



## Telepractice Standards for OASAS Designated Providers

### Introduction

The purpose of this document is to provide implementation guidance to providers designated pursuant to 14 NYCRR Part 830, including use of medication assisted treatment (MAT), and specific minimum requirements using buprenorphine products based upon the [Center for Substance Abuse Treatment](#) (CSAT) guidelines.

Telepractice, for the purpose of these *Standards*, is defined as the use of two-way real time-interactive audio and video equipment to provide and support certain addiction care at a distance. Telepractice is a means of delivering services by an OASAS certified program subject to any other regulations applicable to the certified modality regarding evaluations, admissions, treatment/recovery plan development and review, discharge, etc. The program must have received an operating certificate “designation” from the Office to utilize this means of service delivery.

When authorized by OASAS, telepractice services may be utilized for certain assessment and treatment services only for the treatment of addiction disorders (ie, Substance Use Disorder (SUD) including Opioid Use Disorder (OUD), and Gambling Disorder), including medication assisted treatment (MAT) provided by a practitioner, as defined in 14 NYCRR Part 830, from a site distant (“distant/hub site”) from the location of a patient (“originating/spoke site”).

This document is divided into the following sections plus Appendices:

- A) General Program Standards;
- B) Additional Requirements for Practitioners Treating MAT Patients;
- C) Clinical Standards for Practitioners Treating Patients with Buprenorphine;
- D) Billing Guidance;
- E) Technology and Telecommunication Standards;

### A: General Program Standards

#### 1. Implications for the OASAS Operating Certificate

##### *Adding an optional/additional service to the operating certificate*

- Pursuant to 14 NYCRR Part 830, telepractice is an optional service available to OASAS certified programs. Providers requesting authorization to use this service must submit a written **Telepractice Plan and Attestation (Appendix II)** to their Field Office and to the OASAS Bureau of Certification at 1450 Western Ave., Albany, NY 12203 [oasas.sm.certification@oasas.ny.gov](mailto:oasas.sm.certification@oasas.ny.gov).
- Providers may consult with their Field Office, OASAS Bureau of Certification, or Bureau of Addiction Treatment Centers (BATC) for assistance.

- OASAS-certified providers subject to controlled substances provisions of Article 33 of the Public Health Law and 10 NYCRR Part 80 (Rules and Regulations on Controlled Substances in New York State) i.e., health care facilities taking possession of an individual’s prescription for a controlled substance (including "take home" medication for patients who are enrolled in an outside Opioid Treatment Program) for the purpose of safeguarding and administration of the medication, must obtain a Class 3A Institutional Dispenser Limited license issued by the New York State Department of Health (NYSDOH). See OASAS Local Services Bulletin 2012-03 <http://webdev.oasas.ny.gov/mis/bulletins/LSB2012-03.cfm>.

### ***Approval-Attestation***

- A program applying for designation to provide telepractice services must complete a **“Telepractice Plan and Attestation” form (Appendix II)**. The attestation assures OASAS that the provider’s plan for the use of telepractice services conforms to the technological, clinical and programmatic standards prescribed by 14 NYCRR Part 830 and these *Standards*.
- OASAS will provide a written approval in addition to designation on an operating certificate.

### ***Inspection***

- At any time prior to or after designation the OASAS field office and quality assurance staff may inspect the functioning of the telepractice system at both the originating site and distant practitioner site. Inspection shall be part of any standard re-certification review.

### ***Practitioners***

- Notwithstanding “practitioners” as defined in Part 830, only practitioners, defined as a “telehealth provider” in Public Health Law section 2999-cc, are eligible for Medicaid reimbursement if delivering services via telepractice.
- Any practitioner must either be employed by the OASAS designated program or have an executed contract or memorandum of understanding (MOU) with the designated program for the provision of telepractice services.
- The practitioner must be able to ensure protection of confidentiality, including the use of locked files or protected electronic health records (EHR) and the availability of private space to conduct telepractice sessions.
- If providing MAT the practitioner is responsible for monitoring and supervising response to prescribed medication and ensure compliance with federal, state and local laws as it applies to their professional practice.

