FAQs: Substance Use Disorder Reform

Updated August 2019

* New and updated questions are listed at the end of each section.

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I. Provider Enrollment

Q1. Are there any updates on obtaining CMS approval for the new services?

The Centers for Medicare and Medicaid Services approved our State Plan Amendment in August 2018. The Behavioral Health Division has received approval to add comprehensive assessment, peer recovery support and treatment coordination to the Medicaid benefit set and to add Recovery Community Organizations, Counties, Tribes and individuals in private practice as eligible vendors of certain substance use disorder services.

Q2. What type of documentation will provider enrollment require to enroll as a provider of SUD Treatment Coordination?

Eligible vendors to provide and bill for treatment coordination include licensed nonresidential substance use disorder programs, counties/tribes, and a SUD licensed professional in private practice.

Providers of treatment coordination will need to meet the staff qualifications identified in chapter 245G.11 subdivision 7. Providers will need to attest that the treatment coordination is being completed by a qualified individual. Treatment coordination can also be provided by a staff who meets the qualifications of an alcohol and drug counselor (ADC), as this credential exceeds the qualification requirements of a treatment coordinator. A program is not required to have a staff person designated as “treatment coordinator” if the treatment coordination will be provided by ADC staff.

Note: “Grandfathered” LADCs who do not have a BA are able to provide treatment coordination, as they have a scope of practice to do this service.

Note: Minnesota Statues, contains the term “care coordination,” however in the process of applying for the state plan amendment, the term Care Coordination was changed to Treatment Coordination in the state plan amendment.

Enrollment documentation and requirements can be found on the MHCP enrollment page or you can contact the Provider Call Center at 651-431-2700.

Q3. If we are already contracted or credentialed with DHS, does that automatically make us an "eligible MHCP vendor"?

No. Vendors who have already enrolled with MHCP will need to update their provider file with MHCP by completing the documentation applicable to their vendor type. Certain providers are only eligible to provide certain services. More information on this can be found on the SUD services and enrollment criteria web page. Eligible vendor qualifications are listed in Minnesota Statutes 254B.05 subdivision 1. Providers will also need to amend their contracts with Managed Care Organizations to add new services, as applicable.
Q4. *How do existing 245G non-residential programs enroll for the new services?
As indicated in the December 6th, 2018 WebEx powerpoint on slide 20: “Licensed non-residential SUD treatment providers will have specialty codes of treatment coordination, peer recovery support services, and the comprehensive assessment added to their Minnesota Health Care Programs (MHCP) MMIS file to allow for billing of these services from 1/1/2019.” Programs will need to update their contracts with managed care organizations to reflect these services. Existing 245G non-residential programs will not need to provide any additional items to MHCP enrollment at this time.

Q5. *Is there a specific assurance statement for recovery peers?
Recovery peers cannot enroll as eligible vendors. Recovery Community Organizations (RCO’s) can enroll as eligible vendors. There is no assurance statement for RCO’s at this time.

Q6. *How do existing 245G residential programs enroll to provide treatment coordination and peer recovery support services outside of the residential program?
Residential programs are required to offer treatment coordination as a part of the per diem payment. For residential programs wishing to provide treatment coordination and peer recovery support services outside of the residential program, a license holder must contact their DHS licensor and identify if they wish to add non-residential services to their existing license.

Q7. *How do I contact the Provider Call Center?
Enrollment will be managed by Minnesota Health Care Programs (MHCP), Provider Eligibility and Compliance. Contact the call center to enroll as a new vendor, track the status of your enrollment, update your provider record, or if you have questions on enrollment documents.

Contact: 651-431-2700, Toll-free line, 800-366-5411

Q8. *How do individual professionals enroll for the new services?
Individual professionals will need a National Provider Identifier (NPI) in order to enroll with Minnesota Health Care Programs (if you do not already have one). (Website to apply)

Please see the Minnesota Health Care Program’s substance use disorder enrollment page- Website for forms.

Q9. *How do Recovery Community Organizations enroll for the new services?
Recovery Community Organizations (RCOs) will need to apply for a National Provider Identifier (NPI) (Website to apply). RCOs will need to enroll with Minnesota Health Care Programs after they have received an NPI, since they are a new vendor (Website for forms). RCOs will also need to contact Managed care Organizations to contract with them to provide services for payment, if desired.
Q10. *Do I need to become an eligible vendor to continue providing Rule 25 assessments or comprehensive assessments at a non-245G licensed hospital?*

Rule 25 assessments can continue to be administered until June 30, 2020. Rule 25 assessments will continue to not be reimbursable by the CCDTF.

To provide comprehensive assessments at a non-245G licensed hospital, you can enroll with MHCP as a licensed professional in private practice if you meet the requirements of an alcohol and drug counselor supervisor (245G.11, subdivision 1 and 4). You can then contract with the hospital to provide the assessments. The alcohol and drug counselor supervisor will need to bill the CCDTF themselves. Any comprehensive assessments performed for MCO enrollees will require that the assessor be enrolled with the relevant managed care plan provider. In addition, ADC staff employed by a 245G program could provide a Comprehensive Assessment service at a non-245G licensed hospital and the 245G program could bill for this service.

