

## Part 816

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### CHEMICAL DEPENDENCE WITHDRAWAL AND STABILIZATION SERVICES

**Part 816 has been adopted effective November 21, 2009.**

[Statutory Authority: Mental Hygiene Law Sections 19.09, 19.15, 19.40, 22.09]

Notice: The following regulations are provided for informational purposes only. The Office of Alcohol and Substance Abuse Services makes no assurance of reliability. For assured reliability, readers are referred to the *Office Compilation of Rules and Regulations*.

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## **Section 816.1 Background and intent.**

(a) These regulations set forth minimum standards for the provision of withdrawal and stabilization services for persons suffering from chemical abuse or dependence. Chemical dependence withdrawal and stabilization services are designed to provide a range of service options, that are the most effective and appropriate level of care, to persons who are intoxicated or incapacitated by their use of alcohol and/or substance

(b) The primary purpose of any chemical dependence withdrawal and stabilization service is the management and treatment of alcohol and/or substance withdrawal, as well as disorders associated with alcohol and/or substance use, resulting in a referral to continued care. Certified providers of chemical dependence withdrawal and stabilization services can be authorized to provide one or more of the following:

(1) medically managed withdrawal and stabilization services;

(2) medically supervised inpatient withdrawal and stabilization services;

(3) medically supervised outpatient withdrawal and stabilization services; and/or

(4) medically monitored withdrawal and stabilization services.

(c) Chemical dependence withdrawal and stabilization services can serve as the initial step in the recovery and rehabilitation process and must be provided in an atmosphere which is humane and protects the patient's dignity. The purpose of these services is the medical management of withdrawal and crisis stabilization. It is the expectation that withdrawal and stabilization services will fully establish linkages, including appointments for the next appropriate level of care. For purposes of this Part, the provider of withdrawal and stabilization services must develop procedures for linkages

and follow-up appointments that are jointly agreed upon for continued treatment with the patient and a chemical dependence provider.

### **816.2 Legal base.**

(a) Section 19.09 of the Mental Hygiene Law authorizes the Commissioner of the Office of Alcoholism and Substance Abuse Services to adopt regulations necessary and proper to implement any matter under his or her jurisdiction.

(b) Section 19.15 of the Mental Hygiene Law bestows upon the Commissioner of such Office the responsibility of promoting, establishing, coordinating, and conducting programs for the prevention, diagnosis, treatment, aftercare, rehabilitation, and control in the field of chemical abuse or dependence.

(c) Section 19.40 of the Mental Hygiene Law authorizes the Commissioner of such Office to issue operating certificates for the provision of chemical dependence services.

(d) Sections 22.09 of the Mental Hygiene Law direct the Commissioner of such Office to promulgate regulations regarding the disposition of alcoholic beverages and substances, respectively, when brought by a person needing or seeking emergency treatment into a facility.

### **816.3 Applicability.**

This Part applies to any person or entity organized and operating pursuant to the provisions of this Title and certified by the Office to provide a chemical dependence withdrawal and stabilization service.

#### **816.4 Definitions.**

(a) Detoxification is defined as a medical regimen, conducted under the supervision of a physician to systematically reduce the amount of the addictive substance in a patient's body, provide reasonable control of active withdrawal symptoms and/or avert a life-threatening medical crisis related to the addictive substance.

(b) Discrete unit means the provision of chemical dependence withdrawal and stabilization services in excess of 5 beds, or greater than 10% of overall patient days (as defined by the Commissioner) of a hospital or other facility possessing an operating certificate pursuant to article twenty-eight of the public health law for purposes of providing inpatient or non-inpatient chemical dependence services.

(c) Medically managed withdrawal and stabilization services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the forty-eight (48) hour observation bed. Patients who have stabilized in a medically managed detoxification service may step-down to a medically supervised service.

(d) Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed or medically supervised inpatient withdrawal service may step-down to a medically supervised outpatient service.

- (e) Medically supervised outpatient withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with a stable environment and who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed or medically supervised inpatient detoxification service may step-down to a medically supervised outpatient service.
- (f) Medically monitored withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or others substances, who are suffering from mild withdrawal coupled with situational crisis, or who are unable to abstain with the absence of past withdrawal complications. Patients who have stabilized in medically managed or medically supervised inpatient withdrawal may step-down to this service.
- (g) Observation bed is a unit of service bed which provides intensive assessment and treatment of withdrawal where the patient has continuous evaluation for up to forty-eight (48) hours. At twenty-four (24) and forty-eight (48) hours, determinations are made as to the indicated level of care and the patient could be transferred to a lower level. The care given in the observation bed is equal to the medically managed level of care.
- (h) Pharmacological services mean the prescription, dispensing and administration of medications.
- (i) Prescribing professional is any medical professional licensed under the appropriate State law and registered under Federal and State law to prescribe schedule drugs, change dosage or sign orders for FDA approved medications.
- (j) Qualified health professionals include all those listed in Section 800.2 of this title and those listed in Section 816.4(j)(1) of this part, who are currently in good standing with

the appropriate licensing or certifying authority, with at least one year of experience or a training program in the treatment of alcoholism, substance abuse and/or chemical dependence:

(1) Licensed Mental Health Counselors

(k) Recovery care plan is a plan which directs the provision of those services of the withdrawal and stabilization service toward continuing care and treatment, and replaces the treatment plan. The plan is patient- driven and recovery oriented, supportive of abstinence and reflective of effective linkage and continuous treatment.