### **Program Policies and Procedures**

The designated OASAS provider is responsible for the overall functioning of the telepractice service. Prior to initiating telepractice services, program policies and procedures addressing the role of both the originating site and the distant site must be in place addressing, at a minimum, the topics listed below and, where applicable, those additional requirements for MAT and buprenorphine treatment:

### ***Practice Procedures***

- Scheduling and patient check-in (patient, practitioner, and room)

- Documentation and record keeping of care provided via telepractice
- Access to patient records at both originating and distant sites (electronic and paper)
- Role of support staff (collecting vital signs, setting up equipment and making video connection for each scheduled session, responding to emergency, etc.)
- Communication interruptions and contingency plans (see Technology and Communications Standards; **Appendix I**)

### ***Physical Environment***

- Location (privacy, proximity for escort or emergency situation)
- Room setting: Lighting, backdrop, furniture
- Ensuring that staff are in close proximity to the patient and may be contacted at any point during the service
- Protection of patient confidentiality at both originating and distant sites.

### ***Emergency Procedures***

- Process to engage with on-site staff should there be clinical or safety concerns.
- Designation of an emergency contact at the originating/spoke site where the patient is located.
- Procedures in the event that emergency hospitalization becomes necessary.
- Education and training related to emergency procedures at both distant and originating sites.

### ***Patient Suitability for Telepractice; Informed Consent***

- Process for determining and documenting a patient's clinical suitability for telepractice services including, but not limited to:
  - Patient awareness and familiarity with the process sufficient to make an informed choice
  - Symptoms that could worsen with telepractice (psychosis, paranoid/delusions related to technology)
  - Language or cultural barriers
  - Medical issues
  - Clinical situation: suicidal ideation, anything requiring an in-person evaluation due to severity of presenting symptoms, cognitive/sensory concerns
- All patients and prospective patients, must have at least one in-person evaluation session with clinical staff prior to participation in telepractice; if found suitable for telepractice, the patient or prospective patient must execute a statement of informed consent prior to receiving services via telepractice

### ***Confidentiality and privacy of health information***

- Procedures must identify how relevant privacy and security regulations and policies will be followed and confirmed (e.g., 45 C.F.R. Parts 160 and 164, including HITECH breach notification procedures (HIPAA); and 42 C.F.R. Part 2).

### ***Quality Review***

- Quality review must be conducted on a periodic basis to identify specific risks and quality failures. Assessments must include, but need not be limited to:
  - Equipment and connectivity failures;

- Number of attempted and completed telepractice sessions;
- Patient and provider satisfaction of the telepractice session;
- Any complaints related to the telepractice session (i.e., surveys); and
- Measures of program quality including appropriate use of a telepractice session.

## **B: Additional Requirements for Practitioners Treating MAT Patients**

In addition to the General Program Standards above, the following constitutes minimum requirements for the practitioner providing treatment using medication assisted treatment (MAT) via telepractice. The practitioner must pursue a team approach to the treatment of addiction, coordinating counseling and other ancillary treatment services with the designated provider and other team members as applicable. This may be included in any formal MAT protocol. Additional requirements apply if prescribing controlled substances (see Part C).

### ***Initial Evaluation of the Patient***

Consistent with the requirements of the designated program regulations, policies and procedures, a recent medical assessment must be documented in the patient record including, but not limited to:

- The nature of the patient's addiction(s); any underlying or co-existing diseases or conditions;
- The effect on physical and psychological function
- History of substance abuse or addictive disorders and any prior treatments
- The suitability of the patient for MAT treatment based upon recognized diagnostic criteria and where applicable, a documented diagnosis of SUD / OUD.

### ***Patient Informed Consent and Agreement for MAT Treatment***

The practitioner must employ the use of a written agreement between patient and practitioner, kept in the patient's case record, and addressing such issues as:

- Alternative treatment options;
- Regular toxicologic testing for drugs of abuse and therapeutic drug levels (if available and indicated);
- Number and frequency of all prescription refills;
- Reasons for which drug therapy may be discontinued (i.e., violation of agreement)

### ***Ongoing Patient Evaluation***

Consistent with designated program regulations, periodic assessment is necessary to determine compliance with:

- The dosing regimen
- Effectiveness of treatment/recovery plan, and
- To assess how the patient is handling the prescribed medication.
- A process description of how coordination of care will occur between sessions.

