MEMORANDUM- Revised 1/30/17

Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapters 69 and 71 of the Laws of 2016.

DATE: December 5, 2016 *Updated 1/30/17

On June 22, 2016, Governor Cuomo signed the Chapters 69, 70 and 71 into law. Resulting from the leadership of Governor Andrew Cuomo, Lieutenant Governor Kathy Hochul, OASAS Commissioner Arlene González-Sánchez and the hard work of Combat Heroin and Opioid Taskforce, these initiatives are designed to improve the addiction treatment field, make recovery a reality for more New Yorkers, and positions New York State as the national leader for addressing the opioid epidemic.

The recently issued Surgeon General's Report on Alcohol, Drugs and Health affirms what New York has long recognized, that a Substance Use disorder is a chronic medical condition, "subject to relapse and influenced by genetic, developmental, behavioral, social and environmental factors".[1] We as a State have sought to ensure that access and coverage requirements for treatment of this chronic brain disorder are both robust and timely.

These laws will increase access through changes to utilization management requirements and expedited access to needed care. With these changes, the dialogue between providers and insurers will shift from what was historically focused on utilization management to a more collaborative patient-centered discussion to assist patients in attaining and sustaining recovery.

The following guidance summarizes the insurance law changes effected by Chapter 69 and 71 of the Laws of 2016 and offers clarifications necessary to implement those provisions.

Required Used of Objective State-Designated Criteria to Determine the Level of Care for Individuals Suffering from Substance Abuse

Impacts care starting January 1, 2017

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[1] U.S. Department of Health and Human Services, Office of the Surgeon General (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Retrieved December 1, 2016, from https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf.

Once effective, all insurers operating in New York State must use an objective level of care tool to make initial and continuing coverage determinations for all substance use disorder treatment, as designated by OASAS.[2] One tool that will be designated is the New York State OASAS LOCADTR 3.0.

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

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2017.

Q. 1-2: Can a tool other than LOCADTR 3.0 be used for level of care and continuing review decisions?

A: Yes, other clinical review tools can be submitted to and designated by OASAS, provided they meet the requirements set forth in statute.

When reviewing, OASAS will consider any peer reviewed level of care tool that is consistent with the NYS substance use disorder treatment service levels, and meets the following **OASAS Standards for Approval of Insurance Level of Care tools:**

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

Q. 1-3: Must all Plans submit their clinical review tools to OASAS for designation, even where a Plan received approval pursuant to Chapter 41 of the laws of 2014?

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

A: Yes a Plan must submit the clinical review tool to be used to make coverage determinations for substance use disorder services to OASAS. Chapter 69 of the Laws of 2016 includes additional statutory requirements, beyond those required by Chapter 41 of the Laws of 2014. To comply with the new laws, Plans must update their processes to reflect the new level of care tool requirements for health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2017.

Q. 1-4: Will it be the same tool for all lines of business?

A: Medicaid Managed Care plans are required, by contract, to use LOCADTR 3.0. Commercial insurers may only use LOCADTR 3.0 or another OASAS designated tool.

Q. 1-5: Will LOCADTR be modified to include prior treatment history over previous 90 days?

A: No. New York State law does not provide for the inclusion of prior treatment history in coverage decisions for substance use disorder services. Coverage is determined based on medical necessity. Medical necessity is based upon the use of an OASAS designated tool.

Prohibition of Prior Insurance Authorization for medically necessary Inpatient Treatment

Impacting care starting January 1, 2017

This law requires insurers to cover in-network medically necessary inpatient services for the treatment of substance use disorders, including detoxification, rehabilitation and residential treatment. There is no prior authorization or certification necessary and insurers may not conduct concurrent utilization review for the first 14-days of treatment, provided the inpatient or residential facility gives the insurer notice within 48 hours of the patient's admission and the initial treatment plan.

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

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2017.

Q. 2-2: Is the 14-day prohibition on prior authorization or concurrent review requirement limited to a request for coverage of inpatient or residential treatment for opioid use disorder only?

A: No. Chapter 71 of the laws of 2016 prohibits prior authorization for medically necessary inpatient or residential services for any substance use disorder.

