New York State HARP Mainstream BH Billing and Coding Manual
For Individuals Enrolled in Mainstream Medicaid Managed Care Plans
And Health and Recovery Plans (HARPs)
March 18, 2015 - DRAFT

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Note 1: As of March 17, 2015, CMS approval for the BH carve-in and the HARPs had not been granted. Therefore, much of what is contained herein is subject to change.

Note 2: Additional guidance will be forthcoming shortly on the following:
1. Service combinations grid – Some HCBS services should not be provided in combination with certain State Plan services.
2. HCBS limits – The final HCBS billing limits may be more restrictive than those published in the draft HCBS Manual.

INTRODUCTION

This manual outlines the claiming requirements necessary to ensure proper behavioral health claim submission with respect to Mainstream Medicaid Managed Care Plans (MMCs) and Health and Recovery Plans (HARPs). Each behavioral health service transitioning to the Medicaid managed care reimbursement model is covered in detail. This manual should be used in conjunction with the coding crosswalks of rate code to procedure code/modifier code combinations that have been prepared by OMH/OASAS for use by both Plans and providers. Both crosswalks are available as Excel files. There is one crosswalk for the existing State Plan services and another for the new Home and Community Based Services (HCBS) that will be available to many HARP members.

This billing manual does not apply to office-based practitioner billing. It applies only to behavioral health services that can be billed under Medicaid fee-for-service rate codes by OMH-licensed or OASAS-certified programs and to the HCBS services that will be delivered by OMH and OASAS “designated” providers.

NOTE: This manual addresses ONLY billing guidance. It does not supersede applicable regulatory requirements or procedures for admission to a program, record keeping, initial and on-going treatment planning and reviews, etc. Those standards are in the regulations for each program.

Managed Care Contracting Requirements

Beginning with the start of the behavioral health transition to Medicaid managed care in each geographic area, and for at least two full years following, managed care plans will be required to contract with providers that serve five or more of their enrolled individuals. This requirement will help ensure that individuals already receiving behavioral health services continue to receive the services they need without interruption. The specifics of this requirement are as follows:

OMH Programs: For each OMH-licensed program type, Plans must contract with providers that serve five or more of their enrollees.

OASAS Programs: Plans must contract with a provider having five or more of the Plan’s enrollees in any combination of Clinic, Outpatient Rehabilitation, or Opiate Treatment Programs (OTP). The Plan must contract with the provider for all of the provider’s program types. Plans must also contract with all OASAS-certified Opiate Treatment Programs in their service area, regardless on the number of Plan enrollees serve by that OTP.
Each Plan has already received a list of providers that meet this contracting requirement. Any OMH/OASAS provider that believes it meets the threshold requirement with a particular Plan, but who has not yet been contacted by that Plan should contact OMH at (518) 474-6911 or OASAS at PICM@oasas.ny.gov.

**Government Rates**

New York State law currently requires that Medicaid MCOs pay the equivalent of APG rates for OMH licensed mental health clinics. Beginning July 1, 2015 in NYC and January 1, 2016 in counties outside of NYC, Plans will be required to pay 100% of the Medicaid fee-for-service (FFS) rate (aka, “government rates”) for all authorized behavioral health procedures delivered to individuals enrolled in mainstream Medicaid managed care plans, HARPs, and HIV SNPs when the service is provided by an OASAS and OMH licensed, certified, or designated program. This requirement will remain in place for at least two full years. For the new HCBS services, the government rate is the reimbursement listed for each program on the HCBS Fee Schedule (link will be provided after the fee schedule is approved by CMS and is placed on the websites). Alternative payment arrangements, in lieu of the FFS rates, may be allowed but only with prior approval from OMH and OASAS.

Government rates are required for the following four categories of services:

- **OASAS Government Rate Services (Mainstream Managed Care and HARP):**
  - OASAS Clinic
  - Opiate Treatment Programs (outpatient)
  - Outpatient Rehabilitation
  - Part 820 – OASAS per Diem Residential Services

- **OMH Government Rate Services (Mainstream Managed Care, HIV-SNP, and HARP):**
  - Assertive Community Treatment (ACT)
  - OMH Clinic (government rates are already mandated for Clinic – continue to use existing billing procedures)
  - Comprehensive Psychiatric Emergency Program (CPEP), including Extended Observation Beds (Note: For CPEP EOB services, Plans are required to pay only 80% of the FFS rate, as opposed to the 100% that is required for all other government rates services. All other CPEP services must be paid at 100% of FFS)
  - Continuing Day Treatment (CDT)
  - Intensive Psychiatric Rehabilitation Treatment (IPRT)
  - Partial Hospitalization
  - Personalized Recovery Oriented Services (PROS)

- **HARP-Only Home and Community Based Services (HCBS)** [Link to HCBS Services Manual]
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support and Treatment (CPST)
  - Habilitation/Residential Support Services
  - Family Support and Training
  - Short-term Crisis Respite
  - Intensive Crisis Respite
  - Education Support Services
  - Empowerment Services – Peer Supports
  - Pre-Vocational Services
  - Transitional Employment
Intensive Supported Employment (ISE)
Ongoing Supported Employment
Staff Transportation
Non-Medical Patient Transportation  (Note: As is already the case with medical transportation, non-medical transportation will be carved out of the Plan benefit, managed by a transportation manager based on the Plan of Care, and paid FFS directly to the transportation provider).

1115 Waiver Demonstration Programs (Mainstream Managed Care, HIV-SNP, and HARP)
Crisis Intervention Service (use 100% of the APG rates for Crisis Services)
OASAS Off-site SUD Services (aka, “other licensed practitioners”, practitioner must work for a clinic, FFS rates will apply – more details to follow)
OMH Off-site Mental Health Services (aka, “other licensed practitioners”, practitioner must work for a clinic, FFS rates will apply – more details to follow)

Claims
Electronic claims will be submitted using the 837i (institutional) claim form. This will allow for use of rate codes which will inform the Plans as to the type of behavioral health program submitting the claim and the service(s) being provided. Rate code will be a required input to MEDS (the Medicaid Encounter Data System) for all outpatient MH/SUD services. **Therefore the Plan must accept rate code on all behavioral health outpatient claims and pass that rate code to MEDS.** All other services will be reported to MEDS using the definitions in the MEDS manual.

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four digit rate code. This is the standard mechanism historically and currently used in Medicaid FFS billing. This field is already used by Plans to report the weight of a low birth weight baby.

NYS will give Plans a complete listing of all existing providers and the rate codes they bill under, as well as the rate amounts by MMIS provider ID and locator code and/or NPI and zip+4. This list will also be posted on the OMH and OASAS websites.

Billing requirements depend on the type of service provided; however, every electronic claim submitted will require at least the following:

- Use of the 837i claim form;
- Medicaid fee-for-service rate code;
- Valid procedure code(s);
- Procedure code modifiers (as needed); and
- Units of service.
Claims Coding Crosswalks

Attached are crosswalks for HCBS and all other ambulatory behavioral health services (including 1115 demo services). Also included in the crosswalk is the per diem rate code for clinic services delivered in OASAS Part 820 Residential settings. Much additional OASAS information is in tabular form near the end of this manual. These crosswalks provide a link between existing FFS rate code-based billing and the unique rate code/procedure code/modifier code combinations that will be required under Medicaid managed care. Providers will use these coding combinations to indicate to the Plan that the claim is for a behavioral health service provided by a behavioral health program, and is to be paid at the government rate. The procedure and modifier code combinations have been created such that even if rate code did not exist, the Plan would be able to differentiate between the various services and mirror the correct FFS payment amount.

Provider Assistance and Including Release / Access to Plan Contract Information:

As part of the state qualification process plans are required to develop and implement a comprehensive provider training and support program for network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. Training and technical assistance shall be provided to BH network providers on billing, coding, data interface, documentation requirements, and UM requirements. BH network providers shall be informed in writing regarding the information requirements for UM decision making, procedure coding and submitting claims. Plans will provide technical assistance in other areas such as claim submission as indicated by provider performance identified through the Plan’s QM and provider profiling programs. Plans will ensure providers receive prompt resolution to their problems.

To facilitate a smooth transition from Fee-for-service to plan billing it is expected that plans will reach out to and offer billing / claim submission training to newly BH providers; this should include a claims submission testing environment; and, issuance of plan contact and support information to assist programs in claim submission.
Ambulatory Behavioral Health Services

- Assertive Community Treatment (ACT):
  - Link to ACT regulations (part 508)
  - Link to ACT program guidelines

ACT services are billed once per month using one rate code for the month’s services. There are three types of monthly payments which are dependent on the number and type of contacts with the recipient or collaterals: full, partial, or inpatient. Claims are submitted using the last day of the month in which the services were rendered as the date of service. A contact is defined as a face-to-face interaction of at least 15 minutes duration where at least one ACT service is provided between an ACT team staff member and the recipient or collateral.

The attached crosswalk indicates the procedure code (H0040) and modifier combinations to be used with the ACT rate codes.

ACT Full Payment (Rate Code 4508)
Full payment requires at least 6 contacts with the recipient or collateral, or at least 4 community-based contacts and at least 6 contacts in total (combination of community and inpatient contacts), if the recipient is admitted or discharged from an inpatient setting during the month.

ACT Partial Payment (4509)
Partial payment requires at least 2 community-based contacts, or at least 1 community-based contact and at least 2 contacts in total (combination of community-based and inpatient contacts) if the recipient is admitted or discharged from an inpatient setting during the month.

ACT Inpatient Payment (4511)
If the recipient has an inpatient stay and at least 2 inpatient contacts are provided, then the claim qualifies for the inpatient payment.

- Clinic (OMH-Licensed Clinic, OASAS-Certified Clinic, OASAS-Certified Opiate Treatment Clinic, and OASAS Certified Outpatient Rehabilitation):

OMH CLINICS: Link to OMH Clinic Regulations (part 599)

OMH Clinics, both hospital-based and free-standing, have been billing FFS under the APG rate setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010. For non-SSI recipients enrolled in managed care, OMH Clinics have been billing Medicaid plans for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012. As of the effective date of the behavioral health managed care carve-in and the creation of the HARPs, plans will cover OMH clinic services for all enrollees and mirror the APG rates as they do now for the non-SSI population.
OASAS TITLE 14 NYCRR PART 822 OUTPATIENT: CLINICS; OPIOID; AND, REHABILITATION PROGRAMS: For a complete description of OASAS Outpatient and Inpatient programs please see the SUD Section of this manual.  Link to OASAS Program Regulations

Prior to the BH carve-in and the implementation of the HARPs, Title 14 NYCRR Part 822 OASAS clinic services (for all three types of OASAS clinics) were billed FFS (carved out) for all managed care enrollees. Those clinics bill FFS using APG rate codes for free-standing clinics and non-APG rate codes for hospital-based clinics. While, OASAS hospital-based clinics still use non-APG rate codes, but are expected to move to the APG billing system, on a retroactive basis, in the near future.

For both Freestanding and Hospital Based Programs, OASAS outpatient service reimbursement will employ government rates upon being carved into Managed Care (including HARPs). The format for billing and reimbursement in Managed Care is the same as FFS. Managed Care Plans should continue to use the same techniques they currently use to identify APG claims for OMH Clinics and adapt those techniques to identify OASAS outpatient services. For a complete list of the OASAS outpatient program rates codes, please see the SUD section of this manual. IMPORTANT!!! Just as will be the case with free-standing OASAS programs, hospitals will use APG rate codes and APG billing techniques when submitting claims to the Plans and the Plans will use the APG methodology to calculate payments. The capitation rates that were calculated for the HARPs and the BH carve-in took this change into account and are fully funded for this implementation. The State Plan Amendment that controls FFS behavioral health APGs in hospitals was just approved by CMS. Consequently, that FFS payment methodology must be mirrored in managed care.

- Continuing Day Treatment (CDT):  
  Link to CDT Operational Regulations (section 587.10)  
  Link to CDT Reimbursement Regulations (section 588.7)

CDT services are billed on a daily basis. The rates of reimbursement are separated into 3 tiers: 1-40 hours, 41-64 hours and 65+ hours. These three tiers span across two types of visits: full-day (4 hours minimum) and half-day (2 hours minimum). Tiers are determined by totaling the number of full-day and half-day regular visits, based on their hour equivalents. As the hours accumulate throughout the month, the provider will need to move from one tier to another to bill. Each subsequent tier has a decline in payment. Providers must keep track of the number of hours of service provision in order to know what rate code (tier) should be billed. When the program hours of any single visit include more than one tier, the provider of service will be reimbursed at the tier that applies to the first hour of that visit. Each CDT service tier has a unique combination of rate code/procedure code/modifier code(s), as indicated on the attached crosswalk.

Half-Day Visit (4310, 4311, 4312) – Requires a minimum duration of two hours. To be eligible for reimbursement for a half-day visit, one or more medically necessary services must be provided and documented.

Full-Day Visit (4316, 4317, 4318) – Requires a minimum duration of four hours. To be eligible for reimbursement for a full-day visit, three or more medically necessary services must be provided and documented.
Claims for collateral, group collateral, preadmission and crisis visits are billed separately (i.e., on different claims) from the CDT regular visits using the rate codes below. The reimbursement is the equivalent to the half-day, tier 1 amount, regardless of the cumulative total of hours for CDT regular visits in that month. Collateral, group collateral, preadmission and crisis visits are excluded from the calculation of the cumulative total hours in the program for a recipient.

**Collateral Visit (4325)** – Clinical support services of at least 30 minutes duration of face-to-face interaction documented by the provider between one or more collaterals and/or family members of the same enrolled recipient and one therapist with or without a recipient.

**Group Collateral Visit (4331)** – Clinical support services of at least 60 minutes duration of face-to-face interaction documented by the provider between collaterals and/or family members of multiple recipients of the continuing day treatment provider and one therapist with or without the recipients.

**Crisis Visit (4337)** – Crisis intervention services are face-to-face interactions documented by the provider between a recipient and a therapist, regardless of the actual duration of the visit.

**Preadmission Visit (4346)** – Services of at least 60 minutes duration of face-to-face interaction documented by the provider between a recipient and a therapist.

**Comprehensive Psychiatric Emergency Program (CPEP):**

- [Link to CPEP Operational Regulations](#) (part 590)
- [Link to CPEP Reimbursement Regulations](#) (part 591)

CPEP is claimed on a daily basis. A patient may receive one brief or one full emergency visit service in one calendar day. If a patient receives one of each, the CPEP will receive reimbursement for the full emergency visit. A provider may be reimbursed for either one crisis outreach service or one interim crisis service and either one brief or one full emergency visit per recipient, per one calendar day. If more than one service is provided, then more than one claim must be submitted (one claim for each rate code). Each CPEP service has a combination of rate code/procedure code/modifier code indicated on the attached crosswalk.

**Brief Emergency Visit (4007)** – Face-to-face interaction between a patient and a staff physician, preferably a psychiatrist, to determine the scope of emergency service required. This interaction should include a mental health diagnostic examination. It may result in further CPEP evaluation or treatment activities on the patient’s behalf or discharge from the CPEP. **Note:** Services provided in a medical/surgical emergency or clinic setting for comorbid conditions are separately reimbursed. If medical and/or nursing evaluations provided outside the CPEP are utilized by the CPEP, the CPEP may be reimbursed for a brief emergency visit only. For example – a patient is evaluated and/or treated in the emergency room (non-CPEP) for a medical condition and subsequently transferred to the CPEP for evaluation. Both the emergency room (non-CPEP) and the CPEP may submit claims. The CPEP should utilize the evaluation completed by the emergency room and submit a claim for a brief visit.