(l) Substance shall mean:

(1) any controlled substance listed in Section 3306 of the Public Health Law;

(2) any substance listed in Section 3380 of the Public Health Law; or

(3) any substance, as listed in the published rules of the Office which has been certified to the Commissioner of New York State Department of Health as having the capability of causing physical and/or psychological dependence.

**816.5 Standards applicable to all chemical dependence withdrawal and stabilization services.**

(a) Goals and objectives. All providers of chemical dependence withdrawal and stabilization services shall include among their goals and objectives:

(1) the safe and effective withdrawal from alcohol and/or substances of persons who are intoxicated or incapacitated therefrom, and the minimization of the multiple impacts of withdrawal on a chemically dependent person;

(2) the promotion of abstinence from alcohol and all substances, except those lawfully prescribed and monitored by a prescribing professional knowledgeable about the patient's chemical dependence;

(3) the screening and referral to other appropriate health or mental hygiene service providers, if such services cannot be provided by the chemical dependence withdrawal and stabilization service; and

(b) Linkages with other providers of services. To facilitate continued participation in the rehabilitation process, all providers of chemical dependence withdrawal and stabilization services must develop referral sources with other chemical dependence treatment providers as well as with other appropriate health, mental hygiene, and human service providers, and keep updated lists of programs in their areas that can meet treatment needs at various levels of care. This must be included in the policy and procedure manual.

(c) Clinical policies and procedures. A provider of chemical dependence withdrawal and stabilization services must develop clinical policies and procedures based on established safety and efficacy which must be approved by the provider's governing authority. These policies and procedures must include the following:

(1) Procedures for the clinical evaluation and management of alcohol and/or other substance specific withdrawal syndromes, to include the use of standardized withdrawal evaluation instruments, (including, but not limited to, Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), if available;

(2) staffing procedures for coverage of the unit;

- (3) screening and referral for physical conditions and/or mental disabilities;
- (4) infection control;
- (5) procedures for public health education and screening with regard to tuberculosis, sexually transmitted diseases, hepatitis, and HIV prevention and harm reduction;
- (6) procedures for the coordination of care with other service providers;
- (7) quality assurance and utilization review procedures;
- (8) procedures for managing or transferring persons incapacitated by alcohol and/or substances; and
- (9) discharge planning procedures.

(d) Medical care policies and procedures. A provider of chemical dependence withdrawal and stabilization service must develop medical care policies and procedures for the service, which must be approved by such provider's governing authority and medical director where appropriate. These policies and procedures must include the following:

- (1) Medical and/or nursing policy and procedure which includes:
  - (i) identifying those symptoms and/or syndromes which necessitate a procedure for referral to acute medical and mental hygiene services;
  - (ii) Policy and procedure for accomplishing medical and/or mental hygiene referrals which includes but is not limited to transportation of the patient;

- (iii) schedule for taking all patients' vital signs and observation of each patient's condition during withdrawal. All changes in the patients condition and appropriate actions taken shall be noted in the patient record;
  - (iv) emergency procedures for patients suffering from medical or psychiatric problems. All providers of withdrawal and stabilization services must have procedures for transfer of patients to one or more hospitals that provide emergency medical/psychiatric services in the area.
- (2) The provision of pharmacological services, including a requirement that they shall be based on a history, whenever possible, and physical examination and shall be provided only on order by a prescribing professional and in accordance with the terms and conditions of such professional's license.
- (i) These services may be monitored by a nurse practitioner, physician's assistant, registered nurse, or licensed practical nurse.
  - (ii) Procedures for the storing and dispensing of any medication must be developed in accordance with applicable state and federal regulations, and established medical practice.
  - (iii) Medication policies shall assure the appropriate continuation of administration of medications which were medically appropriate and lawfully prescribed and taken by the patient prior to admission.
- (3) Medical and laboratory tests which must be conducted in accordance with all applicable State and Federal requirements and shall include, but not be limited to: drug screening; blood alcohol content; pregnancy tests for women of childbearing

age and tests for tuberculosis and other infectious diseases, including, but not limited to, sexually transmitted diseases and hepatitis. The procedures shall identify the staff responsible for the provision of such procedures, and the documentation required.

(4) A requirement that if acupuncture is provided as an adjunct to the services provided by the chemical dependence withdrawal and stabilization service, it must be provided in accordance with Part 830 of this Title.

(5) A requirement that when HIV infection education, testing and counseling are provided, such services must be provided in accordance with Article 27-F of the Public Health Law and Parts 309 and 1070 of this Title, or the most recent recodification thereof.

(6) A requirement that if methadone or any other approved opioid medication or other opioid services are provided as a component of the chemical dependence withdrawal and stabilization service, they must be provided in accordance with all Federal and State requirements which regulate the use of such medications,

(e) Chemical dependence withdrawal and stabilization services may be co-located with other chemical dependence services to ensure improved coordination of care and linkage. Patients enrolled in a medically monitored withdrawal and stabilization service may participate in another level of care if clinically and medically appropriate.

(f) Capacity approved by the Office may not be exceeded at any time.

