MEMORANDUM

DATE: May 18, 2018

In response to the ongoing heroin and opioid epidemic, a bipartisan agreement was reached to incorporate additional protections for coverage of outpatient substance use disorder treatment within the 2018-2019 enacted budget. With these provisions, New York State has removed prior authorization from treatment at all levels of care to ensure timely access to needed treatment services.

This Chapter requires insurers to provide, without prior authorization, access to in-network medically necessary outpatient services for the treatment of substance use disorders, including outpatient, outpatient rehabilitation, intensive outpatient and opioid treatment programs (hereinafter referred to collectively as outpatient programs). There is no prior authorization or certification permitted, and insurers are prohibited from conducting concurrent utilization review for the first two weeks of continuous treatment, not to exceed 14 visits, provided the outpatient program gives the insurer notice of “admission” and an initial treatment plan within 48 hours. This change does not apply to Medicaid Managed care plans, which are already subject to more robust protections based on existing contract requirements.

The following guidance summarizes and clarifies Sections 3, 4 and 5 of Part MM of Chapter 57 of the Laws of 2018 as necessary to implement those provisions.

Prohibition of Prior Insurance Authorization for Medically Necessary Outpatient Treatment

Q. 1: When will this change impact substance use disorder treatment?

A: This change will impact all health insurance policies or contracts issued, modified or renewed on or after April 12, 2018.

Q. 2: What constitutes continuous treatment?

A: Continuous treatment means any combination of services provided to a patient and/or collateral person after the two week time period has started.
Q. 3: When does the two week of continuous treatment period start?

A: The two week period begins at the first service provided to an individual after an initial face to face contact with the patient. Once the service after the initial face to face contact is provided the two week time frame begins. However, coverage and reimbursement should be provided for pre-admission services, including but not limited to pre-admission assessment visits, peer engagement services or pre-admission medication administration. Coverage should also include circumstances where an individual is assessed and determined not to need substance use disorder treatment services at an outpatient program.

As an example, where an individual receives an initial peer engagement service and then comes to the outpatient service for an assessment, the two week time frame would begin when the assessment was provided, and the provider would need to submit required materials to the insurer within 48 hours of the assessment being provided.

Q. 4: What services are included within the no prior authorization or concurrent review for the first two weeks of treatment within an outpatient program?

A: This coverage includes all services authorized by OASAS to be provided as an outpatient service. Such services may include, but are not limited to, physical health, peer support services, individual and group counseling, medication administration, collateral visits and family counseling sessions, medically supervised outpatient withdrawal and stabilization services, or ancillary withdrawal. Such reimbursement shall include outpatient services regardless of the location in which those services are delivered.

Q. 5: Is an insurer required to begin conducting utilization review at two weeks?

A: No. The amendment to the insurance law sets a minimum standard for access to medically appropriate treatment. Where an insurer already provides for more generous access to outpatient services, including no prior authorization or concurrent review for time periods that are substantially longer than that provided in statute, they are not required, or expected, to modify their utilization review program standards to begin utilization review sooner or require additional documentation from the provider beyond what is already required.

Q. 6: Are outpatient services now limited to no more than two weeks?

A: No. Where an individual is appropriate for more than two weeks of continuous treatment, and the insurer begins to conduct concurrent review, the provider should clearly document the justification for additional treatment and communicate that clinical justification to the insurer. Where an adverse determination is received, the provider is expected to exhaust all administrative remedies available to obtain further needed treatment.
Q. 7: Is the two week/14 visit prohibition on prior authorization or concurrent review requirement limited to a request for coverage of outpatient programs for the treatment of opioid use disorder only?

A: No. The amendment to the insurance law prohibits prior authorization for medically necessary outpatient program services for any substance use disorder.

Q. 8: Are Insurers required to have outpatient programs, certified pursuant to Part 822 and Part 825, in their network?

A: Yes. Insurers are required to incorporate sufficient outpatient facilities within their behavioral health network. Network adequacy guidance has been issued by the New York State Department of Financial Services.