Once a stable dosage is achieved and toxicology tests are free of illicit drugs, less frequent telepractice sessions may be required (monthly may be reasonable for patients on a stable dose of prescribed medication(s) who are making progress toward treatment objectives). If reasonable treatment goals are

not being achieved, the practitioner should re-evaluate the suitability of continued treatment. Continuation or modification of opioid therapy should depend on the practitioner's evaluation of progress toward stated treatment objectives such as:

- Absence of toxicity;
- Absence of medical or behavioral adverse effects;
- Responsible handling of medications;
- Compliance with all elements of the treatment/recovery plan (including recovery-oriented activities, psychotherapy and/or other psychosocial modalities); and
- Abstinence from illicit drug use.

### ***Treatment/recovery Plan***

Consistent with the requirements of the designated program regulations a written treatment/recovery plan must state objectives used to determine treatment success.

The treatment/recovery plan must be reviewed periodically pursuant to regulation; the practitioner should adjust any drug therapy to the individual needs of each patient. Treatment goals and alternate treatment modalities should be evaluated and discussed with the patient. The treatment/recovery plan must also contain contingencies for treatment failure (i.e., due to failure to comply with the treatment plan, abuse of other opioids, or evidence that the Schedules III–V medications are not being taken).

### ***Collaborating with patient's multidisciplinary treatment team***

- Identification of patient's primary clinicians in the program where the patient is admitted
- Ensuring that contact information for the patient's primary clinical staff is provided to both the patient and distant site practitioner to facilitate effective coordination of care.
- Specifications regarding how collaboration will occur.

### ***E-Prescribing, Labs and Other Orders***

Program policies and procedures must detail how the following will occur:

- Prescriptions and renewals
- Prior authorizations
- Labs: ordering and obtaining results
- Executing any practitioner orders

### ***Drug Testing***

Pursuant to designated program regulations and/or other federal and state guidelines, treatment for substance use disorder should use results of regular drug testing to guide treatment.

- Where possible testing should be two stage and include a point of care (POC) immediate test followed by the confirmation testing by the laboratory. Where possible, test should screen for a wide range of clinically relevant substances but at minimum should include: opiates, MAT medications, benzodiazepine, barbiturates, synthetics, ETOH, cocaine, and amphetamines.
- Testing should be done at each originating site visit during treatment initiation/stabilization and at least monthly during the maintenance phase of treatment. A random testing, usually in combination with medication callback, may be also utilized routinely and whenever there are concerns about threats to stability or diversion.

- Urine sample collection procedure should minimize the possibility of sample tampering (e.g. the use of temperature cups and measuring urine dilution).
- In situations where test results indicate a potential problem it should be carefully evaluated. Test results positive for opioids or negative for buprenorphine must be discussed with the patient immediately and the treatment/recovery plan adjusted accordingly as indicated.
- Relying solely on urine test results to determine whether a patient is using illicit or unapproved substances and is in danger of relapse should be avoided. Positive urine test should not be an occasion for punishing a patient who is experiencing problems.

## **C: Standards for Practitioners Treating Patients with Buprenorphine**

These criteria are based upon the CSAT guidelines as applied to the office-based opioid treatment (OBOT) programs. The above standards for MAT are also applicable.

### ***Buprenorphine Practitioner Responsibilities***

- Both designated programs and practitioners prescribing buprenorphine products must meet the requirements of the laws and regulations of the U.S. Department of Health and Human Services, Drug Enforcement Administration, and New York state.
- Patients and prospective patients seeking buprenorphine must have at least one in-person evaluation session with a DEA approved practitioner physically present with the patient prior to participation in telepractice for purposes of receiving buprenorphine.
- There is an exception to the requirement that the DEA approved prescriber be physically present for the initial evaluation. If there is another DEA approved practitioner physically present with the patient, then the initial evaluation may be conducted via telepractice with the DEA prescriber. This exception may support MAT accessibility if a DEA practitioner has met their cap.
- The practitioner must be licensed in the State of New York and be certified by CSAT to prescribe buprenorphine in accordance with applicable law.
- If the patient's clinical condition requires treatment as soon as possible (e.g., patient is in severe withdrawal and/or at risk of overdose) the practitioner may review the medical evaluation (including blood work) performed by another health professional to confirm the diagnosis of OUD and determine if the treatment can be initiated.

