

**PART 816**  
**SUBSTANCE USE DISORDER WITHDRAWAL AND STABILIZATION SERVICES**

(Statutory Authority: Mental Hygiene Law Sections 19.09, 19.15, 19.40, 22.09)

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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 acute or crisis stages of substance use disorder.
- (b) The primary function of a withdrawal and stabilization service is the medical management and treatment of acute withdrawal, resulting in a referral to an appropriate level of longer term care. Certified providers of withdrawal and stabilization services may provide one or more of the following as further defined in this Part:
  - (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) Withdrawal and stabilization services can be the first step in the recovery process and must be provided in an atmosphere which protects the patient's dignity. Therefore, it is expected that providers of withdrawal and stabilization services will establish meaningful linkages for

supporting services, including appointments for admission to the next appropriate level of care.

**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 their 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 substance use disorder.

(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) Section 22.09 of the Mental Hygiene Law directs the Commissioner of such Office to designate hospitals and other appropriate facilities as providers of emergency detoxification and stabilization services for persons needing or seeking emergency treatment.

**816.3 Applicability.**

(a) This Part applies to any person or entity organized and operating pursuant to the provisions of this Title and certified, funded or otherwise authorized by the Office to provide a substance use disorder withdrawal and stabilization service.

(b) Nothing in this Part shall be construed to limit the authority of a hospital licensed pursuant to Article 28 of the Public Health Law to provide detoxification and stabilization in a medical/surgical bed or emergency room.

**816.4 Definitions.**

(a) “Detoxification” or “detox” means a medical withdrawal and stabilization regimen under the supervision of a physician to systematically reduce the amount of an 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 an OASAS program certified pursuant to Article 32 of the Mental Hygiene Law providing inpatient or outpatient substance use disorder treatment co-located in a facility licensed pursuant to Article 28 of the Public Health Law because such facility is providing treatment due to a consistent demand exceeding five (5) medical-surgical beds, or greater than 10% of overall patient days.
- (c) “Medically managed” withdrawal and stabilization services means 24/7 services designed for patients acutely ill from substance-related dependence, experiencing severe withdrawal, or at risk of such conditions. This level of care includes the forty-eight (48) hour observation bed. Patients stabilized in a medically managed service may transition to a less intensive medically supervised inpatient service, a medically supervised outpatient service, or other appropriate level of care.
- (d) “Medically supervised” withdrawal and stabilization services are appropriate for persons suffering from mild to moderate withdrawal, coupled with situational crisis such as unstable living environments, or who are unable to detox on their own without withdrawal complications. Patients stabilized in a medically supervised service may transition to a less intensive medically supervised outpatient service or other appropriate level of care.
- (e) “Medically supervised outpatient” means services appropriate for persons who are suffering from mild to moderate withdrawal or persons experiencing non-acute physical or psychiatric complications associated with their substance use disorder and who are unable to detox on their own without withdrawal complications, but who retain a stable living environment.
- (f) “Medically monitored” withdrawal and stabilization services are appropriate for persons who are suffering from mild withdrawal coupled with situational crises, or who are unable to detox on their own without withdrawal complications. Patients stabilized in medically managed or medically supervised services may transition to this service.
- (g) “Observation bed” means a service providing intensive assessment and treatment of withdrawal where the patient has continuous periodic evaluation for up to forty-eight (48) hours. The care given in an observation bed is a medically managed level of care.
- (h) “Recovery/care plan” means a plan directing the provision of withdrawal and stabilization services toward continuing care and treatment and which serves as the treatment

plan. Such plan is patient-centered and recovery-oriented and incorporates appropriate linkages for level of care transitions.

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

(a) *Screening, linkages and referral.* (1) All providers of withdrawal and stabilization services must provide screening, linkages and referral to other appropriate providers of physical and behavioral health services if such services cannot be provided by the withdrawal and stabilization program.

(2) All providers must develop referral sources and keep updated lists of regional programs which provide treatment and recovery services at all levels of care.

(b) *Policies and procedures.* (1) Providers of withdrawal and stabilization services must develop and implement written policies and procedures approved by the program sponsor. Such policies and procedures must include, at a minimum, the following:

- (1) Use of standardized withdrawal evaluation instruments;
- (2) staffing for sufficient coverage and task designation; at least 50% of all clinical staff must be qualified health professionals as defined in Part 800 of this Title;
- (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 including transfers, emergency care and patient transport;
- (7) quality assurance and utilization review procedures;
- (8) medical and nursing procedures consistent with professional practice;
- (9) admission and planning for level of care transitions;
- (10) pharmacological services including storage and dispensing medication pursuant to applicable state and federal regulations and ensuring appropriate continuation of medications prescribed to the patient prior to admission;
- (11) laboratory testing protocols;
- (12) records and reporting;
- (13) incident reporting

