NEW YORK STATE | Office of Addiction Services and Supports

Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019.

DECEMBER 2019

The following guidance summarizes the insurance law changes effected by Chapter 57 of the Laws of 2019, which modified Chapter 69 and 71 of the Laws of 2016 and Chapter 57 of the Laws of 2018. The clarifications included in this document will assist insurers and providers with implementing changes that facilitate a collaborative person-centered approach to payor provider interactions. Additional guidance can be found on the NYS Department of Financial Services website.

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Required Use of Objective State-Designated Criteria to Determine the Level of Care for Individuals Suffering from a Substance Use Disorder

Impacts care starting January 1, 2020

Effective January 1, 2017, all insurers operating in New York State were required to use an objective level of care tool to make initial and continuing coverage determinations for all substance use disorder treatment, as designated by the Office of Addiction Services and Supports (OASAS)[1]. Level of Care is a measure of the least restrictive setting for treatment delivery for the most effective treatment. One tool designated by OASAS is the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0.

Effective **January 1, 2020**, the requirement to use an OASAS designated tool will apply only when the care **is provided within New York State.**

Q. 1-1: When will this change impact Substance Use Disorder care?

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after **January 1, 2020**.

Q. 1-2: Can a tool other than LOCADTR 3.0 be used for level of care and continuing care review decisions where the care is provided outside of New York State?

A: Other clinical review tools can be used to make coverage decisions for care provided outside of New York State.

Q. 1-3: Will the same tool be used for all lines of business in New York State?

A: In addition to requirements within statute, Medicaid Managed Care plans are required, by contract, to use LOCADTR 3.0. Commercial insurers may only use LOCADTR 3.0 or another OASAS designated tool for care provided within New York State.

Q. 1-4: How is the OASAS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0 **Tool utilized during treatment**.

A: There are three different modules for the level of care tool:

1. **LOCADTR 3.0 for SUD Level of Care**: Used at the beginning of the treatment process to determine appropriate level of care.

2. **LOCADTR 3.0 for Problem Gambling Level of Care: ** Used at the beginning of Treatment when someone's primary presenting issue is related to gambling.

[1] See: Part A of Ch. 69 of the Laws of 2016; NYS Ins. law §4902(a)(9); NYS Pub. Health law §4902(1)(i).

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3. **Concurrent Review (CR) LOCADTR:** Used during the treatment episode to determine if the current level of care is still needed or if the individual is appropriate for a different level of care.

   Concurrent Reviews should be completed:

   - When the plan requests a review:
   - For an out-of-network provider
   - After the initial time frame where review is prohibited
   - When considering a change in the current level of care

   Programs should develop policies and procedures on using the Concurrent Review Module for utilization review and treatment planning. Such policies/procedures should include but are not limited to:

   - Establishing effective communication with the Plans regarding Concurrent Review
   - Process for completing Concurrent Review
   - Procedures for following up on additional questions

   If a person no longer meets the current level of care criteria, a LOCADTR 3.0 should be completed to determine further treatment placement.

Q. 1-5: Can a tool other than LOCADTR 3.0 be used for level of care and continuing review decisions?

A: Other clinical review tools can be submitted to and designated by OASAS, provided they meet the requirements set forth in statute. When reviewing, OASAS will consider any peer reviewed level of care tool that is consistent with the NYS substance use disorder treatment service levels, and meets the following OASAS Standards for Approval of Insurance Level of Care tools:

- **Substance Use Disorder focused**: The tool must be clinically driven, evidence based and focused on substance use disorder specific criteria.
- **Person – centered**: The tool must consider the unique individual circumstances, including, but not limited to, the person's co-morbid medical and psychiatric conditions, housing and employment status, and family supports. The tool should support early recovery and longer term rehabilitative/recovery needs.
- **Flexible**: The tool must allow for alternate levels of care to be approved if the ideal level of care is not accessible.
- **Transparent**: The tool should allow both clinicians and review staff to be able to walk through a review with the same basic language and common-sense clinical logic for approvals and denials.
- **Success Driven**: The tool must allow for prompt access to a safe, supportive setting that is the least restrictive and allows the person the best chance to succeed. A person's own resources, or lack of resources, to initiate and develop skills in early recovery should be assessed within the tool. ***Fail first policies are not success driven. The tool must not delay access to care.***

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Q. 1-6: Must all Plans submit their clinical review tools to OASAS for designation pursuant to Chapter 69 of the Laws of 2016, even where a Plan received approval pursuant to Chapter 41 of the laws of 2014?