(g) Patient admission. Admission to and retention for withdrawal and stabilization services shall be in accordance with Sections 816.6, 816.7, or 816.8, of this Part, as applicable

- (1) Admission shall be based upon a diagnosis of chemical dependence identified through the substance dependence diagnostic criteria set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition (DSM IVR), or the International Classification of Diseases, Ninth Edition (ICD 9), or the most recent editions thereof.
- (2) If a patient is referred from another facility certified by the office, the information identified in subdivision (i) of this Part is not required, provided that a copy of the comprehensive evaluation performed by the referring facility accompanies the patient or is provided by the referral facility at the time of admission.
- (3) A level of care determination must be made by the provider with an appropriate level of care assessment tool and documented in the patient record.
- (4) Immediately upon admission to a withdrawal and stabilization service, each patient shall have presenting problems addressed in accordance with the initial orders and general policy requirements, as documented in the approved protocol developed pursuant to subdivision (c) of this section.
- (5) Each person admitted to the withdrawal and stabilization service must be evaluated as soon as possible, but within twenty-four (24) hours.
- (6) A provider of withdrawal and stabilization services may provide maintenance on methadone while a patient is being detoxified from other substances and/or detoxification from methadone, provided the program administering such service meets all federal and State requirements which regulate the use of methadone.
- (7) All admissions shall be voluntary and a patient shall be free to discharge him or herself from the service at any time.

(i) This provision shall not preclude or prohibit attempts to persuade a patient to remain in the service in his or her own best interest.

(ii) Any person who desires to leave the service should be offered an examination as soon as possible by medical personnel of the service.

(iii) If the service's medical personnel determine upon examination that such person is incapacitated by alcohol and/or substances to the degree that he or she may endanger himself or herself or other persons, or that there is an acute need for medical or psychiatric intervention, a referral to a medically managed withdrawal and stabilization service or other appropriate referral shall be made in accordance with Section 816.6 (d) (3) of this Part.

(h) Patient evaluation. Except as otherwise provided in paragraph (2) of this subdivision, a patient evaluation must be conducted by a clinical staff member.

(1) The patient evaluation must contain the following information:

(i) patient identification and contact information, including, but not limited to, name, address, telephone number, date of birth, sex and medical insurance information;

(ii) the name, address, and telephone number of a relative or close friend;

(iii) withdrawal evaluation, including patient's history and recent use of alcohol and/or substance, addiction treatment history, medical history, high risk behaviors, mental status and psychiatric history, living arrangements, level of self-sufficiency, supports, and barriers to treatment services; and

(iv) any information concerning a disability which may affect communication or other functioning.

(2) If the patient had previously been admitted to the same service within 30 days of the current admission, the previous evaluation may be utilized, provided it is appropriately updated.

(i) Recovery care plan. The plan is required within twenty-four (24) hours of admission, and shall be based on the evaluation conducted. The plan shall:

(1) be developed in collaboration with the patient by the responsible clinical staff member(s) including, but not limited to, counselors, nurses and physicians and signed and dated by all parties including the patient when completed and agreed upon;

(2) be based on the admitting and ongoing evaluations;

(3) provide an outline of the intended outcome of the treatment episode, the protocols to be followed for medical withdrawal and the care to be provided;

(4) be updated as appropriate should additional problems requiring immediate treatment be identified;

(5) reflect coordination of medical and/or psychiatric care, and/or the provision of other services, which can be provided concurrently either directly through the withdrawal and stabilization service or through a secondary provider and be developed with the participation of appropriate qualified providers of the additional services and shall specify the additional services to be provided by such other provider or providers, either concurrently or post-discharge; and

(6) be incorporated in the medical record along with written orders, prescriptions and the provision of chemical dependence withdrawal and stabilization services.

(j) Review of recovery care plan.

(1) All components of the recovery care plan shall be reviewed by the responsible staff as often as necessary, but no less often than seven (7) days, in the event that an individual's stay is extended in the service beyond seven (7) days, the entire recovery care plan must thereafter be reviewed and modified accordingly every three days during the course of the extended stay.

(2) Revisions to the recovery care plan shall be reflected in the patient's record, signed and dated by the responsible clinical staff.

(k) Progress notes. Progress notes shall be written signed and dated by clinical staff members; give a chronological picture of the patient's progress; and must be sufficiently detailed to delineate the course and results of the patients progress in treatment.

(1) In a medically supervised outpatient withdrawal and stabilization service, progress notes shall be documented no less often than once per visit; in medically managed and observation bed once per shift and in all other withdrawal and stabilization services, progress notes shall be documented no less often than once per shift for the first five days and no less often than once per day thereafter.

(2) If a patient's condition necessitates more frequent documentation, the appropriate staff must document the provision of those services and/or care in the patient's case record.

(l) Discharge Plan. Discharge planning shall include the patient; be based on best clinical practices; provide a framework for a long-term, patient-driven recovery plan; successfully link the patient to appropriate service to support the plan; and include detailed information on referral and plan specifics.

(1) The discharge plan shall be based on:

- (i) an evaluation of the patient's living arrangement, level of self-sufficiency and available support systems;
- (ii) identification of treatment and other services the patient will need after discharge; and
- (iii) a list of current medications.