Q. 2-3: Are Insurers required to have SUD inpatient and residential facilities in their network?

A: Yes. It is incumbent upon insurers to include substance use disorder inpatient and residential facilities within their network, to ensure patients can access all needed levels of care. Insurers' inpatient or residential facility networks will be closely monitored. Network adequacy guidance has been issued by the New York State Department of Financial Services, and can be found at: http://dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance.pdf.

To view model contract language developed by the New York State Department of Financial Services, which describes the substance use disorder treatment services included in insurance contracts regulated by New York State, please visit: http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm

Q. 2-4: Do the new insurance laws apply to detoxification admissions?

A: The new insurance laws apply to all inpatient admissions for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services, as well as treatment in a residential setting.

Q. 2-5: Are Insurers required to cover residential services?

A: Yes. New York State insurance law requires plans to cover residential services. This includes services provided pursuant to 14 NYCRR 819.2(a)(1), 820.3(a)(1) and (2) and Part 817.

Q. 2-6: Are Inpatient or residential facilities obligated to confirm coverage and benefits prior to admission?

A: Yes. While these changes will impact coverage for many individuals, they do not apply to plans that are not regulated by New York State, i.e. Employer based plans subject to federal ERISA, or issued outside of New York State. The inpatient or residential facility should confirm that the patient is covered by the policy and that the policy is subject to New York State law.

Q. 2-7: Do the Insurance Law amendments require an insurer to cover 14-days of substance use disorder treatment in an inpatient or residential facility without prior authorization when the facility is an out of network provider?

A: No, the new insurance law provisions do not require coverage, without authorization, for services provided by out of network inpatient or residential facilities. Requests for coverage at out of network inpatient or residential facilities are subject to review upon admission.

Q. 2-8: Are the limitations on utilization review during the first 14-days of an inpatient admission impacted by a patient's recent discharge from the same or another level of care?

A: No, as long as the patient meets medical necessity, as determined by an OASAS designated tool, and notice and an initial treatment plan are provided to the insurer within 48 hours of a patient's admission.

Q. 2-9: Does a 14 day coverage requirement exist for each inpatient admission or is it cumulative?

A: Yes, the 14 day coverage requirement exists for each inpatient admission. Where the patient is discharged from an inpatient admission, the 14-day coverage period restarts at a subsequent admission provided the patient is determined to be appropriate for that level of care based upon the use of an OASAS designated tool, and notice and the initial treatment plan are provided to the insurer within 48 hours of a patient's admission..

Q. 2-10: Do the limitations on utilization review during the first 14-days of an inpatient or residential admission apply where a patient transfers from one inpatient or residential facility to another?

A: Yes, the prohibition against prior authorization or concurrent review applies to each inpatient or residential admission. The 14 day time frame is not cumulative. A patient may obtain 14 days of care, if appropriate as determined by an OASAS designated tool, at one provider, be discharged to a subsequent level of care and receive an additional 14 days of care, if appropriate based on a determination using an OASAS designated tool.

Q. 2-11: Do the limitations on utilization review during the first 14-days of an inpatient or residential admission apply despite multiple readmissions?

A: Yes. The prohibition against prior authorization or concurrent review applies to each inpatient or residential admission where the patient is found to be appropriate for that level of care based on a determination using an OASAS designated tool.

Q. 2-12: If a patient steps down within the same facility from detox to inpatient to residential consecutively - are they entitled to an additional 14-days without review at each level of care?

A: Yes. The prohibition against prior authorization or concurrent review applies to each inpatient or residential admission at each level of care. If the patient is found to be appropriate based on a determination using an OASAS designated tool at each step down to a lower level of care, the 14 day time frame would restart at every level of care.

Q. 2-13: If the patient moves between facilities within the same level of care, e.g. from inpatient at facility A to inpatient at facility B, or steps down from detox to inpatient, are they entitled to an additional 14-days without review at each level of care?

A: Yes. The prohibition against prior authorization or concurrent review applies to each inpatient or residential admission where the patient is found to be appropriate for that level of care based on a determination using an OASAS designated tool.

Q. 2-14: Can an inpatient or residential facility request a prior authorization or concurrent review, by the insurer, in cases where treatment might later be deemed medically unnecessary but 14-days have not yet passed?

