NEW YORK STATE | Office of Addiction Services and Supports

Part 822 Outpatient Regulation January 2021 Webinar FAQ's

March 2021

OASAS Certified Outpatient Programs

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I. Introduction

As part of the on-going Medicaid Reform process, OASAS, along with other state agencies, has been working to enhance the quality of patient care while optimizing the use third party reimbursement in a service system driven by quality and treatment outcomes. During this time much change has taken place in the form of reducing the prescriptiveness of regulations to allow providers flexibility to provide person centered treatment services.

On **January 7, 2021** OASAS provided the webinar, **Part 822 Regulations Discussion and Q&A**, to present upcoming changes to the **Current Part 822 Regulations**. The webinar sought to address the effects of the **Updated Part 822 Regulations** on clinical, regulatory, and reimbursement practice. Due to the number of individuals in attendance at the webinar, OASAS requested that providers send their questions into the **Legal** and **PICM Mailbox** for further response. The following pages provide responses to the most commonly asked questions and concerns from the webinar.

Please note this document is focused on changes to the Part 822 Regulations as well as other areas discussed during the webinar. If after reading this information you have further questions please send them to the **Legal** and/or **PICM Mailbox**

II. Changes to the Regulation

What are the major differences between the Current Part 822 Regulations and the Updated Part 822 Regulations?

a. **Assessment and Admission**:
   - Admission decision made by QHP working within their scope of practice, **AND**
   - Approved by the dated signature of a physician, physician's assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker

b. **Treatment planning**:
   - Begins at first patient contact
   - No formal separate, stand-alone Treatment Plan document
   - Plan of treatment including goals, services needed, outcomes documented within progress notes.
   - Refined and/or updated on an on-going as needed basis within progress notes

- Be reviewed and approved by the patient, responsible clinical staff person, and Clinical Supervisor
- Eliminates the 30, 90, 180, etc. treatment plan review requirements in lieu of updates being part of the ongoing progress note documentation.

c. **Discharge Date** - Patients lost to contact must be discharged after a period of **sixty (60) days** unless a reason to maintain the patient as identified in the patient record.

d. **Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (LGBTQ) liaison**:
   - Program must have a staff person identified for this purpose
   - Program must have policies and procedure regarding this person's role within the agency as given in **LSB: Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients**.

III. Regulatory Implications

a. Documentation

1. Are there OASAS Model Case Records and/or New York State Case Record Initiative (NYSCRI) forms to utilize for the new requirements?

OASAS does not provide model case records for the documentation of treatment services. The NYSCRI forms have also been discontinued.

Providers are responsible for reviewing the regulations and developing documentation practices which are compliant and reflective of the treatment process.

2. During the COVID Emergency what are the requirements for obtaining signatures on patient consents?

During the COVID emergency, please refer to the current **COVID Telepractice FAQ's** for guidance regarding documentation of patient consent/signatures when services are delivered via telehealth

b. Assessment/Admission

1. **What is the timeframe for the MD/NP/PA/LCSW/Licensed Psychologist to sign off on the admission decision?**

   The regulations do not specify a timeframe on the admission decision signature. However, since the admission date is the first treatment service after the admission decision is made an admission cannot be determined until the appropriate review and approval takes place. A person cannot be admitted into the program without the appropriate review of assessment information and signature by qualified staff working within their scope of practice.

   Providers should view the admission decision as part of the entire assessment process and have policies and procedures that reflect this process. Data is gathered during the assessment process that is used to determine if individuals have an addictions diagnosis, as well as the initial course of treatment, and level of care. The given signatories can either provide the assessment services directly or review the information gathered by another clinical staff member's interaction with the individual. In either case, the provider's policies and procedures should outline this process as well as how it is documented in the case record.

2. **Can an LMHC sign off on the admission decision?**

   The admission decision is predicated on the individual having an addictions diagnosis. LMHC's are not able to provide an independent diagnosis, therefore would not qualify to approve an admission decision.

