NEW YORK STATE | Office of Addiction Services and Supports

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# Guidance for Implementation and Utilization Review for Addiction Services

## Revised September 2022

**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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# Introduction:

Chapter 57 of the Laws of 2019, modified Chapter 69 and 71 of the Laws of 2016 and Chapter 57 of the Laws of 2018 to included requirements/directions for:

- Level of Care Determinations in Substance Use Disorder (SUD) Treatment.
- Prior authorization prohibitions
    - for medically necessary SUD Treatment in bedded and non-bedded settings, and
    - SUD treatment medications; and
- Copay limitations in Outpatient SUD Treatment.

The information in this document is meant to provide clarity on these changes and guidance regarding implementation of these requirements in clinical and reimbursement practice. The first half of this document includes definitions of key terms and a Summary of the Insurance Law Changes. The second half provides implementation guidance.

Questions regarding the Law itself should be emailed to Legal@oasas.ny.gov

Questions regarding Clinical/Reimbursement implementation should be email to PICM@oasas.ny.gov

# Definitions:

**Admission** is when a treatment provider determines that an individual has met the criteria for a SUD diagnosis or is a significant other who has been effected by another's SUD and would benefit from treatment at a specific level of care.

**Concurrent Utilization Review** is when the Plan and the Provider evaluation of the enrollees continued need for services at the current level of care. Plans and Providers are required to use the OASAS Concurrent Review Tool in making decisions regarding on going care.

**Continual Assessment** is a formal or informal evaluation of the person's progress in treatment, possible adjustments to treatment and/or continued need for the current level of treatment services. Usually done daily for inpatient/residential settings or per visit for outpatient treatment.

**Continuous Treatment** is a combination of two consecutive services in which the second service results in an admission to an outpatient program. The services may include pre-admission services, including peer services, to the extent they are clinically justified, documented consistent with OASAS guidelines, and do not exceed two services for purposes of inclusion in the four (4) weeks of continuous treatment.

**Discharge** is the point at which an individual no longer meets the level of care requirements in their current treatment program and/or the person would no longer benefit from continuing in this level of care. This determination is based on the individual's identified goals for treatment at admission and as adjusted throughout the course of treatment.

**Discharge Plan** includes information regarding an individual leaving their current level of care that is provided to both the patient and the insurer before the patient leaves the premises. The information includes any further action the person may be taking after they leave the current treatment setting including referrals to other levels of care and/or community resources. Such discharge plan should document whether the service has been acquired or is readily available to the patient in the community where they will be located post discharge. Complete information regarding Discharge Plan requirements can be found in the treatment levels individual Operating Regulations.

**In-Network** refers to treatment providers who have contracted with a particular insurer to provide treatment for their enrollees. Treatment services are provided and reimbursed as agreed upon by the provider and plan.

**Inpatient Treatment** refers to **OASAS Part 818 Certified Programs** which offer 24-hour, 7-day a-week care that is supervised at all times by a medical professional. Inpatient services include intensive management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

**Out of Network** means a treatment provider who does not have a contract with a particular insurer to provide treatment for their enrollees. Without a contract a provider is subject to the plans policy and provisions for the reimbursement or non-reimbursement of services.

**Outpatient Treatment** offers a variety of services at various intensity in an ambulatory setting. Services include **OASAS Part 822** Outpatient Clinic and Rehab and Opioid Treatment Programs.

**Level of Care Determination**: Level of Care is a measure of the least restrictive setting for treatment delivery for the most effective treatment. The **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0.** is the New York State (NYS) OASAS approved tool for this determination. Other clinical review tools for level of care can be submitted to OASAS for review and authorization for use[1].

**Medical/Clinical necessity** is the verification and documentation to support that the services the enrollee is receiving are necessary and appropriate to given conditions.

**Medication Assisted Treatment (MAT) also known as Medication for Addiction Treatment** is the use of medications, with the use of psychosocial therapies and supports as needed, to provide a whole-person approach to the treatment of substance use disorders.

[1] Request for level of care review and authorization for use should be send Legal@oasas.ny.gov

**Notification/Authorization** means providing information to a plan that one of their enrollees is being admitted for treatment and the initial plan of treatment. See **Appendix A** for Withdrawal/Detoxification, Inpatient and Residential programs and **Appendix B** for Outpatient programs.