### ***Patients must freely consent to treatment***

- Results of the evaluation must be discussed with the patient and if appropriate (consistent with 42 CFR Part 2) also with their family.
- All available treatment options must be discussed with the patient including agonist treatment with buprenorphine or methadone, detoxification followed by naltrexone treatment, outpatient treatment without medication, or a residential treatment. Risks and benefits of each treatment option as well as patient's provider recommendations must be discussed at length to help the patients make a decision that is the most appropriate for them.
- Before treatment initiation, the patient's program must obtain a written, informed consent for MAT which discusses in detail:

- All treatment procedures, services, program policies, and relevant federal and state regulations
- Treatment structure, goals, stages, conditions for progression through stages, and conditions for administrative withdrawal/discharge
- Medication effects, risks and side-effects
- Patient responsibilities and expectations; Patient rights
- Provisions for confidentiality (consistent with 42 CFR Part 2) and requirements for obligatory reporting

### *Clinical Standards Using Buprenorphine Products*

- Patients should be treated with the adequate dose of buprenorphine with no limit on treatment duration.
- **Induction.** Following the results of initial medical evaluation for treatment with buprenorphine patient should be induced following a standard face-to-face procedure in the clinic:
  - (Day 1) Patient should arrive at a time that allows time for induction and re-evaluation; initially dosed 2 mg and observed for one (1) hour; if well tolerated should receive additional 2-4 mg at the clinic and sent home with the dose in case withdrawal/craving symptoms persist.
  - (Day 2) Patient returns to clinic after taking all of the Day 1 dose (usually 8-12 mg) in AM; if stable should receive a prescription for one week and asked to return for medical evaluation in 2-4 days or earlier if withdrawal/craving persist.
- **Buprenorphine dosage principles.** The optimum dose for buprenorphine varies but most patients require a daily dose of 8-24 mg. The practitioner must use clinical judgment to determine the appropriate dose of buprenorphine, supported by the results of assessments. Adequate dose must accomplish the following objectives:
  - Suppress signs and symptoms of opiate withdrawal
  - Control craving for opiates (e.g., intrusive thoughts or urges to use)
  - Block the "high," or euphoric effects, of heroin or other rapidly acting opiates
  - Avoid undue sedation or euphoria from over-medication
  - Restore or normalize, to the extent possible, any physiological functions disrupted by chronic abuse of opioids such as sleep, appetite, sexual functioning, and motivation.
- **Medication Response.** Medication response should be assessed at each telepractice session and include inquiry into:
  - Presence of any symptomatic cravings/urges, withdrawal, preoccupation.
  - Any problems related (or attributed) to the current medication dose; side effects
  - adherence to the prescribed regimen, dosing interval, missed or doubled doses.
  - How many doses, if any, the patient has in reserve. The patient's reported count of medication doses must match the practitioner's record.
  - Any new medications
  - Any worrisome physical or emotional symptoms, any new medical complaints or treatment for any new problems, and whether the patient feels under greater stress than usual.