3. **If the admission decision form is signed by a physician, PA, NP, LCSW or licensed psychologist does it then need to also be approved by another physician, PA, NP. LCSW or licensed psychologist?**

   No

4. **Do you need to use LOCATOR 3.0?**

   Yes

c. Treatment Planning

1. **Do we have the option to keep our current system of treatment planning in place if we choose to - standalone document, 90/180 days reviews, so long as we also are sure to address treatment plan goals in progress notes?**

   No, this is not recommended and is not in the spirit of the new regulation.

2. **What credentialed staff will be able to update treatment plans in progress notes? Do all the notes need to be signed by a medical doctor, PA, NP, licensed psychologist, or LCSW?**

   Progress notes are written by the primary counselor; there is no staffing requirement regarding who can write progress notes. Review of notes which reflect ongoing progress or changes in treatment can be conducted during clinical supervision.

3. **Does every progress note need to address every goal of the treatment plan or can it address one at a time?**

   Only the goals discussed and worked on within the treatment service should be documented in the progress note and should be driven by the client's articulated needs expressed during the session.

4. **What if a patient refuses to address a life area such as smoking? Do we no longer address this issue?**

   Treatment planning is client driven, however, clinically discussing various issues can certainly happen but does not necessarily have to be incorporated as part of the treatment planning process, unless the client wants to work on this/these goals

5. **Will updating the treatment plan in the notes impact privacy rules regarding the release of psychotherapy notes (normally protected), vs. treatment plan (normally subject to disclosure)?**

   Disclosure is subject to patient consent. The patient record disclosed must be accomplished with the minimum amount of information necessary to meet the purpose for disclosure. The consent form shall include an explicit description of the SUD information to be disclosed such that the patient and the program staff understand the purpose and scope of the disclosure and tailor the information to be disclosed accordingly.

Although patients have the right to obtain their treatment records, subject to the provisions of HIPAA, a provider may withhold information that could be damaging to the patient (such as therapy notes).

d. Discharge/transition plan:

1. Is a discharge summary is no longer required?

A “formal” discharge summary is not required in the new regulation. However, progress notes should contain the same information as the summary once did, e.g. course of treatment, outcomes, reason for discharge, post discharge referrals.

2. What is the length of time a client must be lost to contact before they can be discharged?

Patients lost to contact must be discharged after a period of sixty (60) days unless a reason to maintain the patient is identified in the patient record.

3. How should we report on goal achievement as required on PAS45?

Even though there will no longer be a “formal” treatment plan, goals will continue to be identified and met as documented in the progress notes. Therefore, upon discharge, the primary counselor by reviewing the ongoing report in the progress notes will be able to report on goal achievement as per the PAS-45.

e. Staffing requirements:

1. Regarding "at least one full time QHP" can this be two part time Social Workers or does one have to be a full time person?

There must be at least one full-time Credentialed Alcoholism and Substance Abuse Counselor (CASAC); and there must be at least one full-time qualified health professional.

2. Are outpatient programs required to have a full-time peer advocate or can they be part time?

The certified recovery peer advocate staff person can be part-time.

3. **What is the purpose and role of the LGBTQ liaison?**

   The LSB: **Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients** gives information regarding this position.

4. **What are the responsibilities and requirements of the Medical Director?**

   The **Part 800 General Service Provision Regulation** gives full information regarding the Medical Director.

f. Compliance

1. **When will OASAS begin utilizing the Updated Regulation SRI for compliance audits?**

   The updated site review tool will be utilized beginning August 2, 2021.

2. **How will reviews be handled between now and the time the new regulations become effective on August 1, 2021?**

   Implementation of the regulation was delayed until August 2, 2021. Reviews will be conducted using the currently effective regulation and site review tool prior to August 2nd.

3. **Without a formal treatment plan, how will OASAS Certified Programs also certified by CARF or the Joint Commission comply with their treatment plan requirements.**

   Treatment planning as well as the on-going review will be documented in the case record, therefore meeting accreditation organizations' (i.e., CARF or the Joint Commission) requirements.

4. **During compliance reviews how will auditors evaluate plan of treatment?**

   Providers are required to have policies and procedures regarding their treatment planning process. This information should inform the auditor on how to review the chart for compliance.