A: No. While a provider may ask, an insurer is prohibited by law from conducting such utilization review activities until after the 14th day of care. However, the provider is obligated, by statute to consult with the insurer, and the entities may discuss, prior to the 15th day, the patient's clinical progress in treatment.

Q. 2-15: How will medical necessity be determined?

A: The insurance law changes require an inpatient or residential facility to determine the patient's level of need and appropriate level of care by using an OASAS designated level of care tool. Designated tools will include OASAS LOCADTR and any other tool designated by OASAS. "Medically necessary treatment" is wholly determined by the OASAS designated tool for both the inpatient or residential facility's admission of a patient to an inpatient or residential facility, and when an insurer is conducting retrospective review.

Q. 2-16: What are the next steps for the Plan, the patient, and the facility when it is determined that an inpatient or residential level of care is not medically necessary?

A: Where a patient is deemed inappropriate for an inpatient or residential level of care, based on the use of an OASAS designated tool, unless the individual is already receiving substance use disorder services from another substance use disorder Provider, a referral to a more appropriate service must be made. The reasons for denial of any admission to the inpatient or residential service must be provided to the individual and documented in a written record maintained by the service. Further, the inpatient or residential facility is expected to coordinate with the insurer to directly connect the service recipient with a program offering the appropriate services.

Q. 2-17: What constitutes notice to the insurer of an inpatient admission?

A: Notice will be sufficient where the information is provided in writing, via email, fax, or letter, and sets forth details sufficient to identify the insured person, along with

a copy of the determination from the state designated level of care tool. OASAS has developed a form to be used for this purpose which is included in this guidance as Appendix A.

Q. 2-18: What constitutes an initial treatment plan that must be included with the notice to an Insurer within 48 hours of admission?

A: An initial treatment plan for an admission to a detox services shall include the following: diagnosis for which the patient is being treated; adherence to OASAS approved detoxification tapers and protocols, including medications and planned taper duration; the initial discharge plan; the date of assessment and medication orders for medical and psychiatric stabilization as indicated; and the single member of the clinical staff responsible for coordinating and managing the patient's treatment.

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

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

Q. 2-19: If an inpatient or residential facility fails to provide an insurer with notice of an admission and an initial treatment plan within 48 hours of admission, can the insurer begin concurrent review of services immediately upon learning of the admission, even if it is during the initial 14-day period? Also, may the insurer retrospectively deny any care provided prior to learning of the admission?

A: Yes, if the inpatient or residential facility fails to notify the insurer of either the inpatient admission or the initial treatment plan within 48 hours of the admission, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial 14-day period. Under these circumstances, an insurer may also perform a retrospective review of the treatment already provided during the initial 14-day period. .

Q. 2-20: What if the inpatient or residential facility gives notice to the Plan after 48 hours?

A: Providers are required to give notice of an admission to a Plan within 48 hours and failure to do so is a violation of the law. Because the provider failed to comply, the insurer may begin concurrent review immediately upon learning of the admission, even if it is during the initial 14-day period. Under these circumstances, an insurer may also perform a retrospective review of the treatment provided during the initial 14-day period.

Q. 2-21: The new insurance laws require facilities that are certified by OASAS and participate in an insurer's network to, with respect to an inpatient admission for treatment of substance use disorder, perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by OASAS and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. How can an inpatient or residential facility meet the requirement to "regularly assess the need for continued stay"?

A: The inpatient or residential facility must continually assess the patient to determine their progress in that service and the need to continue at that level of care. Continual assessment does not obligate the inpatient or residential facility to perform a daily clinical assessment using an OASAS designated tool, it requires assessment that is appropriate to the particular needs of a patient. Continual assessment should occur in the normal course of treatment planning and revision by clinical and medical staff. Assessment for continued stay considers the original rationale for the need for the current level of care and current assessment of patient condition to ascertain the medical necessity for continued stay. Where a patient is no longer appropriate for that level of care, the patient should be discharged to the next clinically appropriate level of care.