A: Chapter 69 of the Laws of 2016 included additional statutory requirements, beyond those required by Chapter 41 of the Laws of 2014.

To comply, where a Plan did not intend to use LOCADTR 3.0, the Plan was required to:

- Submit a request to OASAS for designation of an alternate tool and,
- Update their processes to reflect the new level of care tool requirements for health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2017.

This requirement is an ongoing obligation where a plan does not intend to use OASAS LOCADTR 3.0.

Prohibition of Prior Insurance Authorization for medically necessary Inpatient Treatment

Impacting care starting January 1, 2020

This law requires insurers to cover **in-network** medically necessary inpatient services for the treatment of substance use disorders, including detoxification, rehabilitation and residential treatment, when provided by an OASAS licensed, certified or otherwise authorized provider. Going forward, these levels of care will be referred to as inpatient and residential treatment.

Currently since 2017, prior authorization and concurrent utilization review were prohibited for the **first 14 days of treatment** when the provider notified the plan within 48 hours of admission that the person was receiving treatment along with the initial treatment plan.

Effective January 1, 2020 the prior authorization prohibition will be **extended to the first 28 calendar days of treatment**, provided that **within two business days from admission** the treatment provider gives the insurer notice of admission, and an initial treatment plan.

Facilities/Providers must:

- Perform daily clinical assessment of the person
- Conduct periodic consultation with the insurer **at or before the 14th day of treatment** to ensure usage of the OASAS designated tool for determining the medical necessity of the care being provided.
- Give the insurer and the person a written discharge plan which includes arrangements for post discharge services needed as recommended by the OASAS designated tool.
- Such discharge plan document must note whether the recommended services are secured or

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reasonably available.

The 28 calendar day time frame **is not a guarantee** of reimbursement for 28 days of treatment, but a period during which a plan cannot conduct either initial or continuing care review. Providers must ensure that the individual is appropriate for that level of care using the appropriate module of the OASAS designated tool. Providers should use the "periodic consultation" with the plan to discuss the information that is driving the OASAS Level of Care Determination tool. Plans are able to conduct retrospective review of the entire 28 days of treatment to assess the clinical necessity of the care.

Q. 2-1: When will this change impact Substance Use Disorder care?

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2020.

Q. 2-2: Do the Insurance Law amendments require an insurer to cover 28-days of substance use disorder treatment in an inpatient or residential facility 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** inpatient or residential facilities. Requests for coverage at out of network inpatient or residential facilities are subject to review upon admission.

Q. 2-3: What is an "otherwise authorized" OASAS provider?

A: Otherwise authorized is used to identify those providers who may hold a license issued by another New York State agency who have also received an approval from OASAS to provide substance use disorder services without obtaining an additional certification. This would include but is not limited to integrated service providers or hospitals that have received a waiver from OASAS to provide detoxification services above the discrete unit threshold.

Q. 2-4: What situations are covered by the first 28 day prior authorization/utilization review prohibition?

A: Each treatment episode is viewed independently. As long as the person meets medical necessity at the time, as determined by an OASAS designated tool, and notice of admission and an initial treatment plan are provided to the insurer within two business days of a person's admission, the following situations are included in this rule:

- recent discharge from the same or a different level of care;
- each inpatient admission;
- where a person transfers from one inpatient or residential program to another;
- each inpatient/residential admission even when multiple previous admissions exist;

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- steps down within the same facility, for example from detox to inpatient to residential consecutively;
- person moves between facilities within the same level of care, e.g. from inpatient at facility A to inpatient at facility B; or
- person steps down from detoxification to inpatient rehabilitation.

Q. 2-5: Can an inpatient or residential facility request a prior authorization or concurrent review, by the insurer, in cases where treatment might later be deemed medically unnecessary, but 28-days have not yet passed?

A: While a provider may ask, an insurer **is prohibited** by law from conducting such utilization review activities until after the 28th day of care. However, the provider is obligated, by statute to consult with the insurer, and the entities may discuss, prior to the 14th day, the person's clinical progress in treatment.

Q. 2-6: How will medical necessity be determined?

A: Medical Necessity is determined by utilizing the appropriate OASAS designated level of care tool.

- **LOCADTR 3.0 for SUD Level of Care:** Used at the beginning of the treatment process to determine appropriate level of care.

- **LOCADTR 3.0 for Problem Gambling Level of Care:** Used at the beginning of Treatment when someone's primary presenting issue is related to gambling.

- **Concurrent Review (CR) LOCADTR:** Used during the treatment episode to determine if the current level of care is still needed or a possible change to level of care.