- (14) screening of patients and visitors and the disposal of contraband;
  - (15) compliance with other applicable federal and state regulations and Office guidance.
- (c) *Co-location.* (1) Chemical dependence withdrawal and stabilization services may be co-located with other chemical dependence services to ensure improved coordination of care and linkage.
- (2) Patients enrolled in a medically monitored withdrawal and stabilization service may participate in another level of care if clinically and medically appropriate.
- (d) *Capacity.* Capacity approved by the Office may not be exceeded at any time except with written permission from the Office.
- (e) *Admission.* (1) Admission shall be based upon a diagnosis of substance use disorder pursuant to the most recent edition of either the Diagnostic and Statistical Manual of the American Psychiatric Association, or the International Classification of Diseases.
- (2) A level of care determination must be made using the OASAS level of care assessment tool as defined in Part 800 of this Title and documented in the patient record.
- (3) Medication policies must ensure the appropriate continuation of medically appropriate and lawfully prescribed medication taken by the patient prior to admission.
- (4) Each person admitted to the withdrawal and stabilization service must receive a medical evaluation as soon as possible, but no later than the first twenty-four (24) hours.
- (5) A provider of withdrawal and stabilization services may provide maintenance on opioid agonist medications while a patient is being detoxified from other substances and/or tapering from such agonist medications, provided the program administering such service meets all federal and state requirements which regulate the use of approved opioid full agonist treatment.
- (6) All admissions shall be consistent with Part 815 of this Title. Admission is voluntary and a patient shall be free to discharge themselves from the service at any time, provided however, this provision shall not preclude or prohibit attempts to persuade a patient to remain in the service in their own best interest.
- (i) Any person who desires to leave the service should be offered an examination as soon as possible by medical personnel of the service.
- (ii) If the medical personnel determine upon examination that such person is incapacitated by alcohol and/or substances to the degree that they may endanger themselves or

other persons, or that there is an acute need for medical or psychiatric intervention, a referral must be made to a provider designated by the Office to provide emergency services pursuant to section 22.09 of the mental hygiene law or to another appropriate provider.

(f) *Initial services; initial evaluation.* (1) Except as otherwise provided in paragraph (2) of this subdivision, an initial evaluation must be conducted by a clinical staff member. In addition to patient identifying and emergency contact information the following clinical and psycho-social information is required:

(i) withdrawal evaluation, including patient's history and recent use of alcohol and/or substances, 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

(ii) 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 thirty (30) days of the current admission, the previous evaluation may be utilized, provided it is appropriately updated.

(3) Except for patients admitted to a medically supervised outpatient service, no patient may be continued in the withdrawal and stabilization service longer than seven (7) days after admission unless there is a reasonable probability that discharge criteria will be met within an additional seven (7) days. 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.

(g) *Recovery/Care plan.* (1) The plan must be completed within twenty-four (24) hours of admission, and shall be based on the initial evaluation conducted. The plan shall:

(i) be developed in collaboration with the patient by the responsible clinical staff member(s) and signed and dated by all parties including the patient when completed and agreed upon;

(ii) provide goals for outcome of the treatment, the protocols to be followed for medical withdrawal and the care to be provided;

(iii) be updated as appropriate and as required by the level of care should additional problems requiring immediate treatment be identified;

(iv) reflect coordination of medical and/or psychiatric care, and/or the provision of other services provided concurrently either directly or through a secondary provider; and

(v) be incorporated in the patient's case record along with written orders, prescriptions and the provision of withdrawal and stabilization services.

(2) Review of recovery/care plan. All components of the recovery/care plan shall be reviewed by the responsible clinical staff as often as necessary consistent with the level of care, and at least once in the first seven (7) days; in the event that an individual's stay is extended beyond seven (7) days, the entire recovery/ care plan must be reviewed and modified accordingly every subsequent three (3) days during the course of the extended stay. Revisions to the recovery / care plan shall be reflected in the patient's case record, signed and dated by the responsible clinical staff.

(3) 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 patient's progress in treatment.

(i) Unless additional requirements apply to specific levels of withdrawal and stabilization services, progress notes shall be documented no less often than once per shift for the first five (5) days and no less often than once per day thereafter.

(ii) 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.

(h) *Discharge and planning for level of care transitions.* (1) Discharge planning shall commence upon admission and involve consultation with the patient; planning must provide a framework for a long-term, patient-driven recovery plan and link the patient to appropriate level of care transition services to support the plan; and include detailed information on referral and

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

(2) The plan shall include, but not be limited to at least the following:

(i) an evaluation of the patient's living arrangement, level of self-sufficiency and available support systems;

(ii) identification of substance use disorder treatment and other services the patient will need after discharge including alternative medical and psychological providers; and

(iii) a list of current medications.

(3) A member of the clinical and medical staff who participated in preparing the 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.