Q. 2-22: How often and to what extent must an inpatient or residential facility consult with the insurer?

A: Periodic consultation should generally occur as often as is necessary to coordinate care and ensure that the patient is progressing and that the discharge plan is adequate to meet the ongoing recovery needs of the patient. In general once per week contact should be sufficient to ensure good care coordination, however, the frequency of contact should be tailored to individual patient/member need. During the initial 14-days, this consultation is not a mechanism for utilization review, including prior authorization, continued stay or concurrent review, but an opportunity for a dialogue between the provider and the insurer.

Q. 2-23: Must an inpatient or residential facility give notice to the insurer when a patient leaves against medical or clinical advice during the 14-day treatment episode?

A: Yes. A provider must give notice to the Plan any time a patient separates from treatment, including patients who are discharged, leave against medical or clinical advice, or are missing. The Program should provide notice to the Plan within 24 hours.

Q. 2-24: The legislation states that members are held harmless. Are inpatient or residential facilities able to have members sign agreements to pay if insurance does not cover?

A: No. Where payment is denied after an insurer conducts retrospective review, a provider may not seek to recoup those monies from the patient. Such activities are in violation of NYS statute and will subject providers to additional administrative actions.

Q. 2-25: Should an inpatient or residential facility collaborate with the insurer for discharge planning?

A: Discharge planning should begin as soon as the patient is admitted, and include collaboration with the patient's insurer, to permit optimal care coordination.

Q. 2-26: What levels of care are impacted by the prohibition against prior authorization or concurrent review for 14 days?

A: OASAS treatment services levels impacted by the new law include 14 NYCRR Part 816 Chemical Dependence Withdrawal and Stabilization Services, Part 817 Chemical Dependence Residential Rehabilitation Services for Youth, Part 818 Chemical Dependence Inpatient Rehabilitation Services, Part 819 Chemical Dependence Intensive Residential Rehabilitation, and Part 820 Residential Stabilization and Rehabilitation Services.

Q. 2-27: Is retrospective utilization review permitted?

A: Yes. Health plans may perform utilization review of the inpatient treatment after the 14th day of the inpatient admission and the utilization review may include a review of services provided during the first 14-days of the inpatient treatment. These provisions of the Insurance Law further provide that insurers may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that the treatment was not medically necessary if such treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer and designated by OASAS.

Q. 2-28: Are insurers required to cover days 1 – 14 of an inpatient admission if they subsequently determine that some or all of days 1-14 were not medically necessary?

A: No. Health plans may subsequently issue a medical necessity denial if such treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer and designated by OASAS.

Q. 2-29: Can a Provider appeal an Insurers determination that some or all of the treatment provided without authorization or concurrent review during the initial 14 days of treatment was not medically necessary?

A: Yes, pursuant to Article 49 of the Insurance law, a provider may appeal an adverse determination resulting from a retrospective review. During retrospective review, an insurer may only deny that portion of the initial 14 days of inpatient treatment that was not medically necessary because it was contrary to the OASAS designated review tool utilized by the insurer.

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

Prohibits private and commercial insurers from requiring prior approval for a 5-day supply of covered prescription medications for treatment of a substance use disorder where an emergency condition exists. Medications include buprenorphine, long acting injectable naltrexone, or methadone. Any copay charged for an initial and subsequent prescription for the same medication that totals a 30-day supply cannot exceed the copay for a thirty-day supply.

Q. 3-1: When will this change impact Substance Use Disorder care?

A: This change will impact health insurance policies or contracts issued, renewed, modified, altered or amended on or after January 1, 2017.

Q. 3-2: Is a prescriber obligated to review the Prescription monitoring program prior to prescribing a 5-day supply emergency five-day supply of medication assisted treatment?

A: Yes. Consistent with NYS efforts to address the opioid epidemic, any prescriber issuing an emergency 5-day supply of medication assisted treatment should review the prescription drug monitoring program prior to issuing a prescription to a patient.

Q. 3-3: Must a prescriber perform care coordination and continuing treatment for patients receiving an emergency five-day supply of medication assisted treatment?

A: Yes. Where an OASAS provider has prescribed an emergency 5-day supply of medication assisted treatment, where a longer than 5-day course of medication assisted treatment is indicated, the provider should begin the prior authorization

request for any additional medication assisted treatment or refer the patient to another provider for continuing care.