Providers and Plans will utilize clinical information to complete the appropriate tool. If the provider and plan conclusions do not correlate they will need to discuss how the clinical information in the tool is being seen differently. If after this review there is still disagreement, the provider can file for appeal. The appeals process utilizes the following steps:

1. Peer to Peer Review with the plan
2. Doctor to Doctor Review with the plan
3. External Review

If providers feel that the plan has not appropriately followed the appeals process they can file a complaint with the NYS Department of Financial Services (DFS). Information on appeals and complaints can be found on the DFS Website.

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Q. 2-7: What are the next steps for the Plan, the person, and the facility when it is determined that an inpatient or residential level of care is not medically necessary?

A: Where a person is not or is no longer appropriate for an inpatient or residential level of care, based on the use of the appropriate module of the OASAS designated tool, a referral to a more appropriate service must be made. The person should be referred to the level of care as indicated by the tool.

- For those **already admitted** the provider must work with the person on a discharge plan which includes subsequent need for services and/or referrals. The provider should give a copy of the discharge plan, including documentation that the services have been secured or are reasonably available to the person, and the plan. Where individuals have left against medical advice, the provider should attempt to give the person a copy of the discharge plan.

- For those **not already admitted**, the reasons for denial of any admission to the inpatient or residential service must be provided to the individual and documented in a written record maintained by the service. Further, the inpatient or residential facility is expected to coordinate with the insurer to directly connect the service recipient with a program offering the appropriate services.

Q. 2-8: What constitutes notice to the insurer of an inpatient admission?

A: Notice will be sufficient where the information is provided in writing, via email, fax, or letter, and sets forth enough details to identify the insured person, along with a copy of the determination from the OASAS designated level of care tool.

OASAS has developed a form to be used for this purpose which is included in this guidance as Appendix A.

Providers are strongly encouraged to reach out to the plans to determine how best to provide the plan with the Appendix A.

Q. 2-9: What constitutes an initial treatment plan that must be included with the notice to an Insurer within two business days hours of admission?

A: An initial treatment plan for an admission to a **detox service** shall include the following:

- diagnosis for which the person is being treated;
- adherence to OASAS approved Medication induction and/or
- Medication Management protocols,
- the initial discharge plan;
- date of assessment
- medication orders for medical and psychiatric stabilization as indicated; and

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- the single member of the clinical staff responsible for coordinating and managing the person's treatment.

Where the admission is for **rehabilitation services**, the initial treatment plan should include the following:

- the initial goals for individual, group or family sessions;
- single member of the clinical staff responsible for coordinating and managing the person's treatment;
- whether education and orientation to relevant self-help groups was provided;
- whether an assessment and/or referral service for the person and significant others was provided;
- whether HIV and AIDS education, risk assessment and supporting counseling referral were provided; and
- the date of any medical or psychiatric consultation as indicated.

OASAS has developed a form which, together with the LOCADTR report, should be used for this purpose. This form is included in the guidance as Appendix A. The insurer may request documentation to support the provision of the items noted within the initial treatment plan.

Q. 2-10: If an inpatient or residential facility fails to provide an insurer with notice of an admission and an initial treatment plan within two business days of admission, can the insurer begin concurrent review of services immediately upon learning of the admission, even if it is during the initial 28-day period?

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

A: If the inpatient or residential facility fails to notify the insurer of either the inpatient admission or the initial treatment plan within two business days of the admission, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial 28-day period. Under these circumstances, an insurer may also perform a retrospective review of the treatment already provided during the initial 28-day period.

Q. 2-11: What if the inpatient or residential facility gives notice to the Plan after two business days?

A: Providers are required to give notice of an admission to a Plan within two business days and failure to do so is a violation of the law. Because the provider failed to comply, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial 28-day period. Under these circumstances, an insurer may also perform a retrospective review of the treatment provided during the initial 28-day period.

Q. 2-12: The new insurance laws require in-network facilities that are certified by OASAS to perform daily clinical review of the person, including the periodic consultation with the insurer to ensure that the facility is using the appropriate OASAS designated review tool.

How can an inpatient or residential facility meet the requirement to "regularly assess the need for continued stay"?

A: Continual assessment should occur in the normal course of treatment planning and revision by clinical and medical staff. The inpatient or residential facility must continually assess the person to determine their progress in that service and the need to continue at that level of care.

Assessment for continued stay considers:

- the original rationale for the need for the current level of care and
- current assessment of person's condition to ascertain the medical necessity for continued stay.