5. **How will consistency in compliance reviews be assured with these new requirements?**

   OASAS is providing internal training to OASAS staff to ensure consistent interpretation of the new regulations as well as regulatory interpretation. In addition, outreach and education will also occur with all applicable external stakeholders, e.g., insurance plans, Office of the Medicaid Inspector General (OMIG), etc. to ensure understanding and consistency in their review process(s)

6. **There used to be a treatment category called "Outpatient Clinic". How has that service been merged into the new system of services?**

   There are three different treatment settings covered under the Part 822 Outpatient Regulations: Outpatient Clinic (which includes Intensive Outpatient Services), Outpatient Rehabilitation, and Opioid Treatment Programs (OTP). The updated regulation utilizes the term “Substance Use Disorder Outpatient Program” to denote the previously named Outpatient Clinic.

7. **For integrated outpatient programs with OMH as the host--do we follow OASAS regulations or OMH?**

   Integrated programs are required to follow the regulations of the host agency. Consult OMH for any treatment planning guidance for integrated OMH host outpatient programs. For integrated programs with an OASAS host, please see the guidance posted on the website as to how treatment planning shall be conducted.

IV. Clinical

a. Clinical Standards

1. **Will the Clinical Standards for 822 programs be updated and when will they be available?**

The **Clinical Standards for OASAS Certified Programs** are in alignment with the concepts presented in the Updated Part 822 Regulations.

2. **How soon does a client have to be scheduled for their first individual session after intake?**

The regulations do not provide a timeframe between intake and first individual session. From a clinical perspective priority should be given to those at highest risk

and/or most need. Providers should develop a triaging process as part of their policies and procedures.

b. Plan of Treatment

1. **The treatment plan needs to start at the time of the assessment. What if the intake worker will not be the primary therapist?**

   An initial plan from the intake workers perspective can be documented as follows: “Client will meet with primary therapist to initiate treatment; Client will be referred to physician for medication assessment. Client will complete medical assessment: These statements would serve as the initial plan in this case.

2. **There's a reference to an "ongoing assessment process" (pg. 21 - (2) vi -i - what is the process beyond documentation of notes?**

   The ongoing assessment process is documented in the progress notes; there is no other place in the case record where this is written.

3. **Prior to the admission date does an initial plan need to be completed.? Or is it when we make the admission decision which is usually done on the day of admission or the day before the next visit which would be the admission date?**

   Any plan with the client should be documented in the notes from the beginning – even if that plan is continued assessment to determine a plan.

4. **Will there be an "initial treatment plan" requirement for new patients?**

   All new admissions should have an initial plan of treatment that is documented in their patient record.

5. **Can you use an initial treatment plan form if you choose as an agency?**

   Providers are responsible for developing policies and procedures regarding treatment planning. It is important to have a section that includes a plan, it could be a separate form connected to the assessment or incorporated within the assessment documentation.

6. **Should the plan include specific goals and objectives?**

   The plan should incorporate the client’s own unique language, strengths, values, goals, and beliefs about what will work for them. Specificity regarding exclusive

use of “goals” and “objectives” is not indicated. See **Treatment Plan Addendum for examples**.

7. **Treatment plans used to have to be completed “as soon as possible after admission but not later than thirty (30) calendar days after admission”. What due date, if any, is associated with the new regs?**

   The initial treatment / recovery plan will be done as part of the admission assessment. There is no time frame otherwise noted in the regulation

8. **Where and when should the patient sign the progress note(s) indicating they reviewed and approved the plan of treatment?**

   The patient’s “voice” and articulation regarding treatment planning should be documented in the case record; the client’s signature is not a regulatorily requirement.

9. **Are we required to identify and address all life areas in each progress note?**

   All life areas do not need to be discussed in each counseling session. Only the treatment plan goal(s) that is being discussed and worked on as part of the that session needs to be documented. For example, the patient may have indicated 3 things they wished to work on during their initial counseling session. Those 3 goals should be listed in the progress note for the initial session. However only the goal(s) discussed in subsequent sessions would need to be identified in those progress notes. Clinicians will have to be mindful to review past notes to see what if any changes to original goals may need to be discussed.