**Full Emergency Visit (4008)** – A face-to-face interaction between a patient and a psychiatrist and other clinical staff as necessary to determine a recipient's current psychosocial and medical condition. It must include a psychiatric or mental health diagnostic examination; psychosocial assessment; and medical
examination; which results in a comprehensive psychiatric emergency treatment plan and a discharge plan when comprehensive psychiatric emergency program or services are completed. It may include other examinations and assessments as clinically indicated by the recipient's presenting problems. Full emergency visits should be provided to recipients whose presenting symptoms are initially determined to be serious and where the clinical staff believes commencement of treatment should begin immediately, and/or where staff is evaluating a person for retention in an extended observation bed or admission to a psychiatric inpatient unit. No person may be involuntarily retained in a CPEP for more than 24 hours unless the person is admitted to an extended observation bed. (See extended observation beds below.)

Crisis Outreach Service (4009) – Emergency services provided outside an emergency room setting which includes clinical assessment and crisis intervention treatment. This is a per diem service and is billed on a daily basis.

Interim Crisis Service (4010) – Mental health service provided outside an emergency room setting for persons who are released from the emergency room of the comprehensive psychiatric emergency program, which includes immediate face-to-face contact with a mental health professional for purposes of facilitating a recipient’s community tenure while waiting for a first post-CPEP visit with a community based mental health provider.

Extended Observation Bed (4049) - No person may be involuntarily retained in a comprehensive psychiatric emergency program for more than 24 hours unless the person is admitted to an extended observation bed. The director of the CPEP may involuntarily receive and retain in an extended observation bed any person alleged to have a mental illness which is likely to result in serious harm to the person or others and for whom immediate observation, care and treatment in the CPEP is appropriate. Retention in an extended observation bed shall not exceed 72 hours (voluntarily, or involuntarily), which shall be calculated from the time such person is initially received into the emergency room of the CPEP.

Claiming for Extended Observation Beds –
• Admission to the extended observation bed is, for billing purposes, the calendar day after the calendar day in which the full or brief visit is completed.
• The extended observation bed rate may only be claimed when a person has been held in the CPEP for more than 24 hours.
• A brief or full visit claim is submitted for the calendar day in which the visit is completed, and claims for the extended observation bed are submitted for each subsequent day, up to 72 hours from the patient’s initial arrival in the CPEP.
• If the patient is admitted to the psychiatric inpatient unit, the extended observation bed rate is not claimed. The psychiatric inpatient unit rate is claimed instead beginning on admission to the extended observation bed.

➤ Intensive Psychiatric Rehabilitation Treatment (IPRT):
Link to IPRT Operational Regulations (section 587.13)
Link to IPRT Reimbursement Regulations (section 588.10)

Rate codes 4364 – 4368. An IPRT claim is submitted on a daily basis. The applicable rate code / procedure code / modifier codes combination is dependent on the number of hours of service in the day. The
combinations are listed on the attached crosswalk. Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day.

➢ **Partial Hospitalization:**
  
  Link to Partial Hospitalization Operational Regulations (section 587.12)
  Link to Partial Hospitalization Reimbursement Regulations (section 588.9)

  Regular Rate Codes 4349 – 4352, Crisis Rate Codes 4357 – 4363 - A partial hospitalization claim is submitted on a daily basis. The applicable rate code / procedure code / modifier code(s) combination is dependent on the number of hours of service a day. The combination is listed on the attached crosswalk. Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day.

  Collateral Service (4353, 4354) - Clinical support services of at least 30 minutes in duration but not more than two hours of face-to-face interaction between one or more collaterals and one therapist with or without a recipient.

  Group Collateral Service (4355, 4356) - Clinical support services, of at least 60 minutes in duration but not more than two hours provided to more than one recipient and/or his or her collaterals. The service does not need to include recipients and cannot include more than 12 collaterals and/or recipients in a face-to-face interaction with a therapist.

  Pre-admission – Visits of one to three hours are billed using the crisis visit rate codes (4357, 4358, 4359). Visits of four hours or more are billed using partial hospitalization regular rate codes (4349, 4350, 4351, 4352). Per the coding crosswalk, the UA modifier is required on all partial hospitalization pre-admission claims.

➢ **Personalized Recovery Oriented Services (PROS):**
  
  Link to PROS regulations (part 512)
  Link to PROS Guidance

  A comprehensive PROS program is reimbursed on a monthly case payment basis. PROS claims use the last day of the month as the date of service and that date represents all the days for that month. Therefore, all the line level dates of service must also be the last day of the month. Each unique procedure code / modifier code(s) combination should be recorded on its own claim, along with the corresponding units of service and the pre-managed care rate code in the header of the claim. For example: if services provided during the month to an individual would have been billed under rate codes 4521, 4525, and 4532 under the old structure, those services must be submitted to the managed care plan on three claims showing the rate code in the header and the applicable procedure code / modifier code(s) combination and units of service at the line level.

  Claim 1 - Rate code 4521 in the header plus H2019U2 and 13 - 27 units at the line level
  Claim 2 - Rate code 4525 in the header plus T1015HE and 1 unit at the line level
  Claim 3 - Rate code 4532 in the header plus H2019UBU2 and 2 or 3 units at the line level.

  The reimbursement structure for a comprehensive PROS program consists of several elements:
Monthly base rate;
- Intensive Rehabilitation (IR) component add-on;
- Ongoing Rehabilitation and Support (ORS) component add-on;
- Clinical treatment component add-on.
- Additional BIP elements (see below)

**Community Rehabilitation and Support Services (CRS) Monthly Base Rate (4520, 4521, 4522, 4523, 4524)**
The basic measure for the PROS monthly base rate is the PROS unit. PROS units are accumulated during the course of each day that the individual participates in the PROS program, and are aggregated to a monthly total to determine the PROS monthly base rate for the individual. The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation and service frequency (see table below). Daily program participation is measured in 15 minute increments, rounded down to the nearest quarter hour. In order to accumulate PROS units for a day, a PROS program must deliver a minimum of one medically necessary PROS service to an individual or collateral on that day. The maximum number of PROS units per individual per day is five. Services provided in a group format must be at least 30 minutes in duration. Services provided individually must be at least 15 minutes in duration. A minimum of two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate.

**TABLE FOR THE CALCULATION OF “PROS UNITS” (based on “program hours” and “number of services”)**
- This table is used on a daily basis to calculate the PROS units for the day.
- At the end of the month, the daily units for each day in the month are accumulated to determine the total units for the month.
- (see next page for table)

<table>
<thead>
<tr>
<th>Hours at Program for the Day</th>
<th>NUMBER OF SERVICES (for that day)</th>
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<tbody>
<tr>
<td></td>
<td>PROS Units</td>
</tr>
<tr>
<td>1 Service</td>
<td>0.25</td>
</tr>
<tr>
<td>2 Services</td>
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<td>3 Services</td>
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**PROS Component Add-Ons**
In addition to the monthly case payment, PROS providers are also reimbursed for three component add-ons: IR, ORS and Clinic Treatment services. Up to two component add-ons may be billed per individual, per
In no event will an ORS component add-on and an IR component add-on be billed in the same month for the same individual. Component add-ons are not billed prior to the calendar month in which the individual is registered with the PROS program.

**Intensive Rehabilitation -IR (4526):** In order to bill the IR component add-on, an individual must have received at least six PROS units during the month, including at least one IR service. In instances where a comprehensive PROS program provides IR services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an IR-only bill. When an IR-only bill is submitted, the minimum six PROS units required may be limited to the provision of IR services.

**Ongoing Rehabilitation and Support - ORS (4527):** PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of 10 hours per week. However, to allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement. A minimum of two face-to-face contacts with the individual and/or identified collateral which include ORS services must be provided per month. A minimum contact for ORS is 30 continuous minutes in duration. At least two of the face-to-face contacts must occur on separate days. A contact may be split between the individual and the collateral. At least one visit per month must be with the individual only. In instances where a comprehensive PROS program provides ORS services to an individual, but other PROS services are provided by another provider of service or no other PROS services are provided in the month, the comprehensive PROS provider may submit an ORS-only bill.

**Clinical Treatment (4525):** In order to bill the clinical treatment add-on, a minimum of one clinical treatment service must be provided during the month. Individuals receiving clinical treatment must have, at a minimum, one face-to-face contact with a psychiatrist or nurse practitioner in psychiatry (NPP) every three months, or more frequently as clinically appropriate. Such contact during any of the first three calendar months of the individual’s admission will enable billing for the month of contact, any preceding months in which the recipient has been registered with the PROS program, and the two months following the month of contact. Thereafter, each month that contains a contact with a psychiatrist or nurse practitioner in psychiatry will enable billing for that month and the next two months. The clinical treatment component may only be reimbursed in conjunction with the monthly base rate and/or the IR or ORS.

**Pre-admission Program Participation (4510)**
Reimbursement for individuals who are in pre-admission status is limited to two consecutive months, whether or not the individual is ultimately admitted to the program. If pre-admission program participation occurs during the month of admission, the pre-admission program participation may be included in the total number of PROS units accumulated during the calendar month, but the pre-admission rate cannot be billed.

**PROS BIP (Balancing Incentives Program) Rate Codes** [Link to PROS BIP Guidance and Information]
NYS pays an enhanced PROS rate (PROS BIP) to help facilitate the integration of certain populations into the community. Individuals eligible for services associated with PROS BIP enhanced payments must be identified as members of the “target population” by meeting the following eligibility criteria:

- have lived in an adult home (AH) longer than six consecutive months, or
• have lived in a nursing home (NH) longer than six consecutive months, or
• have lived in a state operated community residence (SOCR) longer than six consecutive months, or
• have lived in a state psychiatric center (PC) longer than six consecutive months, and
• have been discharged from a nursing home, adult home, or in-patient state psychiatric center into the community,
• meet all eligibility criteria for PROS admission, as defined in Part 512.7(c)(5)(i-iv)

Individuals will be considered members of the "target population" for up to 12 consecutive months following discharge to the community from one of the identified settings. For the purposes of PROS and use of BIP funds, community settings that determine eligibility may not include Congregate Treatment settings, Community Residences and Family Care. All services must be medically necessary. PROS programs can continue to provide services to these individuals beyond this period of time, but will no longer be able to bill at the increased rates.

**BIP Pre-admission Service (4531)**

Pre-Admission Services can be provided to individuals in the target population for a maximum of four consecutive months (vs. the two maximum consecutive months available for other "non-BIP" individuals). Pre-Admission Services provided to these individuals can also be billed at an increased “BIP payment” of $175 (upstate) and $191 (downstate). The BIP pre-admission rate cannot be billed in combination with billing for the existing PROS Pre-Admission payment. Additionally, the duration of months that pre-admission is billed at the BIP Pre-Admission rate cannot be consecutive with the two consecutive month maximum as currently identified in Part 512.

**BIP Payments for Enhanced CRS (4532, 4533)**

(Rate code 4532 PROS ENHANCED CRS 2 CONTACT – AH/NH/SOCR/PC - for two (2) or three (3) of the identified CRS services, or
Rate code 4533 PROS ENHANCED CRS 4 CONTACT – AH/NH/SOCR/PC - for four (4) or more of the identified CRS services)

This rate code based payment is an add-on (in addition to base rate billing). CRS services eligible for the enhanced payment are as follows:

- Basic living skills
- Benefits and financial management
- Community living exploration
- Information and education regarding self help
- Wellness self-management

In order to be able to bill for the BIP enhanced CRS payment, PROS program staff must provide one or more of the identified CRS services at a community site (grocery store, bank, etc.) so that individuals can regain functional skills and learn to manage mental health barriers. These services can be delivered on a one-to-one basis or in groups. When services are delivered using group modality, the group size cannot exceed 12 participants on a routine and regular basis, as defined in 512.7(d)(7)(i). The enhanced CRS services are to be provided in increments of no less than thirty (30) minute, face to face, and delivered on separate days.

**BIP Payments for IR Services (4534)**

Because it is anticipated that members of the PROS BIP population may have an increased need for IR services, a separate IR rate code (4534 - PROS INTENSIVE REHABILITATION – AH/NH/SOCR/PC) has been established for this population for billing and audit purposes. Claims related to this IR rate code will not be
counted toward a program’s maximum average of 50% for IR claims submitted. In other words, the purpose of this code is to allow PROS providers to circumvent IR utilization limits for this limited population. Rate code 4534 is not to be billed during the same month as rate code 4526. Rate code 4534 acts as a temporary replacement code for 4526 for the PROS BIP population. All other PROS IR billing rules apply to rate code 4534, including the prohibition on billing IR for the same month as ORS.

- **Transportation:**

**Medically Necessary Transportation for Behavioral Health Services:**
As is the current practice for services already in the managed care benefit package, medically necessary transportation for behavioral health will be a carved-out service that will be billed directly to the State on a FFS claim submitted by the transportation provider. These services must be approved by the regional transportation manager.

NOTE: For New York City Based enrollees receiving services at an OASAS Certified Opioid program transportation (metro –card reimbursement) is accommodated through the New York City Human Resources Administration (HRA)/ PTAR system.

**Non-medical Transportation (only for HARP enrollees and individuals in HIV SNPs meeting the HARP eligibility criteria and qualifying under an HCBS needs assessment):**
This service is an HCBS service that will be carved-out of the HARP benefit in order to garner the benefits provided by the use of a transportation manager. It will be billed and managed in the same way as medically necessary transportation; it will be billed directly to the State on a FFS claim submitted by the transportation provider. However, mainstream plans may also provide this service on an “in lieu of” basis outside of their capitation rate (but not through the transportation manager and FFS). All other HCBS services are detailed at the end of this document. Non-medical transportation is an ad hoc, time-limited service. Examples of transportation as a non-medical service would be travel to job interviews or to a GED course. Travel to HCBS services are generally considered to be medically necessary transportation. Again, approval mechanisms and reimbursement to transportation providers is the same for both medical and non-medical transportation, except the non-medical transportation is not reimbursable outside of a HARP.

**HARP HOME AND COMMUNITY BASED SERVICES (HCBS)**

HCBS services are only available to HARP enrollees qualified through the assessment process and HARP eligible individuals enrolled in HIV-SNPs and assessed as HCBS eligible. A mainstream plan may provide HCBS to its enrollees as a cost effective alternative to regular OMH and OASAS licensed/certified services (on an in lieu of basis and paid by the Mainstream plan from its capitation rate). A HARP may also make these service available to an otherwise unqualified individual on an in lieu of basis.

For at least two years, HARPs and HIV-SNPs will be reimbursed for HCBS outside the capitation rate by submitting claims with supplemental rate codes. (These supplemental rate codes are similar in nature to the rate codes used for “kick payments”.) The rate code (TBD – see note)/procedure code/modifier code combinations for all the services below are shown on the attached HCBS coding crosswalk. (Note: The actual HCBS rates codes are still under development – pending CMS approval - and are expected to be released in early April.) NOTE: It is anticipated that all HCBS practitioners will receive health insurance from their employer and the HCBS provider rates have been constructed accordingly.
See the HCBS manual for program/clinical guidance. [Link to HCBS provider manual]

- **Psychosocial Rehabilitation (PSR):**

  PSR is divided into three different types of sessions:
  - **Individual, per 15 minutes**
    - Billed daily in 15 minute units with a limit of 8 units per day.
    - Individual service cannot be billed the same day as a PSR group session or PSR Individual per diem.
    - May be provided on or off-site (two separate rates apply).
    - Transportation is billed separately as appropriate.
    - Maximum of 8 units (2 hours) per day.
  - **Individual, per diem**
    - Billed daily with a max of 1 unit.
    - Individual per diem service cannot be billed the same day as a PSR group session or PSR Individual per 15 minutes.
    - May be provided on or off-site - under a single rate code and payment amount.
    - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
    - Minimum of 3 hours.
  - **Group**
    - Billed daily in 15 minute units with a limit of 4 units per day.
    - Group sessions cannot be billed on the same day as a PSR individual per 15 minutes or per diem session.
    - May only be provided on-site.
    - Maximum 4 units (1 hour) per day.
    - Payment for group sessions is broken into various levels through the use of Px modifier codes to distinguish the number of individuals present in the session (i.e., 2-3, 4-5, 6+). The rate code/procedure code/modifier code combinations are shown on the attached HCBS services coding crosswalk.