**Prior Authorization** is a requirement that services be approved before treatment is provided to the person in need.

**Periodic Consultation** is a communication between a treatment provider **and** insurer to discuss salient issues to an individual receiving treatment services.

**Plan** is a term used to represent the entity that provides insurance coverage for an individual or individuals.

**Provider** is a term utilized to represent the entity that is treating the individual.

**Residential Services** includes **Part 817 Residential Rehabilitation for Youth**, and **Part 820 Stabilization, Rehabilitation and Reintegration** programs.

**Retrospective Review** is when the plan reviews clinical necessity of services already provided, including services provided during first 28 calendar days of treatment for inpatient/residential or 4 weeks of continuous treatment/28 visits in outpatient treatment where concurrent review is prohibited.

**Telehealth** as defined in the Insurance Law §§ 3217-h and 4306-g and Public Health Law § 4406-g is the use of electronic information and communication technologies by a provider to deliver health care services to an insured individual while the individual is located at a site that is different from the site where the provider is located. Services may be delivered by OASAS certified approved or otherwise authorized programs.

**Utilization Review** is conducted to demonstrate that admission was appropriate to the level of care, clinically necessary services are being provided, and the patient still meets criteria for the level of care. This review is internal to the provider and not dependent on or replaced by the Concurrent Review Process.

**Withdrawal and Detoxification Services** include OASAS Part 816 Programs, who provide services for those going through moderate to severe withdrawal. Services are provided in bedded settings for Medically Managed and Medically Supervised settings, and for less intensive services at an Outpatient Detoxification Unit. “Detoxification” or “detox” means a medical withdrawal and stabilization regimen under the supervision of a physician to systematically reduce the amount of an addictive substance in a patient's body, provide reasonable control of active withdrawal symptoms and/or avert a life-threatening medical crisis related to the addictive substance.

# Summary of Insurance Law Changes:

## 1. Required Use of Objective State-Designated Criteria to Determine the Level of Care for Individuals Diagnosed with a Substance Use Disorder (SUD)

| **Previous: Effective January 1, 2017**: | **NEW: Effective January 1, 2020:** |
|---|---|
| All insurers ***overseen by[2] New York State***:<br><br>• Are required to use NYS Office of Addiction Services and Supports (OASAS) authorized level of care tool for determining appropriate treatment settings for all NYS authorized Substance Use Disorder (SUD) treatment.<br><br>Unless otherwise approved by OASAS the authorized level of care tool is the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0. | The OASAS designated tool requirement will apply ***only when*** the care is provided within New York State. |
| **This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2020.** | |

| **Law** | **Commercial** | | | **Medicaid** | | |
|---|---|---|---|---|---|---|
| | **In-Network** | **Out of Network** | **Non NYS** | **Fee for Service** | **MMCP In Network** | **MMCP Out of Network** |
| **LOCADTR and Concurrent Review LOCADTR** | Required | Required | Not-Required | Required | Required | Required |

[2] To search if an insurance company is regulated by New York State, go to: NYS DFS Portal

## 2. Prohibition of Prior Authorization for Medically Necessary Inpatient Treatment

| **Previous: Effective January 1, 2017**: | **NEW: Effective January 1, 2020:** |
|---|---|
| All insurers ***overseen by New York State***:<br>• Applies to in state, in-network providers<br>• Prohibited from requiring prior authorization for medically necessary OASAS licensed or certified SUD inpatient services including detoxification, rehabilitation, and residential treatment.<br>• Plans cannot conduct concurrent utilization review for the first **14 days of treatment,** when:<br>• Providers give insurer notice of admission and initial treatment plan **within 48 hours of admission**.<br>• Provider conducts daily clinical assessment of the need for patient to remain in that level of care<br>• Provider engages in periodic consultation with the insurer | All insurers ***overseen by New York State***:<br>• Applies to in state, in-network providers<br>• Prohibited from requiring prior authorization for in-network medically necessary SUD inpatient services including detoxification, rehabilitation, or residential treatment ***licensed, certified or otherwise authorized by OASAS***.<br>• Plans cannot conduct concurrent utilization review for the first **28 calendar days of treatment,** when<br>• Providers give insurer notice of admission and initial treatment plan **within 2 business days** of admission.<br>• Provider conducts daily clinical assessment of the need for patient to remain in that level of care<br>• Provider engages in periodic consultation with the insurer **at or before the 14th day**.<br>**Provider gives Insurer and Patient a discharge plan noting services that have been acquired or are easily accessible**. |
| **This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2020.[3]** | |

