
CLINIC "ADVICE" HANDBOOK

GUIDANCE ON THE PROVISIONS OF

14 NYCRR PART 679

AS ARTICULATED BY THE

CENTRAL OFFICE REVIEW GROUP

NEW YORK STATE
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL
DISABILITIES

Thomas A. Maul
Commissioner

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Compilation and editing:

Kathleen Keating, RN, MSN, CPNP

Final updates and editorial review:

Rena L. Aggen, RN, MS, CDDN

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Michael Anderson
Aletha Baumann, Ph.D.
Gretchen Booth
Kelli Buchanan
Allen Coleman
Dennis Collins
Catherine DeLong
Carolyn Douville
Gary Lind
Joseph Meloveck
Donald Noble, Ph.D.
James Otis, Ph.D.
John Sabatos
Andrew Ulitsky

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INTRODUCTION

The Clinic "Advice" Handbook is a collection of letters and memoranda interpreting the 14 NYCRR Part 679 regulations that were sent by the Central Office Review Group (CORG) to the field.

This handbook was developed to serve as a resource for the Developmental Disabilities Services Offices and the voluntary providers on issues related to Part 679 Article 16 Clinics.

The order of the text in the handbook follows the regulations.

An Index, to assist you in finding information by subject matter, can be found in the back of the handbook.

The Clinic "Advice" Handbook will be updated on a regular basis.

679.1 INTRODUCTION AND INTENT

- (a) *This Part establishes standards for participation in the provision of approved clinical services (see Glossary and also subdivision 679.3(j)) in a clinic treatment facility (see Glossary) serving persons with developmental disabilities (see Glossary). The operating certificate issued to a clinic treatment facility pursuant to this Part shall specify the clinical service areas, by discipline, approved, and the clinic certified setting(s) (by address(es)) under whose auspice said services are approved for delivery.*
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The intent of the requirement's wording is to ensure that the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) has an opportunity to review and approve the service configuration being submitted for approval by the sponsoring agency. It would be an abrogation of OMRDD's responsibility not to specifically authorize which specific clinical services are going to be available and ensure that the facility has the capacity to deliver the service in accordance with regulatory requirements. For new programs, the submission of service configuration for review and approval will occur through the Certification of Need process.

(CON)

The physical plant/environmental requirements are set forth at 14 NYCRR Part 635-7.1(a)(8)(ii)(a). The requirements therein relate to the NYS Uniform Code and set the occupancy classification for clinics as C-1: Business (In NYC the classification per the City Building Code is E: Business). Pursuant to §635-7.2(a)(1)(ii)(b), Chapter 26 new/Chapter 27 - existing, Business of the NFPA Life Safety Code are required. If the clinic is to be operated on the grounds of other facilities with differential classifications, then the NYS code will likely require fire separation (HPO)

A site should be certified as a satellite if individuals can routinely schedule appointments at that site to receive clinical services from clinicians, and their only reason for being at the site is to access said clinical services.

Designated vs. Dedicated Clinic Space

OMRDD encourages the use of collocated space to the extent practical. Collocating clinics with other programs and services provides convenient access to the consumers, and decreases costs in terms of staff time and transportation. Collocation of clinics can occur in two principal ways: designated space and dedicated space.

Designated space is multipurpose space. A schedule or agreement with the other users of the space indicates the times when the space will be used for the provision of clinical services. This option should be considered whenever:

1. The clinic operates at less than full time.
2. The clinic operates on "unconventional" hours such as early in the morning, in the evening and/or on Saturdays. OMRDD has encouraged clinics to operate in other

than the "normal" 9-5 schedule. Early morning, evening and Saturday hours reduce the time a person must miss from day programming, or a caregiver must miss from his/her job. Early morning and late afternoon hours are convenient as the person can receive his/her clinic service on the way to or from day program.

3. The service can be provided with little or no alteration to the space. For example, individual counseling can often be provided in the psychologist's, social worker's or dietician's office. Group sessions can often be held in a room that is used for other purposes, such as a conference room.

Dedicated space is space that is used exclusively for the provision of clinical services. It is necessary to dedicate space for certain clinical services, such as dentistry, because of the equipment that is involved in the provision of the service. In addition, if the clinic operates on a full time, or more than full time, schedule, it is appropriate to dedicate the space to the clinic.

Off-Site Service Delivery

It is not OMRDD's intent to *a priori* restrict in any way where an "off-site" delivered clinic treatment service might occur. Suffice it to say, the plan of services should provide clear documentation via assessments and clinical team planning decisions as to:

1. Why the service(s) needs to be delivered off-site; and
2. Why the off-site location is the most appropriate location, taking into account programmatic issues, choice considerations and clinical/clinician feasibility.

In addition, clinic providers must all be concerned with, and take into account, the cost effectiveness in each instance of delivering clinic treatment services off-site.

(JPO)

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- (b) *This Part supersedes and replaces in total, previously existing Part 679 pursuant to its initial Emergency Agency Action filing with the Secretary of State effective April 20, 1992.*
 - (c) *Evidence of compliance with Part 679 along with 14 NYCRR Parts 633, 624, and 635 serve as the principal bases for the certification and recertification by the Office of Mental Retardation and Developmental Disabilities (OMRDD) (see Glossary) of a clinic treatment facility serving persons with developmental disabilities.*
 - (d) *The purpose of a clinic treatment facility is to serve principally persons (see subdivision 679.1(f) below) with developmental disabilities and their collaterals (see Glossary) as stipulated herein, either at a main clinic site(s) certified by*

OMRDD, at a certified satellite site listed by address on the facility's operating certificate, or off-site by:

- (1) *Providing clinical services of principally an habilitative clinical nature to ameliorate or limit the disabling condition or other disease, illness, or condition through the provision of professional assessments and therapies, to persons, who because of their developmental disability, require such services to remain in or move to the least restrictive residential and/or day setting; or because such services are unavailable or inaccessible in the person's community.***

It is the position of (OMRDD) that the primary purpose of clinics certified pursuant to 14 NYCRR 679 be principally habilitative in nature. The Department of Health (DOH) has the statutory responsibility for overseeing medical services to the citizens of New York State. Therefore, the provision of primary medical services in a clinic certified pursuant to 14 NYCRR 679 will only be authorized in those instances where the provider can clearly demonstrate that the existing generic service system is inaccessible, unable or unwilling to provide those services. In any event, the number of units of service provided in medical type services must constitute a minimal proportion of the clinic's overall total volume of service. In those instances where the number of units of services constitutes a large portion of the total volume of service, those entities must seek certification through Article 28 of the Public Health Law.

OMRDD's intent with an Article 16 Part 679 clinic is that the facility should operate **principally** as a rehabilitative clinical service provider. OMRDD has no authority to establish facilities which are principally medical or dental providers of service. This authority does belong to DOH. The Mental Hygiene Law does allow entities to be certified by OMRDD to offer limited amounts of medical/dental services as a person's (i.e., someone with a diagnosis of developmental disability) primary source of medical/dental care when there is a documented need and such services are offered with the context of a comprehensive rehabilitative services setting.

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- (2) *Providing services to a person through his/her collaterals for the purposes of enhancing the effectiveness of the treatment; enabling the person to remain in the family or placement setting as long as desired; and/or enhancing the person's quality of life.***
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Rationale

It is standard operating procedure in dealing with children, the elderly and other dependent populations for the practitioner of the healing arts to use others (typically characterized as the primary caregiver) to obtain information about the service recipient's problems and to use the other to implement the treatment regimen whether it be medication administration, special diets, exercise

program, changing dressings, etc. No one questions these as allowable when the physician spends a majority of time explaining/training/counseling the other about how the treatment recommendations are to be carried out. (JPO)

OMRDD takes the position that the care-giving-related needs of collaterals are inextricably linked to the needs of the primary recipient with developmental disabilities. Thus, meeting the needs of a collateral within the context pursuant to paragraph (d)(2):

"...for the purposes of enhancing the effectiveness of the treatment enabling the person to remain in the family or placement setting as long as desired; and/or enhancing the person's quality of life.",

directly links to OMRDD's authority as provided for by Articles 13 and 16 of the Mental Hygiene Law.

It does not make sense either programmatically or cost-wise, in OMRDD's view, to separate for clinical purposes the recipient from his/her environment when the primary purpose of the clinic service is to enhance the person's capacity to meet the demands placed on him/her by the environment. To maximize treatment effectiveness and quality of care, services should be planned and delivered from an integrated and coordinated perspective. Services to collaterals, as presently defined within Part 679, minimizes fractionation and care focused on the primary recipient, promotes the goals of integration and coordination, and is consistent with OMRDD's Mental Hygiene Law mandate to promote quality of care to persons with developmental disabilities.

OMRDD is not, for example, referring to providing mental health counseling services or primary medical/dental care to the collateral in these circumstances. In offering services to collaterals, the clinician should be trying to address the needs of the collateral to:

- (i) understand the primary recipient's developmental disability;
- (ii) be supportive of the primary recipient's coping with life issues.
- (iii) reinforce or carry out treatment interventions outside of the clinic setting or visit; and/or
- (iv) sustain their involvement as the primary caregiver to the primary clinic service recipient.

(JPO)

Medicaid Allowability

Federal definitions of who the service recipient is can be viewed as limiting or expansive, since the matter of "service to collateral" is not spoken to. What is clear, taking all applicable references into account (42 CFR 440.90; 42 CFR 440.2; 42 CFR 441) is that the benefit must accrue to the "outpatient"/primary service recipient. Further, the Federal standards while prohibiting FFP

for certain specific items have not addressed services to collateral and in most cases defer to what is specified in the State Plan for Medicaid Services.

(JPO)

Conditions for Billing

1. The only services to collaterals for which the clinic may claim reimbursement are services which directly benefit the person with developmental disabilities the clinic is serving.
2. This service would have to be charged to the person with developmental disabilities who receives the benefit from the service.

(KH)

3. Mandate that:

- (a) the collateral be identified in the treatment plan of the primary recipient;
- (b) the service to the collateral not be for meeting the deficits/problems of the collateral; rather
- (c) the purpose of the collateral contact be linked to a therapeutic outcome for the primary recipient.

(JPO)

Siblings as Collaterals - The definition at § 679.99(f) provides for a "member of the family, defined as either biological or adoptive". This is intended to be inclusive of siblings.

(JPO)

Exclusions

Collateral billing is not available for training/supporting residential and/or day program staff. Trained staff are viewed as a condition of these programs being certified for operation. The training and supervising of staff is part of the basic responsibility of the contract agent or certified provider regardless of the kind or type of service being provided or how funded. To use billable clinic services to train direct care staff would undermine this basic premise of certification. Similarly, "teachers, employers, supervisors, job coach(s)" are presumed to meet certain expectations relative to their roles. Certainly, clinic staff can and should make recommendations to any and all appropriate service providers for persons who are the primary clinic service recipient (i.e., the person with the developmental disabilities). However, this cannot be a funded/billable clinic service since it is perceived as too far removed from the provision of direct service to the primary recipient and

thus, would not be approved by HCFA pursuant to its review of the clinic related Medicaid State Plan amendment.

(JPO)

Private Payments for Services to Non-Medicaid Eligible Persons

OMRDD requires its licensed providers of Medicaid reimbursed services, to charge program participants for services rendered. Persons who have health insurance and/or Medicaid will not personally receive a bill for their services, as their insurer and/or Medicaid will be billed instead. However, for individuals who are not eligible for Medicaid, providers of service are required to inform the individuals of a potential fiscal liability (equivalent to the facility's approved Medicaid fee) being incurred by receipt of clinic services.

OMRDD does not mandate any specific sliding fee schedule; therefore, the provider may create a sliding fee schedule of its own design to accomplish this. It is OMRDD's expectation that the provider be consistent in its use of its fee schedule, and that the use of the schedule should not be construed to restrict eligibility for, or deny services to, any individual who qualifies for the services.

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- (3) ***Providing convenient access to clinical services, including services available at non-traditional business hours, in non-traditional settings, making use of treatments delivered at certified satellite sites and when authorized, off-site.***
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The Office of Mental Retardation and Developmental Disabilities would argue that the provision of off-site services has the potential of enhancing and/or protecting the welfare of certain persons with developmental disabilities who are receiving, or need to receive, off-site clinic treatment services. The authorization to deliver off-site clinic services to persons with developmental disabilities will greatly enhance OMRDD's and its voluntary agency certified clinic providers' ability to support people living at home. . . The lack of sufficient clinical and other support services can undermine at-home placement, potentially hasten the need for out-of-home placement, and thus, will directly affect said persons' welfare. . . . The provision of such care is viewed by OMRDD as absolutely necessary and appropriate.

(EH)

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- (4) ***Providing clinical services that are not duplicative or substitutive of additional services by existing clinic treatment facilities except when there is documentation that the person's needs so warrant.***
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While it is the intent of the Office of Mental Retardation and Developmental Disabilities to promote and encourage the development and delivery of quality services to any person with developmental disabilities who is in need, it is not this agency's intent to supplant or duplicate services currently in place. OMRDD must proceed cautiously, and justify any expansion of services on documented need. Priorities for development must be given to areas where there is an absolute lack of services, and to those places where it is necessary to reconfigure currently provided services into a clinic in order to provide services in a more efficient manner, or to better meet the need of individuals moving into a more individualized service environment, or from the developmental center into the community. Only those programs that can clearly document actual need will be authorized to go forward.

