For Peer Support Services, are there ranges or rounding for session times?	Peer Support Services are billed in 15 minute increments. Rounding is not allowed.
Is there a visit/unit limit per year or in total for Peer Support Services?	There is a per day limit of 12 units per day. There is no utilization threshold per year for Peer Support Services. For more information, please refer to the Peer Support Services Guidance.
Is the ICD10 code Z65.9 added as a qualifying diagnosis for services?	At this time, Z65.9 is not yet recognized as part of the eligibility criteria for MHOTRS Programs. See MHOTRS Part 599 regulations for allowable eligibility criteria for MHOTRS programs.
Is NPI needed to bill for Peer Support Services?	Additional information on use of NPIs for non-licensed practitioners is included in the MHOTRS Medicaid Billing and Fiscal Guidance.
How are crisis services billed when Peer Specialists/Advocates are involved in the services?	Crisis Intervention services consist of three reimbursable levels of service. There are specific procedure codes for Crisis Intervention. Additional information on billing for crisis services when Peer Specialists/Advocates are involved is included in the MHOTRS Medicaid Billing and Fiscal Guidance.
For billing purposes, does the address of the off-site service need to be specified?	The general location (ex: home, school, etc.) should be specified. There is not a requirement to add a specific address for billing purposes.

Does there have to be a diagnosis to bill for pre-admission services?	Yes, diagnosis is required for billing purposes. However, during pre-admission an organization can use R69 to bill.
Off-site Services	
Are off-site services the same as telehealth services?	No, off-site and telehealth services are not the same and have different regulations. Please review MHOTRS Part 599 regulations for off-site services and OMH Telehealth Services Guidance for telehealth services for more information.
Are off-site services available to all individuals?	Off-site services are available for all individuals however, the off-site rate applies to individuals enrolled with Medicaid Fee-for-Service, Medicaid Managed Care, and Child Health Plus as determined by the individual's needs and goals documented in the individual's record. MHOTRS Programs should check their own contracts and negotiate with MCOs for commercial plans, as well as check the relevant regulations for individuals who have Medicare.
What are some possibilities for off-site services provided during transitions between levels of care? (E.g., individual is discharged from inpatient at 9am, could a MHOTRS Program-based clinician go to hospital to see that individual at 10am and bill for the session?) Does time of discharge matter? What could be possible with Partial Hospitalization, ACT, PROS, etc. from a billing perspective?	MHOTRS program staff can provide a service the same day as discharge from an inpatient unit, but not before the time of discharge. Once the individual is discharged, they will no longer be at the hospital unit to visit there. It is possible to provide an off-site service in the community, or to have the individual come to the MHOTRS program to engage them in outpatient services. Peer Support Services may be utilized as appropriate for engagement. *(Continued on next page)*

	Off-site services may be beneficial to facilitate individual's transitions between levels of care, but consider MHOTRS policies/procedures and billing limitations for potential overlap of time of services. Providers of outpatient services such as MHOTRS, ACT, PROS, CORE, and Partial Hospitalization cannot bill for services if another provider is billing for services provided at the same time.
What constitutes an "off-site location"?	Off-site Location means a location, other than MHOTRS site(s), at which services are delivered. Locations include, but are not limited to, the community or the individual's place of residence. The location in which the service is provided is determined by the individual's needs and goals documented in the individual's record.
Are rates different for off-site services since travel time will be involved?	Off-site Rate Codes can be found in the MHOTRS Medicaid Billing and Fiscal Guidance. The off-site reimbursement is 150% of the onsite rate to allow for that travel time and the time that is built into providing those offsite services.
Are there geographical or regional restrictions on providing off-site services? (e.g., MHOTRS Program in Queens, can clinician go to Long Island to provide off-site services?)	There is no limitation by OMH to the geographical area off-site services are provided. Decisions to provide services in other areas must be based on individual need. Programs/agencies should consider if they can commit resources to providing these services outside of their usual catchment area. Other considerations: • Insurance coverage (out of network) • Service continuity for duration of treatment episode • Temporary continuation of services when an individual/family moves outside of catchment area.