Q. 3-4: Is retrospective utilization review permitted where a patient has received a 5-day emergency supply of prescribed medications?

A: The emergency 5-day supply provisions prohibit insurers from imposing prior authorization requirements on up to a 5-day emergency supply of prescribed medications covered under the policy or contract for the treatment of a substance use disorder where an emergency condition exists. An emergency supply must also be covered for medication for opioid overdose reversal otherwise covered under the policy or contract prescribed to an individual covered under the policy or contract. Health plans may perform a retrospective review to determine if an emergency condition, as defined in the law, existed in the same manner as they are permitted to review other medical emergencies.

Q. 3-5: What is the definition of an emergency condition with respect to the requirement for coverage of an emergency supply of medication for a substance use disorder?

A: Emergency condition is specifically defined in Insurance Law §§ 3216(i)(31-a)(B), 3221(l)(7-b)(B) and 4303(l-2)(2) as a substance use disorder condition that manifests itself by acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(ii) serious impairment to such person's bodily functions;

(iii) serious dysfunction of any bodily organ or part of such person;

(iv) serious disfigurement of such person; or

(v) a condition described in clause (i), (ii), or (iii) of section 22 1867(e)(1)(A) of the Social Security Act.

Q. 3-6: Can insurers limit the number of times they will cover an emergency supply of medication for a substance use disorder?

A: Insurers may review to determine if an emergency condition, as defined in the law, existed in the same manner as they are permitted to review other medical emergencies. Insurers may not limit the number of emergencies they will cover.

Q. 3-7: Does the requirement for coverage of an emergency supply of medication for a substance use disorder apply to over the counter medication?

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

Where the emergency supply of medication is for naloxone, insurers should provide coverage. According to the federal Substance Abuse and Mental Health Services Administration's website, naloxone is an FDA-approved prescription drug used to block or prevent the effects of opiates and opioids, such as heroin and oxycodone. It is often used in an emergency situation to prevent or reverse the effects of an opioid overdose.

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

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

Furthermore, § 52.16(c) of 11 NYCRR 52 (Insurance Regulation 62) prohibits issuers offering individual, small group and large group health insurance policies from limiting or excluding coverage by type of illness, accident, treatment, or medical condition. In order to comply with these requirements, issuers should provide coverage for naloxone on an outpatient basis when prescribed to insureds by authorized providers, as they would for any other prescribed drug, subject to the terms and conditions of the health insurance policy or contract. In addition, naloxone also should be covered on an inpatient basis when medically necessary.

Cost-Sharing:

Q. 3-8: What are an insurer's options for charging a copayment for a 5-day emergency supply of a medication for the treatment of substance use disorder where an emergency condition exists, including a prescribed drug associated with opioid withdrawal or stabilization?

A: Health plans may either charge a copayment that is (1) prorated based on the amount of the drug dispensed, provided that the prorated copayment(s) may not total more than the insured's copayment for a 30-day supply or (2) equivalent to the copayment for a full 30-day supply provided that no additional copayments may be charged for any additional prescriptions of the drug for the remainder of the 30-day supply.

Q. 3-9: If an insured obtains an initial 5-day emergency supply of a medication for the treatment of a substance use disorder where an emergency condition exists, and the insurer charged a copayment that was proportional to the supply dispensed, and the insured then fills a prescription for a 30-day supply of the drug within 30 days of the 5-day fill, how would the copayment for the 30-day supply be applied? Assume that the copayment is $30 for a 30-day supply.

A: If an insurer charged a copayment that was proportional for the initial 5-day supply, a pro-rated copayment may be imposed on the remaining 25-days and on the additional 5-days. For example, assuming a $30 copayment for a 30-day supply, the insured would pay $5 for the initial 5-day emergency supply. If the insured then obtains and fills a prescription for a 30-day supply (within 30 days following the 5-day fill) the insured would pay $25 for the remaining 25-day supply and $5 for the additional 5-days covered by the 30-day script.