(2) The discharge plan shall include, but not be limited to:

- (i) identification of appropriate chemical dependence treatment providers of the services needed as well as alternative medical/psychiatric providers, if necessary; and
- (ii) specific referrals and linkages to identified providers of services as required by the patient.

(3) Except for unplanned discharges, no patient shall be discharged until the discharge plan is complete and identifies a staff member who is assigned to follow up on referrals.

(4) All clinical and medical staff who participates in preparing the discharge and recovery plan shall sign and date the plan upon its completion. Except for medically monitored withdrawal and stabilization services, the program physician shall also sign and date the plan.

(5) The discharge plan shall be given to the patient upon discharge.

(6) With the appropriate patient consent, the recovery care plan shall be forwarded to the subsequent providers of service.

(7) For a patient who has an uninterrupted transition from a withdrawal and stabilization service to another service within the same facility, a transfer plan may take the place of a discharge plan. To ensure that sufficient information is available to the new service, a transfer plan must include information about the patient's immediate needs, medical and psychiatric diagnoses and plan for meeting those needs.

(m) Recordkeeping. Providers of chemical dependence withdrawal and stabilization services must develop and implement recordkeeping policies and procedures specific to the provision of this service.

(1) Such providers must keep individual case records for each patient who is admitted and provided service. These records must include, at a minimum, all information and documentation required in this Part, including but not limited to:

(i) evaluation at admission;

(ii) recovery care plan and all revisions;

(iii) progress notes;

(iv) documentation of public health education and screening with regard to tuberculosis, sexually transmitted diseases, hepatitis, and HIV prevention and harm reduction;

(v) discharge plan;

(vi) medical orders and prescriptions, and lab results;

(vii) documentation of contacts with a patient's family and/or significant other

(s); and

(viii) signed releases of consent for information, if any.

(2) Patient records shall be maintained and released in accordance with state and federal laws and regulations governing confidentiality, but not limited to 42 C.F.R., Part 2, Health Insurance Portability and Accountability Act of 1996, Article 27-F of the Public Health Law, and Article 33 of the Mental Hygiene Law.

(3) Patient records shall be available to all staff involved in the treatment of such patient and to professional staff of other providers involved in the care of such patient, in accordance with applicable state and federal laws and regulations governing the confidentiality of alcoholism and chemical dependence treatment records. In the event that more than one chemical dependence withdrawal and stabilization service is offered by a facility, the patient record shall be easily identifiable according to the service in which the patient is currently participating.

(4) If the service denies admission due to lack of available capacity or resources, it shall provide a referral to the most appropriate available service.

(n) Utilization review plan. Each withdrawal and stabilization service shall establish and implement a utilization review plan in accordance with this section to consider each patient's need for withdrawal and stabilization services in accordance with the patient's chemical dependence problem, and the continued effectiveness of withdrawal and stabilization services. The utilization review requirement may be met by the following:

(i) the service may perform its utilization review process internally; or

(ii) the service may enter into an agreement with another organization competent to perform utilization review to complete its utilization review process.

(1) The utilization review plan shall include procedures for ensuring that all admissions are appropriate, that retention criteria are met, and that discharges occur based upon the discharge criteria.

(2) All components of the recovery care plan shall be reviewed by the responsible staff as often as necessary, but no less often than every seven (7) days. Except for patients who have been admitted to an medically supervised outpatient service, no patient may be continued in the withdrawal and stabilization service beyond the seventh day after admission unless there is a reasonable probability that discharge criteria will be met within an additional seven (7) days. In addition, current evidence must document a level of instability requiring continued stay for adjustment of medication or attainment of a level of stability to enable functioning outside a structured setting; and either:

(i) there is medical evidence of moderate to severe organ damage related to alcohol and/or other substance use; or

(ii) the patient is pregnant and continued stay is necessary to insure stabilization and/or completed referral to continuing treatment; or

(iii) there is evidence of other medical complications warranting continued care in a withdrawal and stabilization service.

(o) Quality improvement plan. Each withdrawal and stabilization service shall establish a written quality improvement plan in accordance with this section. The quality improvement plan shall identify clinically relevant quality indicators, based upon professionally recognized standards of care. This process shall include but not be limited to:

- (1) periodic self-evaluations to ensure compliance with applicable regulations;
- (2) findings of other management activities, including but not limited to: annual samples of linkage outcomes, utilization reviews, incident reviews, and reviews of staff training, development and supervision needs; and
- (3) surveys of patient and/or referent satisfaction.

(p) The chemical dependence withdrawal and stabilization service shall prepare an annual report and submit it to the governing authority. This report shall document the effectiveness and efficiency of the chemical dependence withdrawal and stabilization service in relation to its goals and indicate any recommendations for improvement in its services to patients, as well as recommendations for changes in its policies and procedures.

(q) Assignment and training of staff.

- (1) Staff may be either specifically assigned to the chemical dependence withdrawal and stabilization service or may be part of the staff of the facility within which the chemical dependence withdrawal and stabilization service is located, provided that:

(i) they have specific training in the treatment of chemical dependence, including the treatment needs of patients withdrawing from alcohol and/or substances, including but not limited to tobacco; specific to the services provided; and

(ii) the service identifies and documents the percentage of time that each shared staff member is assigned to each service.