Q11. *Where will we find the application to enroll our LADC as an independent provider and where will the application need to be submitted?*

245G licensed programs do not enroll LADCs separately to Minnesota Health Care Programs (MHCP). An alcohol and drug counselor who meets the criteria in 245G.11 subdivision 1 and 4, who would like to practice independent of a program, will need to enroll with MHCP. The enrollment application and necessary forms are located on the MHCP enrollment page. Note: Prior to enrolling with MHCP, independent supervisor level alcohol and drug counselors will need to establish a National Provider Identifier (NPI) number.
II. Substance Use Disorder Reform

Q1. What does the Substance Use Disorder (SUD) Reform do?
Substance use disorder reform (SUD) seeks to transform the service continuum from an acute episodic model to a chronic and longitudinal model that includes ongoing recovery support services. The person centered changes will seek to provide the right level of service at the right time and treat addictions like other chronic health conditions. You can find additional resources about SUD reform on our website and through our e-memo communications. You can sign up for the e-Memo on our website.

Q2. How will the Chemical Health Assessment and Treatment Services (CHATS) system be utilized with SUD reform?
Certified Community Behavioral Health Clinics (CCBHCs) will continue to use CHATS. Continuum Of Care Pilot programs will enter data in CHATS for all services prior to July 1, 2018. For service on or after July 1, 2018 service agreements will be utilized. Service agreements will be utilized for all CCDF services prior to direct access being fully implemented. An announcement will be released via e-memo communication when direct access has begun.

Q3. Is there payment for mileage if seeing a Patient in a hospital, jail or detox center?
No. Medicaid/MA does not reimburse providers for their mileage.

Q4. Where is the application for the SUD 1115 waiver posted?
We have posted a copy of the waiver request titled “Minnesota Substance Use System Reform” on our website. Scroll to Section 1115 waivers/Substance use disorder system reform waiver request/New request for public comment.

Q5. Will DHS be providing training on the billing process?
Provider Screening and Enrollment will notify providers of training opportunities.

Q6. Will DHS be sending out instructions on the new Client Placement Authorization (CPA) form? Is the old form being replaced by 2780A and 3070? Do we use these effective immediately?
We will continue to use the DHS-2780 form as long as we are operating under Rule 25 guidelines. There will be training provided as to how the form should be used. Any other forms that will be used once we move to direct access will be introduced to you via an E-memo prior to implementation. Form 3070 belongs to a different area and isn’t appropriate to use for CCDTF purposes now or in the future.
Q7. *What are the new modifiers that go with the new service codes?*

These are the rates that have been approved by CMS in the State Plan Amendment.

- **T1016- Treatment Coordination**- proposed rate: $11.71 per 15 min unit
  - Must be billed with modifiers U8 and HN
  - 8 Units/per client/day billable

- **H0038- Peer Recovery Support**- proposed rate: $15.02 per 15 min unit
  - Must be billed with modifier U8

- **H0001- the Comprehensive Assessment**- proposed rate: $162.24
III. Substance Use Disorder Treatment Program Standards
MN Statutes, Chapter 245G

Q1. What 245G templates are posted on the DHS Licensing Website?
The following 245G templates have been updated to reflect the changes effective July 1, 2019 and are posted on the DHS Licensing website:

1. Comprehensive Assessment Example
2. Comprehensive Assessment Summary Example
3. Discharge Summary Example
4. Individual Treatment Plan Example
5. Initial Services Plan & VA Determination Example
6. Treatment Service Treatment Plan Review Example

Q2. When will a checklist for 245G be available?
Please contact your licensor to obtain the 245G checklist.

Q3. Will there be a sample Policy & Procedure template?
We do not intend to do sample policy and procedures, this is the responsibility for each program to do.

Q4. Do we need a 245G license for outpatient group services at an Adolescent Residential Correctional Program? Or, can these outpatient group services be provided under the Location of Service Provision in 245G?
If your program is planning to provide regular outpatient group services, you would need to get the site licensed under 245G.

Q5. What is the estimated timeframe for the service location request process?
Minnesota Statute 245G does not indicate a specific time frame for response. DHS Licensing target date is to respond within 30 days of submission.

Q6. Is the statute for off site services applicable to the provider offering the services or provider to provider?
The statute refers to the licensed provider providing services at a location other than the location listed on their license to clients of that provider.
Q7. What is the expectation for discharge summaries if the client abandons treatment and no further contact with client occurs?

Minnesota Statutes, Chapter 245G.06, subdivision 4 states that an alcohol and drug counselor must write a discharge summary for each client, regardless of whether the client completed treatment. Providers should also be aware of new language and requirements pertaining to service termination policies in 245G.14, subdivision 3. A discharge summary example is available through the DHS Licensing website.

Q8. Will staff that had previous training in co-occurring disorders need to take training in co-occurring disorders that includes competencies related to trauma-informed care and person-centered treatment planning?