Q. 3-10: If an insured obtains an initial 5-day emergency supply of a medication for the treatment of a substance use disorder where an emergency condition exists, and the insurer charged a copayment for a full 30-day supply, and the insured then fills a prescription for a 30-day supply of the drug within 30 days of the 5-day fill, how would the copayment for the 30-day supply be applied? Assume that the copayment is $30 for a 30-day supply.

A: The insurer would not be able to collect an additional copayment for 25-days of the 30-day fill. The insurer could collect a $5 copayment to cover the portion of the prescription fill that exceeds the remainder of the initial 30-day fill.

Q. 3-11: If an insured obtains a 5-day emergency supply of a medication for the treatment of a substance use disorder where an emergency condition exists, and then fills a prescription for a 30-day supply of the drug within 30 days after the 5-day fill, but at a different pharmacy than the 5-day fill, would the above copayment prorating be applicable since the 30-day prescription was filled at a different pharmacy?

A: Yes, the prorating would be applicable regardless of whether the prescription was filled at the same pharmacy or a different pharmacy.

Q. 3-12: If an insured obtains an initial 5-day emergency supply of a medication for the treatment of substance use disorder where an emergency condition

exists, and then fills a prescription for a 30-day supply of the drug more than 30 days after the 5-day fill, what copayment may be charged? Assume that the copayment is $30 for a 30-day supply.

A: The insurer may charge the $30 copayment. The plan would not have to pro-rate the copayment because the prescription was filled more than 30 days after the 5-day fill.

Q. 3-13: If a large group policy or contract does not include coverage for prescription drugs, are there restrictions on the cost-sharing that can be imposed on medications for detoxification or maintenance treatment of a substance use disorder?

A: The coverage of medication for the detoxification or maintenance treatment of a substance use disorder do not address cost-sharing. Health plans can impose cost-sharing amounts that comply with DFS coverage guidelines designed to ensure a substantial economic benefit to the insured, consistent with Insurance Regulation 62, (e.g., no greater than 50% coinsurance liability on the part of the insured) and that comply with federal Mental Health Parity requirements.

Q. 3-14: If a large group policy does not include coverage for prescription drugs, can an insurer use a formulary to specify the medications it will cover for detoxification or maintenance treatment of a substance use disorder?

A: Yes, insurers can use formularies and medical management policies for coverage of detoxification or maintenance treatment of substance use disorder provided they comply with State and Federal requirements.

Prohibition on Medicaid Prior Authorization for Medications for Treatment of Substance Use Disorder

Similar provisions remove prior authorization requirements for inpatient or residential facilities treating Medicaid recipients with the preferred formulary version of buprenorphine and long acting injectable naltrexone.

Q. 4-1: When will this change impact Substance Use Disorder care?

A: This change was effective June 22, 2016.

Q. 4-2: Is there a restriction on Medicaid that requires prior authorization for some, but not all, formulations of buprenorphine?

A: The new law removed prior authorization for patients covered by Medicaid, where the medication is the preferred version of buprenorphine and long acting injectable naltrexone. Non-preferred versions require prior authorization.

Additional FAQ's - 1/30/17

Q. Can an insurer request additional clinical information, during periodic consultations or only after a patient is discharged from an inpatient or residential stay?

A: Yes. The 2016 laws require the provider and plan to consult periodically which allows an insurer to request additional information to assist in care coordination and discharge planning. The insurer may also request additional information to better understand the care being provided to the patient. After a patient has been discharged, an insurer may request, within reason, additional information to ensure that the care provided was not contrary to the OASAS designated clinical review tool.

Q. 2-18: What constitutes an initial treatment plan that must be included with the notice to an Insurer within 48 hours of admission?

A: An initial treatment plan for an admission to a detox services shall include the following: diagnosis for which the patient is being treated; adherence to OASAS approved detoxification tapers and protocols, including medications and planned taper duration; the initial discharge plan; the date of assessment and medication orders for medical and psychiatric stabilization as indicated; and the single member of the clinical staff responsible for coordinating and managing the patient's treatment.

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

OASAS has developed a form which, together with the LOCADTR 3.0 report, **MUST** be used for this purpose. This form is included in the guidance as Appendix A. **Appendix A and the completed LOCATDR 3.0 MUST be submitted to the plan within 48 hours of admission.**

Q. 2-21: The new insurance laws require facilities that are certified by OASAS and participate in an insurer's network to, with respect to an detox, inpatient or residential admission for treatment of substance use disorder, perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by OASAS and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. How can an inpatient or residential facility meet the requirement to "regularly assess the need for continued stay"?