- **Community Psychiatric Support and Treatment (CPST):**

  - Billed daily in 15 minute increments with a limit of 6 units (1½ hours) per day.
  - Payment for CPST services is broken into various levels through the use of Px modifier codes that indicate the type of staff providing the service (i.e., physician, psychologist, NP, RN, all other professions).
  - There are no group sessions for this service.
  - May only be provided off-site.
  - Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
Habilitation/Residential Support Services:
- Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day.
- There are no group sessions for this service.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Family Support and Training (FST):
- Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day.
- FST is detailed by using modifiers that indicate whether the service was provided to the family with the recipient present or to the family without the recipient present.
- There are no group sessions for this service.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Short-Term Crisis Respite:
- Billed daily with a max unit of 1 per day.
- Stays may be no longer than 1 week per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual).
- May only be provided in site-based residential settings.
- Fee includes transportation, do not bill transportation separately.

Intensive Crisis Respite:
- Billed daily with a max unit of 1 per day.
- Stays may be no longer than 1 week (7 days).
- Provided off-site in residential, community-based settings.
- Fee includes transportation, do not bill transportation separately.

Education Support Services:
- Billed daily in 1 hour units with a max unit of 1 (1 hour).
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
Empowerment Services – Peer Supports (OMH):
- Billed daily in 15 minute units with a limit of 16 units (4 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Pre-Vocational Services:
- Billed daily in 1 hour units with a limit of 2 units (2 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Transitional Employment:
- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Intensive Supported Employment (ISE):
- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.
- Modifier is used to indicate “Complex Level of Care”.

Ongoing Supported Employment:
- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day.
- May be provided on or off-site.
- Staff transportation is billed separately as appropriate. Transportation claiming is done at the recipient level and then is only for a single staff member, regardless of the number of persons involved in providing the service.

Staff Transportation:
The staff transportation service covers the actual cost of provider staff travel to off-site service locations – and only for selected HCBS services. There is no reimbursement for “staff time” while in travel status and that time is not billable under the other HCBS rate described above. The cost of staff time while in travel status is built into the rates above.
Staff transportation billed under the recipients Medicaid ID (CIN) and is only allowable for a single staff person for a single service. There is no travel reimbursement for additional staff persons traveling to the service location.

Staff transportation is divided into two types:

- **Per mile**
  - Billed daily in per mile units with a limit of 60 miles for a round trip.
  - 56 cents per mile (per Federal guidelines).

- **Per round trip**
  - Billed monthly using the first day of the month as date of service.
  - Each round trip counts as one unit, with a limit of 31 units per calendar month.

➢ **Crisis Intervention:**

Plans may not deny coverage for Crisis Intervention. This service is billed using the APG methodology and is divided into two separate types of sessions:

- **Crisis Intervention (per hour)**
  - Billed daily in 1 hour units with a limit of 4 units (4 hours) per day.
  - Requires the participation of at least 2 staff (one can be non-licensed).
  - Provided off-site.
  - Fee includes transportation, do not bill transportation separately.

- **Crisis Intervention (per diem)**
  - Billed daily with a max unit of 1 (5+ hours).
  - Requires the participation of at least 2 staff.
  - Provided off-site
  - Fee includes transportation, do not bill transportation separately.

➢ **OMH Community Mental Health Services (aka, Other Licensed Practitioners):**

Services provided by a licensed behavioral health practitioner (LBHP) licensed in the State of New York to prescribe, diagnose and/or treat individuals with mental illness or substance abuse who operates within an agency licensed by the Office of Mental Health (pursuant to 14NYCRR Part 599).

- Claims submitted using OMH Clinic off-site rate codes
- All services require prior approval.
- A LBHP includes individuals licensed as:
  - Licensed Psychiatrist or Advanced Nurse Practitioner,
  - Licensed Psychologist,
  - Licensed Psychoanalyst,
  - Licensed Social worker (LMSW, LCSW),
  - Licensed Marriage & Family Therapist, and
  - Licensed Mental Health Counselor
  - Licensed LMSW, LCSW, PsyD, Phd and MDs may supervise unlicensed professionals in licensed agencies who have at least Bachelor’s level such as a Registered Nurse or a peer with state
training and certification.

- Services may be provided in any setting permissible under State practice law, outside of the OMH licensed clinic.
- Services provided while a person is a resident of an IMD, such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not separately reimbursable.
NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS) - SUBSTANCE USE DISORDER (SUD) SERVICES AND BILLING

MANUAL PURPOSE:
There are two main purposes of the SUD section of the New York State Behavioral Health service and billing manual is to provide:

ONE: Provide descriptive information regarding the full scope of Substance Use Disorder (SUD) services available in New York State as authorized by the New York State Medicaid State Plan (SPA)/1115 waiver; and,

TWO: Provide the specific Qualified Mainstream Plans (QMPs); and, Qualified Health and Recovery Plans (HARPS) coding for: Title 14 NYCRR Part 822 outpatient clinic, outpatient rehabilitation, and opioid programs; and, Part 820 SUD services in a residential setting. These services are newly incorporated into the benefit package; and, for the first 24 months of integration into the benefit package are paid at the prescribed government rates. As such, this manual provides the statewide / standardized required codes; and, associated payment amounts for all /any QMP or HARP enrollees.

NOTE: The Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services are already incorporated into the benefit package. Providers of such services should speak with the enrollee’s plan regarding the plan coding; contract; and reimbursement policies.

All Substance Use Disorder treatment programs in New York State are certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) pursuant to Article 32 of the New York State Mental Hygiene law and the associated / applicable State regulations. All New York State authorized SUD SPA services are delivered in the least restrictive setting based on an individual risk and needs assessment.

BACKGROUND – SUD SERVICES AND MEDICAID MANAGED CARE:
Previously, the New York State Medicaid Managed care benefit package included only: Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services. As such, when these services are delivered to plan enrollees the service is reimbursed by the plan; at the negotiated / contracted rate and not billed to Medicaid Fee-For-Services (FFS).

Title 14 NYCRR OASAS Part 822 Certified Outpatient Clinic; Outpatient Rehabilitation; and Opioid Programs have not been included in the benefit package and were billable through Medicaid fee-for-service and reimbursed at the government / Ambulatory patient group (APG) rate.

New York is now integrating the full complement of SUD services into the Qualified Mainstream Plans (QMPs); and, Qualified Health and Recovery Plans (HARPS) benefit packages. The integration of SUD services, in particular 14 NYCRR OASAS Part 822 OASAS Certified outpatient clinic and opioid programs, is new to the New York State Medicaid managed care system. Therefore, the State has opted to utilize this...
manual to provide plans and providers with a comprehensive overview of all the SUD services; and, the related coding for the services that are being newly incorporated into the capitated benefit package.

The SUD section of the Billing Manual for OMH / OASAS Behavioral Health Services is comprised of the following Sub-Sections and parts.

**Sub - Section One: SPA service and associated OASAS Certified program / setting:**

**Part A:** General Service Overview to orient the reader to the general scope and settings of SUD services within the New York State Medicaid system.

**Part B:** General Provider Qualifications for all SUD and Addiction Services provides a description of the types of services providers delivering services within an OASAS certified Program. Please note: When offering a contract to an OMH or OASAS licensed or certified programs the Plan / Contractor may not separately credential individual staff members in their capacity as employees of these programs and must contract for the full range of services offered under their license.

**Part C:** LOCADTR – NYS Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR is required within New York State for all Medicaid patient placements. NYS does not use ASAM for determining placement of Medicaid patients.

**Part D:** For each level of SPA service and the associated OASAS certified / setting this manual will provide:

State Regulatory Certification Authority; General service / program type overview including services delivered in each certified setting; admission criteria; physical health services; screening / assessment / treatment planning; and, staffing expectations.

**Sub - Section Two: Reimbursement for SUD and Addiction Services:**

This section:

- Provides information regarding the associated Medicaid fee schedule/ reimbursement for the specific services; coding; and, what modality / OASAS certified program delivers such services.
- Identifies SUD and addiction service limitations
- Coding and Medicaid Fee-for- Service Table

**Section Three: Listing of OASAS Certified Programs**

Listing of OASAS certified programs that deliver the authorized SPA / 1115 demonstration services; the applicable authorizing New York State program regulation; and, where appropriate a cross walk to ASAM levels of care.
Section One - Part A:

General Overview SPA /1115 service and associated OASAS Certified program / setting:

New York State SUD services include an array of participant-centered crisis, inpatient, residential and outpatient services consistent with the individual’s assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for managing substance use disorder symptoms, and behaviors.

SUD services are provided by programs that are OASAS certified pursuant to applicable program specific sections of Title 14 NYCRR (Part 822; Part 818, Part 820 and Part 816). Additionally, programs are subject to shared title 14 NYCRR Part 800 regulatory staffing definitions for: Clinical staff; medical director; medical staff; and, Qualified Health Professionals Appendix B.

This subsection offers a brief overview on the primary SUD service settings:

- Outpatient (including: clinic; opioid; outpatient rehabilitation);
- SUD Services in a Residential Setting; and,
- Inpatient (including: detoxification and inpatient rehabilitation);

1. **Outpatient services:**

   **Setting:**
   The setting will be determined by the goal which is identified to be achieved in the individual’s written treatment plan and may include OASAS outpatient settings Certified by Title 14 NYCRR Part 822 (clinic, opioid; and, outpatient rehabilitation)

   **Services:**
   Outpatient services include participant-centered services consistent with the individual’s assessed treatment needs with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms and behaviors associated with substance use disorders. These services are designed to help individuals achieve and maintain recovery from SUDs. Services should address an individual’s major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Outpatient services are delivered on an individual, family or group basis in a wide variety of settings including site-based facility, in the community or in the individual’s place of residence.

   These services may be provided on site or on a mobile basis as defined by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

   **Clinical Indications:**
   Outpatient clinic settings and services are indicated for individuals whose severity of illness warrants this level of treatment, or when an individual steps-down from a higher level of care based on an individualized assessment, LOCADTR and treatment plan. Medication-assisted therapies should be utilized when a client has an established substance use disorder that has been shown through sufficient research to respond to the specific medication. This includes methadone, buprenorphine and naltrexone for opiate use disorder where tolerance and withdrawal criteria are met and naltrexone and acamprosate (Campral) for alcohol use disorder when clinically indicated. Medication assisted treatments should be available to the patient in the most appropriate treatment setting.
• Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals with a moderate to severe dependence condition or for whom there is substantial risk of relapse.

• Outpatient rehabilitation services may be warranted when the client has significant functional impairment and an inadequate social support system to provide the emotional and social support necessary for recovery, physical health care needs or substantial deficits in functional skills.

2. SUD services in a residential setting:

Setting:
Residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential setting certified by OASAS under Title 14 NYCRR Part 820 and designed to help beneficiaries achieve changes in their SUD behaviors

Services:
Include participant-centered residential services consistent with the beneficiary’s assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing SUD symptoms and behaviors.

Clinical Indications:
These services are designed to help beneficiaries achieve changes in their SUD behaviors within a safe and supportive setting when the individual lacks a safe and supportive residential option in the community. Services should address the beneficiary’s major lifestyle, interpersonal, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUDs; (3) counseling to address a beneficiary’s major lifestyle, attitudinal, and behavioral problems; and (4) Medication assisted treatment when medically necessary.

3. Inpatient services include:

Crisis or Detoxification Setting:
Crisis or detoxification services are provided in hospital or community based inpatient setting that is certified by OASAS under Title 14 NYCRR Part816.

Services
Crisis or detoxification services are medically directed with 24 hour medical staff monitoring including vital sign monitoring, medication to manage withdrawal and other medical intervention required to stabilize the individual. Crisis SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) Medication assisted treatment as medically necessary, and linkage to the next level of SUD care.
Inpatient Setting:

These services are delivered in inpatient settings certified by OASAS under Title 14 NYCRR Part 818.

Services

Inpatient services are participant-centered services consistent with the beneficiary’s assessed treatment needs, with a rehabilitative and recovery focus designed to stabilize acute SUD, medical and psychiatric needs within a structured setting with 24 hour medical oversight. Inpatient SUD services include medically necessary care according to assessed needs including: (1) assessment and clinical treatment plan development; (2) skill development for coping with and managing symptoms and behaviors associated with SUDs; (3) counseling to address a beneficiary’s major lifestyle, attitudinal, and behavioral problems; and (4) Medication assisted treatment when medically necessary.
Section One – Part B:
Provider Qualifications for all SUD and Addiction Services

When offering a contract to an OMH or OASAS licensed or certified programs the Plan / Contractor must contract for the full range of services offered under the program’s license / certification and MAY NOT separately credential individual staff members in their capacity as employees of these programs; and must accept the OASAS program certification as the credential.

Within an OASAS Certified Program services are provided by licensed; certified; and unlicensed professional staff, who are at least 18 years of age with a high school or equivalent diploma, according to their areas of competence as determined by degree, required levels of experience as defined by state law and regulations and departmentally approved program guidelines and certifications. Licensed practitioners are licensed by the New York State Department of Education and include, but are not limited to licensed master social worker (LMSW), licensed clinical social worker (LCSW), licensed mental health counselor (LMHC), licensed marriage and family therapists (LMFTs), licensed psychoanalysts; registered nurses (RNs); licensed practical nurses; nurse practitioners (NPs); medical doctors (MD and DO) and psychologists. Any staff who is unlicensed and providing addiction services must be credentialed by OASAS as a credentialed alcoholism and substance abuse counselor (CASAC); a credentialed alcoholism and substance abuse counselor – trainee (CASAC-T); or be under the supervision of a qualified health professional (QHP). State regulations require supervision of CASAC-T and non-credentialed counselors by QHP meeting the supervisory standards established by OASAS. A QHP includes the following professionals who are currently registered with their respective New York board or OASAS: CASAC; LMSW; LCSW; NP; occupational therapist (OT); physician; physician assistance; RN; psychologist; rehabilitation counselor certified by the Commission of Rehabilitation Counselor Certification; a therapeutic recreation specialist who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience; a family therapist currently accredited by the American Association for Marriage and Family Therapy; a licensed mental health practitioner registered as such by the New York State Education Department (Title VIII, Article 1630; a counselor certified by and currently registered as such with the National Board of Certified Counselors. The QHP provides clinical/administrative oversight and supervision of non-credentialed staff.
Section One – Part C:
NYS - LOCADTR - Level of Care for Alcohol and Drug Treatment Referral

LOCADTR Summary Overview

LOCADTR is the New York State level of care placement tool which guides placement, continued stay and transfer/discharge of patients within the New York State system of OASAS certified programs. The use of LOCADTR is REQUIRED within New York State for all patient placement.

Level of care determinations are made through an individualized assessment of risks, resources, community support services and other clinical considerations through an interview process and the decision logic within the LOCADTR tool. It is based on the following risk and resource questions and associated decision trees

LOCADTR – Who may complete / Staffing

A licensed practitioner or unlicensed counselor or assessor under the supervision of a QHP may complete the assessment. However, interpretation of the information must be within the assessor’s scope of practice. Consultation with the interdisciplinary team is required whenever the individual completing the assessment is functioning outside of his or her scope of practice and expertise.

LOCADTR Outline – Risk and Resources when assessing placement

Risk:

1. Does the person have significant medical condition(s) that need to be managed in an inpatient rehab setting for SUD treatment to be effective?
2. Does the person have significant psychiatric disorders(s) that need to be managed in an inpatient rehab setting for SUD treatment to be effective?
3. Does the person use in hazardous situations or in amounts or frequencies that are likely to imminently cause severe physical or emotional harm to self or others?
4. Do all of the following apply (please check all that apply)?
   i. Is medication-assisted treatment (MAT) available in the community?
   ii. Is the person willing to utilize it on an outpatient-basis?
   iii. Is the person expected to stabilize on medication on outpatient basis?