[3] For contracted services after January 1, 2020 Chapter 57 of the Laws of 2019 became effective and apply to contracts issued, reviewed, modified, altered or otherwise amended on or after January 1, 2020.

| Law | Commercial | | | Medicaid[4] | | |
|---|---|---|---|---|---|---|
| | In-Network | Out of Network | Non NYS | Fee for Service | MMCP[2] In Network | MMCP[2] Out of Network |
| **Prior Authorization for Inpatient/Residential Treatment** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **UR within 28 Days of Admission Inpatient/Residential Treatment** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **Notification of Care within 2 Business Days Inpatient/Residential Treatment** | Required | Subject to review or request | Subject to review or request | Not Required | Required | Subject to review or request |

[4] Part 817 Residential Services for Youth are not currently reimbursed through Medicaid Managed Care.

### 3. Prohibition of Prior Insurance Authorization for Medically Necessary Outpatient Treatment

| **Previous: Effective April 12, 2018**: | **NEW: Effective January 1, 2020:** |
|---|---|
| All insurers[5] ***overseen by New York State***:<br>• Prohibited from requiring prior authorization for **In-Network** medically necessary SUD outpatient services including outpatient clinic, outpatient rehabilitation, and opioid treatment programs.<br>• Plans cannot conduct concurrent utilization review for the first **two weeks of continuous treatment, not to exceed 14 visits,** when<br>• Providers give insurer notice of admission and initial treatment plan **within 48 hours of admission**. | All insurers ***overseen by New York State***:<br>• Prohibited from requiring prior authorization for ***in-network*** medically necessary SUD outpatient services including outpatient clinic, outpatient rehabilitation, and opioid treatment programs.<br>• Plans cannot conduct concurrent utilization review for the first **four weeks of continuous treatment[6] not to exceed 28 visits,** when the Outpatient Provider:<br>a. Is in-network<br>b. Licensed or otherwise certified or otherwise authorized by OASAS,<br>c. Gives the insurer notice of admission and initial treatment plan **within 2 business days of the person's admission**.<br><br>**SUD Provider *must* conduct at least one clinical consultation with the insurer[3] at or before the 14th day of treatment.**<br><br>**SUD Provider *must* conduct a clinical assessment of the patients need or ongoing treatment at every visit.** |
| **This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2020.** | |

[5] This change does not apply to Medicaid Managed Care Plans, which are already subject to more robust protections based on the existing contract requirements.

[6] Continuous treatment is defined ** See definition provided in first section

| Law | Commercial | | | Medicaid | | |
|---|---|---|---|---|---|---|
| | In-Network | Out of Network | Non NYS | Fee for Service | MMCP In Network | MMCP Out of Network |
| **Prior Authorization[5] for Outpatient Treatment** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **UR within 4 weeks of Admission** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **Notification of Care within 2 Business Days** | Required | Subject to review or request[3] | Subject to review or request[3] | Not Required | Subject to review or request[7] | Subject to review or request |

## 4. Copay Limitations for Outpatient Programs

As of January 1, 2020, Large Group Policy[8] or Contracts are:

- Imposing co-payments/coinsurance for Outpatient SUD Services that exceed the copayment/coinsurance for a primary care office visit.
- Imposing greater than one co-payment for all services provided on a single date by an OASAS certified, or otherwise authorized Outpatient SUD Provider.

| Law | Commercial | | |
|---|---|---|---|
| | In-Network | Out of Network | Non NYS |
| **Imposing higher co-pays for SUD Outpatient TX** | Prohibited | Not Prohibited | Not Prohibited |
| **Imposing Greater than one copay for single date of service in a SUD Outpatient Program** | Prohibited | Not Prohibited | Not Prohibited |

[7] Medicaid Managed Care Plans are prohibited from requiring "prior authorization" for ambulatory services. Providers should reach out to plans to determine if "notification/authorization" is needed.

[8] A large group policy when an employer has more than 100 employees and has purchased the health insurance plan to cover their employees. This change will impact health insurance policies or contracts issued, renewed, modified, altered, or amended on or after **January 1, 2020**.