10. **If we are doing our treatment planning during individual sessions are the minimum amount of sessions/month per regulations going to increase?**

    There is no regulatory requirement regarding a minimum number of counseling sessions that have to occur per month. Frequency of counseling sessions should be based on individual client treatment needs.

11. **Are there any suggestions/best practices of how to document the review of the progress notes?**

    Each individual may find different approaches to keeping track of progress note review. You may utilize a log of discussions and any feedback for treatment in supervision notes.

12. **With the plan of treatment being contained within the progress notes how and when will other required clinical staff members, e.g. MD, psychiatrist, etc. review and sign off on the information? Will these staff have to go back through and review the entire chart to approve?**

    Once the admission decision has been reviewed and approved, the clinical supervisor will be responsible for reviewing the documentation of the primary counselor. The regulation continues to require and support the multidisciplinary team. During case conference clinicians should present any patient situation which would benefit from the input of other clinical specialist. Such a review should be documented in the case review notes.

13. **Are all clinicians supposed to be referenced on all notes even if not worked on? if not where are people supposed to be seeing the full list of active goals since they won't all be on a single document.**

    Progress notes are meant to document the service(s) provided on that date. If a particular goal being attended by a different clinician is not provided on that date the information would not be included in the note.

    Case conference provides the opportunity to review and discuss the patient's comprehensive treatment process including input from all involved staff.

14. **Does every single SW/counselor Progress Note need to discuss/mention the primary treatment plan goal(s) as articulated by the patient?**

    No, each progress note should discuss / mention the treatment planning goal/s that reflect what the client wished to currently work on. Short term treatment planning should be documented in the progress note.

15. **Will it be acceptable for a CASAC to perform the assessment, but have the QHP review, approve and sign off on it?**

    A CASAC is a QHP. For regulatory purposes a MD, PA, NP, LCSW, or licensed psychologist would review the findings to determine diagnosis and if the person meets the admission criteria.

16. **What if QHP disagrees with diagnosis of CASAC how would that work if you already started treatment?**

    A CASAC is a QHP. For regulatory purposes a MD, PA, NP, LCSW, or licensed psychologist would review the findings to determine diagnosis and if the person meets the admission criteria. An admission / start of treatment services cannot occur without the approving dated signature as given above. ~~QHP.~~

For pre-admission or extended pre-admission services the clinical staff person's supervisor would be responsible for reviewing the appropriateness of the current service provision and a licensed staff will need to review the information collected to affirm a provisional diagnosis of SUD.

17. **With patients no longer being required to attend group, how is treatment to be provided? Most programs have target numbers, with mandates to decrease traffic.**

    Individuals seeking treatment have never been required to attend group in Outpatient Clinic or OTP's. Programs are required to provide group services but, not all individuals need or want to receive group counseling services. Person-centered care is driven by the patient's identified needs not by target numbers. OASAS Regional Office Program Managers should be consulted regarding any issues regarding units of service.

18. **What about the peer advocates wellness plans, would they need to continue or are they eliminated?**

    The goal for a client working with a peer should be addressed in a clinical note. Peers must document interaction with the client including the purpose of the visit and wellness planning is an appropriate way to do that, but not required.

19. **How are new, post-assessment goals to be addressed?**

    Any updates to the patient's identified goals should be included in the progress note for the date of service where this was indicated.

20. **How should we update treatment goals if a patient is not attending treatment?**

    The requirement for treatment plan reviews to occur within a specific time frame, i.e. 90,180,etc days, has been eliminated in the updated regulations. The treatment plan goals would remain the same as indicated by the progress note from the last attendance date.

21. **Will there be similar treatment planning updates for other levels of care?**

    Yes, to the extent possible under CMS authority.

c. Continuing Care:

1. **Is there a cap on the frequency of individual counseling sessions and peer support services delivered to a patient in continuing care?**

   There is no longer a hard number but people in continuing care are there for long term management of medication, or symptoms and it would not be appropriate for them to be receiving active treatment over time.