- **Dose adjustments** can be done rapidly until stabilization is achieved. Patients with the sub-optimal response may require higher dose (e.g. above 24 mg/d). Higher doses are justified provided that the patient:
  - Is adherent to the medication regimen (when possible document supervised administration)
  - Is closely monitored (at least weekly and preferably several times per weekly visit)
  - Participates in an intensive behavioral treatment program
  - Prescriptions should be given for short time intervals (e.g. weekly) and regular random call backs and pill counts must be utilized.
  - Maintenance doses should be given as long as the patient benefits from treatment, treatment is medically necessary, the patient wants to remain in treatment and is adherent to the MAT protocol and the rules of the provider program.
- **Patient satisfaction.** At every telepractice session the practitioner must review the patient's satisfaction with the current dose regimen and discuss whether an adjustment is necessary.
  - Any request for dose change must be thoroughly explored in an atmosphere of mutual trust to determine what symptoms and events may be contributing to the patient's desire for a dose change.
  - Decisions must be based on clinical observations, clinical staff reports, toxicology, record of treatment and medication adherence, medication count, and documented discussions with the patient regarding both subjective feelings and objective signs.
- **Continual assessment required to assure optimal OUD/MAT response.** Following induction, the frequency of practitioner evaluation and duration of prescription may be adjusted.
  - If the patient has a good treatment response the practitioner evaluation and prescription may take place at weekly intervals for the first 1-2 months.
  - If patient remains stable during that period, the frequency of evaluation and prescription will be adjusted accordingly but must remain at least monthly.
- **Managing threats to stability.** Most patients maintained on buprenorphine will remain stable, requiring only routine medical care, adjustments of dose level, and counseling; a small percentage do experience some threat to stability.
  - Early signs of destabilization include changes in behavior (missing/rescheduling visits, missing therapy visits or self-help meetings, losing medications, not giving urine, unexpected toxicology results, changes in mental status) and self-reports of difficulties (increased stress, cravings, work/relationship problems, reconnecting with “drug” friends).
  - If such situations emerge, a careful evaluation is warranted. Targeted testing should be used to assure the validity of testing. If concerns persist then the frequency of monitoring and therapeutic contacts should be increased.
  - The following strategies may be utilized in case of recurrence of OUD symptoms:
    - a. Implement supervised medication administration.
    - b. Increase the dose of buprenorphine
    - c. Increase frequency and intensity of behavioral treatment
    - d. Implement additional behavioral techniques (e.g. contingency management)
    - e. When appropriate involve family/significant other/friends in treatment
    - f. Attendance at support groups.



- If none of those measures produce the desired outcome then the patient may be referred to a more intensive treatment program such as MMTP. Repeated or gross violation of the MAT Protocol (e.g. substituting urine, selling medication) suggests that the patient is not appropriate for OBOT and should be transferred to a more intensive level of care or administratively discharged if refusing recommendations for more intensive treatment.
- **Pain Management.** Pain management needs of OUD patients maintained on buprenorphine may differ from those of other patients.
  - The practitioner must coordinate treatment with the patient’s pain management provider if different from the patient’s OASAS provider.
  - The routine buprenorphine dose offers only a limited analgesia and additional doses of a full opioid agonists may be required. In acute pain situations buprenorphine may be temporarily stopped or decreased and short-acting opioid agents may be given taking into account patient's opioid tolerance.
  - Untreated chronic pain can be a trigger for relapse. Splitting daily buprenorphine doses into equal portions to be taken four (4) times per day can be used to maximize pain control.
  - Alternative, non-opioid pharmacological and non-pharmacological strategies to manage pain must be utilized.
- **Pregnancy.** Buprenorphine maintenance is associated with healthy outcomes for both mother and infant.
  - Buprenorphine-only products are preferred over buprenorphine/naloxone products for maintenance during pregnancy and patients who become pregnant must be transitioned to an equivalent dose of a mono product. However, if there is an indication that the mono product is abused (e.g. injected) then the combination preparation must be used.
  - Buprenorphine is not teratogenic to the fetus; there is no evidence that it causes developmental problems. Patients may breast feed their infants.
  - Withdrawal from buprenorphine or reduction of dosage during pregnancy is hazardous to the fetus and may destabilize the mother; consequently, these must never be attempted without the careful evaluation of risks and benefits of such procedure. The patient must be reminded that the safest place for the baby to be withdrawn is outside the womb in the hospital nursery under direct medical care.

## **D: Billing Guidance**

- **Office approved services.** If applicable, Medicaid or other third-party reimbursement for services delivered via telepractice by OASAS designated providers may be sought only for services the Office has approved as deliverable via telepractice pursuant to Part 830.
  - **APG Rates.** Once the certified OASAS program has received designation from OASAS to provide telepractice, claims may be submitted for government approved APG rates (“fee for service”) and Medicaid managed care reimbursement. Medicaid Managed Care plans are required to reimburse programs at the APG rates as required by contract between the managed care plans and the state of New York.
  - Programs must submit the managed care claims using the same codes and modifiers

required by fee-for- service Medicaid.