## 5. Prohibition of Prior Insurance Authorization for Medications used for the Treatment of Substance Use Disorder(s)

| **Previous: Effective January 1, 2017** | **NEW: Effective January 1, 2020:** |
|---|---|
| All insurers[9] ***overseen by New York State***:<br><br>• Prohibited from requiring prior approval for a 5-day supply of covered prescription SUD treatment medication for emergency conditions.<br><br>• Emergency supply applied to naloxone prescribed to a individual covered under the policy.<br><br>• Prohibited from charging a co-pay for above condition, for initial and subsequent prescriptions, that exceeds the co-pay for a 30 day supply of the same SUD medication. | In addition to previous requirements all insurers ***overseen by New York State*** are:<br><br>• Prohibited from requiring prior approval for any covered prescription medications for treatment of a substance use disorder contained on the statewide single formulary.<br><br>• **Large groups/issuers** must: cover prescription drugs to treat substance use disorder on parity with prescription drugs to treat medical conditions[10] |

**Prohibition Against Prior Authorization for Medication Assisted Treatment Applies to Medicaid recipients:**

In accordance with § 367-a (7) (e) of Social Services Law, Effective October 1, 2021, a statewide single Medication Assisted Treatment (MAT) formulary was implemented.[11] This single formulary applies to Medicaid Managed Care Plans and the Medicaid Fee for Service Program. According to the single formulary, Medicaid Managed Care Plans and the Medicaid Fee for Service Program must follow a single formulary and provide consistent coverage parameters across the Medicaid Program.

In addition, the following changes were subsequently made to comply with this requirement and have been **effective since March 22, 2022**[12]:

- Prior authorization is prohibited for medications prescribed to treat SUD, provided they are prescribed according to generally accepted national professional guidelines for the treatment of SUD. Prescriptions written outside of accepted guidelines may be subject to prior authorization.

- Prescriptions for a brand name multisource drug will be filled with a generic equivalent, as

[9] This change does not apply to Medicaid Managed Care Plans, which are already subject to more robust protections based on the existing contract requirements.

[10] For information on mental health parity guidance, please visit: https://omh.ny.gov/omhweb/bho/parity-compliance-toolkit.pdf

[11] For a database of reimbursable medications, please visit: https://www.emedny.org/info/formfile.aspx

[12] For more detailed information on the changes, please visit: New York State Medicaid Update - February 2022 Volume 38 - Number 2 (ny.gov)

required by New York State Social Services and Education Law, unless the prescriber indicates "Dispense as Written (DAW)", and "Brand Medically Necessary" on the prescription. The prescriber must also make a notation in the Medicaid member's medical record that the drug is "brand medically necessary," and the reason that a brand name multi-source drug is required.

# Guidance for Implementation of Insurance Law

### 1. Provider – Plan Communication:

Provider and Plan Communication is imperative to effective, efficient treatment provision as well as to compliance with Insurance Law.

- Providers need to review and understand their contract with the plans.[13] What does the contract say regarding:
    - Contacts
    - Allowed Service Provisions
    - Reimbursement Requirements
        - Claiming Process
        - Coding for claims
        - Appeals for denials
- Build relationships with the plan – don't wait until there is a problem to try and find the plan resources for resolution.
- Specific to the Insurance Law:
    - Find out from the plan how to, where required, submit initial treatment plan, e.g., fax, email, phone, letter, etc.
    - Work out developing a common understanding of periodic consultation including what types of information would be helpful to share to demonstrate the need for ongoing placement within the level of care, clinical necessity.
    - Ask about their use of the LOCADTR 3.0 and Concurrent Review LOCADTR, as much as possible find a common language and understanding in terms of how you both use and interpret the LOCADTR.
    - Lastly, find out what the plans understanding of the insurance law and insurance law changes are to ensure they are aware of the most current requirements.

Having a common understanding with the plans ahead of time will hopefully decrease issues in the future.

[13] Model Language can be found at the Department of Financial Services Website: https://www.dfs.ny.gov/apps_and_licensing/health_insurers/ah_product_filing/ml/mental_health_substance_abuse

## 2. Use of the LOCADTR 3.0:

Under the Insurance Law and Part 819 of OASAS Regulations, the **LOCADTR 3.0** (or a similarly OASAS approved program) must be used by plans and providers for treatment services delivered **in NYS**. Other level of care tools can be used for NYS Residents being treated outside of NYS. Also Plans can submit an alternative level of care tool to OASAS for review and possible authorization for use, by submitting this request in writing to Legal@oasas.ny.gov.