(2) A chemical dependence withdrawal and stabilization service shall have regular, scheduled, and documented training made available in the following:

(i) chemical dependence;

(ii) signs and symptoms of withdrawal; and

(iii) complications of withdrawal; and public health education and screening with regard to tuberculosis, sexually transmitted diseases, hepatitis, and HIV prevention and harm reduction.

(3) Each service shall have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases."

(4) Clinical staff shall have primary responsibility for implementing the recovery care plan including, but not limited to, crisis intervention, brief therapy focused on engagement and increasing motivation of patients, ongoing coordination of care, monitoring progress, and continuity of care and successful linkage of patients.

(5) Medical staff shall have primary responsibility for coordinating medical care including, but not limited to, physical examination, prescription and administration of

medications, observation of symptoms and vital signs and the provision of nursing care.

(6) Additional staffing requirements specific to the type of chemical dependence withdrawal and stabilization service provided shall be provided in accordance with Sections 816.6, 816.7, and 816.8 of this Part, as applicable.

(r) Procedures for disposal of alcohol and/or other substances not allowed in treatment.

(1) If a person presenting for a withdrawal and stabilization service possesses alcohol or other substances not allowed in treatment, such items shall be confiscated and immediately disposed of.

(2) If a person enters the service with a supply of medications prescribed by an outside physician, the service shall handle such medications in accordance with the service's policy and procedure.

**816.6 Standards applicable to medically managed withdrawal and stabilization services.**

(a) Applicability. Medically managed withdrawal and stabilization services shall be provided in facilities certified by the Office to provide a chemical dependence withdrawal and stabilization service and certified by the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law. A provider of medically managed withdrawal and stabilization services must demonstrate to the Office that it can meet the applicable standards of this section.

(b) Purpose of service. Medically managed withdrawal and stabilization services are designed for patients who are acutely ill from alcohol-related and/or substance-related

addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. Individuals, who are incapacitated to a degree which requires emergency admission, may be admitted to such facility in accordance with Section 22.09 of the Mental Hygiene Law. Such services shall not be provided on an ambulatory basis.

(c) Requisite services. Medically managed withdrawal and stabilization services must provide, at a minimum, all of the following services:

(1) medical management of acute intoxication and withdrawal conditions;

(2) a level of care determination process in accord with the governing authority's policy and procedures and incorporating the use of an Office approved protocol;

(3) medical evaluation within 24 hours of admission which includes a comprehensive health evaluation;

(4) a patient evaluation;

(5) an observation period for up to 48 hours of admission. The patient should be evaluated at twenty-four (24) and forty-eight (48) hours to determine the most appropriate level of care and to establish a recovery care plan. This plan includes an evaluation of need for medically managed withdrawal and stabilization services. Patients found to be stable and able to step-down to a lower level of care including methadone or buprenorphine treatment, medically supervised inpatient or outpatient withdrawal services and residential, inpatient or outpatient chemical dependence services shall be transferred to the appropriate level of care with specific discharge

instructions as soon as possible. This step-down may occur within the hospital service if available;

(6) medically supervised inpatient withdrawal services;

(7) pharmacological services, as defined in Section 816.4 of this Part, shall be provided as a means of controlling, or preventing, active withdrawal symptoms and/or averting a life-threatening medical crisis or major suffering and/or disability;

(8) referral and linkage to other appropriate chemical dependence services to complete stabilization and/or withdrawal as required by patient in support of recovery; and

(9) referral and linkages to other appropriate and necessary services as required by the patient in support of recovery.

(d) Admission and retention.

(1) A patient shall be admitted to a medically managed withdrawal and stabilization service by a physician.

(2) All admissions shall be voluntary and a patient shall be free to discharge himself or herself from the service at any time, except as otherwise provided in Section 22.09 of the Mental Hygiene Law for emergency services for persons intoxicated, impaired or incapacitated by alcohol and/or substances to the degree that he or she may endanger himself or herself or other persons, the examining physician may determine that he or she may be retained for emergency treatment over his or her objection.

(i) In no event may such person be retained over his or her objection beyond whichever occurs first of the following:

(a) the time that he or she is no longer incapacitated by alcohol and/or substances to the degree that he or she may endanger himself or herself or other persons; or

(b) forty-eight hours.

(ii) If any person is retained in the service over his or her objection, prompt notification must be given to the person's closest relative or friend, with his or her consent and, if so requested by such person, to his or her attorney and personal physician.

(iii) This provision shall not preclude or prohibit attempts to persuade a patient to remain in the service in his or her own best interest.

(3) If an individual requires all of the following services, the individual must be admitted to a medically managed withdrawal and stabilization service:

(i) medical therapy which is supervised by a physician (carried out by the medical team) in order to stabilize the patient's medical condition is still indicated;

(ii) physician attendance is required daily;

(iii) vital signs at least every 6 hours or more often are still indicated;

(iv) medication administration (detoxification medications) to prevent or modify withdrawal is still being adjusted and monitored; and at least one of the following is required:

- (A) CIWA greater than 12; or
- (B) seizures, delirium tremens or hallucinations within the past 24 hours; or
- (C) acute intervention needed for co-occurring medical or psychiatric disorder; or
- (D) severe withdrawal (continued vomiting, continued diarrhea, abnormal vital signs) requiring intravenous medication and/or fluids that cannot be handled at a lower level of care; or
- (E) pregnancy.