Continual assessment does not obligate the inpatient or residential facility to perform a daily clinical assessment using an OASAS designated tool. Where a person is no longer appropriate for that level of care, the person should be discharged to the next clinically appropriate level of care.

Q. 2-13: How often and to what extent must an inpatient or residential facility consult with the insurer?

A: Periodic consultation:

- should generally occur as often as is necessary to
  - i. coordinate care;
  - ii. ensure that the person is progressing in individually identified treatment goals; and
  - iii. that the discharge plan is adequate to meet the ongoing recovery needs of the person.

- be a **bi-directional discussion** in which both the provider and the insurer participate.

- at a minimum should occur **at least once** by the 14th day of treatment. The frequency of contact should be tailored to individual person/member need.

- Periodic consultation is not a mechanism for utilization review, including prior authorization, continued stay or concurrent review, but an opportunity for a dialogue between the provider and the insurer during the first 28 days of treatment.

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Providers are *strongly encouraged* to reach out to each plan to coordinate the best method for notifications and periodic consultation.

Q. 2-14: What actions shall be deemed sufficient to satisfy the requirement that the provider consult with the insurer at or before the 14th day of treatment?

A: Efforts which are completed in writing or by verifiable electronic means can be utilized to demonstrate the date and time that at least a request for consultation took place.

Q. 2-15: Must an inpatient or residential facility give notice to the insurer when a person leaves against medical or clinical advice during the 28-day treatment episode?

A: A provider must give notice to the Plan any time a person separates from treatment, including individuals who are discharged, leave against medical or clinical advice, or are missing. Notification should be given within 24 hours of the provider establishing that the person has left or is missing from treatment.

Q. 2-16: The legislation states that members are held harmless. Are inpatient or residential facilities able to have members sign agreements to pay if insurance does not cover?

A: Where payment is denied after an insurer conducts retrospective review, a provider may not seek to recoup those monies from the individual. Such activities are in violation of NYS statute and will subject providers to additional administrative actions. Providers are strongly encouraged to establish relationships with the plans that are likely to reduce the occurrence of denials.

Q. 2-17: Should an inpatient or residential facility collaborate with the insurer for discharge planning?

A: Discharge planning is an extension of the treatment plan that is developed at admission. As such the discharge plan should include collaboration with the individual as well the insurer and begin as soon as the person is admitted.

Individuals should be considered for discharge once they have resolve or diminished the acute issues which led to their level of care placement. Progress related to treatment plan goals should be included when consulting with the plans around the individual's treatment and continued care needs. Inherent in this discussion would be the utilization and review of the outcome from the persons level of care tool.

Where a person leaves the program without permission, refuses continuing care planning or otherwise fails to cooperate, the program may utilize the discharge plan created during the course of treatment to provide to the individual and the insurer. In this instance the provider need only note whether the services were already secured or if the services are reasonably

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available.

Q. 2-18: What elements must be included in a discharge plan?

A: A discharge plan must include the determination from the OASAS designated tool, any arrangements made for additional services and note whether those services have already been secured for the individual or are reasonably available to the person.

Where a person leaves the program without permission, refuses continuing care planning or otherwise fails to cooperate the program may utilize the discharge plan created during the course of treatment to provide to the individual and the insurer. In this instance the provider need only note whether the services were already secured or if the services are reasonably available.

Q. 2-19: What services would be deemed reasonably available?

A: A service is reasonably available where the person would be able to rapidly obtain an appointment for that service with limited travel or other obstacles which could negatively impact recovery.

Q. 2-20: How can a program show that services have been secured?

A: The provider should include the name, location, date and time for any appointments on the discharge plan to demonstrate that the services have been secured on behalf of the individual. Progress notes can also be used to document these arrangements and subsequent results.

Where a person leaves the program without permission, refuses continuing care planning or otherwise fails to cooperate, the program may utilize the discharge plan created during the course of treatment to provide to the individual and the insurer. In this instance the provider must note the nature of the person's discharge and whether the services were already secured or if the services are reasonably available prior to the person's leaving.

Q. 2-21: What levels of care are impacted by the prohibition against prior authorization or concurrent review for 28-days?

A: OASAS treatment services levels impacted by the new law include:

- 14 NYCRR Part 816 Chemical Dependence Withdrawal and Stabilization Services;
- Part 817 Chemical Dependence Residential Rehabilitation Services for Youth;
- Part 818 Chemical Dependence Inpatient Rehabilitation Services;
- Part 819 Chemical Dependence Intensive Residential Rehabilitation; and
- Part 820 Residential Stabilization and Rehabilitation Services.