The application for certification of need requires that the applicant outline the unmet needs to be served, and indicate why the clientele to be served is in need of the services proposed. The application further requires that the applicant document that alternative, less costly or more effective methods of accomplishing the proposed results are absent. In order to provide sufficient documentation of need for the application of certification of need, the following information/data is to be included:

1. Boundaries of the projected service area.
2. Within the projected service area, identify by name, location and certification type (e.g., Article 16-OMRDD, Article 28-DOH) of existing clinic service providers, noting the types of services provided, and what unused capacity, if any, exists at each provider.
3. A person-by-person listing of the potential service population. For each individual projected to be a potential clinic service recipient:
 - a. age;
 - b. current residential type (e.g., ICF/DD, community residence, family care, individualized residential alternative, living with relatives);
 - c. current day program/services;
 - d. projected clinical service(s) needed and frequency by discipline and/or service (e.g., annual comprehensive assessment);
 - e. where services would be offered (at the certified site or elsewhere);
 - f. where this individual currently receives services, and why this individual requires alternative/additional services; and
 - g. documentation that indicates what efforts have been made to secure services within the current service delivery system, and the result of those efforts.

4. If it is impossible for an applicant to provide a person-by-person list, an agency may document need by obtaining information from other agencies. This information must include written documentation from the agency indicating, by discipline, the following information:
 - a. the number of people the agency has on a waiting list;
 - b. the age of those individuals on the waiting list;
 - c. their current place of residence and day program;
 - d. the frequency of service needed;
 - e. what efforts have been made by the agency to secure services within the current services delivery system; and
 - f. an indication of the number of these individuals that the agency would refer to the applicant should the applicant establish a clinic treatment facility.

5. Documentation that the potential applicant has complied with the requirements of 14 NYCRR Part 620.4(a)(5) and 620.4(b). That is, prior to the formal submission of the certification of need application, the potential applicant has consulted with applicable local authorities, local governmental units and the appropriate Health Systems Agency to ensure, to the extent possible, that all of the parties agree that the proposed project is needed and appropriate. It is at this time in the planning process that both the local governmental units and the Health Systems Agencies are to consider and comment on:
 - a. The availability of facilities or services which may serve as alternatives or substitutes for the whole or any part of the proposed Part 679 clinic treatment facility.
 - b. The need for the facility or services at the time, place and under the circumstances provided.

The agency submitting the CON application is in control of the content relative to how its program will be administered both initially and over time as long as the minimum regulatory standards for both the CON per 620 and the operating certificate based regulations have been accounted for. Typically most CONs are submitted and analyzed based on how the facility will function on the first day of operation. However, there is nothing to preclude the applicant from submitting a longer term CON that describes both the facility's initial configuration and potential future expansions of services at a later date. Obviously, this makes for a much more complicated application since the information necessary to sustain approval of the initial opening, must be expanded to encompass inclusion of comparable information to sustain the expansion. This means

that issues relative to the documentation of need, fiscal viability, expected adherence to applicable regulations, etc. (i.e., standard CON criteria) must be substantively addressed specific to the expansion in the single application.

The DDSO, CORG, HSA, and LGU in reviewing the CON should address both the approval for initial opening and approval for the specified expansion at a later date. As part of the approval statement(s), any party can recommend exceptions or special conditions/contingencies to be attached to the expansion even though the initial opening is approved by the reviewing agent as submitted by the applicant. OMRDD can condition its final approval of the CON with conditions applicable to the expansion, such as the opportunity to be notified and formally review the facility's current operation prior to the noted date of expansion and may specify retention of the right to retract its previous conditional approval based on documented problems with adherence to the initial Part 620 criteria.

If the precipitating question presupposes an approval already given for a previously submitted CON application which included an expansion aspect, and OMRDD approved the CON as worded without conditions relative to the specified expansions, then the provider can proceed in conformance with the original application.

(JPO)

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- (5) *Providing quality services through the use of staff who hold the certification or licensure appropriate to their discipline and by program and/or staff affiliations with training institutions that can provide a source of continuing education as required to maintain current licensure.*
 - (6) *Offering managed health care (see Glossary) as part of approved medical services (see section 679.3(k)(2)) when serving as the person's principal care provider, by providing medical and/or dental care as well as coordinating tertiary medical care services, where it can be demonstrated that the generic health care system is either unavailable, without the specific capacity to provide quality services, inaccessible, and/or unable to serve such persons.*
 - (e) *This Part is organized in a format consisting of principles of compliance and standards of certification. In reviewing the continued eligibility of a facility for an operating certificate, OMRDD shall survey for compliance with all "standards of certification" herein and any other applicable requirements. OMRDD may make inquiries into and evaluate evidence of non-compliance with the applicable "principles of compliance." The detailed premises for the principles of compliance and standards of certification format may be found at 14 NYCRR Part 633.2.*
 - (1) *Principles of compliance set forth the basic conditions for the operation of a facility. Facilities will not be routinely examined against principles of*

compliance at surveys for recertification. OMRDD reserves the right to monitor compliance with any applicable requirements at any time pursuant to the responsibilities of the commissioner (see Glossary) under the Mental Hygiene Law.

- (2) Standards of certification are criteria specified by OMRDD as necessary for compliance in order for a facility to demonstrate on a regular and ongoing basis that it can and will continue providing the appropriate environment to assure an adequate level of quality of care, welfare, individuals' rights, safety, and fiscal accountability. Surveys are conducted for the purpose of documenting compliance with standards of certification. Compliance with all applicable statutes and regulations, or an acceptable plan of correction, is a basis for issuing an operating certificate and/or renewing an operating certificate.*
- (f) As used herein, the terms, "people" and "person(s)" shall be understood to refer to those who have been admitted and are receiving services at a clinic treatment facility.*
- (g) Facilities certified by OMRDD as clinic treatment facilities prior to the effective date of this Part, shall have 18 months to come into compliance with the new requirements.*

For existing programs, the operating certificate upon recertification subsequent to issuance of revised Part 679, will be issued with a listing of the authorized services which meet the requirements of new Part 679. Providers, pursuant to §679.1(f), have up to 18 months to come into compliance with the new requirements. Hence, recertification and the issuance of an operating certificate with the list of authorized services will require an acceptable plan of corrective action if any deficiencies exist in relationship to compliance with the new requirements.

(JPO)

679.2 *Statutory Authority*

- (a) The following sections of the Mental Hygiene Law authorize the commissioner to establish separate classes of operating certificates for facilities serving persons with developmental disabilities and to establish the standards governing such facilities.*
 - (1) Section 13.07 of the Mental Hygiene Law makes it the responsibility of OMRDD to assure the development of comprehensive plans, programs and services in the areas of research, prevention, care, treatment, rehabilitation,*

education and training of persons with developmental disabilities. The OMRDD also has the responsibility to ensure that such care, treatment and other appropriate services provided under its aegis are of high quality and effectiveness and the personal and civil rights of persons receiving care and treatment are adequately protected.

(2) Sections 13.09 and 16.00 of the Mental Hygiene Law set forth provisions enabling the commissioner to regulate and assure the consistent high quality of services provided to persons with developmental disabilities. The commissioner may adopt and promulgate any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by this article.

(b) Sections 364 and 364(a) of the Social Services Law provide that OMRDD shall be responsible for establishing and maintaining standards for medical care and services in facilities under its jurisdiction and that it will do so in accordance with cooperative arrangements with the Department of Social Services and other State agencies.

679.3 Principles of Compliance

(a) There shall be a governing body (see Glossary) with the policy making authority for the clinic treatment facility and legal responsibility for its operation and management. Each member of the governing body shall be identified by name and address in the agency/facility (see Glossary under "Agency/Facility") records. No one shall serve as both a member of the governing body and of the paid staff of the clinic treatment facility.

(b) The governing body shall be responsible for the operation of the clinic treatment facility according to the principles and standards established in this Part and other applicable rules, regulations, and statutes. This includes, but is not limited to, 14 NYCRR Parts 620, 624, 633, 635 and 636.

(c) The governing body shall be responsible for the development, implementation, revisions when necessary, and use of a written policy and procedure (see Glossary under "Policies/Procedures") manual(s). The manual shall specify the facility's operational procedures and the staff titles operationally responsible for various clinic activities in at least the following areas:

(1) Services available, treatment planning, service delivery.

(2) Treatment coordination.

(3) Staffing, qualifications, and personnel policies.

- (4) *Administration.*
 - (5) *Admission and discharge criteria.*
 - (6) *Quality assurance including program and individual service evaluation.*
 - (7) *Program goals.*
 - (8) *Recordkeeping and reporting.*
 - (9) *Budgeting and expenditure controls.*
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If the administration changes an existing policy or develops a new policy to address a new topic not previously covered, it should:

- (i) obtain Board approval of the new/changed policy pursuant to the agency's own procedures;
- (ii) ensure that staff are notified, advised and trained accordingly; and
- (iii) ensure staff have working knowledge of the policy information and are operating accordingly.

(JPO)

- (d) *The governing body shall ensure the development and implementation of a written quality assurance program (subject to OMRDD's approval), that includes a planned and systematic process for monitoring and assessing on an ongoing basis, the quality and appropriateness of the treatment, regardless of service delivery location, and clinical performance of staff. The plan shall include a means to resolve identified problems, pursue opportunities to improve the care and treatment provided and incorporate the regular, ongoing input of consumers, collaterals and referral source representatives. The plan shall be subject to OMRDD review and approval as part of the process for issuing a new operating certificate, or for a facility's first recertification occurring after April 1, 1993.*
- (e) *The governing body shall ensure that admission and discharge policies, including those pertaining to eligibility for service/treatment and a description of available services, shall be written and be made available to staff members; persons served and their families; cooperating/referring agencies; and as requested, to the general public.*

- (f) *The governing body of a facility providing medical or dental care in circumstances where such care represents the person's principal source of health care, shall ensure the development of policies and implementation of related activities which:*
- (1) *Assure continuity of care in the area of medical services, including access to emergency medical care.*
 - (2) *For medical care, address the parameters associated with managed health care (see 679.99(e)).*
 - (3) *Ensure that its medical/dental practitioners are current in their treatment practices and knowledge, particularly with respect to serving persons with developmental disabilities.*
 - (4) *Ensure access to specialist care and consultation, when needed.*
 - (5) *Access outside peer credential review of physicians and dentists.*
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OMRDD remains convinced that MR/DD providers generally (several exceptions to be sure) are not in a position to knowledgeably or adequately evaluate physicians' credentials. Hence, the rationale for providers to set up a formal or informal mechanism for obtaining additional credible sources of review for physician credentials. If the facility is going to be doing medical care as the principal source of medical care for some of its clientele, then it is required to have a formal affiliation with one of the various types of health/medical related institutions (679.3(n)). Part of that affiliation relationship might include an arrangement to review a potential physician's credentials for accuracy, completeness, soundness, advisement, etc., prior to a clinic's decision to hire. Such information provides an expanded relevant source of input, and while guarantees are not assured or expected, such information is germane to the clinic's decision and responsibilities for quality health care, and is expertise not available internal to the facility.

(JPO)

- (6) *Reinforce the importance of quality hands-on medical/dental care.*
 - (7) *Provide opportunities for medical/dental training placements in the clinic treatment facility itself.*
- (g) *Ongoing direction and control of the facility's delivery of services and treatments shall be delegated by the governing body to an appropriately qualified administrator (see Glossary) who may also function as the clinic's medical or dental director (see Glossary). If the administrator is not a physician or dentist, he or she shall:*

- (1) Have at least a bachelor's degree from an accredited institution of higher learning; and*
 - (2) Have at least one year's post degree experience in a human services setting serving persons with developmental disabilities; and*
 - (3) In a clinic treatment facility providing medical or dental services as principal sources of such health care to appropriately admitted persons, have at least one year's experience in actual health care administration, or a masters degree in health care administration.*
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Appropriately Qualified Administrator - There are basically two sets of qualifications applicable to the position of clinic administrator

If the clinic is principally a habilitation clinic and not providing medical or dental care as a principal source of such care to some of its service population, then the administrator's qualification minimum is a bachelor's degree and one year post-graduate experience in serving persons with a developmental disability.

If the clinic facility plans on or is delivering primary medical care as a principal source of such care, then the administrator must additionally have a year's experience in "actual health care administration" or a master's degree in health care administration.

An ICF/MR administrator or Day Treatment program administrator having a bachelor's degree and one year experience of working with persons with developmental disabilities, would qualify as an administrator for a clinic providing principally habilitation services and not serving as a principal source of medical or dental care for any of the persons receiving services from the clinic. While HCFA may consider ICFs/MR and day treatment programs "health related facilities", they are not health care facilities within the intent of Part 679 which was to draw on parties with experience in administrating programs where primary medical/and dental services are delivered.