- To constitute a reimbursable service, the patient must be physically present at a site approved by the Office and the designated program to which s/he is seeking admission or is admitted.
- Programs designated to utilize telepractice **MUST use the claim modifier “GT”** to identify telepractice visits/services. This modifier must be on each claim line that represents a telepractice service. Telepractice visits/services that are NOT identified on Medicaid FFS claims or Medicaid Managed Care “paid encounter” claims with the telepractice GT modifier will be considered non-compliant on audit.
- In addition to a claim for specific services delivered via telepractice (using the GT modifier) programs may, if/when approved by DOH, also submit a claim for an administrative fee (transmission per minute).
- **Contract or MOU.** Providers participating in telepractice services via agreement (contract or MOU) with practitioners must submit claims pursuant to the terms of the agreement.
- Practitioners must be licensed to practice in New York state and Medicaid enrolled in New York and physically located in the USA.
- It is the obligation of the distant practitioner and the designated program to make sure that the documents required by regulation are received in a timely manner and entered into the patient’s clinical record.

**E: Appendix I: Technology and Telecommunication Standards**

**All telecommunication technology must be compliant with confidentiality standards of federal law (42 CFR Part 2).**

## APPENDIX I

### Telepractice Services Technology and Telecommunications Standards Checklist

Technical complexities and variances in user demand impact the Quality of Service (QoS) between two end points. OASAS has collaborated with the NYS Information Technology Services (ITS) to develop videoconferencing technology criteria. In order for telepractice claims to be reimbursed, videoconferencing equipment must be employed allowing quality synchronous video and voice exchange between provider and the patient.

**All telecommunications technology must be compliant with confidentiality standards of federal law.**

<input type="checkbox"/>	<b>Video Cameras</b> - Videoconferencing is achieved using Telepresence Systems such as the MX200, MX300 or DX90 integrated videoconferencing systems. For lower cost video cameras, many high-definition WebCam for sufficient image quality can be employed. It is highly recommended that all video cameras in the dedicated videoconferencing configuration include pan, tilt, zoom, and incorporate remote control features.
<input type="checkbox"/>	<b>Computer Hardware</b> - With high-definition videoconferencing units, a separate computer is unnecessary because the camera, monitor, microphone, and audio speakers are all integrated. For lower cost solutions, business desktop computers with sufficient RAM and CPU meeting the minimum performance requirements of the camera and videoconferencing software are adequate.
<input type="checkbox"/>	<b>Operating Systems</b> - No operating system is required to configure high-definition dedicated videoconferencing.
<input type="checkbox"/>	<b>Video Conferencing Software</b> - Videoconferencing software should satisfy HIPAA and 42 CFR Part 2 requirements, with dedicated videoconferencing solutions preferred. New York State Information Technology Services currently supports Cisco Movi for desktop video conferencing and secure WebEx. Support for Movi is expected to sunset in 2018. <b>Skype and other video conferencing solutions not endorsed by ITS may not to be used for clinical care.</b>
<input type="checkbox"/>	<b>Audio</b> - It is important to conduct telepractice sessions using high-quality audio at 7 kHz, full duplex with echo cancellation. Equipment should be capable of eliminating room return audio echo and present mute and volume adjustment features.
<input type="checkbox"/>	<b>Microphones</b> - Both configurations have built-in microphones. In cases where sound does not transmit satisfactorily an external microphone may be added for satisfactory audio quality if employing Movi for a PC-Based Solution Configuration.
<input type="checkbox"/>	<b>Speakers</b> - Dedicated Videoconferencing contains built-in speakers. With the exception of Movi WebCams, PC-Based Solution Configurations also have built-in speakers. Supplemental speakers can be employed with Movi WebCams.
<input type="checkbox"/>	<b>Headset</b> - With the Dedicated Videoconferencing Configuration, headsets are not applicable as sometimes the clinical rooms host family members of the patients. In such cases, the integrated speakers and microphone in the room detect audio produced by all participants in the clinical session. For the PC-Based Solution headsets or ear-buds are recommended in order to reduce background noise dissonance.
<input type="checkbox"/>	<b>Monitors and Screens</b> - Video monitors at the practitioner site should be no less than 24" in diameter; video monitors in the room with the patient should be no less than 32" in diameter. Large screen monitors allow providers to detect important body language exhibited by the patient. In the case of the PC-Based Solution, desktop computers can be tethered to large monitors to project the videoconference onto a large screen display. Practitioner should be able to see patient's mid-chest and up.
<input type="checkbox"/>	<b>Wireless/Wired Connectivity</b> - Mandatory on the Dedicated Videoconferencing Configuration; on the PC- Based Solution Configuration, wired connections are preferred. If a wireless system is used any/all connections must be validated as secured, e.g., tunnel/vpn, private network.
<input type="checkbox"/>	<b>Connection Speeds</b> - On the Dedicated Videoconferencing Configuration, 512 Kbps is the standard for videoconferencing. On the PC-Based Solution Configuration, variable speeds are up to 512 Kbps, which may be affected by bandwidth usage. The WebEx High Quality video client requires a minimum of 384 kbps Internet bandwidth for audio/video/web collaboration to operate.
<input type="checkbox"/>	<b>Screen Resolution</b> - A minimum of 640 x 480 resolution at 30 frames per second should be achieved as specified by the American Telemedicine Association.
<input type="checkbox"/>	<b>Quality of Service (QoS)</b> - The Dedicated Videoconferencing Configuration can tag the video conferencing data packets with a value that can lead to priority handling if the network handling these packets has been configured to honor the QoS tag. This feature accounts for the primary reason this configuration is rated the best overall. The PC-Based Solution cannot tag packets for potential priority handling by the network between video end points.

**Authorization** - Dedicated Videoconferencing equipment provisioned by ITS does not require authorization. The utilization of a passphrase or equivalent authorization feature to access the device is desirable. When multi-factor authentication is available, it should be used, and timeout features should not exceed 15 minutes.

**Privacy Settings** - It is important to configure video conferencing settings to ensure HIPPA and 42 CFR Part 2 compliance and patient privacy. For both configurations, 128 bit encryption or stronger should be used to best protect the video session from eavesdropping. Cisco Movi licensing and WebEx Meeting Protected Areas may be employed to ensure private sessions on the PC-Based Solution.

**Data Security** - When bridges are employed with the Dedicated Videoconferencing Configuration, 128 bit encryption or stronger shall be employed. Session recording is not permitted without the patient's written consent.

**Bridge** - A bridge must be employed between dissimilar networks or when there's more than two endpoints. However, if WebEx is employed no bridge is necessary.

**Social Media Software** - No social media software should be present on videoconferencing devices with notification functions that activate when a user logs on to a contact list.

**Configuration Overall Rating** - The Dedicated Videoconferencing Configuration is ranked as the best overall platform to deliver Telepractice services. The PC-Based Solution Configuration is ranked as the second best platform to deliver Telepractice services.

It is ATA recommendation that the provider and/or patient use link test tools (e.g., bandwidth test) to pre-test the connection before starting their session to ensure the link has sufficient quality to support the session.

Videoconferencing software shall allow only a single session to be opened, although the session may include more than two sites/participants. If there is an attempt to open a second session, the system shall either log off the first session or block the second session from being opened.

Whenever possible, each party should use the most reliable connection method to access the internet as determined by the ITS Team associated with the OASAS certified originating site.

**Additional Requirements for NYS OASAS Addiction Treatment Centers**

**Network** – The Dedicated Videoconferencing and PC-Based Solution Configurations are to be deployed over the State controlled network.

**Carrier** – The Dedicated Videoconferencing and PC-Based Solution Configurations are to be deployed over the State carrier called NYeNET.

## Attachment II

### Plan and Attestation for OASAS Approval to Offer Telepractice Services

A program applying to provide Telepractice Services must complete this Plan and Attestation and required attachments and submit it to: NYS OASAS, Bureau of Certification, 1450 Western Avenue, Albany, NY, 12203 or by e-mail to [Certification@oasas.ny.gov](mailto:Certification@oasas.ny.gov).

General Information	
Applicant's Legal Name	
Operating Certificate Number	PRU Number(s)
Originating Site Address	
Name of Contact Person	Position/Affiliation with Applicant
Address (Street, City, State, Zip Code)	
Telephone Number for Contact Person	E-Mail Address of Contact Person
Telepractice Services Program Standards	
1.	Telepractice services being offered by the above-noted provider are in accord with Part 830 "Designated Services" regulation.
2.	Select the services to be delivered via telepractice: <input type="checkbox"/> admission assessments, direct transfers <input type="checkbox"/> psycho-social evaluations and mental health consultations <input type="checkbox"/> medication assisted treatment prescribing and monitoring <input type="checkbox"/> other services as approved by the Office (requires an OASAS approved waiver – attach copy)
3.	Telepractice services will be conducted via a telecommunication system which employs acceptable authentication and identification procedures by both the sender and receiver.
4.	Telepractice services to be provided meet Federal and State confidentiality requirements, including, but not limited to, 42 CFR, Part 2 and 45 CFR Parts 160 and 164 (HIPPA Security Rules).