2. **Is there a timeframe from the discharge date where individuals can opt into Continuing Care?**

   Individuals can opt into Continuing Care any time after discharge as long as they continue to meet the criteria for **Continuing Care Services.**

3. **Can patients in continuing care be involved in groups?**

   Individuals in continuing care may receive counseling or peer services, rehabilitative support services including case management and medication management services as needed.

4. **Are treatment plans required for continuing care?**

   The goals and objectives for receiving Continuing Care services should be written in the progress notes, the same as for patients in active care.

5. **Can those discharged from OTP's be referred to Continuing Care?**

   Those utilizing other than methadone addiction medications can be referred to and participate in Continuing Care. These individuals would not count towards the program's capacity.

d. Opioid Treatment Programs:

1. **Is the expectation for Opioid Medical Maintenance programs to provide individual counseling and treatment planning?**

   All OASAS Certified Opioid Treatment Programs are required by OASAS Part 822 Regulations to provide the same services as Outpatient Clinics, i.e. individual, group counseling, etc. The provision of these services should be based on the patient's expressed needs.

2. **Would the OTP federal requirement for a periodic assessment be used to review the long-term treatment goals?**

   Long term treatment goals are not a federal requirement, treatment planning is. The periodic assessment requirement indicated in the federal guidelines align with the new treatment planning requirements.

3. **In OTP's does the MD signing off on the initial physical authorizing the first dose serve as the admission decision, correct?**

   Yes.

4. **Does the Medical Director, rather than another physician, have to review and confirm the appropriateness for take-home medication?**

   Per federal regulation, the medical director is ultimately responsible for the take home policies and procedures of the OTP. Physicians working under the OTP's Medical Director will make individual patient decisions regarding take home appropriateness based on the Medical Director's direction and expectations.

5. **Is OASAS going to reduce/limit caseload sizes in OTPs?**

   The Part 822 Regulations require that Outpatient Programs, including OTP's, have an adequate number of counselors sufficient to carry out the objectives of the program and to assure the outcomes of the program are addressed. Retention of patients in treatment and patient stability in treatment are factors to be considered when determining case size. The program should also monitor clinical staff subjective ability to manage caseload and adjust as needed.

6. **How do OTP's document and bill for services provided to significant others admitted into treatment?**

   Documentation and billing requirements are the same for significant others as for those with an SUD being admitted into treatment. The only exception is that the LOCADTR 3.0 would not be utilized.

7. **With telehealth are we still looking to provide at least 8 random toxicology tests a year?**

   Telepractice counseling and medical visits (as applicable) are separate from the 8 toxicology tests per year requirement, which is required by federal regulation. However, during the COVID 19 Emergency certain guidance has been issued

regarding the limiting of routine toxicology testing. Please review **OASAS Outpatient COVID 19 Guidance** and **OASAS OTP Reopening Guidance** and

8. **Must a nurse always be present when medication is being administered in OTP?**

   Federal Law requires that a nurse be present.

9. **What are the requirements for a patient's readmission to treatment when it is within 3 months of discharge?**

   The OTP should not repeat admission procedures, nor need to repeat a medical and laboratory examination, unless the patient received a medical / laboratory examination within the previous year, PROVIDED that… the patient's prior medical records must be combined with the new medical records within thirty days of the patient's readmission.

10. **Is there a time requirement for Physical exam upon admission into an OTP?**

    A comprehensive physical examination must be completed within fourteen days, or otherwise in accordance with federal rules.

11. **Can an individual who is admitted into an OTP also receive services at a separate Outpatient Clinic?**

    It is expected that an OTP should be able to address all needed services. Only in special circumstances should an OTP patient be referred to an outpatient clinic service.

12. **Are OTPs going to continue the 28-day regular take home schedule for patients who maintain compliance and abstinence for 2+ years?**

    Yes.

e. Evidence Based Practices

1. **Do you have any suggestions for practices in coordinating care for families?**

   The **OASAS Family Services Guidance** provides information on incorporating family members into treatment.

2. **Are there any provisions to build in parenting classes and anger management classed into programs.**

   Providers are responsible for developing services in support of their patient's identified needs.