5. Does the person have one of the following?
   Interpersonal and personal skills deficits indicated by (please check all that apply):
   i. an inability to establish and maintain stable employment;
   ii. an inability to establish and maintain stable relationships;
   iii. persistent disregard for social norms, rules and/or obligations.
   For example, history of repeated arrests or involvement in the criminal justice system.
6. Does the person have a recent history of violence towards others or manipulation that creates harm to others?
7. Does the person have a psychiatric condition that requires 24-hour care in a secured environment?
8. Does the patient have strong cravings and/or urges to use OR medical or psychiatric conditions that require stabilization with medical oversight within a residential setting?

Resource:

1. Is the person adequately performing responsibilities in their work, social and family roles?
2. Does the person have strong self-efficacy/confidence that he/she can pursue recovery goals outside of an inpatient setting?
3. Is the person connected to social/family network supportive of recovery goals?
4. Had the person demonstrated a therapeutic alliance with at least one professional helper in the past?
5. Can the person be managed in an outpatient setting with additional recovery supports (e.g., Case Management, Certified Paraprofessional?)

Additional Housing Questions:

6. Can the person manage triggers for substance use in their environment?
7. Does the person have stable access to food and shelter?
8. Is the person able to meet recovery goals in an independent living environment with supports?
OUTPATIENT SERVICES

Setting: Outpatient Clinic - In New York these are delivered in / by OASAS outpatient settings Certified by Title 14 NYCRR Part 822

Outpatient clinic services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure standards. All outpatient SUD programs are certified under OASAS Regulation in accordance with Mental Hygiene Law.

These services include, but are not limited to individual, group, family counseling including psycho-education on recovery, and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity but are fewer than nine contact hours per week. New York State LOCADTR criteria are used to determine level of care.

Admission Guidelines:

- Individuals have a SUD diagnosis based on the DSM criteria.
- Individuals are not in need of emergency medical care of inpatient detoxification services.
- Based on an individualized assessment of risk and resource, individuals are recommended for this level of care based on LOCADTR decision tree logic or clinical rationale.

Screening/Assessment/Treatment Plan Review

Admission Assessment:

Prospective patients will receive a face-to-face pre-admission service with clinical staff person for the purpose of determining a preliminary diagnosis, appropriateness for service and development of an initial plan of treatment, including identifying problem areas to be addressed in the treatment/recovery plan, and the type and level of services needed by the patient. (Part 822.6 (c) 822.9 (a). The decision to admit an individual must be made by a clinical staff member who is a qualified health professional and must be documented by the dated signature (physical or electronic signature) of the qualified health professional and include the basis for admitting the patient. 822.9 (b) (3)

Level of care needs to be completed within 21 days and submitted to the OASAS data base with the informed signed consent of the beneficiary.

Physical Health.
For those patients who have not had a physical examination within one year prior to admission, each such
patient must either be assessed face-to-face by a member of the medical staff (except LPN) to ascertain the
need for a physical examination or referred for a physical examination. For those patients who have had a
physical examination within one year prior to admission, or for those patients being admitted directly to the
outpatient program from another chemical dependence service authorized by the Office, the existing medical
history and physical examination documentation may be used to comply with the requirements of this
subdivision, provided such documentation has been reviewed by a medical staff member and determined to
be current. Part 822.9 (b) (2)

Treatment / Recovery Plan Development:

Each patient must have a written patient-centered treatment/recovery plan developed by the responsible
clinical staff member and patient as soon as possible after admission but not later than 21 days after
admission. The treatment/recovery plan must: (1) include each diagnosis for which the patient is being
treated; (2) address patient identified problem areas specified in the admission assessment and identify
methods and treatment approaches that will be utilized to achieve the goals developed by the patient and
primary counselor; (3) identify a single member of the clinical staff responsible for coordinating and
managing the patient’s treatment who shall approve and sign (physical or electronic signature) such plan;
and (4) be reviewed and approved by the patient, supervisor of the responsible clinical staff member, and the
Medical Director or other physician employed by the program within 10 days of the development of the
treatment plan. If the supervisor of the responsible clinical staff member is not a Qualified Health
Professional (QHP), another QHP must be designated to sign (physical or electronic signature) the plan,
except: i) for patients whose services are reimbursed by other than fee-for-service Medicaid, the plan shall
be signed (physical or electronic signature) by a either a physician, licensed psychologist, nurse practitioner,
or licensed clinical social worker. Part 822.10 (a) (b)

Treatment / Recovery Plan Updates

Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed, and revised
if necessary, at least once within every 90 calendar days from the date of admission for the first year and at
least once within every 180 calendar day window period thereafter. Reviews should occur more frequently
when a patient is not responding to treatment as planned or if a significant incident occurs. Reviews of the
treatment plan should be signed (physical or electronic signature) by the supervisor of the responsible clinical
staff member (or other designated QHP) and the Medical Director or other physician with 10 days of the
review. For patients whose services are reimbursed by other than fee-for-service Medicaid, the plan shall
be signed (physical or electronic signature) by a either a physician, licensed psychologist, nurse practitioner,
or licensed clinical social worker. Part 822.10 (c).

Discharge Planning

Discharge/transfer planning begins at admission. Individuals entering treatment should progress by meeting
treatment milestones including: stabilization; engagement; goal setting; early, partial or full remission of
substance use disorder; and attainment of goals supporting recovery. Individuals should be considered for discharge once they have stabilized, met remission criteria for substance use disorder, and attained the support necessary to support long term remission. Part 822.13 (a)

A discharge plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve. The discharge plan shall specify needed referrals with appointment dates and times, medications (including frequency and dosage) and recommendations for continued care. If the patient is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11. Part 822.13 (b)

No patient may be discharged without a discharge plan which has been reviewed and approved by the responsible clinical staff member and the clinical supervisor prior to the discharge. This requirement does not apply to patients who stop attending, refuse continuing care planning, or otherwise fail to cooperate. That portion of the discharge plan which includes referrals for continuing care must be given to the patient upon discharge. 822.13 (c)

Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

**Staffing Outpatient Program:**

Each Outpatient program shall 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. Part 822.8 (k) (5). There must be at least one full-time CASAC and/or a qualified health professional licensed in their own profession to provide addiction services; and there must be at least one full-time qualified health professional qualified in a discipline other than substance use disorder counseling Part 822.8 (k) (6). At least 50 percent of all clinical staff must be qualified health professionals. CASAC-Ts may be counted towards satisfying the 50 percent requirement 822.8 (k) (7). Each program must designate a Health Coordinator to assure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV/AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases 822.8 (k) (4)

**Clinical Staff:**

Clinical staff provide services directly to patients as prescribed in the treatment/recovery plan; clinical staff includes licensed medical staff, credentialed or licensed staff, non-credentialed staff, and student interns Part 822.6(k).

Each program must have a qualified health professional designated as the full-time on-site clinical director who is responsible for the daily activities and supervision of services provided. Such person must have at least three years of full-time clinical work experience in the chemical dependence field, at least one year of which must be supervisory, prior to appointment as clinical director. (Part 822. 8 (k) (1)
Medical Staff

Each program must have a physician designated by the governing authority to be the medical director. The medical director shall be a physician licensed and currently registered as such by the New York State Education Department and shall have at least one year of education, training, and/or experience in substance use disorder services Part 822.6(u). Programs will choose to have additional medical staff such as physicians, nurse practitioners, registered physician’s assistants, registered nurses, and licensed practical nurses licensed by the State Education Department practicing within the scope of such licenses and working with, or under the supervision of, a physician 822.6(u). At a minimum in an outpatient program a physician, registered physician's assistant or nurse practitioner must provide on-site coverage for a minimum of one hour per week for up to 25 active patients and an additional hour for each additional 25 active patients or part thereof. Part 822.8K (3)(ii)

Other Staffing Requirements:

If other specialized services are directly provided by the program, staff must be appropriately qualified to provide such services; and, be appropriately supervised this includes: Unpaid Volunteers and Student Interns; and, Peer Advocates Part 822.8 (L)(1)(2)(3).

OPioid Treatment Services: Opioid Treatment Programs (OTP)

Setting Opioid Treatment Programs (OTP) - In New York Opioid Treatment Programs are certified by OASAS under Title 14 NYCRR Part 822.

OTPs are federally regulated programs that include direct administration of daily medication (opioid agonists: methadone or buprenorphine or antagonists following a successful agonist taper: naltrexone and injectable (Vivitrol) as well as a highly structured psychosocial program that addresses major lifestyle, attitudinal, and behavioral issues that could undermine recovery-oriented goals. The participant does not have a prescription for the methadone or buprenorphine, but receives daily medication from the OTP.

Admission Guidelines: Including initial services; and, initial dosage

Prospective patients will receive a face-to-face pre-admission service with a clinical staff person for the purpose of determining a preliminary diagnosis, appropriateness for service and development of an initial plan of treatment, including identifying problem areas to be addressed in the treatment/recovery plan, and the type and level of services needed by the patient. (Part 822.6 (c) 822.9 (a)

The decision to admit a prospective patient for treatment is finalized on the date of administration of the initial approved medication dose after satisfaction of all applicable requirements (Part 822.9(d)(1), including identification initial dosage; and treatment needs. Specifically, In order to provide the first medication dose, a physician must make an in person evaluation of each prospective patient within 72 hours of the first on-site visit to determine that the prospective patient has had a physiological dependence on opioids for at least the previous 12-month period, and must diagnose and document an addiction or dependence (Part 822.9 (d)(2).

Physical Health:
The prescribing professional must conduct a full physical examination, including required laboratory tests, and any other test as clinically indicated or as may be required by the Office, during the first week after admission to determine the patient’s overall health. A prescribing professional must annually repeat the physical examination required at admission. A patient may choose to have a licensed practitioner outside the OTP complete the annual physical examination to determine health condition and OTP clinical staff shall make diligent efforts to record all required results, including ordered tests, in the patient’s case record Part 822.9(e). Additionally, initial laboratory tests must be conducted (Part 822.9(e)(i); and, HIV testing must be recommended but may not be conducted without patient written informed consent except in situations specifically authorized by law. HIV testing may be done on site or by referral. Blood and skin test results and explanation must be provided to the patient within 3 weeks of the test Part 822.9(e)(ii).

**Screening/Assessment/Treatment Plan Review:**

**Initial Treatment Plan and identification of initial dosage:**

As part of the admission process prospective OTP patients will receive a face-to-face pre-admission service with clinical staff person for the purpose of determining a preliminary diagnosis, appropriateness for service; development of an initial plan of treatment (Part 822.6(c) and, identification of initial dosage (Part 822.9 (d)(1)(2)

**Treatment / Recovery Plan Development:**

Part 822.10(a) and (b) Each patient must have a written patient-centered treatment/recovery plan developed by the responsible clinical staff member and patient as soon as possible after admission but not later than 21 days after admission. The treatment/recovery plan must: (1) include each diagnosis for which the patient is being treated; (2) address patient identified problem areas specified in the admission assessment and identify methods and treatment approaches that will be utilized to achieve the goals developed by the patient and primary counselor; (3) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign (physical or electronic signature) such plan; and (4) be reviewed and approved by the patient, supervisor of the responsible clinical staff member, and the Medical Director or other physician employed by the program within 10 days of the development of the treatment plan. If the supervisor of the responsible clinical staff member is not a Qualified Health Professional (QHP), another QHP must be designated to sign (physical or electronic signature) the plan, except: i) for patients whose services are reimbursed by other than fee-for-service Medicaid, the plan shall be signed (physical or electronic signature) by a either a physician, licensed psychologist, nurse practitioner, or licensed clinical social worker.

**Treatment / Recovery Plan Updates**

Part 822.10 (c) Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed, and revised if necessary, at least once within every 90 calendar days from the date of admission for the first year and at least once within every 180 calendar day window period thereafter. Reviews should occur more frequently when a patient is not responding to treatment as planned or if a significant incident occurs. Reviews of the treatment plan should be signed (physical or electronic signature) by the supervisor of the responsible clinical staff member (or other designated QHP) and the Medical Director or other physician with 10 days of the review. For patients whose services are
reimbursed by other than fee-for-service Medicaid, the plan shall be signed (physical or electronic signature) by a either a physician, licensed psychologist, nurse practitioner, or licensed clinical social worker.

Discharge Planning

Part 822.13 (a) Discharge/transfer planning begins at admission. Individuals entering treatment should progress by meeting treatment milestones including: stabilization; engagement; goal setting; early, partial or full remission of substance use disorder; and attainment of goals supporting recovery. Individuals should be considered for discharge once they have stabilized, met remission criteria for substance use disorder, and attained the support necessary to support long term remission.

822.13 (b) A discharge plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve. The discharge plan shall specify needed referrals with appointment dates and times, medications (including frequency and dosage) and recommendations for continued care. If the patient is a minor, the discharge plan must also be developed in consultation with his or her parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11.

822.13 (c) No patient may be discharged without a discharge plan which has been reviewed and approved by the responsible clinical staff member and the clinical supervisor prior to the discharge. This requirement does not apply to patients who stop attending, refuse continuing care planning, or otherwise fail to cooperate. That portion of the discharge plan which includes referrals for continuing care must be given to the patient upon discharge.

Staffing

OASAS Certified OTP program must satisfy the staff requirements previously identified in this manual for outpatient programs; and, the OTP specific staff requirements / accommodations identified below:

Clinical Director:
Generally, OTPS must have a full time on site clinical director. OTP may have a part-time on-site clinical director only if the OTPs certified capacity is less than 100 patients and the OTP is part of a multiple OTP system or part of a larger health, mental health or chemical dependence service. Such an OTP must designate and assign all clinical director responsibilities to another staff member qualified and capable of completing all duties. Part 822.8(k)(1)

Medical Staff:

In OTPs, prescribing professionals may be used to meet physician staffing requirements provided that no less than one third of the required 35 hours per 300 patients is fulfilled by the attendance of the physician and no more than two-thirds of such time is filled by other prescribing professionals. In addition, anytime an OTP is open and a physician is not present, a physician must be available for consultation and to attend to any emergency situation.
OTPs must have at least the equivalent of two full-time on-site nurses for up to 300 patients, one of whom shall be a registered nurse. Programs approved to serve more than 300 patients must have one additional full-time nurse for each additional 150 patients or part thereof. A nurse must be present at all times when medication is being administered. A registered nurse or nurse practitioner must be present or immediately available by telephone when services are provided by a licensed practical nurse.

**INTENSIVE OUTPATIENT TREATMENT**

In New York these are delivered in OASAS outpatient settings Certified by Title 14 NYCRR Part 822

Intensive outpatient services” (IOS) is an outpatient treatment service authorized by the Office and provided by a team of clinical staff for patients who require a time-limited, multi-faceted array of services, structure, and support to achieve and sustain recovery. Programs that offer intensive outpatient treatment schedule a minimum of 9 service hours per week delivered during the day, evening or weekends. The treatment service must make available individual and group counseling, family counseling when appropriate, relapse prevention and coping skills training, motivational enhancement, and drug refusal skills training (Part 822.6(t))

**Admission Guidelines ASAM Level 2.1**

- Individuals have a SUD diagnosis based in the DSM criteria.
- Individuals are not in need of emergency medical care of inpatient detoxification services.
- Based on an individualized assessment of risk and resource, individuals are recommended for this level of care based on NYS OASAS LOCADTR decision tree logic or clinical rationale.

**Screening/Assessment/Treatment Plan Review**

OASAS authorized Intensive outpatient services programs must satisfy the screening / treatment plan development / and treatment plan review requirements previously identified in this manual for outpatient programs.