Can an individual have "only off-site services" and not be seen in the clinic?	Individuals can be 100% off-site, especially if there are mobility issues or medical conditions that would prevent or make it difficult for individuals to go to the MHOTRS Program location. The off-site option enables individuals to receive services that meet their needs. Decisions to provide off-site services should be made based on individual needs, goals, and clinical appropriateness, and reassessed regularly and documented in the record.
Can injections be provided off-site and is it billable?	Yes, injections can be provided off-site, following guidance and program policy requirements for safe administration.
Are off-site services a requirement or is it optional for individuals in the MHOTRS Program?	MHOTRS Programs are not required to offer off-site services at this time. If off-site services are offered from the program, the off-site services are optional depending on the preference of the individual receiving the services.
Can the clinician visit one of our housing programs for an off-site service if they go infrequently, or would that automatically be considered a satellite?	Off-site services can be provided at a community residence or housing program based on individual need. However, a clinician should not set up their schedule to provide services all day at a community residence, because that would constitute regular and routine services in that location. Establishing a satellite in a community residence is not allowed. MHOTRS programs should direct questions regarding establishing a satellite site to the Local Government Unit (LGU) first, before contacting the relevant OMH Field Office.

Can MHOTRS programs provide services (in-person and telehealth) to individuals residing in congregate settings like nursing homes, etc?	There are some restrictions on providing services in facilities like nursing homes, because nursing homes may have an all-inclusive rate that would often include psychological or psychiatric services. There are some case dependent situations, such as when a nursing home may not have those services included in their contract. However, providers should talk to their OMH Field Office and the Nursing Home's administration to find out if it is allowable.
How are MHOTRS off-site services different from OLP under CFTSS or CPST under CORE?	CFTSS and CORE are community-based programs. MHOTRS still remains predominantly an onsite program with the ability and flexibility to meet the individualized needs of children and families. If it is more appropriate that children and families be engaged in their natural environment and the services within CFTSS are most conducive to community-based work, then a referral to CFTSS may be more appropriate. Whereas, if a more therapeutic option like MHOTRS fits the needs of the individual/family more, then off-site services provided by the MHOTRS Program may be the more appropriate option. CORE CPST was designed to engage individuals who have struggled to participate in or maximally benefit from traditional mental health services like MHOTRS. The intake and evaluation process for CORE CPST is streamlined to allow rapid engagement in services. Most CPST providers do not have a prescriber on staff, so individuals may choose to still engage with a MHOTRS clinic for medication management. CORE services are available only for individuals who are enrolled in HARP and have agreed to receive CORE services, whereas MHOTRS off-site is available to all individuals enrolled in Medicaid.

Regarding the off-site visits, how will the counselors be sure of their safety?	MHOTRS Programs are encouraged to develop policies, procedures, and workflows that support clinician safety in the community. Programs should have training and resources available to staff providing off-site services specific to safe and appropriate service provision in the community.
Can Peer Specialists/Advocates provide services off-site prior to admission?	Yes, Peer Support Services off-site prior to admission is allowed.
Can off-site services be provided to an individual in the hospital? Is there a difference if the individual is in the hospital for a mental health vs. medical reason? Can off-site peer support services be provided to an individual who is in a “medical” inpatient unit? Can you go to the collateral’s home or can the collateral come to the clinic if the hospital services are not billable?	Medicaid will not pay for an outpatient visit, off-site, telehealth or otherwise, for an individual who is inpatient. The inpatient facility would be responsible for providing all the care the patient requires, including behavioral health.
Does the guidance for off-site services apply for individuals with Medicare?	Providers need to consult with Medicare regarding allowable and billable services.
If off-site services are being provided in an ad hoc manner to check in with an individual temporarily, and only infrequently, does it have to be added to the individual’s treatment plan?	No, if the service is ad hoc and not regularly provided, it does not have to be added to the treatment plan. However, off-site services provided just once or twice to meet individuals’ needs should be clearly documented in progress notes.
If a Skilled Nursing Facility (SNF) does not have psychiatric services, but multiple individuals have mobility limitations, can off-site services be provided there?	Providers should talk to their OMH Field Office and the Nursing Home’s administration to determine if it is allowable.

