NEW YORK STATE | Office of Addiction Services and Supports

Part 822 Outpatient Regulation FAQ's

October 2021 UPDATE

OASAS Certified Outpatient Programs

Table of Contents

I. Introduction

On **August 2, 2021**, the **Part 822 Regulation**, with updates became effective. Webinars offered on January 7 and April 8, 2021 along with provider comments sent to OASAS identified areas that would benefit from further clarification. This document is focused on changes to the Part 822 Regulations and frequently asked questions.

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 Previous Part 822 Regulations and the current 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

Assessment/Admission

1. **What services can be delivered prior to admission?**

   The **OASAS Medicaid APG Clinical and Billing Manual** identifies what services can be delivered prior to admission.

2. **What determines the admission date?**

   The admission date is the date of the first treatment services after the decision to admit has been signed by the QHP.

3. **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 for the **MD/NP/PA/LCSW/Licensed Psychologist** to confirm the diagnosis and plan of treatment. Providers should develop policies and procedures regarding their review process.

   PLEASE NOTE: Admission and subsequent services are predicated on an addiction diagnosis. Though services can be provided prior to these signatories claiming and reimbursement may come into question during the timeframe between the decision to admit and those signatures. Providers are reminded that claim forms require a Medicaid Enrolled Practitioner in the Ordering/Referring Field for reimbursement.

4. **Can the initial plan of treatment be documented in the summary section of our intake/assessment form?**

   Global treatment plan goals can be documented in the summary. However, the subsequent goals and plan should be documented in the progress note for the assessment service.

Plan of Treatment/Progress Notes

1. **Should the treatment plan be documented at assessment or first client meeting with the counselor.**

   Treatment planning begins at the first clinical or peer contact. First visits may result in planning for more acute needs but should become more comprehensive in the pre-admission assessment process.

2. **How does the plan of treatment carry over from the assessment to the treatment counselor.**

   The assessment identifies first step goals of engaging in treatment. The treatment counselor should review these goals with the patient at the first session and throughout the course of treatment. Establishing engagement through an individual counseling session as soon as possible after admission.

3. **Are SUD goals required?**

   Individuals who are admitted for treatment or those seeking services typically have life issues that are being impacted by their use. These life issues, such as relationship, criminal justice, homelessness, etc. are usually what the person identifies as their pressing need(s). While the goal is the life issue the discussion and interventions will need to take into consideration what, if any, impact someone's use has on those issues.

4. **What about abstinence as a goal?**

   Abstinence is often the focus of treatment. However, in the context of person-centered care abstinence is not required as a condition for admission or continued treatment.

   When developing a plan of treatment, it's important to address the areas of need that the person identifies. During the course of treatment individuals may come to believe that they do have to abstain for their lives to improve. Some individuals may find relief from their identified areas of concern by reducing their use or even by becoming aware of how their use impacts these issues.

   For those who abstinence is their goal, it's important that clinical staff work with that person to develop reasonable, attainable steps in working towards that goal. Slips, relapses need to be considered in adjusting the plan of treatment in obtaining that goal, not as being non-compliant or an automatic reason for discharge.

In many cases a court or other mandating referral source has mandated that the individual remain abstinent. Within a person-centered framework, the choice to comply with the mandate remains with the patient and the counselor remains aligned with the person they are working with. This does not preclude reporting of progress with appropriate release of information.

5. **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.

6. **Is it only individual session notes that discuss the treatment plan or should this also be documented in group counseling notes as well?**

   The plan of treatment should be documented in counseling notes for individual sessions. All other types of service, including group, should have notes that reflect the content and process of the group including individual contributions and any connection to goals and plan that are shared.

7. **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.**

8. **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 health issues such as tobacco and nicotine use should be documented and is consistent with good practice. It does not have to be incorporated as part of the treatment planning process, unless the client wants to work on this/these goals

9. **How do we document review and approval of the plan of treatment by the patient, the clinical staff member, and the clinical supervisor?**

   The narrative of the progress notes should document the collaboration, discussion with the patient regarding their plan of treatment. Each progress note has to be signed by the clinical staff member who provided the service which denotes their review and approval. Providers should include the process for

clinical supervisor review and approval of treatment planning in their policies and procedures. Staff should be aware of the policy and procedures.

10. **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.

11. **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.

12. **Will we be cited if we have standalone plans for other entities such as criminal justice, commercial insurers, etc.?**

    Standalone treatment plans can be within the case record but do not replace the requirement to document the plan of treatment as given in the Part 822 Regulations. Providers can populate information required by other entities by the information contained in the progress note plan of treatment documentation.

13. **If there is a change in a goal, does the supervisor countersign the progress note to acknowledge review of the change?**

    The supervisor does not need to countersign the progress note to denote the goal change. Treatment goal revisions would be reviewed in clinical supervision sessions and/or case conference.

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.

Staffing requirements:

1. **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.

2. **Can Peers run groups independently?**

   No

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. **Can any staff person be the LGBTQ liaison, i.e., peer advocates, etc.**

   The regulations do not specify staff for this role. However, the staff person should meet the requirements as outlined in the **Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients LSB**.

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

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

Compliance

1. **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.

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

   OASAS will resume reviewing Part 822 Programs in February of 2022. Provider case records should reflect that changes from the regulation effective date of August 2, 2021.

3. **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.

4. **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

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. **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.

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.

   From a clinical perspective someone in Continuing Care would not require on-going, regular, group counseling services to meet their continuing care plan, therefore group participation would be the exception not the rule.

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.

6. **What does it mean to administratively discharge to Continuing Care?**

   The Part 815 Regulations require providers to develop policies and procedures to "help patients follow their treatment/recovery plan." The policies state specific standards and expectations for patient conduct and in working towards achieving goals of treatment. One option is to discharge the person to continuing care so that they stay engaged and can return to more active care when they choose to do so.

7. **What should we do when individuals have completed the court ordered or mandated portions of treatment but want to continue coming for sessions?**

   Using the LOCADTR 3.0 providers should support the best level of care for the individual in treatment. Providers may need to work with the courts or mandating entities regarding their indicators of treatment completion. A person who seeks care to continue work on recovery goals beyond that mandated by the courts is appropriate to continue in active treatment with a plan that is individualized to their needs.

Issues Specific to OTP's

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 clinical decision making.

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

   Federal Law requires that a nurse be present.

8. **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.

9. **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.

10. **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.

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

    Yes.

Evidence Based Practices

1. **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.

2. **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.

3. **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**.

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

   The OASAS Guidance on Mental Health Screening provides this information.

4. **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.

5. **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.

6. **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.

7. **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.

V. Reimbursement

Medicaid

1. **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.

2. **"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?**

   Appendix B includes the initial goals and should be consistent with the goals identified in assessment and/or progress notes.

3. **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.

4. **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.).

Medicare/Commercial Insurers

1. **Medicare and some Commercial Insurers require a formal treatment plan, how will this work with the new regulations?**

   Treatment planning has itself not been eliminated. The treatment plan still exists but now it's held in progress notes not a separate plan. Providers can use Appendix B Initial Notification and Treatment Plan, found in the **Insurance Law Guidance of 2019** to inform insurers of the treatment plan based on information in the progress notes.

VI. Implementation – Electronic Health Record

1. **What is the implementation date of the new Part 822 Regulations?**

   The updated regulations become effective August 2, 2021.

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

1. **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
   - **Updates to Part 822 Outpatient Programs**,
   - **Early Treatment Engagement Using Person Centered Care**,
   - **Part 822 Regulations Discussion and Q+A Session**, 1/27/21
   - **Overview of Part 822 Regulation Q&A**, 4/14/2021

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.