This applies to all insurance lines of business in NYS including Medicaid and commercial. It does not apply to Medicare. **OASAS Operating Regulations** specific to the service level give requirements as to timeframe for the LOCADTR 3.0 to be completed.

Providers and Plans will utilize clinical information to complete the appropriate tool. Providers should be ready and able to supply the information that was used in answering the LOCADTR 3.0 questions. 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.

## 3. Authorization:

Plans are prohibited from requiring prior authorization for medically necessary ***in-network OASAS licensed, certified or otherwise authorized*** SUD inpatient services including detoxification, rehabilitation, residential treatment, intensive outpatient, outpatient clinic, outpatient rehabilitation, and outpatient opioid treatment. When Providers within two business days of admission submit:

- Notification that the enrollee is receiving services, and
- An initial plan of treatment.

Please see **Appendix A** for Inpatient/Residential and **Appendix B** for Outpatient notification forms.

If the provider fails to provide the needed information within two business days the plan may begin concurrent review at any time.

## 4. Use of Concurrent Review:

In addition:

- For **Inpatient/Residential in-network providers,** plans cannot conduct utilization review for clinically appropriate/necessary services for the **first 28 calendar days of treatment beginning at admission date.**

- For **Outpatient in-network providers** plans cannot conduct utilization review for clinically appropriate/necessary services for the **first four weeks of continuous treatment, not to exceed 28 visits.** Continuous treatment starts with the date of first clinical service after an initial face to face clinical contact with the person.

**Reimbursement** for service provided within the prohibition period ***is not guaranteed***. All services provided during the course of treatment are subject to review for clinical necessity. The Insurance Law provisions indicate that insurers may only deny coverage for any portion of the initial 28-day inpatient treatment, or first 4 weeks of outpatient 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.**

To decrease the instances of disallowance, during the **28 day, first four week** time period

**Providers must**:

- ensure that the individual is appropriate for that level of care using the appropriate module of the OASAS designated tool.
- perform daily or per visit formal or informal clinical assessment of the person.
- use "periodic consultation" with the plan to discuss the information that is driving the OASAS Level of Care Determination tool.

**Plans must:**

- participate in periodic consultation with the provider at a minimum should occur **at least once** by the 14th day of treatment
- Generally, this should occur as often as is necessary to
  - coordinate care.
  - ensure that the person is progressing in individually identified treatment goals; and
  - that the discharge plan is adequate to meet the ongoing recovery needs of the person.

**All efforts at communication should be documented, including results.**

**After the initial 28 days for inpatient/residential or the first 4 weeks of treatment in outpatient:**

Concurrent Reviews, utilizing the **OASAS Concurrent Review Tool** should be completed:

- When the plan requests a review:
  - (i) For an out-of-network provider
  - (ii) When considering a change in the current level of care

Programs should develop policies and procedures on using the Concurrent Review for utilization review and ongoing plan of treatment.

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.

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.

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.

### 5. Utilization Review:

OASAS certified programs are required to have a utilization review plan. Utilization Review is distinct from Concurrent Review in that it is the providers internal process or reviewing if admissions are appropriate, clinically necessary services are being rendered, and that the person still meets the level of care requirements. Programs should have a systematic way of reviewing records. The UR Plan should include what their internal UR process is including who conducts the review ,how determinations are made, how often reviews should take place, what percentage of records should be reviewed and how the process/results are documented. [14]

### 6. Discharge and Discharge Planning:

**Discharge begins at admission** is a commonly made statement which people sometimes struggle to understand and apply. Treatment is a continuous evaluation process. When an individual comes to treatment they identify the areas they would like to improve upon while receiving services. This identification of areas of improvement at the beginning, along with any modifications which are needed during the course of treatment set the basis for determining readiness to be discharged from active treatment at that level of care.

Treatment can help an individual achieve their "goals." Concurrent Review takes an episodic look at what was identified as the person's desired goals and whether or not the current level of care is the best way for the person to achieve them. Discharge then becomes the place where the person has met what they intended to do and/or the treatment setting is no longer the best place to assist them in doing so.