Q. 2-22: Is retrospective utilization review permitted?

A: Health plans may perform utilization review of the inpatient treatment after the 28th calendar day of the inpatient admission. The utilization review may include a review of services provided during the first 28-days of the inpatient treatment.

The Insurance Law provisions further indicate that insurers may only deny coverage for any portion of the initial 28-day inpatient treatment where the treatment was not medically necessary as indicated by the OASAS designated level of care review tool. Providers can appeal this denial utilizing the NYS DFS Appeals and Complaint process.

Q. 2-23: Are insurers required to cover days 1 – 28 of an inpatient admission if they subsequently determine that some or all of days 1-28 were not medically necessary?

A: 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. 2-24: Can a Provider appeal an Insurers determination that some or all of the treatment provided without authorization or concurrent review during the initial 28-days of treatment was not medically necessary?

A: Pursuant to Article 49 of the Insurance law and Article 49 of the Public Health Law, a provider may appeal an adverse determination resulting from a retrospective review. During retrospective review, an insurer may only deny that portion of the initial 28-days of inpatient treatment that was not medically necessary because it was contrary to the OASAS designated review tool utilized by the insurer. The NYS DFS Appeals and Complaint process gives further information on this process.

Q. 2-25: Is the 28-day prohibition on prior authorization or concurrent review requirement limited to a request for coverage of inpatient or residential treatment for opioid use disorder only?

A: Chapter 71 of the laws of 2016 prohibited prior authorization for medically necessary inpatient or residential services for any substance use disorder for 14 days. Chapter 57 of the Laws of 2019 extended this coverage to 28-days and continues to apply to all substance use disorders.

Q. 2-26: Are Insurers required to have SUD inpatient and residential facilities in their network?

A: Insurers must include substance use disorder inpatient and residential facilities within their network, to ensure individuals can access all needed levels of care. Insurers' inpatient or residential facility networks will be closely monitored. Network Adequacy Guidance has

been issued by the New York State Department of Financial Services.

The New York State Department of Financial Services Model Contract Language describes the substance use disorder treatment services included in insurance contracts regulated by New York State.

Prohibition of Prior Insurance Authorization for medically necessary Outpatient Treatment

Impacting care starting January 1, 2020

Since April 12, 2018 insurers have been required 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).

Effective January 1, 2020 this prohibition will be extended to the **first 4 weeks of treatment not to exceed 28 visits**, provided the outpatient facility:

- is **in-network** and
- licensed, certified or otherwise authorized by OASAS and
- gives the insurer notice and
- an initial treatment plan **within two business days** of the person's admission.

Facilities must still perform clinical necessary services at every visit. However, a change from existing requirements is that **the provider must conduct periodic consultation with the insurer at or before the 14th day of treatment** to ensure usage of the OASAS designated tool for determining the medical necessity of the care being provided.

The statute regarding the four week time frame is not a guarantee of reimbursement for 28 days of treatment, but a period during which a plan cannot conduct either initial or continuing care review. The provider must ensure that the individual is appropriate for that level of care using the appropriate module of the OASAS designated level of care tool.

Q. 3-1: 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. 3-2: What constitutes continuous treatment?

A: Continuous treatment means any combination of services provided to an individual

and/or collateral person after the four week time period has started.

Q. 3-3: When does the four weeks of continuous treatment period start?

A: The four week period begins at the first service provided to an individual after an initial face to face contact with the person. The date of the second service initiates the 28 day time frame **regardless of an individual's admission status**. The provider has 48 hours after the second service to notify the plan of the person's attendance.

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 also includes circumstances where an individual is assessed and determined not to need addiction 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 four week time frame would begin when the assessment was provided, and the provider would need to submit required materials to the insurer within two business days of the assessment being provided.

Q. 3-4: What services are included within the no prior authorization or concurrent review for the first four 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. 3-5: Is an insurer required to begin conducting utilization review at four weeks?

A: 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.

Insurers under certain contracts, e.g. Medicaid Managed Care Plan, must comply to the level of prior authorization prohibitions as required in that contract even in instances where the standard is greater than the one given in Statute.

Q. 3-6: Are outpatient services now limited to no more than four weeks?

A: Services continue to be delivered in a duration and frequency that is clinically determined as necessary. The four week/28 day prohibition applies only to the portion of time where plans cannot request concurrent review. Providers 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. 3-7: Is the four week/28 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: The amendment to the insurance law prohibits prior authorization for medically necessary outpatient program services for any substance use disorder.