(JPO)

- (h) An appropriately qualified physician shall be responsible for the ongoing direction of all clinical services. The medical director shall be licensed to practice medicine in New York State, and shall be designated as responsible for maintaining the general health conditions and practices of the program. If the clinic provides dental care, the medical director may be a dentist.*
- (i) The facility shall have sufficient professional (see Glossary) staff to deliver the services offered in accordance with the intensity, duration, and frequency recommended by the treating clinician(s) for persons admitted to the facility.*

- (1) *The Medical Director shall be appointed for at least one-third time (i.e., .34 full time equivalent) or additionally at a level sufficient to provide adequate oversight of the constellation of services offered by the clinic facility for a clinic in operation 5 days or more per week.*
- (i) *For programs operating less than 5 days per week on a regular basis, the Medical Director coverage shall be at least proportional.*
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The major reason that a minimum level of employment is specified for the medical director is because of the advice of outside counsel regarding the State's potential Medicaid vulnerability in both day and clinic treatment programs due to inadequate oversight and participation of the medical director. The authorizing Federal regulations at 42 CFR 440.90 are very clear regarding the importance of the role of a medical director regardless of the type or configuration of services offered by the facility. These requirements underlying Federal approval require that all services must be delivered by or under the direction of a licensed physician.

OMRDD reviewed the various options of what would be prudent, feasible and cost effective in terms of specifying a minimum FTE level. The 0.34 FTE level specified in Part 679 must be taken within the context that Article 28 clinics offering a somewhat similar configuration of services, function with an average of .6 FTE Medical Director per facility.

- (ii) *Nothing herein shall preclude the Medical Director as a physician from delivering appropriate and needed medical services for up to one half of his/her assigned time. If the services are not principal source primary medical care, the requirements at 679.3(f), 679.3(k) and 679.3(n) need not be met.*
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The Medical Director may conduct assessments/evaluations to support the need for clinic services, to ensure there are no medical contraindications, to fill an information void, or to determine a better fix on the etiology of a person's presenting circumstances. Said evaluations are considered secondary and/or tertiary medical care, and do not require specific CON or operating certificate authorization. However, if the facility plans on offering primary medical care as a person's principal source of health/medical care, such service must be authorized through the Part 620 process and subsequently be specified on the facility's operating certificate.

(JPO)

A general rule is that out of the required 0.34 FTE of medical director staffing, a maximum of 50% (or 0.17 FTE) of the assigned time may be spent in treatment activities for which claims can be generated. For example, in a clinic, where there are three physicians serving to make up the 0.34 FTE medical director, there should be a minimum 0.17 FTE of physician time with the primary

responsibility of medical director. Medical director staffing allocation in excess of 0.127 FTE, up to a maximum of 50% of the total FTE assigned, may be spent providing billable services.

(AB)

(iii) *Nothing herein shall preclude the clinic provider from filling the Medical Director position allocation utilizing more than one physician, as long as only one physician is formally designated as having overall responsibility for the facility's medical direction.*

(2) *The designated administrator shall be appointed in sufficient amount to cover the hours the clinic is in operation up to one full-time equivalent.*

(j) *Approved clinical services in a clinic treatment facility certified in accordance with this Part, may include the following types of services delivered by practitioners of the healing arts (see Glossary) or otherwise herein authorized parties (see 679.3(l) and 679.99(n))*

(1) *Rehabilitation/habilitation services:*

The addition of "habilitation" as a distinct service to the list of allowable clinical services would be inappropriate. A clinic treatment facility is not designed to be a 30 minute a day treatment program. Rather, its focus is to provide direct face-to-face clinical service (treatment or assessment) by a licensed/certified clinician. While the issue of habilitation in the provision of any clinical service is obviously inherent in the service (e.g., the provision of speech therapy develops speech skills), the focus is on therapy and the professional clinical skills as applied by the licensed/certified practitioner.

(i) *Occupational therapy.*

Limited permits to practice occupational therapy:

1. The following persons are eligible for a limited permit:
 - a. An occupational therapist who has graduated from an occupational therapy curriculum with a baccalaureate degree or certificate in occupational therapy which is substantially equivalent to a baccalaureate degree satisfactory to the board of occupational therapy; or

- b. a foreign occupational therapist who is in this country on a non-immigration visa for the continuation of occupational therapy study, pursuant to the exchange student program of the United States Department of State.
2. A permittee shall be authorized to practice occupational therapy only under the supervision of a licensed occupational therapist or a licensed physician and shall practice only in a public, voluntary, or proprietary hospital, health care agency or in a preschool or an elementary or secondary school for the purpose of providing occupational therapy as a related service for a handicapped child.

(ED Law §7904)

Occupational Therapy Assistants

Occupational therapy assistants shall mean a person who is certified by the commissioner (of education) as having successfully completed a program for occupational therapy assistants in accordance with the commissioner's regulations. Occupational therapy assistants shall provide services under the direct supervision of a licensed occupational therapist or a licensed physician. Such supervision shall include meeting with and observing the occupational therapy assistant on a regular basis to review the implementation of treatment plans and to foster professional development. An occupational therapy assistant registered by the State Department of Education is allowed to implement a treatment plan either under the general supervision of a licensed occupational therapist or the occupational therapist providing periodic direct supervision visits to observe and instruct the occupational therapy assistant. The supervising occupational therapist does not have to be on site.

(letter Hausheer to Keating 5/3/95)

In the case of an occupational therapy assistant working under a licensed physician, the occupational therapy assistant may only provide services in a public, voluntary or proprietary hospital or health or home care agency.

(Ed Law § 7906(6))

(ii) *Physical therapy.*

The provision of services by physical therapy assistants in off-site settings, especially has it pertains to such individuals providing services in the absence of the registered physical therapist. OMRDD certified clinic treatment facilities are governed by the exemption set forth in Section 6738 of the Education Law as such pertains to the requirements that physical therapy assistants receive "continuous on-site supervision" by a licensed physical therapist. It is OMRDD's policy that such supervision is to be considered continuous and within the Education Law's provisions for exemption when the facility's treatment plan for the person is one of "maintenance consistent with Title XVIII of the Federal Social Security Act. In the context it is recognized that persons in OMRDD

supervised or authorized programs do not generally receive “rehabilitation (i.e., restorative) services. Rather, pursuant to practice and Medicaid authority, such individuals are considered to be receiving habilitation services which are intended to maintain an individual’s level of functioning avoid, to the extent possible, a decline in ability and to increase a person’s level of ability, if possible. Thus, the rehabilitation generally provided by a physical therapist under the category of restorative services in other contexts, is not the charge in an OMRDD certified or authorized facility.

The above being said, it is expected and required that physical therapy assistants be supervised by licensed physical therapists whether the service is delivered at a certified main or satellite setting, or off-site. In this context, supervision by the licensed physical therapist includes the following aspects:

- (i) the licensed physical therapist's setting of goals, establishing a plan of care and determining whether the patient is appropriate to receive the services of a physical therapist assistant subject to the licensed physical therapist's evaluation;
- (ii) an initial joint visit with the patient by the supervising licensed physical therapist and the physical therapist assistant;
- (iii) periodic treatment and evaluation of the patient by the supervising licensed physical therapist, as indicated in the plan of care and as determined in accordance with patient need, but in no instance shall the interval between such treatment exceed every six patient visits or thirty days, whichever occurs first; and
- (iv) a final evaluation by the supervising licensed physical therapist to determine if the plan of care should be terminated.

Part 679 off-site clinic services may be delivered in any other location, including, but not limited to, certified satellite sites, schools, preschools, day care centers, supported work sites, day treatment sites, day training sites, day habilitation sites, sheltered workshops and in the person’s home. In those settings, the provisions contained in Section 6738(a) of the Education Law apply. These include:

- (i) off-site supervision, but not physical presence by the licensed physical therapist is permitted given that for OMRDD certified facilities, the person’s physical therapy treatment plan is to be considered of a “maintenance” nature (as discussed previously); and
- (ii) no more than four physical therapy assistants may be supervised by one licensed physical therapist.

Day treatment facilities are **not** responsible for the assessment of a person’s adaptive/assistive equipment needs or the design/construction of said equipment. The Day treatment facility’s physical therapist (PT) and occupational therapist (OT) clinicians **are** responsible for the

assessment of developmental habilitational needs in the particular discipline areas, program planning, and the actual habilitation of consumers using adaptive/assistive equipment which means that they may be training them in use, and/or focusing on improving general adaptive behavior skills.

The adaptive/assistive equipment specialty clinic service authorized by Part 679 as a "rehabilitative/habilitative service" (see 679.99(r) (4)), was intended to address this unique gap in service availability in both the generic and MR/DD communities. This is **not** a same day issue since it is for a specific clinic service which is **not** part of the day treatment facility's authorized services. Hence, it is a separately claimable service and does **not** represent any duplication of service. Obviously, it is expected that the PT/OT will be consulting and communicating with their counterparts in day treatment to ensure coordination and integration of service. However, this is not a claimable activity unless it involves a face-to-face contact with the consumer and the consumer is receiving actual treatment/assessment which is merely being observed incidentally by the day treatment's facility's PT/OT.

(JPO)

(iii) Psychology and/or Psychiatry.

There is no intent on the part of OMRDD by virtue of inclusion of psychiatry as an allowed service to diminish the responsibility of OMH certified programs to meet the mental health needs of those with developmental disabilities. Psychiatry was included in Part 679 for several reasons:

- Several existing Part 679 clinics already offer the service to a significant number of persons with dual diagnoses.
- There are many areas of the State where there are no or limited amount of mental health services available.
- There has been a history of much resistance by mental health services providers to meet the needs of persons with DD. While this may be a philosophically intolerable situation, the reality remains that people with DD may need the service, have a right to the service, and OMRDD has the obligation to promote access to the service in a timely fashion.

Psychiatry is listed with psychology as a "habilitation" service in order to avoid any misunderstanding that a Part 679 clinic offering psychiatry is providing primary/routine medical services; which, while allowed (on a minimal basis) in a Part 679 clinic, carry with them the trappings of "managed health care" and affiliation requirements.

(JPO)

The listing of psychology and psychiatry on the same line in the regulation does **not** indicate that authorization for one is also authorization for both services. Psychology and psychiatry must be listed as separate service designations on the operating certificate.

(AB)

(iv) Rehabilitation counseling.

The concept of rehabilitation counseling in a Part 679 clinic treatment facility, is to view it as a true clinical service. That is, it involves a face-to-face contact between the recipient and the clinician for the purposes of:

- i. Assessment and follow-up reassessments;
- ii. Service/activity design and actual hands-on training to use equipment at a job site;
- iii. Problem solving/counseling;
- iv. Job modification and/or obtaining and training in the use of assistive devices; and
- v. Skill development assistance in maintaining/obtaining employment.

For the purposes of a reimbursable service, rehabilitation counseling does **NOT** include so-called "floor supervision" as might typically occur at a workshop/SEP.

(JPO)

(v) Speech and language pathology and/or Audiology.

(vi) Social Work.

Social work -- An MSW without certification (but moving towards qualification) may function as a "Student-in-Training" under the supervision of a certified social worker pursuant to 679.3(1). All provisions in paragraph (1) (2) apply. OMRDD's intent with the allowability of the student/intern option is **NOT** to create a loophole whereby, on an ongoing basis, use of non-licensed/certified parties is sanctioned.

(JPO)

It was the intent of the designer/writers of the regulation and the Commissioner upon issuance of Part 679 that only licensed/certified persons, plus the ABSS and Rehabilitation Counselor titles, be the ones under whose name/title services could be claimed. A Social Worker Assistant (SWA)

is an unlicensed/uncertified paraprofessional Civil Service title. Previous acceptability as a "QMRP" is not sufficient rationale since the intent of OMRDD is to make these programs as mainstream as possible within the authority of the Mental Hygiene Law. Nothing, however, precludes the licensed/certified party from using (consistent with professional licensure/certification provisions and community practice standards), the assistant as an "assistant" (under direct supervision) in carrying out some of the activities engaged in by the professional during the visit session.

A Part 679 clinic is designed and reimbursed on the basis of a capacity to deliver professional level services. Thus, to authorize said SWA parties to deliver claimable clinic treatment services would be antithetical to the OMRDD clinic program's intent.

(JPO)

(2) Medical/Dental

- (i) Medicine (may include primary care as well as specialties).***
- (ii) Dentistry (includes services of qualified dental assistants/hygienists operating under the direct supervision of a licensed dentist).***

(3) Health Care Services

- (i) Nursing.***
-

All nursing services which are provided through the clinic can only be provided in conjunction with a physician or nurse practitioner who is following the medical problem. The medical (ICD-9) diagnosis must be provided by a physician or nurse practitioner, and "signed-off" by the medical director.

Most of the time, nursing services through the clinic would be provided for on-going medical problems, either short term or long term, and these services must be on the treatment plan.

RN's can provide routine nursing care (e.g., visiting a community residence or family care home to check on a cut; or the person's not feeling well). In such a case, the service delivered is categorized as a "health assessment" service, and the diagnosis listed on the claim form is the DD diagnosis that forms the person's initial eligibility for admission to the Part 679 clinic.

To minimize any potential audit vulnerability relative to the above, the following conditions should exist:

- It is most desirable that the Part 679 Clinic, in addition to providing habilitation-based clinical treatment services to the person, also be functioning as the source of the person's primary medical care. This circumstance emphasizes the "managed care" notion that is built into Part 679.
- The second best circumstance, is where the person's primary care physician in the community has directed that the person needs a source of routine nursing services (e.g., monitoring blood pressure) and has referred, approved, or recommended that the Part 679 clinic treatment facility provide such routine services. The example here is not intended to be limiting, and indeed the community physician's referral can be relatively broad based. This scenario also reinforces the managed care concept albeit at a more arm's length level.

Nursing -- Licensed practitioner of the healing arts does include a licensed practical nurse (LPN) provided that s/he functions within the scope of practice of his/her license. S/he cannot deliver RN services. An LPN may deliver service only when the supervision requirements associated with the discipline's practice are met. A program electing to offer nursing services must have an RN on staff. The program may NOT offer nursing services via solely LPN staffing.

(JPO)

(ii) Dietetics and Nutrition.

Dietary and Nutrition Services: Can a nurse administer these services? It depends on the level and extent of the service. A nurse could therapeutically counsel a person about diet and nutrition issues to address an acute circumstance/need or a relatively uncomplicated diet, such as a simple low fat diet. For persons with chronic and/or complex dietary/nutritional needs, the service should be given by a certified (as of July 1, 1992) dietician/nutritionist.

Dietician shall mean a person who has received a baccalaureate degree with major studies in food and nutrition from a college or university approved by the Education Department and is registered by The American Dietetic Association.

To qualify for New York State certification, an applicant shall fulfill the following requirements:

1. A. (1) Have received an education including a bachelor's degree, or its equivalent as determined by the department, in dietetics/nutrition or an equivalent major course of study which shall include appropriate core curriculum courses in dietetics/nutrition from

an accredited college or university as approved by the department, in accordance with the commissioner's regulations; and

(2) Have completed a planned, continuous experience component, in accordance with the commissioner's regulations, in dietetic or nutrition practice under the supervision of a certified dietitian or certified nutritionist or a dietitian or nutritionist who is registered by, or is a member of, a national dietetic association or national nutrition association having registration or membership standards acceptable to the department; such experience shall be satisfactory to the board and in accordance with the commissioner's regulations; OR

B. (1) Have received an education including an associate's degree in dietetics or nutrition acceptable to the department, and

(2) In the last fifteen years, have completed ten years of experience and education in the field of dietetics or nutrition satisfactory to the board in accordance with the commissioner's regulations. These ten years must be the full time equivalent of any combination of post secondary dietetic or nutrition education and dietetic or nutrition work experience satisfactory to the board in accordance with the commissioner's regulations, and

(3) Have obtained the endorsement of three dietitians or nutritionists acceptable to the department;

2. Pass an examination satisfactory to the board and in accordance with the commissioner's regulations; provided that such examination shall test a level of knowledge and experience equivalent to that obtained by an individual satisfactorily meeting the requirements of paragraph A. of paragraph 1.

3. Be at least 18 years old.

(k) Persons receiving medical services from a clinic treatment facility certified pursuant to Part 679, and such services constitute the person's principal source of health care, shall have such services delivered pursuant to an individualized managed health care plan which incorporates the requirements at 679.99(e).

While OMRDD can appreciate providers' concerns regarding future DSS regulations governing "managed care", this Agency feels constrained to incorporate some such provisions in Part 679. As part of OMRDD's preparations to include the potential for offering medical services as a principal source of medical care in a Part 679 clinic, the Agency engaged in discussions with the Department of Health, as well as, with OMRDD's own Office of Counsel relative to the OMRDD commissioner's authority under the Mental Hygiene Law to certify facilities providing primary medical/dental care. The precepts of managed care cited at 679.99(e) are recognized

factors contributing to these goals. Further, the factors listed at 679.99(e) are general enough principles, such that compliance with them at this time will not be compromised by, or will not compromise any future DSS promulgated regulations governing generic managed care systems.

The issue is control of referrals for secondary opinions. It is my understanding relative to a "managed care" context, that the primary care physician is responsible for all referrals whether or not for second opinions. If a person desires a second opinion outside of the managed care plan, it becomes his/her personal financial responsibility. Within the context of the state's policy to move to a managed care system for Medicaid recipients, the issue of quality of secondary opinions was not considered to be a problem area.

(JPO)

(1) The facility's staffing plan shall include the representation of professional staff members qualified in at least four (4) of the following disciplines: Dentistry (and dental hygiene services); Medicine (including any appropriate specialty); Nursing; Occupational Therapy; Physical Therapy; Psychology; Rehabilitation Counseling; Social Work; and Speech Therapy. As permitted by New York State Law pertaining to the practice of disciplines, and/or authorized by this Part, facilities may utilize assistants, physician assistants; nurse practitioners, and applied behavioral sciences specialists (see Glossary) to deliver services. Clinics may utilize the services of students-in-training to deliver billable services in accordance with the following requirements:

- (1) Medical/dental interns and residents (without a NYS license as a physician or dentist) participating in an accredited medical/dental school program.***
- (2) Students-in-training in other discipline areas must:***
 - (i) Be in a training program operated by an institution of higher learning with an accredited program in the applicable area.***
 - (ii) Have completed the majority of their classroom requirements and the purpose of the placement is part of an approved and required internship or clinical training aspect of the degree program.***
 - (iii) Have their activities governed in accordance with a written plan for supervision of the student by both the training institution and the clinic treatment facility.***

- (iv) *Be provided onsite supervision when and where the service is delivered, involving a party with licensure/credentials appropriate to the student's clinical area and include face-to-face contact with the student for review of performance, as well as, periodic observation of the student's contact with the admitted person.*
 - (3) *Any facility policies authorizing the use of students-in-training to provide billable clinical services must include the following provisions:*
 - (i) *The service recipient and his or her correspondent or referral agent is notified prior to receipt of care that the service will be provided by a student (non-licensed/credentialed party) under supervision; and*
 - (ii) *The recipient is advised that he or she may reject service provided by a non-licensed/credentialed party at any time without prejudice or loss of entitlement to service.*
 - (iii) *There is a means to ensure that the licensed/certified professional providing student-in-training supervision, is fully aware that he/she is directly responsible for the quality of care delivered by the supervised student.*
-

OMRDD acknowledges that the provision to allow students-in-training only goes part way in meeting the request for allowing the provision of claimable clinic treatment services by staff without professional qualifications or other contingencies. However, OMRDD takes the position that the Part 679 clinic model was designed and intended to deliver professional level services and that such an intent is consistent with the Federal authorization for clinic services. Also it should be noted that the Department of Health regulations governing the certification of Article 28 Diagnostic and Treatment Centers (i.e., clinics) at 10 NYCRR Part 751.6 require that all "employees" to be qualified by holding appropriate licensure/certification and does not authorize billing for services by students or interns, although OMRDD understands that such practice may occur in reality.

OMRDD is not especially supportive of having students in training deliver claimable clinic services. To many, it represents a distinctly second-class basis of service delivery which is not a message this Agency wants to send regarding the value placed on service to those with developmental disabilities. However, OMRDD recognizes that having students function in an MR/DD clinic does serve the valuable goals of:

- 1) sensitizing future clinicians to the need of those with developmental disabilities; and

- 2) increasing the potential pool of future clinicians who would positively consider a career or service in the OMRDD or voluntary MR/DD service delivery system.

In line with this, and given that sound supervision can still maintain an acceptable level of quality, OMRDD has elected to authorize students-in-training to deliver claimable service. However, this allowance is something that has a potential for abuse through over-utilization. Hence, a limit of 15 percent of the facility's aggregate units of service was chosen as being reasonable and prudent.

(JPO)

(m) All services shall be provided so as to maximize each person's continuity of care. A single professional or otherwise qualified (i.e., holding at least a baccalaureate degree or a license as a registered nurse) staff member of the clinic shall be designated as a treatment coordinator (see Glossary) for each person admitted to the clinic. This staff member shall be assigned primary coordination responsibility for all services delivered by the facility to the person. This staff member shall function as the contact point and liaison at the clinic for referral sources and for any outside-of-the-clinic case managers assigned to the person. The treatment coordinator shall ensure that the recommendations of treatment plans developed by the clinic, and implemented as appropriate by the clinic, are communicated, when pertinent, to other caregivers and referral sources.

Within a clinic setting where the emphasis is on a professional level of clinical assessment and treatment services, OMRDD is taking the position, that at a minimum, responsibility for treatment coordination requires someone with a bachelor's level credential. A professional level of service for treatment coordination is expected and while some authority for routine tasks can be delegated to those without a BA/BS degree, the responsibility must lie with the party having at least the minimum qualification.

(JPO)

Part 679 clinic was designed to provide a professional level of service and hence, requires the use of certified/licensed parties for the delivery of billable clinic services. The minimum qualification of a clinic treatment coordinator at a bachelor's level is consistent within this context. Given the context of the clinic and the professional level of services expected to be provided, it is not unreasonable and in fact is prudent, to require someone with at least a bachelor's degree to do treatment coordination. The exception is that OMRDD will include the option of a licensed registered nurse who may not have a four year degree, but who could still qualify for a license.

(JPO)

Treatment Coordination vs. Case Management

Treatment coordination is a required service of all Part 679 clinics and a treatment coordinator must be assigned to all service recipients at the time of intake. This role is internal to the clinic itself and is separate and distinct from any external case management service the person receives (e.g., CMCM, Waiver CM). Internal treatment coordination involves, for example:

1. Ensuring intake and decision to admit procedures are appropriately completed.
2. Obtaining any necessary and past information from the referral source and/or present programs outside of the clinic and ensuring that there is no duplication of service.
3. Counseling the service recipient (and/or collateral) as to the clinic's procedures; rights of recipients; financial considerations; transportation arrangements.
4. Bringing any concerns of the person to the attention of appropriate clinic personnel and following up to ensure resolution.
5. Ensuring that the person is receiving the service(s) as scheduled.
6. Following-up with the clinic's own service providers as to the status of treatment.
7. Transmitting information to referral sources, the person's outside case manager(s), and/or other interested and appropriate parties.
8. Ensuring progress notes are up-to-date in the clinical record.
9. Following up on outside referrals by the clinic for ancillary services and ensuring that any resulting information is entered into the record in a timely manner.
10. Evaluating the person's/collateral's satisfaction with the services(s).
11. Reviewing the clinical record with the person/collateral(s) and providing explanations of its content.
12. Ensuring that the person's annual reassessment by the physician and any other assessment information contained in the clinical record continues to document the need for the service(s) being provided.

(JPO)

- (n) *All clinic treatment facilities providing medical and/or dental care as the principal source of such care to admitted persons, shall have a formal affiliation with a medical/dental school, to a teaching hospital, or an acute care hospital, accessible as appropriate to meet the emergency medical/dental needs of those persons receiving medical or dental services from the clinic facility.*
-

This applies only to facilities providing medical or dental care services as the principal source of medical/dental care to admitted persons. This does not include psychiatry.

- (o) *All services shall be provided in accordance with generally accepted community standards of professional practice. All medical care provided as the principal source of health care to any of the clinic's participants shall be provided within the context of managed health care as defined at 679.99 (e).*
-

Managed care is a comprehensive and coordinated system of medical and health care delivery encompassing preventive, primary and specialty services, as well as acute in-patient care. The focal point of a managed care system is the primary care practitioner. This practitioner is responsible for the delivery of primary care, and also coordinates most other medically necessary services.

Managed care's primary feature is continuity of care. Continuity of care is achieved by assigning a single primary care practitioner, or team of such practitioners, to assume the principal responsibility for the care of each person, and by following that person on each health care encounter. Managed care is designed to improve the relationship between the recipient of care and his/her health care providers, and to ensure the proper delivery of preventive medical care.

Managed care requires:

1. Medical care coordination. Medical care coordination will include at a minimum the coordination, monitoring and follow-up of the individual's medical and health care needs, the scheduling of elective hospital admissions, assistance with emergency admissions, management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, and scheduling for ancillary services.
2. 24-hour, seven day per week primary care. This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients. A back-up physician must be available in circumstances where the assigned primary care physician is unavailable. This

requirement cannot be met by the use of a recording which refers callers to an emergency room.

3. Qualified primary care physician who:
 - a. is board certified (or board admissible for no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics;
 - b. has an active hospital admitting privilege at an accredited hospital.
4. Practitioners adhere to the Child/Teen Health Plan visit schedule and examination content standards for children 21 years of age or younger.
5. Procedures through which individuals will be assured access to all Medicaid services to which they are otherwise entitled. Such services shall include those which are not available from the managed care provider, emergency services, and services which are not geographically accessible.
6. Access to family planning services from either providers affiliated with the managed care provider, or directly on a fee-for-service basis from other qualified Medicaid providers not affiliated with the managed care provider.
7. Appropriate utilization and referral requirements for furnishing services to participants by non-participating physicians, hospitals, and other medical services providers, including emergency room visits and in-patient hospital admissions.
8. A grievance procedure. A grievance procedure is a process established by a managed care provider for receiving and promptly adjudicating any complaint which a recipient of care submits.

(p) Any service, appropriate to the needs of the person, meeting the definition of preventative, therapeutic, rehabilitative or palliative services (see section 679.99(o)), and delivered within the scope of the practitioner's licensure/certification, shall be allowable, providing said service(s) are identified and described within the proposal approved as part of the facility's certification of need application. New or revised services shall be submitted and approved by OMRDD prior to such services being offered or delivered by the facility.

For information on licensing standards, credentials, and/or professional practice, clinics may contact the appropriate bureau within the Office of the Professions at the State Education Department:

Social work	474-4974
Dentistry	474-3838
Nursing	474-3842
Medicine, Dietetics and Nutrition	474-3841
Podiatry and Physical Therapy	474-6374
Occupational Therapy; Speech-Language Pathology and Audiology	474-0221
Psychology	474-3866

Special educators: factors in decision not to include as a specific title or service:

1. The primary role of the Part 679 clinic is to provide "clinical" services (whether such be assessment or treatment) by licensable/certifiable disciplines/practitioners of the healing arts. Special education typically is not considered within this context.
2. The term "practitioner of the healing arts" is used quite consciously within the context of Part 679. It represents one of the bases considered for Federal HCFA authorization of clinic treatment facilities pursuant to 42 CFR 440.90. The title educator or special educator is not typically considered appropriate within this classification.
3. The primary responsibility for the assessment of children with handicaps is retained by the local school districts' Committee on (Preschool) Special Education (CSE or CPSE). Part 679 clinics can provide contract clinical services to the CSE/CPSE to assist the CSE/CPSE in meeting its responsibilities, but it would seem appropriate that the "special education" component of any such assessment should remain under the aegis of the school district and its CSE/CPSE. Further, a Part 679 clinic can incorporate such special education assessment results into its comprehensive overall assessment of school age children and does not need to resort to controlling all aspects of obtaining relevant assessment information.
4. Special education and education would not appear to be within the scope of the federal authorization of a clinic's scope of services which includes only "preventive, palliative, diagnostic and rehabilitative/habilitative categories."

(JPO)

(q) All treatment plans and referrals for services, regardless of source, shall be reviewed and approved by the medical director or other designated physician/dentist. Such review shall not be interpreted as meaning that a facility certified pursuant to this Part has responsibility for services or treatment plans delivered by others not under its auspice.

The basic premise behind Federal authorization of clinic treatment services is that all treatment must be delivered by or under the supervision of a duly licensed physician. OMRDD's means to ensure compliance with this basic requirement is to require that the Medical Director or other designated physician sign off on all treatment plans at least annually and when there are any substantive changes to an already approved treatment plan.

(JPO)

The physician must sign-off/approve the initial recommendations for service, the initial treatment plan, the annual reauthorization and treatment plan, and any substantive changes in the treatment plan undertaken during the course of treatment. These recommendations are consistent with the various professional practice act requirements and meet the basic Federal clinic requirements at 42 CFR 440.90.

What happens if the physician signs off on the treatment plan and for reasons outside of his/her control (e.g., a staff vacancy), the person does not get all the treatment that the plan describes? Is there some sanction on the physician?

Any potential sanction would be on the facility and its governing body since it is responsible for the person getting the service(s) as set forth in the treatment plan. In such a circumstance as an extended staff vacancy, the treatment plan should be modified, deleting the delivery of the missing service, but noting that such a service has been assessed as being needed. The clinic should use its treatment coordination capacity to carry out referral services to obtain the missing services from an alternative source.

The principal purpose of the annual physician reviews/(re)assessment is to determine the service recipient's continuing need to be served by the clinic treatment facility. Thus said physician's annual (re)assessment may include either or both of the following:

- a) review of the service recipient's current treatment, evaluative and clinical/medical information; and/or
- b) a "hands-on" face-to-face assessment of the service recipient directly by the physician.

In terms of compliance documentation, the service recipient's record should reflect the time and date of the (re)assessment; the physician's recommendation regarding continuing treatment, and, briefly, the rationale used to sustain said recommendation.

Annual medical examination by service recipients' private physicians, not affiliated with the clinic, may be clinically appropriate for said recipients, and may provide useful, supplemental information for integration into the Part 679 clinic's evaluations, treatment planning and actual treatment of the service recipient. However, said (re)assessments may not substitute for the

clinic's own medical director or physician making his/her own determination as to the person's continuing need for part 679 clinic treatment services as required by Part 679.

(JPO)

(r) Ongoing treatment (see Glossary) services shall be provided principally to persons with a diagnosis of developmental disability and, as necessary and appropriate, to their collaterals for the purposes of enhancing treatment results for the person. Persons without a known developmental disability diagnosis may be admitted for the purposes of clinical screening (i.e., intake) or comprehensive clinical assessment to determine whether or not a condition of developmental disability diagnosis exists. However, where it can be substantiated through appropriate clinical documentation that because of unique and individual circumstances a diagnosis cannot be made due to maturational delays or the complexities of the condition which make it resistive to diagnoses by available clinical assessment processes, persons up to their eighth birthday may continue to be served where a substantiated suspicion of developmental disability exists.

(1) For persons five years of age or younger, at least a substantiated suspicion of a developmental disability or documented indicator of such risk, shall exist in order for the person to remain eligible for further treatment as a participant with developmental disabilities.

(2) For persons six years of age or older, the clinic assessment shall substantiate a specific developmental disability diagnosis in order for the person to remain eligible for further treatment as a participant with developmental disabilities.

For infants and toddlers, documented indicators of a risk for developmental disability would include any prenatal complications experienced by the mother, such as toxemia, diabetes, and abruptio placenta, as well as the child's perinatal and neonatal history including, but not limited to:

1. Prolonged decreased fetal heart rate.
2. Low APGAR scores at 1 and/or 5 minutes.
3. Small for gestational age.
4. Less than 34 weeks gestation.

5. Meconium aspiration.
6. Neonatal intensive care stay of 3 days or more.
7. Supplemental oxygen therapy of more than 24 hours.
8. Severe hyperbilirubinemia.
9. Respirator support for longer than 3 days.
10. Blood oxygen of less than 50.
11. Seizure disorder.
12. Birth defects associated with developmental disability such as hydrocephalus.

(KK)

The clinic billing requires the provider to provide an ICD 9 code. In the instance of children without a definitive diagnosis, this might prove difficult. However, the ICD-9-CM has a code for such a situation. If one is certain that there was a developmental delay of some kind, the 315.9 Unspecified delay in development code could be used. What this essentially means is disorders in development that do not meet the criteria for MR or for more specific DD at this time (particularly useful in the case of very small children).

(s) No person shall be admitted for a service unless he/she meets the facility's admission criteria, there is a documented need for the service, and the program has sufficient capacity to provide the service. This shall not be interpreted to preclude conducting intake visits for the purposes of determining the appropriateness of someone for admission.

Limiting service to specific populations. Can a clinic limit its operation?

The clinic program is an entitlement service. The program can limit its specialization to populations with specified functional characteristics.

The program may not serve only those with a diagnosis of mental retardation or to those with an artificial residence classification. While the clinic doesn't have to actively go looking for others, it cannot deny service to someone who presents (given the clinic has the capacity to deliver the service both in terms of expertise and staff time and availability).

- (t) *All persons shall be assessed annually by the Medical Director or other clinic physician as to the person's continuing need to be served by the clinic.*
-

The authorizing Federal regulations at 42 CFR 440.90 are very clear regarding the importance of the role of a medical director regardless of the type or configuration of services offered by the facility. These requirements underlying federal approval require that all services must be delivered by or under the direction of a licensed physician. The Medicare and Medicaid Guide published by HCFA clarifies the intent by stating:

"...To meet this requirement, a physician must see the person at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. The physician must assume professional responsibility for the service provided and assure that the services are medically appropriate" (paragraph 4320(b); pg. 9545).

The Federal requirements and guidelines do not distinguish between the discipline nature of the service and the need for physician prescription and supervision of all services as well as the physician's ongoing approval of the person's appropriateness for service generally.

Regardless of the discipline nature of the services needed and/or the physician's scope of experience, the annual renewal of the physician's order acts to validate the decisions of the intake process, the person's continuing eligibility for the service, the person's need for the service, and the substantiating clinical information.

(JPO)

What are the requirements, if any, for the annual review by the physician?

The medical director or designee (physician) must physically see the individual at least once per year to review the need for ongoing treatment. This is to be a meaningful review, such as an assessment and a physical examination or observation, not solely a records review.

- (u) *Clinics providing services in NYS Regents designated physician shortage areas, may provide services to persons without a diagnosis of developmental disability in accordance with such person's assessed needs. In such cases, persons with a diagnosis of developmental disability shall receive priority for services whenever the facility's service capacity is limited.*
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The policy determination relative to the implementation of the provisions of Part 679 set forth at subdivision 679.3(u), pertaining to service to those without a diagnosis of developmental disability, is as follows:

- If a Part 679 clinic has a specified service area which includes a Regent's designated "physician shortage area" (PSA), it may serve non-DD persons **residing** in the PSA.
- As a critical point, the facility must be able to provide **ongoing** verification that, in providing services to the non-DD, it hasn't compromised its capacity to serve persons with a developmental disability.
- Since the Regent's designated PSAs are subject to change, it is incumbent upon the facility to **at least annually**, obtain the current census tracts for the updated PSAs from the State Education Department, **and** adjust its caseload/service delivery practices accordingly.
- When considering the delivery of services to non-DD persons, it must be kept in mind that a basic premise underlying the OMRDD expansion of the clinic treatment program, is that such facilities are **not** to be established or expanded for the purpose of supplanting or replacing existing, available services. Thus, the same issues governing the documentation of need must be addressed when the facility is expanding its service capacity.
- If the facility is going to provide "principal source, primary medical care," then it must meet the affiliation requirements set forth at 679.3(n), and the managed health care requirements set forth at 679.3(o) and 679.99(e).
- If the facility is serving Medical Assistance (MA) ineligible persons, it must charge at least the same schedule of fees as set forth in Part 679 for services to MA eligible persons. It may utilize a sliding fee schedule relative to what a person actually pays, but the schedule must be the same for all, regardless of his/her diagnostic classification.
- When a Part 679 clinic **adds services** (i.e., increases capacity) to a non-DD population, a Certification of Need (CON) process is required. If the increase in volume of service units on an annualized basis is less than ten (10) percent, it is an administrative review pursuant to Part 620. If the increase in volume is 10 percent or greater, the CON is a "substantial review" process.
- Even though the criteria for the allowability of service to non-DD persons is based on the PSA designation, OMRDD is not limiting service options to only medical/dental services. Other clinical services can be made available as well, as long as the basic principle of no compromise of service availability/capacity to those with developmental disabilities is adhered to.

- The facility may serve the non-DD population at its main certified site, or at any prior approved satellite sites.

Physician shortage areas should be viewed in the broad perspective. If an area has a physician shortage, probably there will be a shortage of other qualified clinicians. It must be highlighted in the CON to be considered. The CON must confirm census tracts from the NYS Regents.

679.4 *STANDARDS OF COMPLIANCE*

- (a) OMRDD shall verify (see Glossary) that each operator of a Part 679 clinic treatment facility has annually submitted the names and addresses of the current members of its governing body to the commissioner in accordance with the requirements of section 13.39 of the Mental Hygiene Law.*
- (b) OMRDD shall verify that the governing body has established, maintained, and implemented a plan of organization for the facility which accurately indicates lines of accountability, the nature of professional responsibility to be exercised, and the professional qualifications required.*

Corporate authority to do things is supposed to be expressed in certificates of incorporation. When a corporation proposes to add the power to establish and operate a clinic, the appropriate Certificate of Incorporation should be reviewed by the DDSO to ensure that the agency has the legal authority of the corporation to do so. This should be done by the DDSO before OMRDD approves any other action by the corporation. There must be sound legal basis for the corporation's activities. If the certificate of incorporation does not include the authority to operate a clinic, then a Certificate of Amendment must be filed prior to the issuance of an approval letter.

-
- (c) OMRDD shall verify that since the last survey:*
 - (1) Any new/revised policies have been approved by the governing body;*
 - (2) Said new/revised policies have been distributed to staff, and they have been advised or trained regarding their responsibilities;*
 - (3) Said staff are knowledgeable regarding their responsibilities under any new/revised policies/procedures.*
 - (d) Minutes of all official meetings of the governing body of other than state operated Part 679 clinic treatment facilities shall be maintained as a permanent*

record in relation to the policy making decisions and any decisions made relative to the operation of the facility.

- (e) OMRDD shall verify that the facility's staffing plan and actual day-to-day allocation of staff includes provisions for all services to be delivered by or under the direct supervision (see Glossary) of practitioners of the healing arts or otherwise herein authorized parties.*
- (f) At least 25 percent of the full time equivalent professional staff as identified in 679.3(p) shall have at least one year of full time treatment experience with persons having developmental disabilities, in programs serving a population with developmental disabilities. If the program has been established to serve a particular group of persons with specialized characteristics/needs, then the staff experience shall be appropriate to serving those with similar needs.*
- (g) OMRDD shall verify that the facility has assigned a staff member to each person admitted for service, to perform the functions of treatment coordinator and who is the contact point for the person's comprehensive Medicaid case manager (if applicable). The person's clinical record (per 14 NYCRR Part 636) reflects the activities of this treatment coordination.*
- (h) OMRDD shall verify that all treatment has been given upon the written order of a physician or dentist, at least annually or when there are significant changes to the ongoing treatment plan, and is delivered under the supervision of a physician, dentist or practitioner of the healing arts (see Glossary) subsequent to an intake visit assessment documenting the need for admission to the clinic.*
- (i) OMRDD shall verify when services have been delivered by students-in-training that:*

 - (1) The facility's plan for supervision of the service where it is delivered, has been implemented consistently and appropriately.*
 - (2) Persons receiving services from students-in-training have been so advised and that recipients rejecting such services have not had their rights to services compromised.*
 - (3) No more than 15 percent of a facility's total billed for units of service are delivered by students-in-training.*
- (j) OMRDD shall verify that there is a clinical record maintained in a confidential manner for each person admitted to the facility which contains at least:*

- (1) *Identification information about the applicant/service recipient and his or her family and services received outside of the clinic (including identification of practitioner or responsible entity).*
 - (2) *Source of referral, date commencing service/treatment, and the name of the party responsible for treatment coordination.*
 - (3) *Initial, interim, and/or final diagnosis(es), as applicable, set forth in appropriate official terminology, including those related to the person's developmental disability, other mental disability(ies) if present, and medical condition/diagnoses.*
-

Only a licensed physician, psychiatrist, nurse practitioner or licensed psychologist may issue a formal diagnosis using ICD-9, DSM-III or other standardized diagnostic coding. Procedure codes are another matter, and are within the purview of the licensed/certified practitioner of the healing arts.

- (4) *Reports of all known, recent (i.e., within the last two years) diagnostic examinations and assessments including findings and conclusions, regardless of source, including reports of any special studies and/or laboratory procedures performed at the clinic's recommendation.*
 - (5) *The individual written plan of services for all treatments being recommended and delivered by the clinic.*
 - (6) *Treatment notes signed by the professional staff member or treatment coordinator making the note.*
- (k) *There shall be a written plan of services which also documents that the outcomes and/or course of treatment has been reviewed as to the achievement of said outcomes and the need for continued course of treatment pursuant to the following schedule:*
- (1) *As specified by the treating physician or dentist for medical or dental treatment.*
 - (2) *At least semi-annually by the treating practitioner or treatment coordinator in consultation with the person receiving the service and/or his/her collaterals (unless the person is an adult, has the capacity to object, and does so object to the provision of such services), for all other ongoing habilitational clinical services (see 679.3(j)(1)) or health care services (see 679.3(j)) of six months or longer duration.*

- (l) *OMRDD shall verify that there is a licensed physician or dentist, as appropriate, assigned responsibilities as the medical director for the facility who shall:*
- (1) *If a physician, be board certified by the American Board of Medical Specialties in pediatrics, adult medicine, neurology, family practice medicine, or internal medicine, or be eligible for said certification. Given documentation of the unique or specialized needs of the majority of persons to be served, the clinic, subsequent to OMRDD approval, may employ a candidate with or eligible for an alternative board certified specialization such as psychiatry; or*
 - (2) *If a dentist, be board certified in an appropriate specialty (if engaging in any amount of specialized dental practice under the clinic treatment facility's auspices), or be eligible for said certification.*
 - (3) *Be qualified pursuant to agency policy for the position by training, experience, and administrative ability.*
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In general, OMRDD wants to encourage recruitment of the specialists listed to be the clinic's medical director (i.e., pediatrics, adult medicine, neurology, family practice medicine or internal medicine) since such fields of medicine would appear to generally be the most relevant to the habilitation needs of persons with DD. The prior approval process will not be onerous, and it is highly likely that any proposed alternative specialty will be approved given that the provider has made the argument about the relevancy and/or appropriateness of the choice.

(JPO)

- (m) *OMRDD shall verify that the written plan for the facility's quality assurance program describes the program's objectives, organization, responsibilities of all staff members, scope of the program and procedures for overseeing the effectiveness of monitoring, assessment and problem-solving activities and that the plan has been implemented. The quality assurance process shall define methods for the identification and selection of clinical and administrative problems to be reviewed, and include:*
- (1) *The establishment of review criteria developed in accordance with current standards of professional practice for monitoring and assessing the appropriateness of treatment and clinical performance.*
 - (2) *Regularly scheduled reviews of clinical records, complaints, suggestions from persons served and their collaterals, reported incidents or*

allegations of abuse, and other documents pertinent to problem identification.

- (3) Documentation of all quality assurance activities, including but not limited to the findings, recommendations, and actions taken to resolve identified problems.*
 - (n) OMRDD shall verify that the clinic's administration has reported the findings, conclusions, recommendations, and actions taken as a part of the quality assurance program to the governing body. OMRDD shall verify, that when problems have been identified, the outcomes of the quality assurance program have resulted in one or more of all of the following:*
 - (1) Changes in the treatments/services received by persons who have been admitted;*
 - (2) Improvements in the efficiency and effectiveness of service delivery;*
 - (3) Revision or development of facility policies/procedures; and/or*
 - (4) Changes in the granting or renewing of staff privileges, as appropriate.*
 - (o) The agency/facility shall cause to be completed or obtained from every person referred for intake, a developmental/demographic inventory of information on the person's characteristics and needs. Said inventory shall be completed and submitted to OMRDD in a manner and on a schedule acceptable to the commissioner.*
-

A DDP 1 should be completed for each person at the time he/she is admitted to the clinic for services. For person's with existing and current DDP forms completed at another source, the clinic must obtain a copy and keep it in the person's clinical record. However, if there is any reason to doubt any of the information on the DDP, then sound practice prevails and a new DDP should be completed. If there is no DDP, the clinic must complete one.

(JPO)

OMRDD has no problem with a clinic only completing a DDP-4 form for persons who are referred for service, but for whatever reason are not admitted. This Agency would also probably accept the clinic's obtaining a recent DDP on the person done by the referring source or by others. As justification for this requirement, I would point out that OMRDD needs to get an idea about the people being served in these programs in order to help evaluate the value of the clinic treatment model.

The completion of the DDP is not subject to capricious rejection by the recipient and/or his/her advocate or referral source. It is a condition of receiving services and as such, is similar to participating in a facility's intake process or the requiring of a clinical assessment prior to the delivery of clinical services. If some think that confidentiality is the issue, I would note that the DDP system allows for identity codes to be used so that the person's name does not directly appear on the form.

(JPO)

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- (p) *OMRDD shall verify that the facility has made persons served at the facility aware of its hours of operation, of the availability and source of emergency services, of phone number(s) of answering services for messages at times when the facility is not in operation, and rights associated with the receipt of services. Such information, and including the provision of an assessment and treatment services, shall be provided in a person's primary language and/or in a manner that facilitates communication and understanding.*

679.5 Units of Service-Definitions and Restrictions

- (a) *The unit of service shall be a clinic visit as defined below whether the service is delivered at the main certified site, at a certified satellite site or off-site.*
- (b) *There shall be reimbursement claimed for only one clinic visit per day per person or his/her collateral, regardless of the number, types or locations of service(s) provided.*
- (c) *The following types of clinic visits are authorized for reimbursement:*
- (1) *Intake Visit - A clinic visit consisting of a preliminary clinical interview or assessment of at least 30 minutes duration of the potential admittee, his or her collateral, and/or the referral source by or under the supervision of a licensed professional and/or other authorized party (see Glossary) pursuant to this Part, for the purpose of determining the appropriateness of admission.*
 - (2) *Full Clinic Visit - A 30 minute or more period of assessment, treatment, therapy, or clinical intervention, for an appropriately admitted person by one or more licensed/certified professional(s), and/or those authorized pursuant to 679.3(m), or other authorized parties (see Glossary) as defined pursuant to this Part.*
 - (3) *Brief Clinic Visit - Less than 30 minute period of assessment, treatment, therapy or clinical intervention for an appropriately admitted person by one or more licensed/certified professionals, or those authorized*

pursuant to 679.3(m), or other authorized parties as defined pursuant to this Part.

- (4)** *Group Clinic Visit - A period of direct or indirect assessment, treatment, or counseling, by a licensed/certified professional, and/or those authorized parties pursuant to 679.3(m), or other authorized parties as defined pursuant to this Part, of a group of persons, none or not all of whom are related by blood or marriage. A group clinic visit for persons over 18 years old, or their collaterals, shall last at least 45 minutes and the group shall be limited to a maximum of twelve (12) persons. For persons under 18 years old, the group clinic visit shall have a duration of at least 30 minutes.*
- (5)** *Collateral Clinic Visit - A period of counseling lasting at least 30 minutes duration of the collateral(s) of the appropriately admitted person relative to his/her needs, by a licensed/certified professional and/or those authorized pursuant to 679.3(m), or other authorized parties as defined pursuant to this Part.*
- (6)** *Comprehensive Diagnostic and Evaluation Visits consisting of two types:*

 - (i)** *Interdisciplinary Assessment Visit - A single claimed clinic visit (which may require more than one encounter), lasting at least two hours, during which the person receives an assessment of his/her developmental status, functional capacities and service needs from at least three separate discipline specific professionals. Said visit shall also include treatment coordination by the assigned treatment coordinator pursuant to subdivision 679.3(n) and preparation of a written report synthesizing the assessment results/conclusions and specifying any further treatment and/or referral recommendations. In addition, the following restrictions shall apply:*

 - (a)** *Except as allowed below, a provider may claim for only one comprehensive assessment visit per person per 12 month period.*
 - (b)** *A maximum of two comprehensive assessment visits per year may be claimed for children from age three to six years.*
 - (c)** *A maximum of four comprehensive assessment visits per year may be claimed for children under the age of three years.*

- (ii) *Discipline Specific Assessment Visit - A single claimed clinic visit (which may require more than one encounter) during which the person receives from a single discipline specific professional, a full range comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, needs for service and treatment recommendations in that clinical area. Payment for said visit shall include assignment of a treatment coordinator and preparation of a written report setting forth findings and recommendations, forwarding of the report to the referral source and consultation with the referral source, if requested. A provider may claim only one discipline specific assessment visit per discipline per year. The duration of contact and/or observation shall be at least two hours.*
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Medicare Billing:

The primary billing rule for any service provided in Article 16 clinics is: Medicaid is the payor of the last resort. This means that if there is any other entity obligated to pay for the service provided, then it must be pursued first. A provider pursues reimbursement from all sources and if the total received is equal to or exceeds the Medicaid fee for that service, then no Medicaid billing is required or allowed. If however, the total payment received is less than the Medicaid payment level, then Medicaid can be billed for the difference.

The one exception to this rule is the rules related to Medicare/Medicaid billing, commonly referred to as "crossover claims". The main issue related to these "crossover" claims is the Medicaid billing rule concerning processing changes relevant to the payment of Medicare Part B co-insurance and deductibles. When the Medicaid fee is greater than the Medicare Part B approved amount for a given service, and a consumer has both Medicare and Medicaid coverage, the provider's reimbursement is capped at the Medicare approved amount. Where a consumer has only Medicaid, the provider is reimbursed the full Medicaid fee. [Example: Medicare approved amount \$55. Medicaid fee \$84.90 (Schedule B). If a consumer has both Medicare and Medicaid coverage, then the total maximum reimbursement will be capped at \$55; whereas for a Medicaid only consumer, reimbursement will be \$84.90.]

These issues are further complicated by the fact that Medicare recognizes for reimbursement only some of the services provided in an Article 16 clinic. Also, the required qualifications of the practitioner in order for the service to qualify for Medicare reimbursement are more stringent for Medicare than Medicaid.

Part 679 requires that all services be integrated and coordinated, that all services be provided only when authorized by a physician and that each consumer's services be part of an overall treatment plan. Medicaid fees for Article 16 clinic services are developed recognizing the cost of compliance with Part 670 requirements. Medicare Part B fees are established recognizing

only the professional component of the service and established based on the assumption that the provider is an independent clinical practitioner.

The Code of Federal Regulations 42 CFR 447.321 states:

(a) General rule. FFP is not available for any payment that exceeds the amount that would be payable to providers under comparable circumstances under Medicare.

(b) Applications of the rule. Payments by an Agency for outpatient hospital services may not exceed the total payments received by all providers from beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.

The key phrase here is “for providing comparable services under comparable circumstances”. The services provided in an Article 16 clinic that are recognized for reimbursement by Medicare Part B, with very few exceptions, represent only a component of what is defined as the Medicaid service and therefore, the Medicare fee represents only a component of the reimbursement fee either Schedule A or B. This provides a solid argument against the applicability of the billing rule when billing for Medicare recognized clinical services provided in Article 16 clinics.

Part 679.6 (h) states: “If the facility is authorized to provide any medical or dental care as a person’s principal source of such care, the facility shall become a Medicare Provider”. If a part 679 certified clinic does not provide services as stated in this citation, then Medicare enrollment is not required. However, this does not preclude Medicare enrollment. It is OMRDD’s position that Medicaid should always be viewed as the provider of last resort. Even though enrollment in Medicare is only required under certain circumstances, Article 16 providers should still pursue Medicare enrollment and reimbursement.

The Code of Federal Regulations 42 CFR 447.325 states: “The agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances”. What this means is a provider is only entitled to receive as total payment for a service from all payors no more than the prevailing charge. (This is applicable only when Medicaid and/or Medicare is/are payors.)

If a Part 679 certified clinic provider pursues reimbursement from Medicare, any payment received must be used to adjust subsequent billing to Medicaid. Example: Medicaid reimbursement fee is \$84.90 (Schedule B). A consumer on a given day sees the psychologist and the physical therapist. The clinic bills Medicare for the psychology service and receives a payment of \$40. The clinic is now only entitled to receive \$44.90 from Medicaid in addition to the \$40 Medicare payment.

The two-tiered clinic fee methodology is in fact a per diem payment structure similar to Intermediate Care Facility (ICF) Day Treatment (DT) and Community Residence Habilitation (CR Hab) per diem fees. If you chose to pursue Medicare reimbursement for the service

components provided in those programs that are recognized by Medicare as reimbursable, your per diem would not then be capped by whatever the Medicare approved amount was for those components.

Currently there is no agreement with Department of Social Services on the above interpretation of Medicaid/Medicare crossover billings as it relates to Part 679 certified clinics. If there was, this would be a non-issue. Unfortunately, it is not likely that any agreement will be forthcoming since DSS feels that any flexibility on this issue could cost the Medicaid program more money.

This letter contains all of the information currently available on this issue. All of this information has been provided so that you are in a position to interpret, for yourself, the rules as they apply when billing for services provided at a Part 679 certified clinic.

This information provides a Part 679 certified clinic the justification to bill to Medicaid the difference between the amount paid by Medicare and the Medicaid fee authorized for the facility. There is also justification for these facilities to not enroll in the Medicare program unless the requirement of Part 679(h) is applicable. Without written approval from DSS, there continues to be some vulnerability. There is one option that would eliminate all vulnerability and that is to extract from a Part 679 certified clinic all Medicare Part B reimbursement activity; cost it separately and bill it separately. Contact Revenue Support to pursue this option.

A request has been submitted to DSS to change the billing edicts to allow Part 679 certified clinics to take the necessary adjustments for Medicare payments on their Medicaid claims.

(Collins)

Glossary

- (a) **Administrator - That party, by whatever title known, designated in an agency's administrative structure with responsibility for:**
- (1) **The day-to-day operation of the clinic treatment facility.**
 - (2) **Ensuring the conformance of the facility and its services to the requirements of all applicable statutes and regulations.**
 - (3) **Ensuring that arrangements are made for the timely delivery of treatments to persons admitted to the facility.**
 - (4) **Ensuring adherence to the overall policies of the agency/facility as approved by the governing body.**

- (b) **Agency/Facility** - As used in the Part, a term used to indicate that the stated requirement needs to be considered in relation to the administrative structure of both the agency and the site-specific facility and acted upon accordingly. The term "agency" used alone means the "agent" or operator of a facility operated or certified by OMRDD. In the case of State-operated facilities, the Developmental Disabilities Services Office (DDSO) is considered to be the "agency".
- (c) **Arts, Licensed Practitioner of the Healing** - Anyone who holds licensure/certification appropriate to his or her discipline in medicine, dentistry, and/or other physical or mental health disciplines as identified at 679.3(j) or otherwise authorized by this Part.
- (d) **Body, Governing** - The policy-making authority that exercises general direction over the affairs of one or more certified facilities in the same class, and establishes policies concerning the operation of such facility or facilities for the welfare of the persons served.
- (1) The governing body of a clinic treatment facility operated by a voluntary, not-for-profit corporation is the board of directors as empowered by the agency's articles of incorporation, consisting of at least three persons.
 - (2) The governing body of a proprietary clinic treatment facility is the Proprietor(s) of the clinic.
 - (3) The governing body of a State-operated clinic treatment facility is the Central Office Administration of OMRDD and includes the administration by the Developmental Disabilities Services Office (DDSO) director and his/her delegate(s).
- (e) **Care, Managed Health** - The use of a service delivery management system for medical care (see 679.3(k)(2)) delivered by the Part 679 certified facility, designed to minimize the need for accessing hospital emergency room services and the length of stay for in-patient hospital care as well as ensuring access to appropriate health care. Nothing herein shall preclude a person's access to emergency medical care as appropriate, solely because of his or her disability or because he or she is receiving medical care from a Part 679 clinic. It includes the following components applicable to every person admitted for and receiving medical care as his or her principal source of health care in an OMRDD certified clinic treatment facility:
- (1) An individually assigned primary care physician, responsible for coordinating all aspects (including access to emergency medical care)

of a person's medical care for the purposes of maintaining continuity of care and developing an individualized managed health care plan.

- (2) **Access to specialty medical care by a referral by the primary care physician. Referrals for a second opinion also shall be made by the primary care physician.**

Control of referrals for secondary opinions. In a "managed care" context, that the primary care physician is responsible for all referrals whether or not for second opinions. If a person desires a second opinion outside of the managed care plan, it becomes his/her personal financial responsibility. Within the context of the state's policy to move to a managed care system for Medicaid recipients, the issue of quality of secondary opinions is not considered to be a problem area.

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- (3) *Provision of treatment coordination (internal to the clinic facility) of the clinic's services by a designated clinic staff member for persons receiving services from the facility.*
 - (4) *After office hours, weekend, and holiday service or phone availability. Availability of a back-up physician in circumstances where the assigned primary care physician is unavailable.*

Managed care is a comprehensive and coordinated system of medical and health care delivery encompassing preventive, primary and specialty services, as well as acute in-patient care. The focal point of a managed care system is the primary care practitioner. This practitioner is responsible for the delivery of primary care, and also coordinates most other medically necessary services.

Managed care's primary feature is continuity of care. Continuity of care is achieved by assigning a single primary care practitioner, or team of such practitioners, to assume the principal responsibility for the care of each person, and by following that person on each health care encounter. Managed care is designed to improve the relationship between the recipient of care and his/her health care providers, and to ensure the proper delivery of preventive medical care. Managed care requires:

1. medical care coordination. Medical care coordination will include at a minimum the coordination, monitoring and follow-up of the individual's medical and health care needs, the scheduling of elective hospital admissions, assistance with emergency admissions, management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as

necessary and with request for follow-up report, and scheduling for ancillary services.

2. 24-hour, seven day per week primary care. This will be accomplished by having an after-hours phone number with an on-call physician, nurse practitioner or physician's assistant to respond to patients. A back-up physician must be available in circumstances where the assigned primary care physician is unavailable. This requirement cannot be met by the use of a recording which refers callers to an emergency room.
3. qualified primary care physician who:
 - a. is board certified (or board admissible for no more than five years from completion of a post graduate training program) in family practice, internal medicine, obstetrics and gynecology, or pediatrics;
 - b. has an active hospital admitting privilege at an accredited hospital.
4. practitioners adhere to the Child/Teen Health Plan visit schedule and examination content standards for children 21 years of age or younger.
5. procedures through which individuals will be assured access to all Medicaid services to which they are otherwise entitled. Such services shall include those which are not available from the managed care provider, emergency services, and services which are not geographically accessible.
6. access to family planning services from either providers affiliated with the managed care provider, or directly on a fee-for-service basis from other qualified Medicaid providers not affiliated with the managed care provider.
7. appropriate utilization and referral requirements for furnishing services to participants by non-participating physicians, hospitals, and other medical services providers, including emergency room visits and in-patient hospital admissions.
8. a grievance procedure. A grievance procedure is a process established by a managed care provider for receiving and promptly adjudicating any complaint which a recipient of care submits.

(f) Collateral - A party or parties (1) having a care-giving relationship with the person receiving services, and (2) who needs ancillary support and reinforcement to maximize the potential benefit the relationship may bring to the person. For the purposes of this Part, a collateral may only be a member of the family, defined as biological/adoptive family, guardian, foster care parent,

or family care provider of a person who is receiving services; or, a non-related party who has an established long term care-giving relationship with the person. The purpose of said services to a collateral shall be limited to those which contribute to meeting the identified needs of the admitted person with developmental disabilities.

In offering services to collaterals, the clinician should be trying to address the needs of the collateral to:

- (i) understand the primary recipient's developmental disability.
- (ii) be supportive of the primary recipient's coping with life issues.
- (iii) reinforce or carry out treatment interventions outside of the clinic setting or visit; and/or
- (iv) sustain their involvement as the primary caregiver to the primary clinic service recipient.

(JPO)

Exclusion of direct care personnel and clinicians definition of "collateral"

Assuming that all collateral visits are billed to the account for the disabled person, it is highly questionable that those visits are legally chargeable to Medicaid (or Medicare or private insurance) because the clinician, by his/her training/licensure/certification is presumed to have the expertise to carry out any treatment recommendations. It is also questionable whether such billings to the disabled person's account for a direct care collateral visit would be allowable inasmuch as the employer of the direct care worker is responsible for seeing to it that he/she is able to carry out the functions of the direct care position. Likewise, the same would hold true if the direct care worker were an independent contractor because an independent contractor is presumed to know how to do the job for which s/he contracted.

(Hester)

- (g) ***Commissioner*** - *the commissioner of the New York State Office of Mental Retardation and Developmental Disabilities, or his or her designee.*
- (h) ***Coordinator, Treatment*** - *The single professional or otherwise qualified (i.e., holding at least a baccalaureate degree or a license as a registered nurse) staff member, by whatever name known at the clinic, designated for each person receiving services to coordinate the provision of all treatments, activities, experiences, or therapies as prescribed through the clinic's admission process and by the treating professionals in the person's treatment plan. In this circumstance, "coordinate" includes (as appropriate to the person in question), but is not limited to, checking on maintenance of appointments; obtaining information to address any recipient questions;*

transmitting information to referral sources, the person's outside case manager, and/or other interested and appropriate parties; ensuring progress notes are up-to-date in the clinical record; following up on outside referrals by the clinic for ancillary services and ensuring that any resulting information is transmitted to the treating clinician and is entered into the record in a timely manner; evaluating the person's/collateral's satisfaction with the service(s); reviewing the clinical record with the person and providing explanations of its content; bringing any concerns of the person to the attention of appropriate clinical personnel and following-up to ensure resolution; being aware of other services outside the clinic received by the person and ensuring that there is no duplication of service; ensuring that the person's annual reassessment by the physician and any other assessment information contained in the clinical record continues to document the need for the clinic service(s) provided, etc. The treatment coordinator also functions as the facility's liaison to the person's comprehensive Medicaid case manager, if applicable, and to other providers of service.

Being aware of other services outside the clinic received by the person and ensuring that there is no duplication of services:

Over the years, numerous questions have arisen regarding the propriety of a person receiving both a day treatment service (full or half-day visit), and a separate, distinct clinic treatment visit. As background, it is important to appreciate that both these facility classes are, for State Medicaid Plan purposes, considered by the Health Care Financing Administration (HCFA) to be "clinics." As such, there has always been a general prohibition against a person receiving two "clinic" visits on the same day. This has been particularly true in cases where the service was in the same clinical discipline area. This said, OMRDD recognizes that the clinical needs of persons with developmental disabilities do not stop at the doorstep of a day treatment facility. In fact, a person's clinical needs may manifest themselves differently in residential or other environments separate from the day treatment setting. In order to accommodate the broad range of clinical support needs and environments experienced by persons with developmental disabilities, while at the same time precluding duplication of service, the following general guidelines have been designed to inform providers as to when same day services may be acceptable for reimbursement by both the day treatment and clinic treatment providers.

It is generally expected that most people receiving full or half-day day treatment services are having their basic clinical support needs accommodated within the day treatment setting. However, in individual cases, the person's need for clinical services may extend beyond the day treatment facility's scope of responsibility. In such cases, and in other appropriate circumstances, it is OMRDD policy that a person may receive a day treatment service and a Part 679 certified clinic treatment service on the same day as long as the following guidelines are taken into account:

1. A person receiving day treatment services five days per week, may, as needed, receive a Part 679 clinic treatment service in the clinical areas of audiology, special medical, routine medical, and dentistry without any restriction. This presumes that the person receives the full visit duration of day treatment being claimed, and the clinic treatment service(s) is/are provided outside of the time the person is at the day treatment setting.
2. A person participating in less than five full days per week of day treatment may receive a reimbursable Part 679 clinic treatment service on those days he/she does not attend day treatment. The clinic services(s) may consist of any clinical discipline treatment area(s) deemed necessary and appropriate, other than a comprehensive interdisciplinary assessment visit. A comprehensive interdisciplinary assessment visit may not be claimed as a clinic treatment service, since this is required to be provided by the day treatment provider as part of its admission and initial and/or annual programming process. However, for second opinion purposes, and where the person's needs are particularly complex and/or intractable or resistive to conventional treatment interventions, a person in day treatment may receive a reimbursable clinic treatment in-depth discipline specific assessment visit on a same day he/she is in day treatment. It is expected that the day treatment facility or other referral agent will provide, and the clinic treatment facility will keep on file, the documentation substantiating the person's need (i.e., diagnostic clarification and/or new treatment recommendations) for the discipline specific assessment and the reasons why the day treatment facility's means for this type of assessment are inadequate. (NOTE: Unavailability of day treatment qualified clinical professionals due to insufficient staff for whatever reason, is not sufficient justification.)
3. A day treatment facility may make contractual arrangements with a Part 679 clinic treatment facility for specific day treatment "allowable" clinical services, but only the day treatment facility should submit a claim for such services, and then may reimburse the clinic treatment facility provider directly for the service that was delivered.
4. A same day clinic visit for any authorized Part 679 clinical service may be allowable if the person receiving day treatment services also has clinical needs which are clearly separate from his/her participation in the day treatment facility (i.e., related primarily to the person's residence/home). The residential facility's plan of service (or in the case of a waiver participant living in a private home, the person's overall individualized service plan (ISP) for the person should clearly articulate the use of a Part 679 clinic to deliver the residentially needed clinical support service(s). The following especially should be taken into account:
 - (i) For both ICFs/DD and community residences, the residential provider should be able to demonstrate, upon request or audit, that the services for which the residential provider is being reimbursed through its residential

rate/fee, are clearly separate from the clinic services received by the person through the Part 679 Clinic.

- (ii) All facilities involved (day treatment, clinic treatment, and residence) should be able to document their efforts at integration and coordination of the services with each other, to ensure that the persons are provided necessary services in the most economical and efficient fashion available.
5. People participating in collocated day treatment (a.k.a., partial day treatment) may receive a clinic treatment service only on the days when they are NOT receiving the collocated day treatment service. In addition, the clinic service must be necessary to support the person's living situation.

In summary, it is the purpose of these guidelines to ensure that people receive the clinical support services they need and where they need them; that duplication and the provision of uncoordinated services are precluded; that service providers are appropriately reimbursed; and that all services are provided in an economic and efficient manner.

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- (i) ***Director, Medical/Dental*** - Any New York State licensed physician or dentist by whatever title known, delegated with the overall responsibility for the delivery of professional services.
 - (j) ***Disability, Developmental*** - A disability of a person which:
 - (1) *is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism;*
 - (2) *is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of persons with mental retardation, or requires treatment and services similar to those required for such persons;*
 - (3) *is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;*
 - (4) *originates before such person attains age twenty-two;*
 - (5) *has continued or can be expected to continue indefinitely; and*

- (6) *constitutes a substantial handicap to such person's ability to function normally in society.*
- (k) *Facility - Any place certified or operated by OMRDD in which either residential or non-residential services are provided to persons with developmental disabilities in accordance with the provisions of the applicable facility class regulation. See also, "Facility, Clinic Treatment."*
- (l) *Facility, Clinic Treatment - A certified physical space or setting and/or its services, including any certified satellite location(s) and providing clinical services pursuant to Part 679, principally to persons with developmental disabilities, where such services are provided on an outpatient (i.e., non-residential) basis. The term "facility" also includes the headquarters for administration, management (including clinical records management), and clinician office (but not treatment) space for a provider authorized to provide exclusively off-site services, which holds an appropriate certificate of occupancy in accordance with the requirements of the locality having jurisdiction.*
- (m) *OMRDD - The New York State Office of Mental Retardation and Developmental Disabilities and all of its administrative subdivisions.*
- (n) *Off-site services - Allowed clinic services (see 679.99 (r)) delivered by practitioners of the healing arts (see 679.99(c)) at any location(s) other than the clinic's main certified site or a certified clinic satellite site (see 679.99(s)). This may include delivery of authorized clinic services from a mobile van that meets appropriate Department of Transportation vehicular requirements and is suitably equipped and staffed.*
- (o) *Party, Authorized - Someone who:*
- (i) *Holds licensure/certification appropriate to a discipline recognized by this Part;*
or
- (ii) *Holds the qualifications and functions as the facility's administrator pursuant to subdivision 679.3(g); or*
- (iii) *Holds the qualifications and functions as a treatment coordinator at the facility pursuant to subdivision 679.3(m); or*
- (iv) *Meets the definition of professional as set forth at subdivision 679.99(p) below;*
or
- (v) *Meets the designation of student-in-training as set forth at paragraph 679.3(l)(2).*
- (p) *Policies/Procedures or Policy/Procedure - As used in this Part, the term indicating the need for appropriate written guidance for staff, whether such guidance is in a form of*

a policy statement, a policy statement with accompanying procedures, or procedures only. Determination of the nature and wording of the material's content is that of the agency/facility.

Title III - For the Purposes of Public Policy Making

The above notwithstanding,

§35.130.(c) of Title III, states:

“Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.”

While this may not seem to contribute much, the analysis in the ADA Handbook accompanying this paragraph describes paragraph (c) as expanding the provisions found in section 504. That is, these provisions allow for the ability to limit Federally assisted programs to a specific class of individuals with disabilities, to include those services provided under the auspice of State or local governments. Specifically,

“Because coverage under this part is not limited to federally assisted programs, paragraph (c) has been revised to clarify to that State and local governments may provide special benefits, beyond those required by the nondiscrimination requirements of this part, **that are limited to individuals with disabilities or a particular class of individuals with disabilities, without thereby incurring additional obligations to persons without disabilities or to other classes of individuals with disabilities.**” (The ADA Handbook p. II-43) (emphasis added)

(JPO)

(q) *Professional - For the purposes of this Part, anyone who by virtue of training, licensure, certification and/or applicable State law and/or regulation (including this Part), has the authority to perform those activities granted or presumed pursuant to community practice standards by the professional discipline in question. For state-operated clinics, it also includes those who meet the Civil Service qualifications at the professional level appropriate to their discipline. In addition, it shall include the following clinical and professional treatment areas with their associated qualifications:*

(1) *Applied Behavior Sciences Specialist -- Someone having a master's degree in a clinical and/or treatment field of psychology from an accredited institution, who*

has training in assessment techniques and behavioral program development and who functions under the supervision of a licensed psychologist.

- (2) *Rehabilitation Counselor - Someone who holds the following qualifications:*
- (i) *A master's degree in a human services discipline from an accredited institution of higher education whose program includes supervised clinical experience in a vocational setting of at least six months.*
 - (ii) *A bachelor's degree in a human services discipline from an accredited institution of higher learning and three years supervised experience in providing rehabilitation services in a vocational setting.*
-

It is acknowledged that it is quite common for individuals providing rehabilitation services to have obtained their experience in other than a vocational setting. However, in this circumstance, OMRDD is attempting to define professional credentials in a specific discipline field (i.e., rehabilitation counselor) which would be comparable to certification/licensure, if such existed. Further, it was a general consensus among many who commented on this point, that the credentials specified were appropriate and appreciated since the requirements were consistent with VESID requirements for this title.

- (r) *Services - Allowable services by a clinic include those delivered by a practitioner of the healing arts and reasonable classified as:*
- (1) *Diagnostic - Any medical/clinical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, primary developmental disability, or other health deviation in the person.*
 - (2) *Palliative - Services provided by a physician or other practitioner of the healing arts focused on reducing the severity of a disease or condition; to cause to lessen or abate; to ease without curing.*
 - (3) *Preventative - Services provided by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law to:*
 - (i) *Treat and prevent disease, disability, and other health conditions or their progression;*

- (ii) *Prolong life;*
- (iii) *Promote physical and mental health and efficiency.*
- (4) *Rehabilitative/Habilitative - Any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It includes the fitting, training and modification of assistive devices by licensed practitioners or trained others under their direct supervision.*

The Regulatory Affairs Unit staff found the following in their review of the **American Disabilities Act (ADA)** regarding Part 679 Clinic Treatment Facilities and the offering of services exclusively to persons with developmental disabilities.

Title III - For the purposes of the Delivery of Services

§36.202 (c) of Title III states:

“Separate benefit - A public accommodation shall not provide an individual or class of individuals, on the basis of disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals, unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is effective as that provided to others.”

The intent of clinic treatment facilities is to provide persons with developmental disabilities with services that are “...unavailable or inaccessible in the person’s community.” (§679.1 (d)(1)) Or, as in the instances of providing medical and/or dental care, “...where it can be demonstrated that the generic health care system is either unavailable, without the specific capacity to provide quality services, inaccessible, and/or unable to serve such people.” (§679.1(d)(6))

Also, in line with the philosophy of consumer choice, the ADA does support that a person has the right to choose to receive a service that may not be the most integrated or inclusive:

§36.203 (c) of Title III states:

“Accommodations and services, (1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit available under this part that such individual chooses not to accept.”

However, when it comes to “choice,” it is important to understand that (as discussed in the Analysis accompanying this section of Title III) when determining what is “appropriate” for an individual, and how to define a “need,” Title III does not mandate that the responsibility either rests solely with the person or the public accommodation. “Rather, the determinations are to be made based on an objective view, presumably one which would take into account views of both parties.” (Analysis p.III-50 of the Americans with Disabilities Act Handbook.)

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- (s) ***Site, Satellite*** - *A physical location or dedicated space meeting the physical plant and environmental standards of 14 NYCRR subpart 635-7 appropriate to a clinic treatment facility, where the clinic treatment program regularly or periodically delivers Part 679 authorized services, which is available to any eligible consumer to "walk-in" for service by appointment, and which is specifically approved, periodically inspected, and listed by address as a satellite clinic on the operating certificate issued by OMRDD.*
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The physical plant/environmental requirements are set forth at 14 NYCRR Part 635-7.1(a)(8)(ii)(a). The requirements therein relate to the NYS Uniform Code and set the occupancy classification for clinics as C-1: Business (In NYC the classification per the City Building Code is E: Business). Pursuant to §635-7.2(a)(1)(ii)(b), Chapter 26 new/Chapter 27 - existing, Business of the NFPA Life Safety Code are required. If the clinic is to be operated on the grounds of other facilities with differential classifications, then the NYS code will likely require fire separation.

(JPO)

A site should be certified as a satellite if individuals can routinely schedule appointments at that site to receive clinical services from clinicians, and their only reason for being at the site is to access said clinical services.

Designated vs. Dedicated Clinic Space

OMRDD encourages the use of collocated space to the extent practical. Collocating clinics with other programs and services provides convenient access to the consumers, and decreases costs in terms of staff time and transportation. Collocation of clinics can occur in two principal ways: designated space and dedicated space.

Designated space is multipurpose space. A schedule or agreement with the other users of the space indicates the times when the space will be used for the provision of clinical services. This option should be considered whenever:

1. The clinic operates at less than full time.
2. The clinic operates on "unconventional" hours such as early in the morning, in the evening and/or on Saturdays. OMRDD has encouraged clinics to operate in other than the "normal" 9-5 schedule. Early morning, evening and Saturday hours reduce the time a person must miss from day programming, or a caregiver must miss from his/her job. Early morning and late afternoon hours are convenient as the person can receive his/her clinic service on the way to or from day program.
3. The service can be provided with little or no alteration to the space. For example, individual counseling can often be provided in the psychologist's, social worker's or dietician's office. Group sessions can often be held in a room that is used for other purposes, such as a conference room.

Dedicated space is space that is used exclusively for the provision of clinical services. It is necessary to dedicate space for certain clinical services, such as dentistry, because of the equipment that is involved in the provision of the service. In addition, if the clinic operates on a full time, or more than full time, schedule, it is appropriate to dedicate the space to the clinic.

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- (t) ***Specialist, Applied Behavioral Sciences*** - A person with a master's degree from an accredited program in a clinical and/or treatment field of psychology, who has training in assessment techniques and behavioral program development and who functions under the supervision of a licensed psychologist.
 - (u) ***Supervision*** - Authoritative procedural guidance by a professional for the accomplishment of a function or activity within his/her sphere of competence (as defined in the State Education Department licensing/certifying regulations), with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise stated in regulations, the supervision must be on the premises if the part does not meet the assistant-level qualifications specified.
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As part of its general operating responsibilities, a Part 679 clinic should have a facility plan for the provision of supervision at all levels, but particularly in the case of supervision by licensed clinicians. A facility's plan should take into account:

- (1) The type of services being provided and by whom;
- (2) The training and experience of the supervising clinicians;
- (3) The discipline area;

- (4) Individual service recipient circumstances and the interaction with the complexity of the services being delivered;
- (5) The availability, experience and expertise of the general administrative and/or Medical Director supervision.

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- (v) *Treatment, Ongoing - Approved and recommended therapies or interventions provided on a routine schedule over a period of time exceeding three months.*
 - (w) *Verify - Any means including, but not limited to, observation, interview, and the written word that provides OMRDD with a basis for being reasonably assured that a requirement has been met.*
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