Peer Support Services	
Are Peer Support Services billable and how do the rates compare with clinical services?	Peer Support Services are billable. Please refer to the OMH MHOTRS Billing and Fiscal Guidance for more information. OMH also maintains up-to-date rates, weights and procedure codes under the CPT Procedure Weight and Rate Schedule on the OMH website.
Is CRPA credential billable?	Peer Specialists/Advocates who hold a credential from a certifying authority recognized by the Commissioner of the Office of Addiction Services and Supports (Certified Recovery Peer Advocate) are eligible to work in MHOTRS provided they qualify for and obtain provisional OMH Peer Certification or Credentialing within 12 months of being hired. It is expected that, within a reasonable amount of time, they will then complete full OMH Peer Certification or Credential their work experience hours post provisional certification/credentialing. Please refer to the OMH Peer Support Service Guidance document, for more information.
Do peers need to be a part of the preadmission phase?	Peer Support Services may be a helpful way to engage individuals who are ambivalent or undecided about whether to engage in services. Peer Support Services during pre-admission can help those individuals to make an informed choice. However, PSS are not required to be a part of preadmission.
Is contracting out with peer-run organizations allowed? Is contracting out for supervision of peers allowed?	Contracting and partnering with peer-run organizations is allowed. Contracting out for supervision of peers is also allowed.

	When Peer Support Services are provided via contract with a MHOTRS Program, every effort must be made to coordinate services to foster an integrated care approach. Collaboration across agencies promotes a comprehensive, holistic, and individual/family-driven team that strategically informs and monitors interventions. Peer Support Services being delivered through a contract with the MHOTRS Program does not eliminate the expectation of collaboration through Peer Specialists/Advocates being a part of the multidisciplinary team.
Do Family Peer Advocates and Adult Peer Specialists provide the same services, given that they are similar?	No. Family Peer Support Services are focused on working with family/caregivers, whereas Adult Peer Services are working with adults who have mental health challenges and are on their journey of recovery. Family Peer Advocates and Adult Peer Specialists share similar skills but the individuals they support, and context of their work, is different. Family Peer Advocates and Adult Peer Specialists also are required to have distinct credentials to provide their respective services. Please refer to the Peer Support Services Guidance for more information.
Do the 2000 hours of work experience for the NYCPS certification have to be after the core courses are taken? Can hours for a Youth Peer Advocate's certification be used toward Adult Peer Specialist's Credentialing?	Questions related to credentialing should be referred to the appropriate credentialing body. For Adult Peer Support Credentialing, contact the NY Peer Specialist Certification Board. For Family and Youth Peer Credentialing, contact Families Together in New York State.
Is there a specific amount of supervision for Peer Specialists/Advocates that is required?	There is no requirement stipulated in regulations, but organizations are encouraged to consider best practices for

	supervision and supporting Peer Specialists/Advocates in their work. Each credential may have specific requirements for supervision hours and programs should verify that with the credentialing entity for certified peers.
Can a Peer Specialist/Advocate be hired (within a specific program) if they are a former participant in a specific program?	Programs should develop their own policies and procedures regarding hiring of Peer Specialists/Advocates, integration into the multidisciplinary team, and considerations for agency culture change. Programs should have agency-specific policies and procedures regarding this that includes an understanding that it is unethical in any practice to require an employee to provide a dual role (i.e., roommate and Peer Bridger). Programs may consider consulting with peer-run or peer-led organizations to inform the development of applicable policies and procedures and guide appropriate practices.
Can Peer Specialists/Advocates provide pre-admission services for clients on wait lists for services/clinics that do not have capacity?	The needs of the individual should be considered first and the purpose of Peer Support Services should be clear. Peer Specialists/Advocates can provide pre-admission services if the specific purpose is to engage the individual in deciding whether to enroll in clinic services at the MHOTRS program. However, they cannot provide services if the sole purpose is to check in on individuals on the waitlist.
If a nursing home has psychiatric services but not peer services, can peer services be provided by the MHOTRS program?	No, if the Skilled Nursing Facility (SNF) provider has psychiatric services included as part of their services in their all-inclusive rate, then MHOTRS programs may not provide services to residents of that facility. However, MHOTRS programs could consider working with the SNF to develop a contract and then provide services that would be reimbursed by the SNF. *(Continued on next page)*