Q. 3-8: Are Insurers required to have outpatient programs, certified pursuant to Part 822 and Part 825, in their network?

A: 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.

View the New York State Department of Financial Services, Model Contract Language for a description of the addiction treatment services included in insurance contracts regulated by New York State.

Q. 3-9: 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 is utilizing OASAS Approved Ancillary Withdrawal Service protocols.

Q. 3-10: Must the outpatient Program confirm coverage and benefits prior to admission?

A: 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. Programs should confirm that the persons insurance plan and/or eligibility to verify that the policy is subject to New York State law.

Q. 3-11: Do the Insurance Law amendments require an insurer to cover four weeks with an outpatient provider without prior authorization when the facility is an out of network provider?

A: 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. 3-12: What situations are covered by the first four weeks without prior authorization/concurrent review?

A: The prohibition against prior authorization or concurrent review applies to each admission at each level of care. As long as the person meets medical necessity, as determined by an OASAS designated tool, and notice and an initial treatment plan are provided to the insurer within 2 business days of admission, the following situations are included in this rule:

- recent discharge from the same or a different level of care;
- each outpatient admission; even when multiple previous admissions exist;
- where a person transfers from one outpatient program to another;
- when a person steps down from a bedded program to an outpatient program; or
- from more intensive outpatient level of care (intensive outpatient services, outpatient rehabilitation service) to a less intensive outpatient program.

Q. 3-13: 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 four weeks of continuous treatment, not to exceed 28 visits, have not yet passed?

A: While a provider may ask, an insurer is prohibited by law from conducting such utilization review activities until after the four weeks of continuous treatment. However, the provider is obligated by statute to consult with the insurer, and the entities may discuss the person's clinical progress in treatment. prior to the end of either the four week or 28 visit period.

Q. 3-14: 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. 3-15: 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. 3-16: What constitutes an initial treatment plan that must be included with the notice to an Insurer within two business days of admission?

A: An initial treatment plan for an admission to an outpatient program shall include the following: individual identifying information; insurance identification; diagnosis for which the person is being treated; current level of care; next anticipated service and the next anticipated date of service.

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. 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.

Q. 3-17: 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 2 business days of the provision of any service after an initial assessment of the person.

Q. 3-18: If an outpatient program fails to provide an insurer with notice of an admission and an initial treatment plan within 2 business days of admission, can the insurer begin concurrent review of services immediately upon learning of the admission, even if it is during the initial four week or 28 visit period?

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

A: If the outpatient facility fails to notify the insurer of either the first visit after an initial contact with the person or the initial treatment plan within 2 business days of the first visit after an initial contact with this person, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial four week or 28 visit period. Under these circumstances, an insurer may also perform a retrospective review of the treatment already provided during the initial four week or 28 visit period.

Q. 3-19: What if the outpatient facility gives notice to the Plan within 2 business days 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, sent emails or read receipts.

Q. 3-20: What if the outpatient facility gives notice to the Plan after 2 business days?

A: Providers are required to give notice to a Plan within two business days of a first visit after an initial contact with this person. Failure to do so subjects all services to immediate review by the insurer, even if it is during the initial four week or 28 visit period. Under these circumstances, an insurer may also perform a retrospective review of the treatment provided during the initial four week or 28 visit period.

Q. 3-21: How can an outpatient facility meet the requirement to "regularly assess the need for continued stay" as given in the new insurance law?

A: Continual assessment should occur in the normal course of treatment planning and revision by clinical and medical staff. The Program must continually assess the person to determine their progress in that service and the need to continue at that level of care.

Assessment for continued stay considers:

- the original rationale for the need for the current level of care
- current assessment of the person's condition to ascertain the medical necessity for continued stay.
- the clinical justification for the treatment or retention of a person at the current level of care when overriding the LOCADTR outcome for a different level of care.

Continual assessment does not obligate the inpatient or residential facility to perform a daily clinical assessment using an OASAS designated tool. Where a person is no longer appropriate for that level of care, the person should be discharged to the next clinically appropriate level of care.

Q. 3-22: 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. At a minimum the provider must ensure a best effort to engage in a clinical consultation with the insurer at or before the 14th visit. The provider can document such efforts through the use of written or electronic communications and should note all efforts within the person's record.

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Q. 3-23: Must an outpatient program give notice to the insurer when a patient leaves against medical or clinical advice during the initial four week treatment episode?

A: A provider must give notice to the Plan any time a person separates from treatment, including individuals 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 an individual has separated from treatment.