**Staffing**

1. OASAS authorized Intensive outpatient service programs must satisfy the staff requirements previously identified in this manual for outpatient programs generally;
2. Intensive outpatient settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers, and credentialed behavioral health technicians operating within their scope of practice.

**SETTING OUTPATIENT REHABILITATION** - In New York these are delivered in OASAS outpatient settings Certified by Title 14 NYCRR Part 822

Chemical dependence outpatient rehabilitation services (outpatient rehabilitation services) are services provided by an outpatient program which has been certified by OASAS to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions who are typically
scheduled to attend the outpatient rehabilitation program three to five days per week for at least four hours per day. (Part 822.6 (i)) outpatient rehabilitation services for individuals with more chronic conditions emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. These services are provided in combination with all other clinical services provided by outpatient programs. If an outpatient program is providing outpatient rehabilitation services, the following services must be available either directly or through written agreements: (1) socialization development; (2) skill development in accessing community services; (3) activity therapies; and (4) information and education about nutritional requirements, including but not limited to planning, food purchasing, preparation and clean-up. (e) A provider of outpatient rehabilitation services must assure the availability of one meal to each patient who receives outpatient rehabilitation services for four or more hours per day (Part 822.16 (a) (d) (e).

Admission Guidelines Chemical Dependence Outpatient Rehabilitation

- Individuals have a SUD diagnosis based in the DSM criteria.
- Individuals are not in need of emergency medical care of inpatient detoxification services.
- Based on an individualized assessment of risk and resource, individuals are recommended for this level of care based on LOCADTR decision tree logic or clinical rationale.

Screening/Assessment/Treatment Plan Review

OASAS authorized Outpatient Day Rehab Programs must satisfy the screening / treatment plan development / and treatment plan review requirements previously identified in this manual for outpatient programs.

Staffing

OASAS Certified Outpatient Rehabilitation programs must satisfy the staff requirements previously identified in this manual for outpatient programs generally; and, the Outpatient Rehabilitation specific staffing requirements below (Part 822.16(c)(1)(2).

1. There must be at least one full-time equivalent counselor or therapist for every 20 patients receiving outpatient rehabilitation services. If volunteers or student interns are used, they may not be counted in the counselor-to-patient ratio.
2. at least one half-time therapeutic recreation therapist or occupational therapist or vocational specialist, certified as a rehabilitation counselor or qualified health professional with one year of experience and/or training in providing recreation, occupation and/or rehabilitation services; and  
3. at least one part-time nurse practitioner, registered physician's assistant, or registered nurse, or a licensed practical nurse supervised by a registered nurse employed by the governing authority.

SETTING: MEDICALLY SUPERVISED OUTPATIENT WITHDRAWAL (MSOW)

Medically supervised outpatient withdrawal and stabilization services can only be delivered by a provider of services which is certified by the Office to provide residential, inpatient or outpatient chemical dependence treatment services in order to assure appropriate continuation in treatment. Such programs are certified by OASAS pursuant to Title 14 NYCRR Part 816.8
Services must be provided under the supervision and direction of a licensed physician, and shall include medical supervision of persons undergoing mild to moderate withdrawal or who are at risk of mild to moderate withdrawal, as well as persons experiencing non-acute physical or psychiatric complications associated with their chemical dependence. Part 816.8(b)(1)

Such services are appropriate for persons who are intoxicated by alcohol and/or substances, or who are suffering from mild to moderate withdrawal and are unable to abstain with an absence of past withdrawal complications. Part 816.8 (b) (2).

**Admission Guidelines**

Admission shall be based upon a diagnosis of chemical dependence identified through the substance dependence diagnostic criteria set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition (DSM IVR), or the International Classification of Diseases, Ninth Edition (ICD-9) (Part 816.5(g)). For each patient level of care determination must be made by the provider through the use of LOCADTR.

Based on a medical evaluation, outpatient medically supervised withdrawal and stabilization services to a patient if: (1) the patient is suffering moderate alcohol or substance withdrawal or both, or mild withdrawal when moderate withdrawal is probable.; (2) there is an expectation of a moderate level of withdrawal symptoms based on the amount of alcohol and/or other substances used by the patient, history of past withdrawal syndromes and/or medical condition of the patient; the patient does not meet either the admission criteria for medically managed withdrawal and stabilization services, or for medically supervised withdrawal services in an inpatient or residential setting; and (4) the patient is assessed as having, and responding positively to, emotional support and a living environment able to provide an atmosphere conducive to ambulatory withdrawal and stabilization. The patient shall be retained in outpatient medically supervised withdrawal and stabilization services if: (1) such patient is receiving medication to treat symptoms of withdrawal, and such medication is being prescribed to complete withdrawal; and (2) such patient is not otherwise too ill to benefit from the care that can be provided by the medically supervised withdrawal and stabilization service. Part 816.8 (d) (e)

**Physical Health**

All Providers of chemical dependence withdrawal and stabilization service must develop medical care policies and procedures for the service, which must be approved by such provider’s governing authority and medical director where appropriate. These policies and procedures must include the following: identifying those symptoms and/or syndromes which necessitate a procedure for referral to acute medical and mental hygiene services; (ii) Policy and procedures for accomplishing medical and/or mental hygiene referrals which includes but is not limited to transportation of the patient; schedule for taking all patients’ vital signs and observation of each patient’s condition during withdrawal. All changes in the patient’s condition and appropriate actions taken shall be noted in the patient record; emergency procedures for patients suffering from medical or psychiatric problems. Additionally, the provision of pharmacological services, including a requirement that they shall be based on a history, whenever possible, and physical examination and shall be provided only on order by a prescribing professional and in accordance with the terms and conditions of such professional’s license. (Part 816.5 (d)(1)(2))
All NYS OASAS Certified MSOW programs specifically must provide (1) medical supervision of intoxication and withdrawal conditions, including monitoring of withdrawal symptoms and vital signs and regularly scheduled toxicology screens; (2) evaluation, including medical examination within twenty-four (24) hours of admission; (5) patients must be seen by the physician, nurse practitioner, physician assistant or registered nurse daily unless otherwise specified by the physician based on the patient's physical and emotional condition; and, (6) a medical evaluation must be completed on each patient, and referral for and linkage to ongoing treatment made as indicated; (Part 816.8 (c) (1) (2)(5)(6)

**Screening/Assessment/Treatment Plan Review**

MSOW services are appropriate for persons who are intoxicated by alcohol and/or substances, or who are suffering from mild to moderate withdrawal and are unable to abstain with an absence of past withdrawal complications.

Immediately upon admission to a withdrawal and stabilization service, each patient shall have presenting problems addressed in accordance with the initial orders and general policy requirements, as documented in the approved program. Each person admitted to the withdrawal and stabilization service must be evaluated as soon as possible, but within twenty-four (24) hours. (Part 816.5 (g)(4)(5). A signed and dated collaborative recovery plan that is developed between the patient and the responsible clinical staff member(s) plan is required within twenty-four (24) hours of admission, and shall be based on the evaluation conducted. (Part 816.5 (i)(1-6)

All components of the recovery care plan shall be reviewed by the responsible staff as often as necessary, but no less often than seven (7) days, in the event that an individual's stay is extended in the service beyond seven (7) days, the entire recovery care plan must thereafter be reviewed and modified accordingly every three days during the course of the extended stay. (Part 816.5 (j)(1-2)

Progress notes. Progress notes shall be written signed and dated by clinical staff members; give a chronological picture of the patient's progress; and must be sufficiently detailed to delineate the course and results of the patients progress in treatment. In a medically supervised outpatient withdrawal and stabilization service, progress notes shall be documented no less often than once per visit; (Part 816.5 (k)(1-2)

**Staffing**

Each outpatient medically supervised withdrawal and stabilization service shall have a service director who is a qualified health professional (Part 800.2; and, Part 816.4). Such service director shall have at least one year of full-time work experience in the chemical dependence treatment field prior to appointment as service director and may also serve director of another service provided by the same governing authority.

There shall be a physician, nurse practitioner and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination of all patients and to prescribe any and all necessary pharmacological medications necessary to secure safe withdrawal.
There shall be physicians, nurse practitioners, registered nurses, licensed practical nurses, or physician assistants available to all patients on call or available within the facility during all hours of operation.

There shall be sufficient qualified clinical staff to achieve a ratio of one counselor to 15 patients; fifty (50%) percent of such staff shall be qualified health professionals.

One of the full-time equivalent health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed.
RESIDENTIAL SUD AND ADDICTION SERVICES

All programs are certified under OASAS regulation Title 14 NYCRR Part 820 Part in accordance with Art 32 of the New York State mental hygiene law.

STABILIZATION: Stabilization in a Residential Setting

This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, ancillary withdrawal and medication assisted substance use treatment, psychiatric evaluation and ongoing management, group, individual and family counseling focused on stabilizing the patient and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the safety of the residence.

Admission Criteria

- Individuals have a SUD diagnosis based on the DSM criteria.
- Individuals are not in need of emergency medical care of inpatient detoxification services.
- Patients appropriate for this level of care are not in need of detoxification in a hospital or community based setting with 24 hour medical staff oversight.
- Patients have interpersonal and/or personal skills deficits that seriously impact their functioning in community based setting including: inability to maintain stable employment based on personal and interpersonal functioning; inability to maintain supportive, stable relationships; persistent disregard for social rules, norms or obligations.
- The patient does not have a recent history of violence toward others or serious predatory behavior that puts others at serious risk of harm that would pose a serious risk in a residential community setting.
- The patient has medical, psychiatric conditions or significant cravings or urges to use substances that require medical oversight to stabilize.
- Based on an individualized assessment of risk and resource, individuals are recommended for this level of care based on LOCADTR decision tree logic or clinical rationale.

Screening/Assessment/Treatment Plan Review

1. A urine drug screen and a tuberculosis test are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider.
2. Comprehensive bio-psychosocial assessment consistent with Title 14 NYCRR Part 820 within 72 hours which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.
3. Physical examination performed within 45 days of admission consistent with Title 14 NYCRR Part 820
4. Individualized, interdisciplinary treatment/treatment plan, which includes problem formulation and short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the individual within 72 hours of admission.
5. The treatment/treatment plan is reviewed in collaboration with the individual every 30 days and
6. Discharge/transfer planning begins at admission.
7. Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

Services

Medical

Medical Evaluation including history and physical exam
Nursing Assessment including assessment of self-medication
Chronic illness management
Nutrition assessment and counseling
Some on-site primary care -
Dental services by agreement
Oversight of self-medication

Psychiatric

Psychiatric Assessment
Medication management
Co-occurring treatment – psycho educational group or individual
Symptom management

Substance Use Disorder and Social/Emotional Regulation

Assessment of Urges and Cravings
Develop individualized recovery plan
Medication assisted treatment available, if appropriate to individualized treatment
Peer/mentor led group or informal interaction to orient and begin process of adjustment to community
Clinical intervention aimed toward adjustment to community and management of symptoms – urges, cravings, thoughts, behaviors, feelings associated with long-term drug use
Engagement in pro-social and pro-health activities including groups, individual and family counseling

Discharge Planning/ Linkages

Assessment of work/educational history and plan for discharge
Assessment of housing history and plan for independent living supportive of recovery and plan.

**Staffing**

- Physician and physician extenders
- Psychiatrist and nurse practitioner
- RN full time and weekend staff.
- LPN 1.5 full time
- LMSW/LCSW/LMHC or Family therapist
- CASAC to provide individual counseling and treatment plan preparation, monitoring and review
- CASAC ADL’s, community meetings, engagement, carry out of treatment planning in milieu
- Peer/Milieu staff all shifts
- Vocational Counselor.
- Case Manager

**Screening/Assessment/Treatment Plan Review**

The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan.

The comprehensive evaluation shall obtain that information necessary to determine whether a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol is indicated.

Each comprehensive evaluation shall be based, in part, on clinical interviews with the resident, and may also include interviews with significant others, if possible and appropriate.

(No later than fourteen days after admission, staff shall complete the resident’s comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the resident’s:

- chemical use, abuse and dependence history;
- history of previous attempts to abstain from chemicals and previous treatment experiences;
- comprehensive psychosocial history, including, but not limited to, the following:
  - legal involvements;
  - HIV and AIDS, tuberculosis, hepatitis or other communicable disease risk assessment;
  - relationships with, history of the use of chemicals by, and the impact of the use of chemicals on, significant others;
  - an assessment of the resident’s individual, social and educational strengths and weaknesses, including, but not limited to, the resident’s literacy level, daily living skills and use of leisure time;
  - the resident’s medical history, mental health history, current status, and the resident’s lethality (danger to himself/herself or to others) assessment; and
  - a specific diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol.)
An initial treatment/service plan addressing the resident's individual needs must be developed within three days of admission, or readmission, to the chemical dependence residential service and shall be prepared in consultation with the resident, as documented by the resident’s signature on the treatment/service plan. This initial treatment/service plan must contain a statement which documents that the individual is appropriate for this level of care, identifies the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and includes a preliminary schedule of activities, therapies and interventions.

A comprehensive treatment/service plan ("treatment/service plan"), based on the admitting evaluation, shall be prepared within thirty days of development of the initial treatment/service plan to meet the identified needs of the resident, and shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of each resident. For individuals moving directly from one chemical dependence service to another, an updated treatment/service plan shall be acceptable if it is in conformance with the requirements of this Section.

**REHABILITATION- Rehabilitation Services in a Residential Setting**

In this setting medical staff is available in the residence however, it is not staffed with 24 hour medical/nursing services. This setting provides medical and clinical services including: medical evaluation, ongoing medication management and limited medical intervention, medication assisted substance use treatment when medically necessary, psychiatric evaluation and ongoing management, group, individual and family counseling focused on rehabilitation and increasing coping skills until the patient is able to manage feelings, urges and craving, co-occurring psychiatric symptoms and medical conditions within the community. The treatment includes at least 30 hours of structured treatment of which at least 10 hours are individual, group or family counseling. Programs are characterized by their reliance on the treatment community as a therapeutic agent. It is also to promote abstinence from substance use and interpersonal behaviors to effect a global change in participants’ lifestyles, attitudes, and values. Individuals typically have multiple functional deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values. LOCADTR criteria are used to determine LOC.

**Admission Criteria**

Individuals appropriate for this level of care are not in need of detoxification in a hospital or community based setting with 24 hour medical staff oversight.

Individuals meet the criteria for Substance Use Disorder based on DSM 5 criteria.

Individuals have interpersonal and/or personal skills deficits that seriously impact their functioning in community based setting including: inability to maintain stable employment based on personal and interpersonal functioning; inability to maintain supportive, stable relationships; persistent disregard for social rules, norms or obligations.

The individual does not have a recent history of violence toward others or serious predatory behavior that puts others at serious risk of harm that would pose a serious risk in a residential community setting.

Medical, psychiatric conditions or significant cravings or urges to use substances that are stable but may require ongoing management.
**Services**

**Medical**

Medical Evaluation including history and physical exam

Nursing Assessment including assessment of self-medication

Chronic illness management

Nutrition assessment and counseling

Some on-site primary care -

Dental services by agreement

Oversight of self-medication

**Psychiatric**

Psychiatric Assessment

Medication management

Co-occurring treatment – psycho educational group or individual

Symptom management and long-term wellness management

**Substance Use Disorder and Social/Emotional Regulation**

Assessment of Urges and Cravings

Develop and carry out individualized recovery plan

Medication assisted treatment available, if appropriate to individualized treatment

Peer/mentor led group or informal interaction to orient and begin process of adjustment to community

Clinical intervention aimed toward adjustment to community and management of symptoms – urges, cravings, thoughts, behaviors, feelings associated with long-term drug use

Engagement in pro-social and pro-health activities including groups, individual and family counseling

**Discharge Planning/ Linkages**

Assessment of work/educational history and plan for discharge

Assessment of housing history and plan for independent living supportive of recovery and plan.
Staffing

- Physician and physician extenders
- Psychiatrist and nurse practitioner
- RN full time and weekend staff
- LPN sufficient for monitoring and documentation of patient self-medication and other medical monitoring under the supervision of an RN.
- LMSW/LCSW/LMHC or Family therapist CASAC to provide individual counseling and treatment planning
- CASAC ADL’s, community meetings, engagement, carry out of treatment planning in milieu
- Peer/Milieu staff
- Vocational Counselor
- Case Manager

Screening/Assessment/Treatment Plan Review

The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan.