(4) The plan shall be given to the patient upon discharge and with appropriate patient consent, the care plan, including level of care transition planning, shall be forwarded to any subsequent service providers. The patient and their family/significant other(s) shall be offered naloxone education and training and a naloxone kit or prescription.

(5) For a patient transitioning directly 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 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.

(i) *Case records.* (1) Providers must keep individual case records for each patient admitted. 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 including progress notes and discharge plan;

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

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

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

(2) Patient records shall be maintained, shared with other staff involved in the treatment of a patient and with professional staff of other providers involved in the care of such patient,



and released in accordance with state and federal laws and regulations governing confidentiality.

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

(j) *Utilization review and quality improvement.* Each withdrawal and stabilization service must have a utilization review process, a quality improvement process, and a written plan that identifies key performance measures for that particular program.

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

(i) they have specific training in the treatment of substance use disorder; and

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

(2) A withdrawal and stabilization service shall have regular, scheduled, and documented training made available in the following subject areas, or as determined by the Office:

(i) substance use disorder and other addictive disorders;

(ii) signs and symptoms of withdrawal; and

(iii) complications of withdrawal; and

(iv) 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 to 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 care plan.

(5) Medical staff shall have primary responsibility for coordinating medical care including, but not limited to, physical examination, prescription, dispensing, and/or administration of medications, observation of symptoms, and vital signs and the provision of nursing care.

(6) Additional staffing requirements specific to the type of withdrawal and stabilization service provided pursuant to applicable sections of this Part

**816.6 Additional requirements for medically managed withdrawal and stabilization services.**

(a) Unless otherwise authorized medically managed withdrawal and stabilization services, as defined in section 816.4(c) of this Part, shall only be provided in facilities certified by the Office and certified by the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law.

(b) *Required services.* Medically managed services must provide, at a minimum, all of the following services:

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

(2) an observation period for up to 48 hours of admission. Patients found to be stable and able to step-down to a lower level of care shall be transferred within or without the facility, with specific discharge instructions, as soon as possible.

(3) medically supervised inpatient withdrawal services;

(c) *Staffing.* (1) The medical director of a medically managed withdrawal and stabilization service, whether full or part time, may also serve as director of another service provided by the same program sponsor.

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

(3) There must 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 medications necessary to ensure 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 substance use disorder 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 substance use disorder.

(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 and one-half shifts, seven (7) days per week.

(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 Additional requirements for medically supervised inpatient withdrawal and stabilization services.**

(a) Medically supervised withdrawal services can only be delivered by a provider of services certified by the Office to provide a continuum of care encompassing: residential, inpatient or outpatient substance use disorder treatment services in order to ensure appropriate continuation in treatment.

(b) Each inpatient medically supervised withdrawal service shall have a director who is a qualified health professional with at least one year of full-time clinical work experience in the treatment of substance use disorder prior to appointment. The director may also serve as director of another service provided by the same governing authority.

**816.8 Additional requirements for medically supervised outpatient withdrawal and stabilization services.**

(a) Unless otherwise authorized by the Office medically supervised outpatient services may only be delivered by an OASAS certified provider of residential, inpatient and outpatient services in order to assure appropriate continuation in treatment.

(b) *Required services.* (1) All providers of outpatient medically supervised services must, at a minimum, provide the following services in addition to those required pursuant to section 816.5 of this Part:

(i) 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;

(ii) 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.

(c) *Staffing.* (1) Each outpatient medically supervised service shall have a service director who is a qualified health professional. 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 program sponsor.

(2) There shall be sufficient qualified clinical staff to achieve a ratio of one counselor to 15 patients.

(4) Progress notes shall be documented no less often than once per visit.

### **816.9 Additional requirements for medically monitored services.**

(a) Medically monitored services are designed for persons intoxicated by alcohol and/or substances, or who are suffering from mild withdrawal coupled with situational crisis, or persons who have previously been unable to withdraw without complications. Such services do not require physician direction or direct supervision by a physician, and are designed to provide a safe environment with medical monitoring in which a person may complete withdrawal and secure a referral to the next level of care.

(b) All medically monitored services must provide at least all of the following services:

(1) assessment;

(2) monitoring of withdrawal symptoms and vital signs; and

(3) individual and group counseling

(c) 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.

(d) *Staffing.* (1) Each medically monitored service of 10 beds or more shall have a full-time program director who is a qualified health professional. Such director shall have at least one year of full-time work experience in the field of substance use disorder prior to appointment. A medically monitored service with fewer than 10 beds shall have a similarly qualified 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) There shall be at least two patient care staff on duty at all times.

(ii) 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.

(iii) 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 14 NYCRR Part 841.

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

(1) visits to the premises of a 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.

**816.11 Savings and renewal clause.**

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.

**816.12 Severability.**

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part that can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable.