CONTINUING CARE FAQ’S

1. How do we admit a person into Continuing Care?

   People do not need to be admitted into Continuing Care. Notation in the person’s case record will suffice. Please note a PAS 45 Discharge Form needs to be completed. The form should indicate that the person is being referred to Continuing Care.

2. Do we have to close the active treatment case record and open a new one for Continuing Care?

   For continuity of care we suggest having one case record.

3. Does a person have to return to the original provider of treatment services for Continuing Care?

   A person can receive Continuing Care Services from any Outpatient Clinic Provider. Providers should contact the previous service provider to coordinate care.

4. How many treatment services may a person receive?

   A person in Continuing Care may receive the following services per month:
   - One (1) Counseling Session, **OR**
   - One (1) Peer Advocate Service,

   A person may receive unlimited Medication Management services per month.

5. How about if a person is in crisis, are we allowed to see them in Continuing Care for more than 1 session during the month without returning them to active care?

   If a person is in need of more than one counseling session a month they should be returned to active care. Please note Peer Services and Brief Intervention services are available prior to admission.

6. Can Opioid Treatment Programs offer Continuing Care Services?

   In OTP’s individuals who are taking Methadone cannot receive Continuing Care Services. As long as they are receiving Methadone they are considered to be in “active” treatment.
7. Can someone who was discharged from treatment for non-compliance receive Continuing Care services?

For Continuing Care a person must be discharged from treatment AND the service must be clinically/medically necessary. A person can be treated as long as it is clinically necessary. Generally speaking it’s not recommended that individuals be continued on medication without a successful or productive episode of counseling. However, there are instances where this may be necessary and/or beneficial, e.g. keeping someone engaged.

8. If a person has had no or an unsuccessful treatment history can we utilize Continuing Care until they are ready to commit to active treatment?

The ideal situation is to have the person in the most clinically appropriate level of care. However, if they are not willing to commit to active treatment then engagement would be the next best thing. Providers may utilize pre-admission Peer or Brief Intervention services to help motivate the person to treatment or Continuing Care Services to stay engaged.

9. Can a significant other be seen in Continuing Care?

The regulations do not limit continuing care to those with an SUD. However for Medicaid reimbursement, the services for significant others have to be clinically necessary.

10. How long can someone be in Continuing Care?

As long as clinically necessary.

11. Can Continuing Care Services be provided in the Community?

Continuing Care Services can be provided in the Community. However, only those individuals who have Medicaid Managed Care can be reimbursed for such services.

12. Are individuals in Continuing Care supposed to be drug screened?

The Part 822 Regulations do not “require” urine screens for any part of the treatment process. However, the regulations do allow for the use of “clinically appropriate” toxicology screening. Programs would need to determine when in their treatment process toxicology screening would be clinically appropriate.

13. If a person relapses while receiving Continuing Care Services do they have to return to active treatment?

A relapse is not necessarily an automatic return to active treatment. The clinician and individual would need to determine if the relapse warrants a return to treatment. The clinician may use a LOCADTR 3.0 to determine if a change in level of care is needed.
14. How do we document Continuing Care Services?

PAS 126 is the per service report form for Continuing Care. The reporting form can be found in the Application section of CDS. A paper copy can be found on the OASAS Forms page. Provider’s should utilize this form to document service dates and types. A progress note should also be included in the case record that provides, date of service, duration, content, and the date and signature of the person providing the service.

15. What Client Data Systems reporting guidelines do we need to following for those in Continuing Care?

Along with the per service report provider’s should continue to report on the PAS-45N Client Discharge Report if the person has been referred for Continuing Care. Provider’s should also continue reporting the number of Continuing Care Services on the Monthly Service Delivery Report.

16. Can a Continuing Care visit be counted in the total number of visits, towards the total units of service in the Monthly Service Delivery Report?

Continuing Care Visits should NOT be included in the Treatment Visits documented on Lines V6-V10, V14, or V15-24. See attached instructions, these visits should be counted on Line V11. Continuing Care Visits are calculated in the total units of service. This is currently reflected in the MSD summary report and will be added to the Program Performance Report.

17. Does Continuing Care require a treatment/recovery plan?

If a person is being discharged to Continuing Care or at a later time, the person and responsible clinical staff member should discuss how Continuing Care will assist in the person’s recovery process. Some notation should be made in the person’s case record that indicates their goals for Continuing Care and the services needed to meet these goals.

18. How often does the Continuing Care Plan need to be updated?

The Continuing Care plan should be updated whenever clinically necessary.

19. Can the person receive a group counseling service?

Counseling services, including group, have to be clinically appropriate and necessary according to the person’s continuing care plan.

20. How do we discharge a person from Continuing Care?

A person is not formally “discharged” from Continuing Care. Upon each visit a disposition decision can be made to either a) Continue in Continuing Care, or b) refer back to active treatment.
21. If a person receives no Continuing Care Services for a month should we discharge them?

Individuals are not “discharged” from Continuing Care. They can return for Continuing Care in any time frame as long as it is clinically necessary.

22. Are Continuing Care Services reimbursable?

Continuing Care Services are reimbursable through both Medicaid Fee for Service and Medicaid Managed Care. For private insurers reimbursement is determined in the contract between the provider and the company.

23. How do we bill Medicaid for Continuing Care Services?

You will send the same claim type, and use all the same codes that are utilized for active treatment services. There are no specific modifiers utilized for Continuing Care.