	Please note, co-enrollment for the sole purpose of receiving Peer Support Services is not permissible. Peer Support Services must be integrated into the provision of other MHOTRS program services.
Is there a written model of family peer support?	There was a consensus process with a large group of stakeholders that included Family Peer Advocates which resulted in the development of a NYS FPSS program model that is consistent with scope of practice and allows for a very flexible model for Family Peer Support.
Are there differences in the Peer Support Services (PSS) that individuals would receive from CFTSS, CORE, and from MHOTRS?	The scope of practice of Peer Specialists/Advocates is the same across programs. PSS may look a little different in each type of program to best align with the program type. Supervision and training are also similar. Providing PSS in multiple programs allows for increased access to PSS and access within a program an individual may already be engaged with.
Documentation	
When are co-signatures needed for Peer Support Services? Can others aside from LPHA sign the progress note?	The pre-admission documentation for contact by the Peer Specialist/Advocate must be signed by the Peer Specialist/Advocate and a Licensed Practitioner of the Healing Arts (LPHA).
Are there certain documentation guidelines for billable peer groups? (i.e., geared towards engagement vs psychotherapeutic?)	Services and notes should align with the scope of practice for each certified peer and the service components listed in the Peer Support Services Guidance.

Is there a specific consent form for co-enrollment across agencies?	No, there is not a specific consent form template for co-enrollment. Please refer to guidelines around HIPAA and your MHOTRS Program's policies and procedures. Co-enrollment should be provided on an individual, case by case basis.
Can a Peer Specialist/Advocate update an individual's treatment plan directly? Does the treatment plan need to contain goals, objectives, and interventions for Peer Support Services?	Peer Support Services should be used in a planned and intentional way regardless of service frequency. When services are planned to address the goals, objectives, and preferences of the individual/family, the service must be listed in the Treatment Plan. Similarly, when Peer Support Services are used in a targeted, short-term manner (i.e., following a clinically significant event, change in status/engagement, etc.) the event and corresponding program response or plan should be noted in the treatment plan including the use of Peer Support Services. There may be circumstances in which the individual/family may benefit from a singular or ad hoc peer service intervention (e.g., support during a provider or education/Committee on Special Education (CSE) meeting; resource education/connection, etc.). In these cases, while the service and intervention may not be noted in the plan, there should be evidence of rationale for the intervention via progress note, interdisciplinary team meeting minutes, etc. Progress notes should indicate the type of service provided, the purpose of the contact, response of the individual, and progress. The Peer Support Specialist/Advocate should work with the primary clinician for changes or updates to the treatment plan, as the primary clinician is the staff responsible for these changes/updates. Peer Support Services do not necessarily need their own goal, most often the purpose of the service will be related to the overall goals on the treatment plan but may indicate having their own objective.

What is the expectation/frequency for the Peer Specialist/Advocate to ask about enrollment, when Peer Specialist/Advocates meets with individuals? Does that question need to be documented in each session?	Peer Support Services can be provided prior to admission, and the purpose and goal of the preadmission contacts must be identified and documented in the record. The goal of pre-admission services is to engage the individual in informed decision making, resilience and recovery. Each contact must be documented in the chart and should include the purpose of the contact, response of the individual, and progress made towards the goal.
In terms of peer support services being provided non-consecutively on the same day, can one note be written?	Peer Support Services that are provided in multiple units at different times within the same day may be documented in one progress note. The times and duration of each unit must be noted to account for the number of units billed.
Can an LCSW from another organization sign off on a Peer Support Service Note for another organization?	For the LCSW or other Licensed Practitioner of the Healing Arts (LPHA) from a separate organization to be able to sign a note, there needs to be a written contract and formal supervision being provided to the Peer Specialist/Advocate at the other organization. The individual providing supervision has to meet the criteria listed as an LPHA. Signing off on Peer Support Service note is only required in pre-admission.
General regulatory questions	
Do Peer Support Services need to be added to our MHOTRS Operating Certificate?	Peer Support Services are optional, and do not require OMH prior approval to provide these services. Peer Support Services are not included on the Operating Certificate. Peer services can be provided when an agency is ready and able to provide peer services.

Will updated Utilization Review (UR) regs be included in the programmatic guidance?	Yes, UR is addressed in the updated OMH MHOTRS Program/ Service Guidance.
What is the intended frequency for UR in the new requirements?	The OMH MHOTRS Program/Service Guidance provides details on the required minimum of 10% for UR. This is intended to be conducted every 6 months.
Auditing: if clinics are overdue for an audit, which regulations will they be audited from?	MHOTRS programs will be reviewed using the most current Part 599 regulations and Standards of Care (SOC), updated July 2023. Any citations will be based on the Regulations and SOC that were in place at the time the services were delivered.
Does supervision have to be in person or virtual, especially for individuals who are interns or have a limited permit?	There are no requirements for in-person supervision from OMH, but please check with the NYS Office of Professions and schools for their particular requirements for practice.
Can an individual receive services (similar in nature) at two MHOTRS Programs, if one MHOTRS program is able to provide services specialized and specifically for an individual's needs? (E.g., specialized psychotherapy services for individuals who are transitioning, while the individual receives psychotherapy and medication management at a different MHOTRS program)	An individual can be co-enrolled for a specialty service that is not available at the individual's regular program (e.g.: special group treatment not offered at their clinic such as Eating Disorders, OCD, or individual treatment specific to a particular issue such as transitioning, Sex Offender treatment, etc.). Co-enrollment requires separate treatment plans at each program, the services cannot be duplicative, and communication and collaboration are required between the providers from the two agencies. Co-enrollment cannot be used to provide services that are required in every MHOTRS program.

Is there flexibility in providing services outside of the hours listed on an agency's Operating Certificate? Are there any flexibilities, especially for off-site or virtual? For example, if an individual is running late or if a clinician or peer providing services off-site is running late and service is provided outside operating hours, would that be acceptable?	The 599 regulations define after hours as before 8am or after 6pm on weekdays, and all weekends. The service must be provided during the hours of operation listed on the operating certificate, which may be beyond the hours of 8am – 6pm. Providers currently without extended hours that wish to bill the after-hours modifier must have an approved change to their operating certificate to indicate the accurate hours of operation. Providers may update their Operating Certifications to reflect additional hours by appointment. The MHOTRS program must have a plan in place for crisis services when the program is not in operation, including ability to provide brief crisis intervention services. This is specified in the MHOTRS Medicaid Billing and Fiscal Guidance
Do we need to submit an Administrative Action (AA) in order to change MHOTRS hours?	Yes, submit an AA to change the program hours of operation listed on the Operating Certificate.
Is there a limit on how long clinicians can try to continue to engage individuals in care? (If there continue to be no shows, etc.)	There are no limits or requirements around the length of time in the regulations. Organizations can consider and decide their practices around engaging individuals in care.
Will co-enrollment apply to a satellite clinic and a main clinic? And two clinics within same agency?	Individuals receiving services at a satellite MHOTRS program have always had the option to receive additional services at the main site if those were not available at the satellite. If two MHOTRS programs that have separate, distinct Operating Certificates (not a satellite), the individual must be enrolled in

	both sites to receive services at both. This would be considered Co-Enrollment, even if the two sites are in the same agency (same MMIS number). When billing under the same MMIS, if services are provided on the same day they must go on the same claim. The same service cannot be provided on the same day, so communication and coordination of care will be necessary between the providers as with all Co-enrollments. Different services can be provided on the same day, but because they're billed under the same MMIS on the same claim, there will be the 10% reduction in reimbursement for the services with the lesser APG weight (this is the same as with services at a single site). Co-enrollment requires that each site have their own treatment plan to address the goals, objectives, and interventions at each site.
Are the co-enrollment rules that started in November 2022 a change from previous regulations or just clarification?	Prior to November 2022 regulation changes, co-enrollment was not allowed, other than a few exemptions listed in the regulations. Co-enrollment as it is allowable as defined in the updated regulations and guidance.
What are the regulations around co-enrollment with CCBHCs?	Generally, co-enrollment should not occur between a CCBHC and a regular article 31 MHOTRS program. Programs should contact OMH to consider exceptions.