Q. 3-24: 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: Where payment is denied after an insurer conducts retrospective review, a provider may not seek to recoup those monies from the person. Such activities are in violation of NYS statute and will subject providers to additional administrative actions.

Q. 3-25: Should an outpatient program collaborate with the insurer for discharge planning?

A: Programs should collaborate with insurers regarding clinical case management. Identification of and coordination with recovery supports should begin as soon as the person is admitted though coordination with an insurer is not required for this purpose.

Q. 3-26: Is retrospective utilization review permitted?

A: utilization review may include a review of services provided during the four weeks of continuous treatment or 28 visits at the outpatient service from the first contact with the person .

The Insurance Law further provides that insurers may only deny coverage for any portion of the initial four weeks/ 28 visits of outpatient treatment on the basis that the treatment was not medically necessary because such treatment was contrary to the clinical review tool utilized by the insurer and designated by OASAS.

Q. 3-27: Are insurers required to cover visits 1–28 of an outpatient admission if they subsequently determine that some or all of visits were not medically necessary?

A: 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. 3-28: Can a Provider appeal an Insurer's determination that some or all of the treatment provided without authorization or concurrent review during the initial four weeks was not medically necessary?

A: Pursuant to Article 49 of the Insurance law and Article 49 of the Public Health Law, a provider may appeal an adverse determination resulting from a retrospective review. During retrospective review, an insurer may only deny that portion of the initial 28-days of four weeks or 28 visits of outpatient services that was not medically necessary because it was contrary to the OASAS designated review tool utilized by the insurer. The NYS DFS Appeals and Complaint process gives further information on this process.

Q. 3-29: Are Medicaid Managed Care plans subject to additional requirements beyond those included in the insurance law?

A: Medicaid Managed Care plans are also required to comply with benefit coverage requirements enumerated within the Medicaid Managed Care Model Contract. Specifically, for outpatient services, Medicaid Managed Care plans are prohibited from requiring prior authorization for outpatient ambulatory services.

Copay limitations for Outpatient Programs

Impacting Care starting January 1, 2020

Chapter 57 of 2019 added new Insurance Law §§ 3221(l)(7)(C-1) and 4303(l)((3-a) that prohibit a large group policy or contract from imposing copayments or coinsurance for outpatient SUD services that exceed the copayment or coinsurance imposed for a primary care office visit. It further provides that a large group policy or contract may impose no greater than one copayment for all services provided in a single day by a facility licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use disorder services.

Q. 4-1: When does the requirement that outpatient SUD services be subject to a copayment or coinsurance no greater than the primary care provider (PCP) office visit copayment or coinsurance apply?

A: This requirement is effective **January 1, 2020** and applies only to large group coverage. The requirement applies to all outpatient SUD services and **is not limited** to outpatient SUD services provided by outpatient facilities licensed, certified, or otherwise authorized by OASAS. The requirement applies to **in-network services**. The requirement does not apply to out-of-network services.

Q. 4-2: When does the requirement that outpatient SUD services be subject to no more than one copayment per day for all outpatient SUD treatment provided in a single day apply?

A: This requirement is effective **January 1, 2020** and applies only to large group coverage. The requirement applies only to services provided by outpatient facilities licensed, certified, or otherwise authorized by OASAS. The requirement applies to in-network services. The requirement does not apply to out-of-network services.

Q. 4-3:. Are issuers permitted to apply separate copayments for the facility and the professional services for treatment of outpatient SUD in an outpatient facility?

A: Not for large group policies and contracts. The law provides, with respect to large group policies and contracts, that an issuer may not impose more than one copayment per day for all services provided in a single day by the facility.

Q. 4-4: What constitutes a "large group policy or contract?"

A: A group policy is a health insurance policy purchased by an employer to cover its employees. If the employer has more than 100 employees, that policy is considered a large group policy. New York law applies where the employer purchases the policy in New York State.

Prohibition of Prior Insurance Authorization for Medications for Treatment of Substance Use Disorder

Insurers are prohibited from requiring prior approval for any covered prescription medications for treatment of a substance use disorder contained on the insurers formulary. Under the federal Affordable Care Act ("ACA"), individual and small group health insurance policies or contracts must provide a comprehensive package of items and services, which are known as essential health benefits ("EHB"). Prescription drugs are specifically identified as an EHB that must be covered. Pursuant to 45 C.F.R. § 156.122(a)(1), a health insurance policy or contract providing coverage in the individual or small group market would not be considered to be providing EHB unless, in relevant part, it covers at least the greater of at least one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan.