A: The inpatient or residential facility **MUST** continually assess the patient to determine their progress in that service and the need to continue at that level of care. Continual assessment does not obligate the inpatient or residential facility to perform a daily clinical assessment using an OASAS designated tool, it requires assessment that is appropriate to the particular needs of a patient. Such continual assessment should be documented in the individual patient chart. Continual assessment should

occur in the normal course of treatment planning and revision by clinical and medical staff. Assessment for continued stay considers the original rationale for the need for the current level of care and current assessment of patient condition to ascertain the medical necessity for continued stay. Where a patient is no longer appropriate for that level of care, the patient should be discharged to the next clinically appropriate level of care.

Q. 2-22: How often and to what extent must a detox, inpatient or residential facility consult with the insurer?

A: Periodic consultation should generally occur as often as is necessary to coordinate care and ensure that the patient is progressing and that the discharge plan is adequate to meet the ongoing recovery needs of the patient. In general once per week contact should be sufficient to ensure good care coordination, however, the frequency of contact should be tailored to individual patient/member need. During the initial 14-days, this consultation is not a mechanism for utilization review, including prior authorization, continued stay or concurrent review, but an opportunity for a dialogue between the provider and the insurer. The insurer may request a reasonable amount of documentation to develop a clear understanding of patient progress in treatment, services being provided by the program, and the proposed discharge plans for patient. **Providers MUST engage with the plan during the initial 14 days, however, the plan may not conduct utilization review during these consultations.**

Q. 2-27: Is retrospective utilization review permitted?

A: Yes. Health plans may perform utilization review of the inpatient treatment after the 14th day of the inpatient admission and the utilization review may include a review of services provided during the first 14-days of the inpatient treatment. These provisions of the Insurance Law further provide that insurers may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that the treatment was not medically necessary if such treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer and designated by OASAS.

When conducting retrospective review, the insurer can collect information as is necessary to make a determination, but cannot routinely request copies of medical records of all patients reviewed. However, an insurer may request additional documentation beyond the designated clinical review tool and Appendix A, during periodic consultation, or post discharge to ensure that the treatment was not, in whole or in part, contrary to the designated clinical review tool. However, it is not appropriate for a plan to conduct retrospective review for every case.

Please direct any questions regarding this guidance document to Robert Kent, General Counsel, at Robert.Kent@oasas.ny.gov or Trishia Allen, Senior Attorney, at Trishia.Allen@oasas.ny.gov.

Appendix A
48 HOUR NOTIFICATION and INITIAL TREATMENT PLAN

Patient Name:_____
Date of Birth:_____
Insurance ID:_____

Diagnosis:_____

LOCADTR3 Report (Attached)

Detox Initial Treatment Plan

Adhere to OASAS approved detoxification taper/protocol:
Medication(s) _____ Planned Taper Duration: _____

Δ Initial Discharge Plan -- Δ To home outpatient Δ Inpatient Δ Residential
Δ Other:_____

Δ Medical Stabilization:
Date of Assessment: _____ Med Orders: _____

Δ Psychiatric stabilization:
Date of Assessment: _____ Med Orders: _____

Δ Clinician assigned:_____

Rehab Initial Treatment Plan

Initial Goal(s) Δ Individual Δ Group Δ Family Δ sessions:
- Δ Skills/Medication to reduce urges/craving
- Δ Motivational Interviewing to increase internal Commitment
- Δ Coping skills building to improve emotional regulation, self-soothing
- Δ Facilitate engagement with others – social skills to support recovery
- Δ Other: _____

Case Manager Assignment: _____

Δ Education about, orientation to, and the opportunity to participate in, relevant self-help groups

Δ Assessment and referral services for patients and significant others

Δ HIV and AIDS education, risk assessment, and supportive counseling and referral

Δ Date of Medical consultation: _____

Δ Date of Psychiatric consultation (as needed): _____

_____ _____
Signature Date