[14] Please see Department of Financial Services Model Language for Utilization Review

Whether identified by the provider themselves or within cooperation with the plan, when it seems that the person no longer needs the current level of care a Concurrent Review LOCADTR should be completed. Based on the results the provider as part of their periodic review process would notify the plan of this information. The Discharge Plan should be developed in collaboration with the individual and the plan. A copy of the final agreed upon plan should be given to the person and the plan prior to actual discharge.

The discharge plan should identify:

- Any further resources/referrals needed for ongoing recovery,
- If such resources/referral have been secured,
- Medications at the time of discharge, and the plan for continuation,
- For those being referred to continuing care, the need for these services and their frequency, and desired outcomes,
- The clinician responsible for the discharge plan,
- If a person is being referred to a different level of care, a LOCADTR 3.0 should be completed to determine that next level of care.

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. Providers should make every attempt to supply the individual who has left treatment with a Discharge Plan based on their last known status.

### 7. Telehealth:

Telehealth can be utilized to provide clinically appropriate services as indicated in the **OASAS Part 830 Regulation** and **Telehealth Standards for Certified Providers**. Insurers and Insurance Plans that are overseen by the State of New York are required to reimburse for SUD treatment services delivered via Telehealth, which includes delivery of services via audio and video, video only or audio only.

# 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: | | |
| Signature | | |

**Inpatient / Residential 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 groups | | | |
| 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 | |

**Reintegration Initial Service/Recovery Plan**

| | |
|---|---|
| Individual skill building Goal(s): | |
| Self-Reliance for medication administration/management | |
| Motivational Interviewing to increase internal locus of control | |
| Increase coping skills to improve emotional regulation | |
| Facilitate engagement and social skills to support community recovery | |
| Increase autonomy in adult daily living skills | |
| Other: | |
| Case Manager Assignment: | |
| Education about, orientation to, and the opportunity to participate in, community recovery and wellness support. | |
| Employment Supports | |
| Transition to Independent Living | |
| Assessment and linkage to community services for the person and significant others | |
| Hep C, HIV and AIDS education, risk assessment, and supportive counseling and referral | |
| Linkage for Medical Consultation: | |
| Linkage for Psychiatric Consultation (as needed): | |
| | |
| Signature | Date |

# APPENDIX B

| **Appendix B**<br>**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 Plan of Treatment**

| | |
|---|---|
| Current Level of Care: | |
| Next Anticipated Service Date:<br>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: |

# APPENDIX C: Summary Insurance Law Requirements

| Law | Commercial | | | Medicaid | | |
|---|---|---|---|---|---|---|
| | In-Network | Out of Network | Non NYS | Fee for Service | MMCP In Network | MMCP Out of Network |
| **LOCADTR and Concurrent Review LOCADTR** | Required | Required | Not-Required | Required | Required | Required |
| **Prior Authorization for Inpatient/Residential[15] Treatment** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited[16] | Not Prohibited[3] |
| **UR within 28 Days of Admission Inpatient/Residential Treatment[12]** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited[3] | Not Prohibited[3] |
| **Notification of Care within 2 Business Days Inpatient/Residential Treatment[12]** | Required | Subject to review or request[17] | Subject to review or request[4] | Not Required | Required[3] | Subject to review or request[3] |
| **Prior Authorization[5] for Outpatient Treatment** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **UR within 4 weeks of Admission** | Prohibited | Not Prohibited | Not Prohibited | Prohibited | Prohibited | Not Prohibited |
| **Notification of Care within 2 Business Days** | Required | Subject to review or request[3] | Subject to review or request[3] | Not Required | Subject to review or request[18] | Subject to review or request[3] |

[15] OASAS Certified Part 816 Withdrawal and Stabilization Services Part 817 Residential Rehabilitation Services for Youth, Part 818 Inpatient Rehabilitation Programs, Part 819 Intensive Residential Programs, Part 820 Stabilization/Rehabilitation /Reintegration Services.

[16] Part 817 Residential Services for Youth are not currently reimbursed through Medicaid Managed Care.

[17] Providers should reach out to insurers/plan to determine what is or is not required.

[18] Medicaid Managed Care Plans are prohibited from requiring "prior authorization." Providers should reach out to plans to determine if "notification/authorization" is needed.