The comprehensive evaluation shall obtain that information necessary to determine whether a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol is indicated.

Each comprehensive evaluation shall be based, in part, on clinical interviews with the resident, and may also include interviews with significant others, if possible and appropriate.

(No later than fourteen days after admission, staff shall complete the resident’s comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the resident’s:

- chemical use, abuse and dependence history;
- history of previous attempts to abstain from chemicals and previous treatment experiences;
- comprehensive psychosocial history, including, but not limited to, the following:
  - legal involvements;
  - HIV and AIDS, tuberculosis, hepatitis or other communicable disease risk assessment;
  - relationships with, history of the use of chemicals by, and the impact of the use of chemicals on, significant others;
  - an assessment of the resident's individual, social and educational strengths and weaknesses, including, but not limited to, the resident's literacy level, daily living skills and use of leisure time;
  - the resident’s medical history, mental health history, current status, and the resident's lethality (danger to himself/herself or to others) assessment; and
• a specific diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol.

An initial treatment/service plan addressing the resident's individual needs must be developed within three days of admission, or readmission, to the chemical dependence residential service and shall be prepared in consultation with the resident, as documented by the resident’s signature on the treatment/service plan. This initial treatment/service plan must contain a statement which documents that the individual is appropriate for this level of care, identifies the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and includes a preliminary schedule of activities, therapies and interventions.

A comprehensive treatment/service plan ("treatment/service plan"), based on the admitting evaluation, shall be prepared within thirty days of development of the initial treatment/service plan to meet the identified needs of the resident, and shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of each resident. For individuals moving directly from one chemical dependence service to another, an updated treatment/service plan shall be acceptable if it is in conformance with the requirements of this Section.

**RE-INTEGRATION: Re—integration Services in a Residential Setting**

This is a residential setting with access to limited medical and clinical services that are generally provided in the community. There is 24 hour oversight by on-site staff and structured activities to promote increasing independence in independent living skills. The residential program may provide some individual, family or group counseling to support the development of intra and interpersonal coping skills, recovery oriented peer supports and support for ADL and IADL skills. There is access to ongoing medical, psychiatric and other clinical services through the residence or by agreements with outpatient or clinic providers.

**Admission Criteria**

Patients appropriate for this level of care are not in need of detoxification in a hospital or community based setting with 24 hour medical staff oversight.

Patients meet the criteria for Substance Use Disorder based on DSM 5 criteria.

Patient does not have a stable living environment or stable access to food.

The patient does not have a recent history of violence toward others or serious manipulation that puts others at serious risk of harm that would pose a serious risk in a residential community setting.

The patient has medical, psychiatric conditions or significant cravings or urges to use substances that require medical oversight to stabilize.

**Services**

**Medical**

Nursing Assessment including assessment of self-medication

Chronic illness management
Nutrition assessment and counseling
Some on-site primary care possible
Dental services by agreement
Oversight of self-medication

Psychiatric

Psychiatric Assessment by agreement
Medication management by agreement
Symptom management and long-term wellness management

Substance Use Disorder and Social/Emotional Regulation

Assessment of Urges and Cravings
Develop and carry out individualized recovery plan
Medication assisted treatment available by agreement with an outpatient or Opiate Treatment Program, if appropriate to individualized treatment
Engagement in pro-social and pro-health activities including groups, individual and family counseling
Staff or peer run groups or community meetings to support increasing independence in the community and improvement in ADL and IADLs.

Discharge Planning/Linkages

Assessment of work/educational history and plan for discharge
Assessment of housing history and plan for independent living supportive of recovery and plan.

Staffing

- Medical staff available through community linkages
- RN full time to oversee self-medication and coordinate medical care
- LPN under the supervision of RN.
- CASAC coordinate treatment and develop and implement a care plan.
- Peer/Milieu staff
- Vocational Counselor
- Case Manager

Screening/Assessment/Treatment Plan Review
The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan.
The comprehensive evaluation shall obtain that information necessary to determine whether a diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol is indicated.

Each comprehensive evaluation shall be based, in part, on clinical interviews with the resident, and may also include interviews with significant others, if possible and appropriate.

(No later than fourteen days after admission, staff shall complete the resident’s comprehensive evaluation which shall include a written report of findings and conclusions addressing, at a minimum, the resident’s:

- chemical use, abuse and dependence history;
- history of previous attempts to abstain from chemicals and previous treatment experiences;
- comprehensive psychosocial history, including, but not limited to, the following:
  - legal involvements;
  - HIV and AIDS, tuberculosis, hepatitis or other communicable disease risk assessment;
- relationships with, history of the use of chemicals by, and the impact of the use of chemicals on, significant others;
- an assessment of the resident's individual, social and educational strengths and weaknesses, including, but not limited to, the resident's literacy level, daily living skills and use of leisure time;
- the resident’s medical history, mental health history, current status, and the resident's lethality (danger to himself/herself or to others) assessment; and
- a specific diagnosis of alcohol related or psychoactive substance related use disorder in accordance with the International Classification of Diseases, Ninth Revision or another Office-approved protocol.

An initial treatment/service plan addressing the resident's individual needs must be developed within three days of admission, or readmission, to the chemical dependence residential service and shall be prepared in consultation with the resident, as documented by the resident’s signature on the treatment/service plan. This initial treatment/service plan must contain a statement which documents that the individual is appropriate for this level of care, identifies the assignment of a named clinical staff member with the responsibility to provide orientation to the individual, and includes a preliminary schedule of activities, therapies and interventions.

A comprehensive treatment/service plan ("treatment/service plan"), based on the admitting evaluation, shall be prepared within thirty days of development of the initial treatment/service plan to meet the identified needs of the resident, and shall take into account cultural and social factors as well as the particular characteristics, conditions and circumstances of each resident. For individuals moving directly from one chemical dependence service to another, an updated treatment/service plan shall be acceptable if it is in conformance with the requirements of this Section.

**Service Plan Review**
Each service plan, once established, must be completely reviewed and revised at least every three months thereafter by the responsible clinical staff member in consultation with the resident and reviewed and signed by the supervisor.

Any resident who is not responding to treatment, is not meeting goals defined in the comprehensive service plan, including educational and vocational goals, or who is disruptive to the service, shall have the same noted in the case file and the circumstances addressed at a case conference, and the service plan revised accordingly.

**INPATIENT SERVICES**

**Inpatient Detoxification Medically Managed And Medically Supervised – In NYS these services are provided in setting certified by Title 14 NYCRR Part 816**

Medically managed withdrawal and stabilization services:
Medically managed inpatient withdrawal and stabilization services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms, and may include individuals with or at risk of acute physical or psychiatric co-morbid conditions. This level of care includes the forty-eight (48) hour observation bed. Patients who have stabilized in a medically managed detoxification service may step-down to a medically supervised service. (Part 816.4 (c)

Medically Managed inpatient withdrawal and stabilization services shall be provided in facilities certified by the OASAS to provide a chemical dependence withdrawal and stabilization service and certified by the Department of Health as a general hospital pursuant to Article 28 of the Public Health Law (Part 816.6 (a))

Medically supervised inpatient withdrawal and stabilization services:
Are appropriate for persons who are intoxicated by alcohol and/or substances, who are suffering from mild to moderate withdrawal, coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. Patients who have stabilized in a medically managed or medically supervised inpatient withdrawal service may step-down to a medically supervised outpatient service. (Part 816.4 (d). Medically supervised inpatient withdrawal and stabilization services programs are certified by OASAS pursuant to Title 14 NYCRR Part 816.7

**Admission Criteria:**

Admission shall be based upon a diagnosis of chemical dependence identified through the substance dependence diagnostic criteria set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition (DSM IV-R), or the International Classification of Diseases, Ninth Edition (ICD 9) (Part 816.5 (g)). For each patient level of care determination must be made by the provider through the use of LOCADTR

**Medically Managed**

A patient shall be admitted to a medically managed withdrawal and stabilization service by a physician. Individuals who require the following services must be admitted to a medically managed withdrawal and stabilization services: medical therapy which is supervised by a physician (carried out by the medical team) in order to stabilize the patient’s medical condition is still indicated; physician attendance is required daily; vital
signs at least every 6 hours or more often are still indicated; medication administration (detoxification medications) to prevent or modify withdrawal is still being adjusted and monitored; and at least one of the following is required: CIWA greater than 12; or (B) seizures, delirium tremens or hallucinations within the past 24 hours; or (C) acute intervention needed for co-occurring medical or psychiatric disorder; or (D) severe withdrawal (continued vomiting, continued diarrhea, abnormal vital signs) requiring intravenous medication and/or fluids that cannot be handled at a lower level of care; or (E) pregnancy. (Part 816.6 (d) (1-6);

**Medically supervised inpatient withdrawal and stabilization services:**

Person shall be admitted to an inpatient medically supervised withdrawal service upon identification of the following: (1) the presence of moderate withdrawal symptoms judged to be treatable at a medically supervised level of care; or expectation of moderate level of withdrawal symptoms based on the amount of alcohol and/or other substances used by the patient, history of past withdrawal syndromes and/or medical condition of the patient; or (3) continued use after withdrawal services at a less intensive level of care; or (4) the patient is not in need of medically managed level of withdrawal and stabilization services; and/or (5) the patient is not appropriate for a medically supervised outpatient service. A patient may be retain for inpatient medically supervised withdrawal services if: (1) the person is suffering moderate alcohol and/or substance withdrawal, or mild withdrawal when moderate withdrawal is probable; or (2) the person is being medicated for symptoms of withdrawal and the medication is being prescribed to complete the withdrawal; and (3) the person requires withdrawal and stabilization services and does not meet either the criteria for admission to a medically managed withdrawal and stabilization service or the criteria for admission to an outpatient medically supervised withdrawal service. (Part 816.7(d)(1-5) (e)(1-3)

**Physical Health Services:**

All Providers of chemical dependence withdrawal and stabilization service must develop medical care policies and procedures for the service, which must be approved by such provider’s governing authority and medical director where appropriate. These policies and procedures must include the following: identifying those symptoms and/or syndromes which necessitate a procedure for referral to acute medical and mental hygiene services; (ii) Policy and procedures for accomplishing medical and/or mental hygiene referrals which includes but is not limited to transportation of the patient; schedule for taking all patients’ vital signs and observation of each patient’s condition during withdrawal. All changes in the patient’s condition and appropriate actions taken shall be noted in the patient record; emergency procedures for patients suffering from medical or psychiatric problems. Additionally, the provision of pharmacological services, including a requirement that they shall be based on a history, whenever possible, and physical examination and shall be provided only on order by a prescribing professional and in accordance with the terms and conditions of such professional’s license. (Part 816.5 (d)(1)(2))

**Medically Managed Inpatient Withdrawal and Stabilization:**

In addition to the above parameters Medically Managed Withdrawal and Stabilization programs must provide medical management of acute intoxication and withdrawal conditions; medical evaluation within 24 hours of admission which includes a comprehensive health evaluation; and physician attendance is required daily. (Part 816.6 (c)(1)(3)

**Medically Supervised Inpatient Withdrawal and Stabilization:**
In addition to the above parameters that applicable to all chemical dependence withdrawal and stabilization service Medically Supervised Inpatient Withdrawal and Stabilization programs must provider medical evaluation within twenty-four (24) hours of admission; medical supervision of intoxication and withdrawal conditions, including monitoring of withdrawal symptoms and vital signs (Part 816.7 (c)(1)(3)

**Screening / Assessment / Treatment Plan Review:**

Immediately upon admission to a withdrawal and stabilization service, each patient shall have presenting problems addressed in accordance with the initial orders and general policy requirements, as documented in the approved program. Each person admitted to the withdrawal and stabilization service must be evaluated as soon as possible, but within twenty-four (24) hours. (Part 816.5(g)(4)(5). A signed and dated collaborative recovery plan that is developed between the patient and the responsible clinical staff member(s) plan is required within twenty-four (24) hours of admission, and shall be based on the evaluation conducted. (Part 816.5 (i)(1-6)

All components of the recovery care plan shall be reviewed by the responsible staff as often as necessary, but no less often than seven (7) days, in the event that an individual's stay is extended in the service beyond seven (7) days, the entire recovery care plan must thereafter be reviewed and modified accordingly every three days during the course of the extended stay. (Part 816.5 (j)(1-2)

Progress notes. Progress notes shall be written signed and dated by clinical staff members; give a chronological picture of the patient's progress; and must be sufficiently detailed to delineate the course and results of the patients progress in treatment. In a medically supervised outpatient withdrawal and stabilization service, progress notes shall be documented no less often than once per visit; (Part 816.5 (k)(1-2).

**Medically Managed Inpatient Withdrawal and Stabilization:**

Medically Managed patient should be evaluated at twenty-four (24) and forty-eight (48) hours to determine the most appropriate level of care and to establish a recovery care plan. This plan includes an evaluation of need for medically managed withdrawal and stabilization services. Patients found to be stable and may be able to step-down to a lower level of care including methadone or buprenorphine treatment, medically supervised inpatient or outpatient withdrawal services and residential, inpatient or outpatient chemical dependence services shall be transferred to the appropriate level of care with specific discharge instructions as soon as possible (816.6 (c) (5)

**Staffing:**

**Medically Managed Inpatient Withdrawal and Stabilization:**

The medical director of a medically managed withdrawal and stabilization service, whether full or part time, other than medical directors in place as of the date of this regulation, must hold either a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties, an addiction certification
from the American Society of Addiction Medicine, or a subspecialty board certification in Addiction Medicine from the American Osteopathic Association. The physician must also be buprenorphine certified. The director of a medically managed withdrawal and stabilization service may also serve as director of another service provided by the same governing authority. (2) A physician shall be on duty or on call at all times and available if needed. (3) There shall be a physician, nurse practitioner and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination of all patients and to prescribe any and all necessary pharmacological medications necessary to secure safe withdrawal. (4) There shall be registered nursing personnel immediately available to all patients at all times. Nursing services shall be under the direction of a registered professional nurse who has at least one year of experience in the nursing care and treatment of chemical dependence and related illnesses. (5) There shall be sufficient hours of qualified psychiatric time to meet the evaluation and treatment needs of those patients with other psychiatric disorders in addition to chemical dependence. If the psychiatrist is not a staff member of the service, psychiatric services shall be provided through a formal written agreement with another appropriate and qualified provider of psychiatric services. (6) There shall be sufficient clinical staff to both maintain a ratio of one counselor for each 10 beds and be scheduled so as to be available for one one-half shifts, seven (7) days per week; at least fifty percent of the clinical staff shall be qualified health professionals. (7) One of the full time equivalent qualified health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed. Part 816.6 (e)

Medically Supervised Inpatient Withdrawal and Stabilization:

(1) Each inpatient medically supervised withdrawal service shall have a designated director who is a qualified health professional, as defined in Section 816.4 of this Part. Such service director shall have at least one year of full-time clinical work experience in the chemical dependence treatment field prior to appointment as service director, and may also serve as director of another service provided by the same governing authority. (2) There shall be a physician, nurse practitioner, and/or physician assistant under the supervision of a physician, on-site sufficient hours to perform the initial medical examination on all patients and to prescribe medications necessary to secure safe withdrawal. (3) There shall be registered nursing personnel, licensed practical nurses, nurse practitioners or physician’s assistant onsite and available to all patients during all hours of operation. (4) There shall be sufficient clinical staff to both maintain a ratio of one counselor for each 10 beds and be scheduled so as to be available for one one-half shifts, seven (7) days per week; at least fifty percent of the clinical staff shall be qualified health professionals. (5) One of the full time equivalent qualified health professionals employed by the service shall be designated to provide discharge and recovery planning to persons suffering from chemical dependence as needed. (Part 816.7 (f)

Inpatient Treatment

This treatment facility provides 30 hours of structured treatment activities per week including, but not limited to psychiatric and substance use assessments, diagnosis treatment, and rehabilitation services. At least 10 of the 30 hours is to include individual, group, and/or family counseling target population for this level of care (LOC) are participants with risk of moderate withdrawal symptoms, moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require a 24-hour treatment LOC. Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour medically monitored treatment setting. All facilities are certified by NYS OASAS pursuant to Title 14 NYCRR Part 818.