3. **Intensive Outpatient Services (IOS) definition states program must offer DBT and other evidence based practices. Does that mean we must have someone who is certified in DBT on clinical staff?**

   The definition at Part 822.5(p) requires provision of identified EBPs as appropriate and other EBPs as proven effective in meeting patient needs. If a program is utilizing an EBP for providing services the expectation is that the staff providing are appropriately trained and supervised in the practice.

4. **What do you consider as staff that can implement DBT? Does this mean that they have a full DBT certification, a certain number of DBT training hours, etc.?**

   DBT is an example of an EBP. It is always best to have certification when providing an evidence based practice, but counselors may have training and use specific techniques or skills from that training.

5. **Will there be additional training on evidenced based services for working with co-occurring conditions and other fragile populations?**

   OASAS continues to provide resources for working with specific populations or treatment issues. Providers can find these resources on the OASAS Website on the **Treatment and Clinical Support Page** and the **Professional Training Page**.

V. Medical Questions:

1. **The OASAS Medical Director in July 2019 stated "MOUD services must be offered to clients regardless of their ability or willingness to engage in psychosocial treatment." How does that fit in with the new regulations?**

   Providers are required to offer MOUD services, but the patient is not required to accept MOUD. MOUD should be offered more than once to patients and a

declination of services should be explored with the patient. Patients can internalize external stigma regarding MOUD that can impact their decision to accept MOUD. Patients may change their position on MOUD during the course of treatment. It is imperative to discuss clearly with patients the benefits of MOUD, including a decreased risk of mortality due to overdose when on MOUD with methadone or buprenorphine. Patients do drive their plan of treatment, but this should be after a robust discussion of the risks and benefits of MOUD. Clinical staff can, when appropriate, reflect back to patients how their current needs are affected by other circumstances.

2. **What is the new psychiatric visit tool?**

   The **OASAS Guidance For Mental Health Screening** provides information on this topic.

3. **Brief Treatment can now include service for a "health need". What does this include?**

   A health need would be related to any health threat related to use.

4. **Where can we locate mental health screenings acceptable to OASAS?**

   The OASAS Guidance on Mental Health Screening provides this information.

5. **Is the mini mental status still going to be required if patient sees the psychiatrist?**

   The use of the MMS is twofold, first, to establish a baseline mental status to identify patient immediate needs, and second, for on-going monitoring of the efficacy of treatment providing in resolving these needs.

6. **Which patients are appropriate for opioid overdose prevention education and medication upon discharge.**

   Everyone, unless there is a clinical reason not to (e.g., person definitely only uses alcohol and/or cannabis), which should be documented in the patient record.

7. **What is the time frame for completing a medical assessment upon admission (it was prior to the development of the treatment plan)?**

   As soon as is needed to deliver the services the person needs. So, if MAT on the first visit, the medical assessment should be started (but not necessarily completed) after that visit.

8. **Is OASAS providing any additional guidance on clinical use of toxicology testing.**

   Additional guidance is forthcoming as soon as we work out a few lingering but critical issues.

Reimbursement

Medicaid

1. **Please discuss the decrease in the outpatient rehabilitation change from four (4) hours to two (2) hours and the billing and rate implications. Does a meal need to be provided for 2 hours?**

   The ½ day 2-4 hour service has been available since the inception of the APG reimbursement methodology. Providers need to utilize the timeframe that brings the maximum benefit and compliance from the patient. A meal does not have to be provided for a 2 hour service.

2. **Is an update to the APG Clinical and Medicaid Billing Guidance Manual being prepared?**

   The OASAS Medicaid APG Clinical and Billing Guidance document is currently being updated to reflect the changes to both the regulation and billing practice. An announcement will be sent to the field when the updated version is posted.

3. **Will we be given additional time for intakes (say, two 75 minute sessions) since we will be doing more treatment planning with clients in those initial visits?**

   Person centered treatment planning identifies the most pressing issues that the individual wishes to address in treatment. Typically, there should only be a few specific goals to address especially during the initial phase of treatment.

4. **Have all the insurance companies been notified of these changes? Will there be issues with billing Medicaid, Managed Care, Private Insurance companies?**

   Medicaid Managed Care plans were advised. Private insurance companies have individual relationships with providers and have their own contractual expectations.

5. **Would there be a way for OASAS to get the OMIG audit tool to share with providers?**

   OMIG protocols are posted on the OMIG website.

6. **If OMIG considers the treatment plan the order for treatment, what will be considered the order of treatment going forward?**

   With treatment planning beginning at assessment the order will be confirmed when the MD, NP, PA, LCSW, or licensed psychologist reviews the information to approve the admission decision.

7. **Does Medicaid fee for service still require the initial treatment plan to be due within 30 days like OMH?**

   No. OASAS services are provided under the rehabilitation model (rather than the clinic model that OMH currently operates under) per CMS rules which allows for more flexibility in treatment planning.

8. **"Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019" included as Appendix B an "INITIAL NOTIFICATION and TREATMENT PLAN" for payors. How will this be handled going forward?**

   The initial goals on the assessment equal the treatment plan.

9. **Will claims be denied by MCO's if there is no licensed signature on the admission decision?**

   No. Services may be provided before the formal admission process is complete. The signatures required should be obtained in accordance with guidance issued by OASAS.

10. **In the definitions section, services are no longer required to be "face-to-face", is this to emphasize the allowance of telehealth services more clearly?**

    Yes. Service categories are being removed from the Part 830 regulation allowing for provision of any service to be delivered via telehealth provided it is otherwise permissible (i.e. meets clinical requirements, may be delivered via telehealth, delivered by appropriate staff, etc.).

11. **Treatment plans required signatures by, in addition to the client, a CASAC, another member of the treatment team and a member of the medical staff. Will this change and how will this affect payers.**

    Signatures by the Multidisciplinary Team (MDT) on the treatment plan have not been required for years. For Medicaid reimbursement a physician, physician's assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker must review the assessment, plan of treatment and indicated their approval via signature on the admission decision.

12. **Can we bill for collateral sessions during the assessment process?**

    Yes. Consult Part 822, existing guidance and the APG Manual.

13. **Is there a limit of 3 pre-admission visits that are billable prior to admission?**

    No – there is a limit to three assessment visits but visits for outreach and engagement and medication induction can occur and would not impact this limit.

VI. Implementation – Electronic Health Record

1. **Can programs implement the changes before August 2, 2021?**

Programs that are ready to begin implementing the new Part 822 requirements outlined in the regulation effective August 2, 2021 may submit a waiver to request early implementation. In addition to the waiver, the program must also submit:

- Updated Policies and Procedures demonstrating adherence to the new treatment planning requirements, including staff training, clinical supervisory expectation, documentation (treatment planning format, requisite signature requirements, changes to EMR), etc.

- Transition/implementation plan detailing the timeline and any requisite steps that have been or will be taken.
- Target date for implementation.

2. **Did OASAS provide written guidance to EHR vendors that can be shared with providers.**

   No specific written guidance was issued to EHR vendors. However, vendors were provided with the updated regulation and an opportunity to ask questions. Providers should consult with their EHR vendor for any additional information.

3. **Will there be funding available for EHR modification costs?**

   OASAS is not providing any funding to offset the cost of EHR modification. However, many vendor contracts include provisions regarding changes required by regulation which allows for those changes without charge. Providers should consult with their own counsel and check with their EHR vendors on the provisions of their contract.

4. **When will the EHRs will be required to come into compliance? Is there a way for OASAS to monitor/enforce compliance with EHR vendors?**

   The new Part 822 Regulations become effective on August 2, 2021. All documentation must reflect regulatory requirements as of this date. Providers should consult with their own counsel and their contract for compliance and enforcement.

5. **Which EHR vendors has OASAS reached out to?**

   OASAS had held a few forums to discuss the regulatory changes with the most widely used EHR vendors. The following vendors accepted the meeting invitation to OASAS's January 7, 2020 Vendor Meeting on Part 822 Regulatory Changes:

   - 10e11
   - Foothold Technology
   - Cerner
   - Accumedic
   - Millin Medical
   - IMA Systems
   - Athena Health

6. **Who should EHR companies reach out to if they are not currently receiving this information?**

   PICM@oasas.ny.gov

7. **Will we be expected to change all language in the EHR and our current program policies and procedures such as no more "treatment plan" but treatment recovery plan, no discharge but transition planning?**

   Policies and Procedures, as well as documentation, will need to be updated to reflect the new treatment planning regulatory requirements.

8. **Do progress notes need to be written in a Data, Assessment, Plan (DAP) Note? Or can we create a note that contains the data of the session, the mental status exam, and the treatment plan as the plan?**

   DAP or SOAP notes are a couple of examples of standardized progress note documentation. However, providers can and should develop documentation practices which are most useful to them while reflecting the regulatory requirements.

VII. Resources and Training

What training and guidance will be provided to assist in implementing the new Part 822 Regulations?

The following will be offered:

- Technical Assistance in on-going plans of treatment and documentation
- Additional webinar opportunities will be made available to facilitate provider and agency discussion on implementation of the new requirement
- OASAS Learning Thursday from 10/9/2020 (insert link here), a Treatment Planning webinar from 10/30/2020 (insert link here), as well as a Part 822 Q+A webinar dated 02/10/2021 (insert link here) that one can reference regarding the updated regulations effective August 2nd.

VIII. Treatment Plan Addendum

The following are examples of treatment planning within the updated Part 822 Regulations:

A.H

A.H attended session and reports that he forgot to journal urges to use over the past week but was a little more aware of them. He reports thinking that they are less intense as he has increased frequency of contact with his parents and with his daughter who he took out for ice cream.

He needed to cancel a meeting with the peer who he was scheduled to see but is still committed to meeting the peer as he continues to think this will be helpful.

He reports that things are going well and according to the plan – his cannabis use has decreased to " a couple times" per week and he did not drink alcohol at all.

He thinks the journaling will help but he rarely has his phone on him. The counselor gave him a small notebook to carry in his pocket to see if that would help.

Plan:

- A.H will log urges to use with the intensity rating, how he felt and whether he used or not to increase his awareness and learn ways to add time for more choice about whether to use.
- A.H will call the peer on Wednesday in order to build some sober supports.
- A.H will continue to spend time with family to rebuild relationships and support his goal of having better relationships with them.

D.K.

D.K attended session and reports that she is feeling stressed and upset with herself because she missed the last session. She is worried that she will be "in trouble" with drug court.

She states that she is also worried that she will test positive on toxicology because she "slipped up" and used with some friends who were in town.

Counselor redirected to ask about anything that had gone well and D.K had several examples of setting limits with others so that she could focus on school, a positive evaluation at work, and several times when she wanted to use cocaine with a couple friends that she declined.

She reports feeling very positive about being able to say no to her friends and beams when she relates the positive things her supervisor said to her in the interview.

Plan:

- D.K will call her drug court case worker and talk with her to continue her goal of taking more control of her life.
- D.K will practice one of the skills from her mindfulness group that she identifies as helping her the most when really stressed at least one time in the coming week to increase ability to reduce feeling of stress.

M.F.

M.F attended session stating, “I didn’t really feel like coming today.”

He reports that he has been frustrated with everyone and really doesn’t feel like he is making any progress at all.

He reports that hasn’t used any opioids but continues to use cannabis daily and used some Xanax he bought from someone.
M.F. is aware of the risks of using benzodiazepine, risks of fentanyl in street drugs, and the risk of mixing opioids with sedatives.

He did let his girlfriend know what he was doing so he was not alone; she has naloxone and knows what to do.

He reports that he felt pretty good about doing that as he has been in places where he wouldn’t have cared enough to do that.

M.F. reports that he can’t think about long term goals but that he does want to keep his apartment which is the best place he has lived in a long time.

So far, his plan for paying the rent every week, as soon as he gets paid has helped because if he waits, “I am afraid that I will blow it.”

Counselor talked with him about work and how he feels about it. “I probably would have been fired if I didn’t work for family, it’s OK, some days are better than others.”

Plan:

- M.F. will continue to use drugs in a safer way.
- M.F. agreed to have his girlfriend attend a session to talk about the relationship which he values but has difficulty expressing.
- M.F. will continue to work and use his technique of paying rent each week as he gets paid in order to keep the apartment he values.