5.	The spaces occupied by the patient and practitioner for telepractice services meet minimum privacy standards consistent with patient-practitioner interaction at a single location.
6.	Persons receiving services via telepractice may be accompanied by a staff member during the session or may be alone. If an assessment has not yet been done on the patient or if the assessment or treatment plan recommends that the patient be accompanied during the telepractice sessions, the person must be accompanied for the session to be reimbursed by Medicaid or Medicaid managed care. Additional rules apply if intending to prescribe controlled substances.
7.	<p>The distant site practitioner must:</p> <ul style="list-style-type: none"> <li>• Possess a current, valid license to practice in New York State and be Medicaid enrolled; be a “telehealth provider” as defined in subdivision 2 of section 29990cc of the Public Health law.</li> <li>• Directly render the telepractice service.</li> <li>• If the distant site is a hospital, the practitioner must be credentialed and privileged by such hospital, consistent with applicable accreditation standards.</li> </ul>
7.	<p>Telepractice written procedures include, at a minimum:</p> <ul style="list-style-type: none"> <li>• Procedures detailing the availability of face-to-face assessments by medical staff in an emergency situation.</li> <li>• Procedures for a contingency plan in the event of a transmission failure or other technical difficulties which may render the service undeliverable.</li> <li>• Procedures for prescribing medications and monitoring usage.</li> <li>• Administration of medication within the provider facility and a New York State Class 3A License where required.</li> <li>• Procedures for development of progress notes and treatment plans, review procedures, and maintenance of the records.</li> <li>• Review of the telepractice services being provided is incorporated within the provider’s quality management process.</li> <li>• Minimum technology thresholds (i.e., equipment, bandwidth, videoconferencing software, network specifications, etc.), which shall be updated as new technology is approved.</li> <li>• Confidentiality/Consent to Release Confidential Information.</li> <li>• Scheduling.</li> <li>• Documentation and recordkeeping, including practitioner access to patient records.</li> <li>• Role of support staff.</li> <li>• The patient shall be provided basic information about telepractice including alternatives, possible delays in service, need to travel to the originating site, risks associated with not having the services provided and shall acknowledge in writing having received such information.</li> </ul>
8.	<p>Patients</p> <ul style="list-style-type: none"> <li>• The right to refuse to participate in telepractices services.</li> <li>• Telepractice services shall not be recorded without the patient’s written consent.</li> </ul>
9.	The applicant program must be Medicaid enrolled; the practitioner must be Medicaid enrolled and in good standing.
10.	Telepractice services to be provided include culturally competent translation services when the recipient and practitioner do not speak the same language, and identification of methods by which the service will be fulfilled.
11.	<p>Contracts or Memorandum of Understanding (MOU) for the provision of telepractice services with practitioners or non-OASAS certified providers must be in compliance with Part 830 and Part 805 (“Criminal History Information”) regulations.</p> <ul style="list-style-type: none"> <li>• Attach all copies of contracts/MOUs entered into for the provision of telepractice services.</li> </ul>

**Provider Attestation**

Part 830 permits the provision of telepractice services by programs certified pursuant to Article 32 of the NYS Mental Hygiene Law if approved to do so by OASAS. Approval shall be based upon acceptance of this written Plan and Attestation that addresses a series of standards and procedures. This form must be completed and submitted to verify compliance with such required standards and procedures.

**Statement of Compliance and Signature**

I, (print or type full name and title of the applicant) \_\_\_\_\_ hereby attest that the telepractice standards identified on this attestation form are true, accurate and complete to the best of my knowledge and that the provider noted above is in compliance with Part 830 "Designated Services" regulation. I understand that any falsification, omission, or concealment of material fact may result in revocation of approval to provide telepractice services at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability. I also understand that any subsequent changes to the approved plan must be approved by the Office of Alcoholism and Substance Abuse Services prior to implementation.

Date

DRAFT