(4) A patient shall be retained for a medically managed withdrawal and stabilization service beyond forty-eight (48) hours only after an evaluation indicates:

(i) the presence of severe withdrawal symptoms as documented by standardized clinical tools designed to measure the severity of withdrawal and the provision of medication which is being prescribed in order to complete a safe, comfortable withdrawal and allow for the transfer to a lower level of care;

(ii) the presence or continued significant risk of co-morbid physical and/or psychiatric disorders requiring a medically managed level of care; or

(iii) the presence of a physical condition requiring medically managed level of care for alcohol and/or substance withdrawal, including, but not limited to pregnancy.

(5) A person suffering from severe withdrawal, at risk of severe withdrawal or suffering a related acute disorder shall not be denied admission to medically

managed withdrawal and stabilization service due to administrative barriers or other criteria, including but not limited to:

- (i) lack of motivation toward long-term recovery;
- (ii) a previous history of admission to the service, regardless of clinical outcome unless patient posed a serious threat;
- (iii) maintenance on methadone or other medication prescribed and monitored by a physician familiar with the patient's condition;
- (iv) pregnancy; and/or
- (v) HIV infection status.

(6) The service shall be managed so as to permit expedited admissions, based on verification of dependence, and evaluation of the likely severity of withdrawal, and medical and psychiatric clearances to ensure the safety of the admission to self and others, twenty-four (24) hours a day, seven (7) days a week.

(e) Staffing.

(1) The medical director of a medically managed withdrawal and stabilization service, whether full or part time, other than medical directors in place as of the date of this regulation, must hold either a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties, an addiction certification from the American Society of Addiction Medicine, or a subspecialty board certification in Addiction Medicine from the American Osteopathic Association. Physicians may be hired as probationary medical directors if not so certified but must obtain certification within four years of being hired. In addition, the physician must become buprenorphine certified within four months of

employment within this service or within four months of the promulgation of this regulation if currently employed. The director of a medically managed withdrawal and stabilization service may also serve as director of another service provided by the same governing authority.

(2) A physician shall be on duty or on call at all times and available if needed.

(3) There shall be a physician, nurse practitioner and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination of all patients and to prescribe any and all necessary pharmacological medications necessary to secure safe withdrawal.

(4) There shall be registered nursing personnel immediately available to all patients at all times. Nursing services shall be under the direction of a registered professional nurse who has at least one year of experience in the nursing care and treatment of chemical dependence and related illnesses.

(5) There shall be sufficient hours of qualified psychiatric time to meet the evaluation and treatment needs of those patients with other psychiatric disorders in addition to chemical dependence. If the psychiatrist is not a staff member of the service, psychiatric services shall be provided through a formal written agreement with another appropriate and qualified provider of psychiatric services.

(6) There shall be sufficient clinical staff to both maintain a ratio of one counselor for each 10 beds and be scheduled so as to be available for one one-half shifts, seven

(7) days per week; at least fifty percent of the clinical staff shall be qualified health professionals.

(7) One of the full time equivalent qualified health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed.

**816.7 Standards applicable to medically supervised inpatient withdrawal and stabilization service.**

(a) Applicability. Medically supervised inpatient withdrawal services can only be delivered by a provider of services which is certified by the Office to provide residential, inpatient, or outpatient chemical dependence treatment services in order to assure appropriate continuation in treatment.

(b) Purpose of services.

(1) Services must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing moderate withdrawal or who are at risk of mild to moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

(2) Such services are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications.

(c) Requisite services for inpatient medically supervised withdrawal and stabilization services. All inpatient medically supervised withdrawal and stabilization services must provide all of the following:

(1) medical evaluation within twenty-four (24) hours of admission;

(2) the level of care determination process must be in accord with the governing authority's policy and procedures and incorporate the use of an Office approved protocol;

(3) medical supervision of intoxication and withdrawal conditions, including monitoring of withdrawal symptoms and vital signs;

(4) crisis evaluation;

(5) pharmacological services, as defined in Section 816.4 of this Part, shall be provided as a means of reasonably controlling, or preventing, active withdrawal symptoms and/or averting a life-threatening medical crisis or major suffering and/or disability;

(6) referral and linkage to other appropriate chemical dependence services to complete stabilization and/or withdrawal as required by patient in support of recovery;

(7) referral and linkages to other appropriate and necessary services as required by the patient in support of recovery.

(d) A person shall be admitted to an inpatient medically supervised withdrawal service upon identification of the following:

(1) the presence of moderate withdrawal symptoms judged to be treatable at a medically supervised level of care; or

(2) the expectation of moderate level of withdrawal symptoms based on the amount of alcohol and/or other substances used by the patient, history of past withdrawal syndromes and/or medical condition of the patient; or

(3) continued use after withdrawal services at a less intensive level of care; or

(4) the patient is not in need of medically managed level of withdrawal and stabilization services; and/or

(5) the patient is not appropriate for a medically supervised outpatient service.

(e) Based on the evaluation a provider of services certified by the Office may retain an individual for inpatient medically supervised withdrawal services if:

(1) the person is suffering moderate alcohol and/or substance withdrawal, or mild withdrawal when moderate withdrawal is probable; or

(2) the person is being medicated for symptoms of withdrawal and the medication is being prescribed to complete the withdrawal; and

(3) the person requires withdrawal and stabilization services and does not meet either the criteria for admission to a medically managed withdrawal and stabilization service or the criteria for admission to an outpatient medically supervised withdrawal service.