This level of service also provides a planned regimen of 24-hour professionally directed evaluation, observation, and medical monitoring of addiction and mental health treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies,
procedures, and clinical protocols. Appropriate for patients whose sub-acute biomedical and emotional, behavior, or cognitive problems are so severe that they require inpatient care, but who do not need the full resources of an acute care general hospital. LOCADTR criteria are used to determine LOC.

An OASAS Certified Inpatient treatment program shall promote initiation and maintenance of abstinence from alcohol and other mood-altering drugs or substances except those prescribed by a physician, physician's assistant, or nurse practitioner; however, if an inpatient service objects to a patient's continued use of such prescribed drugs or substances, the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and (3) the development of individualized plans to support the maintenance of recovery, attains self-sufficiency, and improves the patient's quality of life. (Part 818.2 (b) (1-3))

OASAS Certified Inpatient Treatment programs Inpatient services shall provide, at a minimum, the following clinical services and procedures as clinically indicated and specified in the individualized treatment plan: (1) individual and group counseling and activities therapy (a counseling group shall contain no more than 15 patients); (2) chemical dependence awareness and relapse prevention; (3) education about, orientation to, and the opportunity for participation in, available and relevant self-help groups; (4) assessment and referral services for patients and significant others; (5) HIV and AIDS education, risk assessment, supportive counseling and referral; (6) vocational and/or educational assessment; and (7) medical and psychiatric consultation.

**Admission Guidelines**

Individuals needing seeking or having been referred for inpatient treatment or evaluation shall have an initial determination made and documented in a written record by a qualified health professional or other clinical staff under the supervision of a qualified health professional, which states the following: (1) that the individual appears to be in need of chemical dependence services; (2) that the individual appears to be free of serious communicable disease that can be transmitted through ordinary contact; and (3) that the individual appears to be not in need of acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with inpatient care or would prevent him/her from participating in a chemical dependence service. (Part 818.3 (a) (1-3))

The determinations made pursuant to the above shall be based upon service provider records, reports from other providers and/or through a face-to-face contact with the individual, all of which must be documented. (Part 818.3 (b))

If an individual is determined to be appropriate for chemical dependence services, using the LOCADTR tool. A level of care determination shall be made by a clinical staff member who shall be provided clinical oversight by a qualified health professional. The level of care determination shall be signed and dated by the clinical staff member. The level of care determination shall be made promptly and in no event not later than one patient day after the patient's first on-site visit at the service. (Part 818.3 (c)(d))

Individuals are appropriate for admission into a Part 818 program if the individual: (1) is unable to participate in, or comply with, treatment outside of a 24 hour structured treatment setting, based on one or more of the following factors: (i) has accessed a less intensive level of care and has failed to remain abstinent; (ii) the individual's environment is not conducive to recovery; (iii) has physical or mental complications and co-morbidities requiring medical management which may include, but not be limited to,
psychiatric and/or developmental disability conditions; pregnancy; moderate to severe organ damage; or other medical problems that require 24 hour observation and evaluation; or (iv) lacks judgment, insights and motivation such as to require 24 hour supervision. (Part 818.3 (f))

If determined appropriate for the inpatient service, the individual shall be admitted. The decision to admit an individual shall be made by a staff member who is a qualified health professional authorized by the policy of the governing authority to admit individuals. The name of the qualified health professional that made the admission decision, along with the date of admission, must be documented in the case record. (Part 818.3 (h))

**Physical Health**

For those patients who do not have available a medical history and no physical examination has been performed within 12 months, within three days after admission the patient’s medical history shall be recorded and placed in the patient’s case record and the patient shall receive a physical examination by a physician, physician’s assistant, or a nurse practitioner. The physical examination may include but shall not be limited to the investigation of, and if appropriate, screenings for infectious diseases; pulmonary, cardiac or liver abnormalities; and physical and/or mental limitations or disabilities which may require special services or attention during treatment. The physical examination shall also include specified laboratory tests. (Part 818.4 (b)(1))

If the patient has a medical history available and has had a physical examination performed within 12 months prior to admission, or if the patient is being admitted directly to the inpatient service from another chemical dependence service authorized by the Office, the existing medical history and physical examination documentation may be used to comply with the requirements of this Part, provided that such documentation has been reviewed and determined to be current and accurate. (Part 818.4 (b)(2))

Patient records shall include a summary of the results of the physical examination and shall also demonstrate that appropriate medical care is recommended to any patient whose health status indicates the need for such care. (Part 818.4 (b)(3))

**Screening/Assessment/Treatment Plan Review**

Comprehensive Evaluation:

The goal of the comprehensive evaluation shall be to obtain that information necessary to develop an individual treatment plan. Each comprehensive evaluation shall be based, in part, on clinical interviews with the patient, and may also include interviews with significant others, if possible and appropriate.

Each comprehensive evaluation shall be based, in part, on clinical interviews with the patient, and may also include interviews with significant others, if possible and appropriate.

The comprehensive evaluation shall include an identification of initial services needed, and schedules of individual and group counseling to address the needed services until the development of the comprehensive
treatment plan. The initial services shall be based on goals the patient identifies for treatment and shall include chemical use and any other priority issues identified in the admission assessment.

The comprehensive evaluation shall bear the names of the staff members who participated in evaluating the individual and must be signed by the qualified health professional responsible for the evaluation. (Part 818.4(a) (1)(3)(4)(5))

Treatment Plan:

A comprehensive written individual treatment plan shall be developed and implemented within seven days after admission to meet the identified needs of the patient in the major functional areas of addiction, physical health and mental health. In addition, the treatment plan shall meet identified needs in other functional areas (i.e., social, emotional, familial, educational, vocational, legal) which are deemed clinically appropriate to address during the patient’s stay at the inpatient service. The treatment plan shall take into account cultural, linguistic, and social factors as well as the particular characteristics, conditions and circumstances of the patient. The patient shall be included and actively participate in the treatment planning process. (Part 818.4 (f)(g))

Progress Notes:

A progress note shall be written, signed and dated by the responsible clinical staff member or another clinical staff member familiar with the patient’s care no less often than once per week. This progress note shall provide a chronology of the patient's progress related to the initial services provided or the goals established in the treatment plan and be sufficient to delineate the course and results of treatment/services. The progress note shall indicate the patient’s participation in all significant services that are provided. (Part 818.4(n))

Treatment Plan Updates:

If, during the course of treatment, revisions to the treatment plan are determined to be clinically necessary, the treatment plan shall be revised accordingly by the responsible staff member. (Part 818.4(l))

Staffing

All staffing requirements are pursuant to Title 14 NYCRR Part 818.8. Staff may be either specifically assigned to the inpatient service or may be part of the staff of the facility within which the inpatient service is located. However, if these staff members are part of the general facility staff, they must have specific training and experience in the treatment of alcoholism, substance abuse and/or chemical dependence specific to the services provided. The percentage of time that each shared staff is assigned to the inpatient service must be documented.
A director of the inpatient service who is a qualified health professional with at least three years of experience in the provision of alcoholism, substance abuse, and/or chemical dependence services, and at least two additional years of supervisory experience prior to appointment as director.

A medical director who will supervise and direct all medical staff and all medical services provided at the inpatient service. The medical director shall have at least one year of education, training, and/or experience in alcoholism, substance abuse or chemical dependence services. The medical director may also serve as a physician of another service which is provided by the facility.

Inpatient services which admit and provide treatment for individuals with severe mental disorders or mental illness in addition to their chemical dependence shall have a psychologist or psychiatrist, and other appropriate clinical and/or medical staff, available for a sufficient number of hours each week to provide evaluation, treatment, and supervision of other services for these patients.

Inpatient services which provide treatment for persons with coexisting medical conditions in addition to their dependence shall have an appropriately qualified physician, physician's assistant, or nurse practitioner for a sufficient number of hours each week to provide evaluation, treatment and supervision of other services.

- at least one full-time registered professional nurse and additional licensed practical nurses, registered nurses, registered physician's assistants, and nurse practitioners sufficient to provide the services required. Such personnel shall be available to all patients at all times.
- at least one clinical staff member designated to provide activities therapy.
- at least one counselor for every eight patients, at least 50 percent of whom shall be qualified health professionals.

Clinical staff available to all patients at all times. During late evening and night shifts, there shall be at least two clinical staff members on duty. This staff shall be awake at all times, make frequent rounds and be available to patients who awaken during the night.

There shall be sufficient clinical staff to achieve an overall ratio of at least the following:

1. If the service has 80 patients or more, one full time equivalent staff for each four patients;
2. If the service has between 31 and 79 patients, at least one full time equivalent staff for each three and one-half patients; and
3. If the service has 30 or fewer patients, at least one full time equivalent staff for each three patients.

In addition to staffing requirements of this Part, an inpatient service may utilize volunteers, students and trainees, on a salaried or no salaried basis. Such personnel shall be provided close professional staff supervision and appropriate education from both internal and external sources.

At least 50 percent of all clinical staff shall be qualified health professionals. Individuals who qualify as a CASAC Trainee pursuant to Title 14 NYCRR Part 853 may be counted towards satisfying the 50 percent requirement; however, CASAC Trainees may not be considered qualified health professionals for any other purpose under this chapter.

Clinical staff members who are not qualified health professionals shall have qualifications appropriate to their assigned responsibilities as set forth in the inpatient service's written personnel
policies, shall be subject to appropriate staff supervision, and shall receive regular and continuing education and training.

Each inpatient service shall have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases.
Section Two: Reimbursement for SUD and Addiction Services

A: General SUD and Addiction Services Requirements and Limitations

General Service Requirements: All state plan SUD services are provided as part of a comprehensive specialized program available to all Medicaid beneficiaries with significant functional impairments resulting from an identified SUD diagnosis.

Services are subject to prior approval, must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license[s] and applicable State law, to promote the maximum reduction of symptoms and/or restoration of the beneficiary to his/her best age-appropriate functional level according to an individualized treatment plan.

Services Delivered in Accordance with Signed Treatment Plan

The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner with the active participation of the beneficiary, family, and providers and be based on the beneficiary's condition and the standards of practice for the provision of rehabilitative services.

The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount, and duration of services.

The treatment plan must be signed by the licensed practitioner or physician responsible for developing the plan with the beneficiary (or authorized representative) also signing to note concurrence with the treatment plan. The development of the treatment plan should address barriers and issues that have contributed to the need for SUD treatment.

The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the beneficiary, family, and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals consistent with all relevant State and federal privacy requirements.

A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services. A new assessment should be conducted when medically necessary.

Service Documentation:

Providers must maintain medical records that include a copy of the treatment plan, the name of the beneficiary, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan. Components that are not provided to, or directed exclusively toward the treatment of the Medicaid beneficiary, are not eligible for Medicaid reimbursement.
Additionally, OASAS Certified programs are required to maintain service documentation in accordance with applicable state regulations, including but not limited to the relevant section of Title 14 NYCRR as applicable to the specific program certification type. Such regulations are available at: https://www.oasas.ny.gov/regs/index.cfm

Non Covered Services:

Services provided at a work site must not be job task oriented and must be directly related to treatment of a beneficiary’s behavioral health needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of a beneficiary receiving covered services (including housekeeping, shopping, child care, and laundry services) are non-covered.

Services cannot be provided in an IMD with more than 16 beds. Room and board is excluded from addiction services rates. [State] residential placement under New York State LONCODTR may require prior approval and reviews on an ongoing basis as determined necessary by the State Medicaid agency or its designee to document compliance with the placement standards.

Medicaid will not reimburse for 12-step programs run by peers. A unit of service is defined according to the HCPCS approved code set per the national correct coding initiative unless otherwise specified for licensed practitioners to utilize the CPT code set. No more than one per diem rate may be billed a day for residential SUD programs, however bills may be submitted for allowable medical procedures in accordance with CPT approved coder set per the national correct coding initiative.

Court Ordered Services

Assessments and testing for individuals not in the custody of the penal system (e.g., not involuntarily residing in prison or jail overnight or detained awaiting trial) are Medicaid eligible, including any laboratory tests and urine tests. Drug court diversion treatment programs are eligible for Medicaid funding. Medicaid eligible individuals who are in the penal system and admitted to medical institutions such as SUD residential treatment programs are eligible for Medicaid funding for eligible medical institution expenditures. Laboratory procedures that the practitioner refers to an outside laboratory must be billed by the laboratory to the Medicaid MCO.

B. Service Reimbursement and Coding for SUD services:

OVERVIEW:

Service reimbursement (negotiated versus government rates) and coding varies (application of government mandated codes / claim for submission requirements) will vary by service type / OASAS certification. This section will detail:

- which services / OASAS certified programs are paid via government rates and any applicable coding requirements;
- which service may be reimbursed via a negotiated rate between the plan and the provider; and any applicable coding. When services are reimbursed via a negotiated rate it suggested that the prevailing Medicaid FFS rate service as an initial starting point for rate negotiations.
INPATIENT PROVIDERS:

The Title 14 NYCRR OASAS Certified Part 816 detoxification / crisis services; and, Title 14 NYCRR OASAS Certified Part 818 Inpatient Rehabilitation Services are already incorporated into the benefit package. Part 820 treatment services are new for the Medicaid managed care benefit package.

Providers of: Part 816; Part 818; services should speak with the plan regarding the plan coding; contract; and reimbursement policies. Part 820 programs are reimbursed at the government rate. However, please note that at a minimum plans must include providers as indicated below to meet minimum network requirements.