To view model contract language developed by the New York State Department of Financial Services, which describes the substance use disorder treatment services included in insurance contracts regulated by New York State, please visit: [http://www.dfs.ny.gov/insurance/health/model_lang_index.htm](http://www.dfs.ny.gov/insurance/health/model_lang_index.htm)

Q. 9: Does the new insurance law apply to ancillary withdrawal admissions?

A: The new insurance laws apply to all outpatient admissions for the diagnosis and treatment of substance use disorder, including ancillary withdrawal services, provided the outpatient program has obtained OASAS approved designation to provide this service consistent with regulatory requirements.

Q. 10: Must the outpatient Program confirm coverage and benefits prior to admission?

A: Yes. While these changes will impact coverage for many individuals, they do not apply to plans that are not regulated by New York State, i.e. Employer based plans subject to federal ERISA, or plans issued outside of New York State. The program should confirm that the patient is covered by the policy and that the policy is subject to New York State law.

Q. 11: Do the Insurance Law amendments require an insurer to cover two weeks with an outpatient provider without prior authorization when the facility is an out of network provider?

A: No, the new insurance law provisions do not require coverage, without authorization, for services provided by out-of-network outpatient providers. Requests for coverage at out-of-network outpatient programs are subject to review upon admission.
Q. 12: Are the limitations on utilization review during the first two weeks for outpatient services impacted by a patient’s recent discharge from the same or another level of care?

A: No, as long as the patient meets medical necessity, as determined by an OASAS designated tool, and notice and an initial treatment plan are provided to the insurer within 48 business hours of admission. This does not apply for Medicaid Managed Care policies.

Q. 13: Does a two week coverage requirement exist for each outpatient admission or is it cumulative?

A: Yes, the two week coverage requirement exists for each outpatient admission. Where the patient is discharged from an outpatient admission, the two week coverage period restarts at a subsequent admission provided the patient is determined to be appropriate for that level of care based upon the use of an OASAS designated tool, and notice and the initial treatment plan are provided to the insurer within 48 hours of a patient’s admission.

Q. 14: Do the limitations on utilization review during the first two weeks of an outpatient admission apply where a patient transfers from one outpatient program to another?

A: Yes, the prohibition against prior authorization or concurrent review applies to each outpatient admission. The two week time frame is not cumulative. A patient may obtain two weeks of treatment, if appropriate as determined by an OASAS designated tool, at one provider, be discharged to a subsequent level of care and receive an additional two weeks of treatment, if appropriate based on a determination using an OASAS designated tool.

Q. 15: Do the limitations on utilization review during the first two weeks of an outpatient admission apply despite multiple readmissions?

A: Yes. The prohibition against prior authorization or concurrent review applies to each outpatient admission where the patient is found to be appropriate for that level of care based on a determination using an OASAS designated tool.

Q. 16: If a patient steps down within the same facility from a bedded program to an outpatient program, or from a more intensive outpatient program to a less intensive outpatient program consecutively - are they entitled to two weeks without review at each level of outpatient treatment?

A: Yes. The prohibition against prior authorization or concurrent review applies to each outpatient admission at each level of care. If the patient is found to be appropriate based on a determination using an OASAS designated tool at each
step down to a lower level of care, the two week time frame would restart at each new level of care.

**Q. 17:** If the patient moves between outpatient facilities within the same level of care, e.g. from outpatient at facility A to outpatient at facility B are they entitled to two weeks without review at each level of care?

**A:** Yes. The prohibition against prior authorization or concurrent review applies to each outpatient program admission where the patient is found to be appropriate for that level of care based on a determination using an OASAS designated tool.

**Q. 18:** Can an outpatient provider request a prior authorization or concurrent review, by the insurer, in cases where treatment might later be deemed medically unnecessary but two weeks of continuous treatment, not to exceed 14 visits, have not yet passed?