(f) Staffing requirements for inpatient medically supervised withdrawal and stabilization services:

(1) Each inpatient medically supervised withdrawal service shall have a designated director who is a qualified health professional, as defined in Section 816.4 of this Part.

Such service director shall have at least one year of full-time clinical work experience in the chemical dependence treatment field prior to appointment as service director, and may also serve as director of another service provided by the same governing authority.

(2) There shall be a physician, nurse practitioner, and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination on all patients and to prescribe medications necessary to secure safe withdrawal.

(3) There shall be registered nursing personnel, licensed practical nurses, nurse practitioners or physicians assistant onsite and available to all patients during all hours of operation.

(4) There shall be sufficient clinical staff to both maintain a ratio of one counselor for each 10 beds and be scheduled so as to be available for one one-half shifts, seven (7) days per week; at least fifty percent of the clinical staff shall be qualified health professionals.

(5) One of the full time equivalent qualified health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed.

**816.8 Standards applicable to medically supervised outpatient withdrawal and stabilization service**

(a) Applicability. Medically supervised outpatient withdrawal and stabilization services can only be delivered by a provider of services which is certified by the Office to provide

residential, inpatient or outpatient chemical dependence treatment services in order to assure appropriate continuation in treatment.

(b) Purpose of services.

(1) Services must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing mild to moderate withdrawal or who are at risk of mild to moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence.

(2) Such services are appropriate for persons who are intoxicated by alcohol and/or substances, or who are suffering from mild to moderate withdrawal and are unable to abstain with an absence of past withdrawal complications.

(c) Requisite services for outpatient medically supervised withdrawal and stabilization services. All providers of outpatient medically supervised withdrawal and stabilization services must, at a minimum, provide the following services:

(1) medical supervision of intoxication and withdrawal conditions, including monitoring of withdrawal symptoms and vital signs and regularly scheduled toxicology screens;

(2) evaluation, including medical examination within twenty-four (24) hours of admission;

(3) discharge and recovery care plan;

(4) pharmacological services, as defined in Section 816.4 of this Part, shall be provided as a means of reasonably controlling, or preventing, active withdrawal

symptoms and/or averting a life-threatening medical crisis or major suffering and/or disability;

(5) patients must be seen by the physician, nurse practitioner, physician assistant or registered nurse daily unless otherwise specified by the physician based on the patient's physical and emotional condition;

(6) a medical evaluation must be completed on each patient, and referral for and linkage to ongoing treatment made as indicated;

(7) family educational services must be provided based upon the identified needs of the patient and family and the availability of the family;

(8) the patient and family member, when available, must be informed, both verbally and in writing, of the signs and symptoms of withdrawal, under what circumstances to call for advice, when to take another dose of medication, and under what circumstances to go to the nearest emergency room. The provider of services must provide or make available a twenty-four (24) hour telephone crisis line to help facilitate the provision of this information; and

(9) referral and linkages to other appropriate and necessary services as required by the patient in support of recovery.

(d) Based on a medical evaluation, a provider of services certified by the Office may provide outpatient medically supervised withdrawal and stabilization services to a patient if:

(1) the patient is suffering moderate alcohol or substance withdrawal or both, or mild withdrawal when moderate withdrawal is probable;

(2) there is an expectation of a moderate level of withdrawal symptoms based on the amount of alcohol and/or other substances used by the patient, history of past withdrawal syndromes and/or medical condition of the patient;

(3) the patient does not meet either the admission criteria for medically managed withdrawal and stabilization services, or for medically supervised withdrawal services in an inpatient or residential setting; and

(4) the patient is assessed as having, and responding positively to, emotional support and a living environment able to provide an atmosphere conducive to ambulatory withdrawal and stabilization.

(e) A patient shall be retained in outpatient medically supervised withdrawal and stabilization services if:

(1) such patient is receiving medication to treat symptoms of withdrawal, and such medication is being prescribed to complete withdrawal; and

(2) such patient is not otherwise too ill to benefit from the care that can be provided by the medically supervised withdrawal and stabilization service.

(f) Staffing for outpatient medically supervised withdrawal and stabilization services.

(1) Each outpatient medically supervised withdrawal and stabilization service shall have a service director who is a qualified health professional, as defined in Section 816.4 of this Part. Such service director shall have at least one year of full-time work experience in the chemical dependence treatment field prior to appointment as service director and may also serve as director of another service provided by the same governing authority.

(2) There shall be a physician, nurse practitioner and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination of all patients and to prescribe any and all necessary pharmacological medications necessary to secure safe withdrawal.

(3) There shall be physicians, nurse practitioners, registered nurses, licensed practical nurses, or physician assistants available to all patients on call or available within the facility during all hours of operation.

(4) There shall be sufficient qualified clinical staff to achieve a ratio of one counselor to 15 patients; fifty (50%) percent of such staff shall be qualified health professionals.

(5) One of the full-time equivalent health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed.

**816.9 Standards applicable to medically monitored withdrawal and stabilization services.**

(a) Applicability. Medically monitored withdrawal and stabilization services can be provided by any provider of services certified by the Office to provide medically monitored residential chemical dependence services.