<table>
<thead>
<tr>
<th>Service</th>
<th>OASAS Regulation / Certification Authority</th>
<th>Negotiated or Gov Rate</th>
<th>Required Rate code to be reported by plan on MEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis</td>
<td>Title 14 NYCRR Part 816 Medically Managed Withdrawal</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Out Obs Days</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/One Obs Days</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW) W/Two Obs Days</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 816 Medically Supervised Outpatient Withdrawal (MSOW). NOTE: While this is not an inpatient</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>service it is a crisis service that been previously included in the benefit package and is not subject to government rates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 816 Medically Supervised Inpatient Withdrawal (MSIW)</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Title 14 NYCRR Part 818 Inpatient Rehabilitation</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title 14 NYCRR Part 818 Inpatient Rehabilitation - State Operated (ATC)</td>
<td>Negotiated</td>
<td></td>
</tr>
<tr>
<td>Residential TX</td>
<td>Title 14 NYCRR Part 820 Residential Programs</td>
<td>Gov Rate 24 months See rate table below</td>
<td>See Table below</td>
</tr>
</tbody>
</table>
For claims submitted by Title 14 NYCRR Part 820 Residential Programs the following rate codes should be used in the claim header; the following CPT / HCPCS codes should be used at the line level; and the plan should assign the indicated specialty code:

<table>
<thead>
<tr>
<th>Title 14 NYCRR Part 820 Residential Program Type</th>
<th>Rate Code</th>
<th>CPT / HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilization</td>
<td>1144 (tx services)</td>
<td>H0010</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1145 (tx services)</td>
<td>H0018</td>
</tr>
<tr>
<td>Re-Integration</td>
<td>1146 (tx services)</td>
<td>H0019</td>
</tr>
</tbody>
</table>

For claims submitted by Title 14 NYCRR Part 820 Residential Programs the following rate will apply:

<table>
<thead>
<tr>
<th>Title 14 NYCRR Part 820 Residential Program Type</th>
<th>Upstate Payment</th>
<th>Downstate Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilization</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Re-Integration</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

OUTPATIENT PROVIDERS:

REIMBURSEMENT:

For first 24 months of inclusion in the benefit package Government Rates to: Title 14 NYCRR Part 822 OASAS Certified Outpatient: Clinic (including intensive outpatient); Opioid; and, Outpatient Rehabilitation Programs. Beginning with the mainstream/HARP implementation start date, for services delivered by an OASAS certified Title 14 NYCRR Part 822 program, plans will be required to pay the Medicaid fee-for-service (FFS) “government rates” for at least two full years. For current OASAS-certified programs, the “government rate” is the reimbursement currently paid by Medicaid fee-for-service for each service (e.g. assessments; groups; individual; medication management) and refers specifically to the Ambulatory Patient Group Rates (APGs) for Freestanding and Hospital Based OASAS Certified Clinic (including intensive outpatient); Opioid; and, Outpatient Rehabilitation Programs.

CODING:

Plans will process provider claims through the NEW YORK STATE APG 3M grouper OR an exact replica to ensure government rates are rendered to OASAS Certified Title 14 NYCRR Part 822 programs (hospital or Freestanding). The following pages includes further claim component detail / requirements
### 837 i CODING CLAIMS SUBMISSION REQUIREMENTS FOR ALL OASAS CERTIFIED: CLINIC; OPIOID; and, OUTPATIENT REHABILITATION:

<table>
<thead>
<tr>
<th>Claim Component</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Form</td>
<td>837i</td>
<td>Required format; plans must accept</td>
</tr>
<tr>
<td>Rate Code</td>
<td>Value code “24”; Assigned four digit rate code in header</td>
<td>SEE TABLE ONE BELOW: The Rate Codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 i claim</td>
</tr>
<tr>
<td>CPT / HCPCS Codes</td>
<td>Line level CPT / HCPCS procedure code(s). HCPCS codes are utilized by OASAS certified programs when service rendered by non-licensed professionals e.g. CASACS.</td>
<td>SEE TABLE TWO BELOW: the CPT / HCPCS codes are the same as what was utilized under APGs. The codes are entered by the program on the 837 i claim</td>
</tr>
<tr>
<td>Procedure Modifiers</td>
<td>CPT / HCPCS specific modifier AND HF modifier for all services delivered in an Title 14 NYCRR Part 822 OASAS Certified Outpatient Program.</td>
<td>KP MODIFIER: OPIOID PROGRAM ONLY The KP modifier must be included KP with the date service CPT / HCPCS coding line associated with first medication administration service (H0020) delivered during a service week. The program will also include the HF modifier. The modifier codes are entered by the program on the 837 i claim</td>
</tr>
<tr>
<td>Service delivery date.</td>
<td>Corresponds to date service delivered; and associated CPT / HCPCS coding</td>
<td>The dates are entered by the program on the 837 i claim</td>
</tr>
<tr>
<td>Service Units</td>
<td>where applicable</td>
<td>The codes are entered by the program on the 837 i claim</td>
</tr>
<tr>
<td>OASAS CASAC ID / NUMBER:</td>
<td>ID number 02249145.</td>
<td>In those instances where a practitioner does not have an NPI, e.g. a CASAC, the equivalent DOH-approved NPI alternative should be used in its place. For OASAS programs, this number is the OASAS unlicensed practitioner number: ID number 02249145. This number should be used when services are delivered by an appropriate program staff person who does not / cannot get an NPI number, e.g. a CASAC</td>
</tr>
</tbody>
</table>
ADDITIONAL CLAIM SUBMISSION REQUIREMENTS FOR OPIOID TREATMENT (OTP) PROGRAMS. See also END note at bottom of page.

NOTE: Historically OTPS claims were submitted with a visit-based claim that utilizes the four digit weekly OTP APG rate code in the claim header. This single claim contains all visit dates and services delivered during the service week, including the first Medication Administration service delivered during the service week. This claim secured payment for the services delivered during the entire week, including the first Medication Administration service reimbursement and enhanced 1st day Medication Administration payment. This claim separately identified each visit date (defined as the calendar date) and services delivered to the patient on the specific visit date. The program submitted the claim using:

- The four digit visit rate code 1564 in the claim header. With the episode week defined as Monday-Sunday.
- Line level visit date(s)
- The first Medication Administration H0020 with Modifier KP on the first occurrence of this service being provided.
- Line level appropriate HCPCS or CPT code for the delivered service(s) associated with the specific visit date including any additional Medication Administration services provided during that week. Additional Medication Administration services provided during the week may not be coded with a KP modifier.
- The State; Providers; Plans; and, Vendors need a discussion regarding continued use of historical weekly episode claim construct (see comment.) versus daily claiming. Final claiming guidance is pending that conversation.
- OTP programs must be reimbursed for additional cost Buprenorphine.

END NOTE: Final weekly versus daily claiming construct is pending conversations with the plans; vendors; and, providers. It is expected that OTP programs will convert to daily process /claiming. In a daily claiming construct the OTP daily claiming would: mirror clinic claiming described above; utilize OTP programs specific rates codes; the KP modifier for first Medication administration visit for the week; and OTP programs must be reimbursed for additional cost Buprenorphine.
**TABLE ONE: OASAS OUTPATIENT RATE CODES**

**OASAS Rate Codes** Outpatient Providers will input the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” and following that immediately with the appropriate four digit rate code. This is the standard mechanism currently used in Medicaid FFS billing.

Rate Codes: Once the claim is received the plan will utilize the rate code for MEDS reporting. Rate codes are assigned based upon Certification / Program type and setting (hospital vs freestanding)

<table>
<thead>
<tr>
<th>Code Table</th>
<th>Rate Code (Same as APG rate code)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Clinic Program</td>
<td>1528</td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28 and Art 32) Chemical Dependence Outpatient Rehab Program</td>
<td>1561</td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28 and Art 32) Opiate Tx Program</td>
<td>1567</td>
</tr>
<tr>
<td><strong>Medical Services</strong></td>
<td></td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Program</td>
<td>1552</td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28/32) Chemical Dependence Outpatient Rehab Program</td>
<td>1558</td>
</tr>
<tr>
<td>Part 822 Hospital (Art 28/32) Opiate Tx Program</td>
<td>1555</td>
</tr>
<tr>
<td><strong>Title 14 NYCRR Part 822 Community / Freestanding</strong></td>
<td></td>
</tr>
<tr>
<td>Part 822 Community (Art 32 only) Chemical Dependence Outpatient Clinic Program</td>
<td>1540</td>
</tr>
<tr>
<td>Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program</td>
<td>1573</td>
</tr>
<tr>
<td>Part 822 Community (Art 32 only) Opiate Tx Program</td>
<td>1564</td>
</tr>
<tr>
<td><strong>Medical Services</strong></td>
<td></td>
</tr>
<tr>
<td>Part 822 Community (Art 32 only) Chemical Dependence Outpatient Program</td>
<td>1468</td>
</tr>
<tr>
<td>Part 822 Community (Art 32 only) Chemical Dependence Outpatient Rehab Program</td>
<td>1570</td>
</tr>
<tr>
<td>Part 822 Community (Art 28/32) Opiate Tx Program</td>
<td>1471</td>
</tr>
</tbody>
</table>
TABLE TWO: OUTPATIENT CPT / HCPCS CODING

For the first two full years plans are required to utilize the CPT / HCPCS codes in TABLE TWO below. When available both CPT and HCPCS codes are provided to support services delivery via different practitioner types / accommodate scope of practice coding requirements. In addition to the CPT / HCPCS codes, all line level service coding for SUD services must also include the “HF” modifier.

<table>
<thead>
<tr>
<th>APG</th>
<th>OASAS Service Category Description</th>
<th>CPT Codes</th>
<th>CPT Code Description</th>
<th>HCPCS Codes</th>
<th>HCPCS description</th>
</tr>
</thead>
<tbody>
<tr>
<td>315</td>
<td>Psychiatric Assessment with Counseling – Brief (30 minute min)</td>
<td>E&amp;M Code Plus 90833</td>
<td>Psychiatric Assessment with Counseling-30 minutes Select E&amp;M Code from Range: 99201-99205, 99211-99215 PLUS Add-on Code 90833</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>316</td>
<td>Psychiatric Assessment with Counseling (45-50 minute min)</td>
<td>E&amp;M Code Plus 90836</td>
<td>Psychiatric Assessment with Counseling-45-50 minutes Select E&amp;M Code from Range: 99201-99205, 99211-99215 PLUS Add-On Code 90836</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>315</td>
<td>Individual Therapy – Brief 25 minute minimum</td>
<td>90832</td>
<td>Alcohol/Substance Interview (Individual Brief 25 minutes minimum)</td>
<td>G0396</td>
<td>Alcohol/Substance assessment and brief intervention</td>
</tr>
<tr>
<td>316</td>
<td>Individual Therapy – Normative 45 minute minimum</td>
<td>90834</td>
<td>Alcohol/Substance Interview (Individual Normative 45 minutes minimum)</td>
<td>G0397</td>
<td>Alcohol/Substance assessment and brief intervention</td>
</tr>
<tr>
<td>317</td>
<td>Family/Collateral Therapy w/o patient 30 minute minimum</td>
<td>90846</td>
<td>Family/Couple Counseling (30 minute minimum) w/o patient</td>
<td>T1006</td>
<td>Alcohol/Substance services family / couple counseling</td>
</tr>
<tr>
<td>318</td>
<td>Group Therapy 60 minute minimum</td>
<td>90853</td>
<td>Alcohol &amp;/or Drug Services (group counseling by a clinician)</td>
<td>H0005</td>
<td>Alcohol/Substance ; group counseling by a clinician</td>
</tr>
<tr>
<td>318</td>
<td>Group Therapy 60 minute minimum</td>
<td>90849</td>
<td>Multiple Family Group (adolescent patients) (60-90 minutes)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>322</td>
<td>Medication Administration &amp; Observation No min. time</td>
<td>N/A</td>
<td>Oral Medication, direct observation</td>
<td>H0033</td>
<td></td>
</tr>
<tr>
<td>322</td>
<td>Medication Administration &amp; Observation No min. time</td>
<td>N/A</td>
<td>Alcohol / drug services methadone admin</td>
<td>H0020</td>
<td></td>
</tr>
<tr>
<td>323</td>
<td>Assessment – Normative 30 minute minimum</td>
<td>N/A</td>
<td>Alcohol / drug assessment</td>
<td>H0001</td>
<td></td>
</tr>
</tbody>
</table>
**TABLE TWO = Providers will enter the line level coding for SUD outpatient services will include:** CPT / HCPCS codes; unit (if applicable); and, the HF modifier.

<table>
<thead>
<tr>
<th>APG</th>
<th>OASAS Service Category Description</th>
<th>CPT Codes</th>
<th>CPT Code Description</th>
<th>HCPCS Codes</th>
<th>HCPCS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>323</td>
<td>Assessment – Extended 75 minute minimum</td>
<td>90791</td>
<td>Behavioral Health Screening – Admission Eligibility (75 minute minimum)</td>
<td>H0002</td>
<td>Behavioral health screening to determine admission eligibility</td>
</tr>
<tr>
<td>324</td>
<td>Assessment – Brief 15 minute minimum</td>
<td>N/A</td>
<td></td>
<td>T1023</td>
<td>Determine appropriateness of individual for participation in a program</td>
</tr>
<tr>
<td>324</td>
<td>Screening 15 minute minimum</td>
<td>N/A</td>
<td></td>
<td>H0049</td>
<td>Alcohol &amp;/or Drug Screening</td>
</tr>
<tr>
<td>324</td>
<td>Brief Intervention 15 minute minimum</td>
<td>N/A</td>
<td></td>
<td>H0050</td>
<td>Alcohol &amp;/or Drug Svcs, Brief Intervention – 15 min service</td>
</tr>
<tr>
<td>324</td>
<td>Brief Treatment 15 minute minimum</td>
<td>N/A</td>
<td></td>
<td>H0004</td>
<td>Alcohol &amp;/or Drug Svcs, Brief Treatment – 15 min service</td>
</tr>
<tr>
<td>426</td>
<td>Addiction Medication Induction/Withdrawal Management 30 minute minimum</td>
<td>99201-99205, 99211-99215</td>
<td>New Patient, Existing Patient</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>426</td>
<td>Medication Management &amp; Monitoring – Routine 10 minute min</td>
<td>E&amp;M Code</td>
<td>Medication Management-Complex (15 minute minimum)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>426</td>
<td>Medication Management &amp; Monitoring – Complex 30 minute min</td>
<td></td>
<td>Select E&amp;M Code from Range: 99201-99205, 99211-99215</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>451</td>
<td>Smoking Cessation Treatment 3 to 10 minutes</td>
<td>N/A</td>
<td></td>
<td>99406</td>
<td>Behavior change Smoking prevention intervention counseling</td>
</tr>
<tr>
<td>451</td>
<td>Smoking Cessation Treatment &gt;10 minutes</td>
<td>N/A</td>
<td></td>
<td>99407</td>
<td>Behavior change Smoking prevention non-counseling</td>
</tr>
<tr>
<td>490</td>
<td>Complex Care Coordination 45 minute minimum</td>
<td>90882</td>
<td>Environmental Manipulation – Complex Care Coordination</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>490</td>
<td>Peer Counseling 30 minute minimum</td>
<td>N/A</td>
<td></td>
<td>H0038</td>
<td>Self-Help/Peer Services-per 15 minutes</td>
</tr>
<tr>
<td>327</td>
<td>Intensive Outpatient Program 9hrs/week at 3hrs / day</td>
<td>N/A</td>
<td></td>
<td>S9480</td>
<td>Intensive Outpatient Program</td>
</tr>
<tr>
<td>328</td>
<td>Outpatient Rehabilitation 2-4 Hour Duration</td>
<td>N/A</td>
<td></td>
<td>H2001</td>
<td>Rehab program per ⅓ day</td>
</tr>
<tr>
<td>328</td>
<td>Outpatient Rehabilitation 4 Hour and Above Duration</td>
<td>N/A</td>
<td></td>
<td>H2036</td>
<td>Alcohol / drug program per diem</td>
</tr>
</tbody>
</table>
TABLE TWO = Providers will enter the line level coding for SUD outpatient services will include: CPT / HCPCS codes; unit (if applicable); and, the HF modifier.

<table>
<thead>
<tr>
<th>APG</th>
<th>OASAS Service Category Description</th>
<th>CPT Codes</th>
<th>CPT Code Description</th>
<th>HCPCS Codes</th>
<th>HCPCS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>840-843</td>
<td>Physical Health – New/Existing Patient – Select CPT Code from Range:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 99201 □ 99204 □ 99211 □ 99214</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 99202 □ 99205 □ 99212 □ 99215</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 99203 □ 99213</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Select Diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluation &amp; Management – No Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>840</td>
<td>Physical Health – Opioid Dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>841</td>
<td>Physical Health – Cocaine Dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>842</td>
<td>Physical Health – Alcohol Dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>843</td>
<td>Physical Health – Other CD</td>
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SECTION THREE

Listing of OASAS certified programs that deliver the authorized SPA services; the applicable authorizing New York State program regulation; and where appropriate, a cross walk to ASAM levels of care.

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<th>OASAS Program Type</th>
<th>New York State Regulation</th>
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