**A:** No. While a provider may ask, an insurer is prohibited by law from conducting such utilization review activities until after the two weeks of continuous treatment. However, the provider is obligated by statute to consult with the insurer, and the entities may discuss the patient’s clinical progress in treatment prior to the end of either the two week or fourteen visit period.

**Q. 19:** How will medical necessity be determined?

**A:** The insurance law changes enacted in 2016 require the use of an OASAS designated tool when making a coverage determination for all substance use disorder treatment. Designated tools will include OASAS LOCADTR unless the insurer has received approval to utilize an alternate tool. “Medically necessary treatment” is wholly determined by the OASAS designated tool for all levels of treatment, and when an insurer is conducting retrospective review.

**Q. 20:** What constitutes notice to the insurer of an outpatient admission?

**A:** Notice will be sufficient where the information is provided verbally, in writing, via email, fax, or letter, and provides details sufficient to identify the insured person, along with a copy of the determination from the state designated level of care tool. OASAS has developed a form to be used for this purpose which is included in this guidance as Appendix B.

**Q. 21:** What constitutes an initial treatment plan that must be included with the notice to an Insurer within 48 hours of admission?

**A:** An initial treatment plan for an admission to an outpatient program shall include the following: patient identifying information; insurance identification; diagnosis for which the patient is being treated; current level of care; next anticipated service and the next anticipated date of service.
The insurer may request documentation to support the provision of the items noted within the initial treatment plan as part of the retrospective review process as permitted pursuant to statute. OASAS has developed a form which, together with the LOCADTR report, should be used as an initial treatment plan. This form is included in the guidance as Appendix B.

**Q. 22: When is the initial treatment plan and notification due to the insurer?**

**A.** The provider must submit the initial treatment plan and “notice of admission” to the insurer within 48 business hours of the provision of any service after an initial assessment to the patient.

**Q. 23:** If an outpatient program fails to provide an insurer with notice of an admission and an initial treatment plan within 48 business hours of admission, can the insurer begin concurrent review of services immediately upon learning of the admission, even if it is during the initial two week or fourteen visit period?

**a.** Also, may the insurer retrospectively deny any care provided prior to learning of the admission?

**A:** Yes, if the outpatient facility fails to notify the insurer of either the first visit after an initial contact with the patient or the initial treatment plan within 48 business hours of the first visit after an initial contact with this patient, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial two week or fourteen visit period. Under these circumstances, an insurer may also perform a retrospective review of the treatment already provided during the initial two week or fourteen visit period.

**Q. 24:** What if the outpatient facility gives notice to the Plan within 48 business hours but the Plan does not have record of the notification?

**A:** Providers should retain any document supporting submission of the required notification, including fax confirmation or email read receipts.

**Q. 25:** What if the outpatient facility gives notice to the Plan after 48 business hours?

**A:** Providers are required to give notice to a Plan within 48 business hours of a first visit after an initial contact with this patient. Failure to do so subjects all services to immediate review by the insurer, even if it is during the initial two week or fourteen visit period. Under these circumstances, an insurer may also perform a retrospective review of the treatment provided during the initial two week or fourteen visit period.

**Q. 26:** The new insurance laws require facilities that are certified by OASAS and participate in an insurer's network to perform routine clinical review of a
patient admitted to an outpatient program, which includes periodic consultation with the insurer to guarantee that the facility is using the age-appropriate evidence-based and peer reviewed clinical review tool designated by OASAS. The OASAS designated tool must indicate that the outpatient treatment is medically necessary for the patient. How can an outpatient or residential facility meet the requirement to “regularly assess the need for continued stay”?

A: Continual assessment does not obligate the outpatient program to perform a full assessment using an OASAS designated tool at every visit. Continual assessment should occur in the normal course of treatment planning and revision by clinical and medical staff. Assessment for continued stay considers the original rationale for the need for the current level of care and assessment of patient’s current condition to ascertain the appropriateness for continued stay. Where a patient is no longer appropriate for that level of care, and is able to attend a different level of care, the patient should be discharged to the next clinically appropriate level of care. Where an override is used, the provider must document the clinical justification for the treatment or retention of the patient at that level of care and provide such justification to the plan.

Q. 27: How often and to what extent must an outpatient facility consult with the insurer?

A: Periodic consultation should generally occur as often as is necessary to communicate a need for clinical case management or a change in clinical need.

Q. 28: Must an outpatient program give notice to the insurer when a patient leaves against medical or clinical advice during the initial two week treatment episode?

A: Yes. A provider must give notice to the Plan any time a patient separates from treatment, including patients who are discharged, leave against medical or clinical advice, or are missing. The Program should provide notice to the Plan within 24 hours of actual knowledge that a patient has separated from treatment.

Q. 29: The legislation states that members are held harmless. Are outpatient programs able to have members sign agreements to pay if insurance does not cover?

A: No. Where payment is denied after an insurer conducts retrospective review, a provider may not seek to recoup those monies from the patient. Such activities are in violation of NYS statute and will subject providers to additional administrative actions.

Q. 30: Should an outpatient program collaborate with the insurer for discharge planning?
A: Only to the extent that the patient needs clinical case a management services. However, Identification and coordination with recovery supports should begin as soon as the patient is admitted though coordination with an insurer is not required for this purpose.

Q. 31: Is retrospective utilization review permitted?

A: Yes. Health plans may perform utilization review of the outpatient treatment after the two weeks of continuous treatment or fourteen visits at the outpatient service starting at the first contact with the patient and the utilization review may include a review of services provided during the first two weeks/fourteen visits of the outpatient treatment. These provisions of the Insurance Law further provide that insurers may only deny coverage for any portion of the initial two weeks/14 visits of outpatient treatment on the basis that the treatment was not medically necessary if such treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer and designated by OASAS. Such determination should be based upon the condition of the patient at time of the first visit after an initial contact.

Q. 32: Are insurers required to cover days 1–14 of an outpatient admission if they subsequently determine that some or all of days 1-14 were not medically necessary?

A: No. Health plans may subsequently issue a medical necessity denial if such treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer and designated by OASAS.

Q. 33: Can a Provider appeal an Insurers determination that some or all of the treatment provided without authorization or concurrent review during the initial two weeks was not medically necessary?

A: Yes, pursuant to Article 49 of the Insurance law and public health law, a provider may appeal an adverse determination resulting from a retrospective review and are strongly encouraged to do so. During retrospective review, an insurer may only deny that portion of the initial two weeks or fourteen visits of outpatient services that were not medically necessary because it was contrary to the OASAS designated review tool utilized by the insurer.

Any additional questions or requests for clarification regarding this guidance document or Sections 2, 3 and 4 of Part MM of Chapter 57 of the laws of 2018 to Robert Kent, General Counsel, at Robert.Kent@oasas.ny.gov or Trishia Allen, Senior Attorney, at Trishia.Allen@oasas.ny.gov.
## Appendix B
### NOTIFICATION and INITIAL TREATMENT PLAN
(Due within 48 Business Hours)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td>Insurance ID:</td>
<td>Patient Number:</td>
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<td>Diagnosis:</td>
<td>Date of Initial Assessment:</td>
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LOCADTR3 Report (Attached)
- Assessed, Not Admitted

Reason:

### Part 822 Services – Initial Treatment Plan

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<th>Current Level of Care:</th>
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<th>Next Anticipated Service Date:</th>
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<th>Next Anticipated Service:</th>
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<td>• Additional Assessment</td>
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<td>• OASAS approved detoxification taper/protocol</td>
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<td>• Medication Assisted Treatment</td>
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<td>• Health Assessment and Physical</td>
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<td>• Individual Session</td>
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<td>• Group Session</td>
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<td>• Family / Collateral Sessions</td>
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<td>• Peer Services</td>
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<td>• Toxicology</td>
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<td>• Psychiatric Assessment</td>
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<td>• Other (Please Specify)</td>
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Signature                             Date