With respect to large groups, issuers must provide coverage for medication approved by the FDA for the detoxification or maintenance treatment of a substance use disorder in all policies and contracts issued, renewed, modified, altered or amended on or after January 1, 2017. However, because MHPAEA requires policies and contracts that currently cover prescription drugs to also cover prescription drugs to treat substance use disorder on parity with prescription drugs to treat medical conditions, all current large group policies and contracts that provide prescription drug coverage must

currently provide coverage for substance use disorder medication on parity with other prescription drugs.

Furthermore, § 52.16(c) of 11 NYCRR 52 (Insurance Regulation 62) prohibits issuers offering individual, small group and large group health insurance policies from limiting or excluding coverage by type of illness, accident, treatment, or medical condition. With regard to opioid overdose medication, in order to comply with these requirements, issuers should provide coverage for naloxone on an outpatient basis when prescribed to insureds by authorized providers, as they would for any other prescribed drug, subject to the terms and conditions of the health insurance policy or contract. In addition, naloxone also should be covered on an inpatient basis when medically necessary. According to the federal Substance Abuse and Mental Health Services Administration's website, naloxone is an FDA-approved prescription drug used to block or prevent the effects of opiates and opioids, such as heroin and oxycodone. It is often used in an emergency to prevent or reverse the effects of an opioid overdose.

Coverage for naloxone is specifically required under New York State law where the medication is prescribed or dispensed to an individual covered under the policy.

Q. 5-1: When will this change impact Substance Use Disorder care?

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after **January 1, 2020**.

Q. 5-2: Does the requirement for coverage of substance use disorder medication apply to over the counter medication?

A: Yes, if over the counter medication for a substance use disorder is otherwise covered under the policy or contract.

Q. 5-3: If a plan does not cover a particular medication under their formulary, is there a process to request access that medication?

A: Yes, a patient or their provider can request coverage of a prescription drug that is not on the plan's list of covered drugs ("formulary"), including a prescription drug to treat a substance use disorder, and the plan must review these requests. The plan must make a decision within 72 hours for a standard request or 24 hours for an expedited request. An expedited request can be made where patient health, life, or ability to regain maximum function is in danger or if the patient is currently being treatment with a non-formulary prescription medication.

Please direct any questions regarding this guidance document to:
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APPENDIX A

Appendix A

INITIAL NOTIFICATION and TREATMENT PLAN

Person's Name:	Date of Birth:
Insurance ID:	
Diagnosis:	Date of Admission:
LOCADTR3 Report (Attached)	

Detoxification / Stabilization Initial Treatment Plan

Adhere to OASAS approved detoxification taper/protocol:			
Medication(s)		Planned Taper Duration:	
Initial Discharge Plan:	To Home outpatient	Inpatient	Residential
Other:			
Crisis Stabilization:			
Date of Assessment:	Med Orders:		
Medical Stabilization:			
Date of Assessment:	Med Orders:		
Psychiatric Stabilization			
Date of Assessment:	Med Orders:		
Clinician Assigned:			

Inpatient / Residential Rehabilitation Initial Treatment Plan

Individual Goal(s):	Individual	Group	Family Sessions
Skills/Medication to reduce urges/cravings			
Motivational Interviewing to increase internal commitment			
Coping skills building to improve emotional regulation, self-soothing			
Facilitate engagement with others – social skills to support recovery			
Other:			
Case Manager Assignment:			
Education about, orientation to, and the opportunity to participate in, relevant self-help			
Assessment and referral services for the person and significant others			
HIV and AIDS education, risk assessment, and supportive counseling and referral			
Date of Medical Consultation:			
Date of Psychiatric Consultation (as needed):			
Signature		Date	

APPENDIX B

Appendix B **INITIAL NOTIFICATION and TREATMENT PLAN**	
Person's Name:	Date of Birth:
Insurance ID:	Identification Number:
Diagnosis:	Date of Initial Assessment:
LOCADTR3 Report (Attached)	
• Assessed, Not Admitted	
Reason:	

Part 822 Services - Initial Treatment Plan

Current Level of Care:	
Next Anticipated Service Date: Planned Taper Duration:	
Next Anticipated Service:	
☐ Additional Assessment	
☐ OASAS approved Detoxification taper / protocol	
☐ Medication Assisted Treatment	
☐ Health Assessment and Physical	
☐ Individual Session	
☐ Group Session	
☐ Family / Collateral Sessions	
☐ Peer Services	
☐ Toxicology	
☐ Psychiatric Assessment	
☐ Other (Please Specify)	
Signature	Date: