February 10, 2022

Program and Billing Guidance for Designated Providers of Community Oriented Recovery and Empowerment (CORE) Services Regarding Emergency Response to COVID-19

Introduction

As a result of the current COVID-19 Disaster Emergency, OMH and OASAS issued Program and Billing Guidance for Behavioral Health Home and Community Based Services Providers (issued 04/16/20, revised 05/08/20). Effective 02/01/2022, four BH HCBS have transitioned to Community Oriented Recovery and Empowerment (CORE) Services. This guidance is intended to outline the State's service expectations, changes in documentation requirements, and minimum billing requirements related to CORE Services for the duration of the federal Public Health Emergency (PHE).

Applicability of this Guidance

This guidance applies to designated providers of CORE Community Psychiatric Support & Treatment, Psychosocial Rehabilitation, Empowerment Services – Peer Support, and Family Support and Training.

Service Provision During Federal PHE Period

During the federal PHE, CORE providers are expected to provide services according to their definitions and service components as described in the CORE Services Operations Manual and as documented on each participant's Individual Service Plan (ISP).

Changes in Documentation Requirements during the Federal PHE Period:

Providers should observe all regular documentation requirements as outlined in the Operations Manual and obtain signed written consent for the following documents:

- Consent to use and/or disclose Protected Health Information (PHI) for which a Mental Hygiene Law (MHL) exception does not apply in compliance with the Health Insurance Portability and Accessibility Act (HIPAA);
- Consent to use and/or disclose PHI from a federally assisted substance use treatment program that is subject to 42 CFR Part 2;
- Any consent for admission or treatment as may be required by the designated provider's Policies and Procedures; and
- Health Information Exchange (HIE), Health Information Network (HIN), and Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Consent.

Per the CORE Services Operations Manual, individuals are not required to sign their individual service plan (ISP), designated providers are required to document an individual's involvement in the development of their ISP which may include a progress note, dated signature or documented refusal to sign. As a best practice individuals should always be offered an opportunity to sign their ISP.

Providers should also note that an ISP must be signed, in person or electronically, by the qualified staff member who developed the plan.

Verbal consent for the provision of telehealth services is allowed under applicable OMH and OASAS regulations. For the duration of the federal PHE the federal Office of Civil Rights has waived its enforcement discretion for HIPAA violations related to the good faith provision of telehealth services including the use of non-public facing applications that allow for video chats such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules.

As noted above, federal rules (42 CFR Part 2) pertaining to the sharing of substance use treatment information prohibit a program from making any *disclosure* of information in a patient's record without the written consent of the patient. Information that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person may not be shared without the express written consent of the patient, or as otherwise permitted by 42 CFR Part 2. Providers may be able to share information pursuant to Business Associate Agreements (BAAs) and/or Qualified Service Organization Agreements (QSOAs) and should confer with their agency Counsel is making such determinations.

Reduction or Elimination of Minimum Billing Requirements:

For the duration of the federal PHE, NYS is reducing the minimum requirements to submit claims to HARPs/HIV-SNPs for CORE Services. These changes will remain in effect until the end of the emergency period.

- Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), Family Support and Training, Empowerment Services – Peer Support:
  - Prior to the emergency, a billable unit for these services had a minimum time requirement of 15 minutes. During the federal PHE, the first billable unit for the above services requires a minimum contact of at least five minutes. For example:
    - 0-4 minutes = non-billable
    - 5-19 minutes = 1 unit
    - 20-34 minutes = 2 units
- If the service provided does not meet the original regulatory requirements, providers must include modifier "CR" (Catastrophe/Disaster related) on the claim. This will not affect the payment. A claim may not be submitted if the minimum requirement has not been met.
- If the contact is provided using telehealth, including telephone, the appropriate telehealth modifier must also be included on the claim.