(b) Purpose of service. Medically monitored withdrawal and stabilization services are designed for persons intoxicated by alcohol and/or substances, or who are suffering from mild withdrawal coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications, or who are individuals in danger of relapse. Such services do not require physician direction or direct supervision by a

physician, and are designed to provide a safe environment in which a person may complete withdrawal and secure a referral to the next level of care.

(c) Requisite services. All medically monitored withdrawal and stabilization services must provide at least all of the following services:

- (1) assessment;
- (2) monitoring of withdrawal symptoms and vital signs;
- (3) individual and group counseling;
- (4) level of care determination; and
- (5) referral and linkages to other appropriate and necessary services as required by the patient in support of recovery.

(d) Admission and retention.

(1) All admissions of patients shall be voluntary and a patient shall be free to discharge himself or herself at any time. This provision shall not preclude or prohibit attempts to persuade a patient to remain in the service in his or her own best interest.

(2) Providers of medically monitored withdrawal and stabilization services shall admit only persons in need of the level of care provided. No person shall be admitted unless observation and evaluation document all of the following:

- (i) the person is intoxicated, experiencing a situational crisis, and/or is suffering or is at risk of suffering mild withdrawal;

(ii) the person is unable to abstain without admission to a medically monitored withdrawal and stabilization service;

(iii) the person is likely to complete needed withdrawal and enter into continued treatment; and

(iv) the person is not otherwise too ill to benefit from the care that can be provided by the medically monitored withdrawal and stabilization service.

(3) A patient may be retained in the medically monitored withdrawal and stabilization service if he or she is awaiting a scheduled admission into appropriate treatment upon discharge. Such retention must be documented and may not exceed twenty-one (21) days from date of admission.

(e) Staffing.

(1) Each medically monitored withdrawal and stabilization service of 10 beds or more shall have a full-time service director who is a qualified health professional as defined in Section 816.5 of this Part. The service director shall have at least one year of full-time work experience in the chemical dependence treatment fields prior to appointment as service director. A medically monitored withdrawal service with fewer than 10 beds shall have a similarly qualified service director who shall serve on at least a part-time basis.

(2) Each medically monitored withdrawal and stabilization service shall employ a sufficient number of staff to adequately serve all patients and to meet the requirements of this Part.

(i) Each medically monitored withdrawal and stabilization service will be required to submit a medical staffing policy that is compliant with the clients needs, federal, state and local laws and suitable for their situation. These protocols must be reviewed and approved by the Office Medical Director. This protocol must be reviewed and approved prior to every re-certification.

(ii) There shall be at least two patient care staff on duty at all times.

(iii) There shall be sufficient clinical staff to achieve a ratio of one counselor for each 10 beds, scheduled so as to be on duty at least one and one-half shifts per day, seven (7) days per week.

(3) All patient care staff of the service shall have current certification in cardiopulmonary resuscitation from the American Red Cross, the American Heart Association or an equivalent nationally recognized organization within 90 days after hiring and thereafter, to be renewed as needed.

#### **816.10 Standards pertaining to Medicaid reimbursement.**

(a) Medicaid reimbursement will be provided in accordance with the provisions of this Title and 18 NYCRR Part 505.

(b) In order to qualify for reimbursement each occasion of service must be documented as a covered medical service in accordance with the following:

(1) the service must meet the standards established in this Part;

(2) the service must be documented in the patient's record; and

(3) the service must be provided by service staff as required by this Part.

(c) Noncovered services. The following services are not eligible for Medicaid reimbursement on a fee for service basis:

(1) visits to the premises of a chemical dependence withdrawal and stabilization service for the sole purpose of attending meetings of a self-help group;

(2) any visits which include only companionship, recreation, and/or social activity;

(3) treatment provided in a medically monitored withdrawal and stabilization service;  
and

(4) services provided in a facility which is not enrolled in the medical assistance program pursuant to Title 11 of the Social Services Law and Title 18 NYCRR.

#### **Section 816.11 Incorporation by Reference**

(a) The provisions of the *Code of Federal Regulations* which have been incorporated by reference in this Part have been filed in the Office of the Secretary of State of the State of New York, the publication so filed being the booklet entitled *Code of Federal Regulations*, title 42, Parts 2 & 8, revised as of January 17, 2001, and Title 21 CFR, Part 291, Part 1300-1399 revised as of April 1, 2006, published by the Office of the Federal Register, National Archives and Records Administration, as a special edition of the *Federal Register*. The regulations incorporated by reference may be examined at the Office of the Department of State, 41 State Street, Albany, NY 12203 at the law libraries of the New York State Supreme Court, the Legislative Library, the New York State Office of Alcoholism and Substance Abuse Services, Office of Counsel, 1450 Western Ave., Albany, NY 12232. They may also be purchased from the Superintendent of Documents,

Government Printing Office Washington, DC 20402. Copies of the *Code of Federal Regulations* are also available at many public libraries and bar association libraries.

### **816.12 Savings Clause**

(a) Any operating certificate which has been issued by the Office pursuant to Part 816 of this Title and before that Part has been repealed shall remain in effect until its term has expired at which time any renewal of such operating certificate will be issued pursuant to this Part 816.