Yes, 245G.13, subdivision 2, paragraph (e). Staff that are currently employed in the field have been required to get the 12 hours of training in co-occurring disorders already, under Rule 31, and have it reflected in their personnel file. This simply requires existing staff to get further training in trauma-informed care and person-centered treatment planning, and then have that documented in their personnel file, but does not require a specific amount of training. Staff can seek this additional training, or programs can offer it as an in-service.

Q9. Where can I find person-centered treatment planning and trauma-informed care trainings that will qualify for the new requirements?

No specific training or education course is required to meet the requirement that treatment planning is person-centered and trauma informed.

Q10. 245G.14, subdivision 3, clause (3) requires that the license holder must confer with other interested persons to review the issues before discharging the client. What about situations where there is violence or the threat of violence?

The service termination policy must include procedures a staff member must follow when a client leaves against staff or medical advice and when the client may be dangerous to the client or others, including a policy that requires a staff member to assist the client with assessing needs of care or other resources.

In emergency situations, such as violence or threat of violence, safety of clients and staff is paramount. Staff must take steps to ensure safety, and then confer with other interested persons to review the issues involved in the decision.

Q11. What will happen with the DAANES process when SUD reform is in effect?

Changes that may be necessary to DAANES have not yet been identified, but there are no current changes to be aware of. However, in the future we do expect changes to DAANES as a result of SUD Reform.
Q12. Under 245G, for administration of medication only one of these three was required (a formal medication training through an accredited program; or internal (program) medication training; or demonstration of competency. For 245G.08, subdivision 5, administration of medication and assistance with self-medication. Does a staff member need to complete:

a. clause (1) and clause (2) or clause (3); OR
b. clause (1) or clause (2) or clause (3)?

A staff member, other than a licensed practitioner or nurse, must meet one of the three methods to demonstrate competency in medication administration, and this must be documented in their personnel file.

Q13. When you talk about medical necessity, are Payors going to be held to Parity?

It is important for providers and consumers to notify the Behavioral Health Division when or if they believe there is a violation, so it can be investigated and remedied.

Q14. If we utilize Suboxone & other MAT (not methadone) as part of our treatment are we now considered an OTP?

No. The term Opioid Treatment Program remains reserved for programs that are federally approved to dispense methadone as a treatment medication. An OTP is permitted to utilize other medications as well, including Suboxone and Naltrexone, but only OTPs may utilize methadone to treat opioid use disorder (OUD).

Q15. If a document is reviewed by a provider, can a scribe be used for documentation based on the scribe’s observations of work being performed and provider statements?

A scribe can transcribe observations and notes dictated by the qualified professionals. However, a scribe would not be able to document their own observations and perceptions and bill as a qualified professional.

Q16. It is confusing on the new paperwork to say a client is receiving non-residential without being able to indicate they are getting sober board and lodge. For example: in an Intensive Outpatient Program (IOP) w/ lodging (e.g. 35 hours of programming and lodging).

The designation on a provider's license as to whether they are “non-residential” or “residential” is both generated by what the provider defines themselves as, when they get their initial DHS license, and how they define themselves when they enroll with Minnesota Health Care Programs Provider Enrollment. Residential programs must meet additional criteria in 245G, and have additional licensing costs, and providers who offer licensed residential services must clearly specify in their Assurance Statements with MHCP Provider Enrollment what intensity of residential services they plan to provide. Providers who define themselves as “non-residential”, but then require, or strongly recommend that their clients stay in a near-by sober board and lodge do contribute to this confusion as they appear to be trying to offer a level of care or intensity of service for which they are not licensed or enrolled to provide.
Q17. Does the Initial Services Plan and the VA determination have to be all one form/assessment?
   No. An Initial Services Plan & VA Determination Example is provided by DHS Licensing for a provider’s convenience.

Q18. Do we still consider an adolescent an entity of one if they are requesting treatment?
   Yes, the adolescent client may be evaluated for income eligibility based on his or her own income alone when seeking treatment and giving effective consent.

Q19. We have a variance in place for the requirement that 50% of supervisors time is non-client time—will we need a new variance to meet the requirements of 245G?
   Please contact your licensor for variance questions.

Q20. *What are the staff qualification requirements for alcohol and drug counselors in the new program license requirements?
   See Minnesota Statutes, section 245G.11, subdivision 5 and the recently published “Qualified Professional” list from the Behavioral Health Division.

Q21. *What additional information can you provide about the group size in Minnesota Statutes, 245G.10, subdivision 4?
   Group Counseling is now defined under Minnesota Statutes, 245G.01, subdivision 13a. All group counseling must be defined in your service description and identified per requirements in Minnesota Statutes, 245G.07, subdivision 1. Group counseling that is identified in your service description may not exceed 16 clients.

Q22. *How do I get a list of all variances that have been approved for our licenses?
   Providers can contact their licensor for a list of current variances. If the provider is unaware of who your assigned licensor is, please e-mail dhs.mhcdlicensing@state.mn.us.

Q23. *Can an RN, psychologist or an addiction psychiatrist provide the education for an educational group? Or does it need to be an LADC?
   Please see “Qualified Professional” list published by the Behavioral Health Division.

Q24. *Please provide clarification on what services, and under what circumstances services can be provided off-site without having to get a separate license?
   Minnesota Statutes, Chapter 245G.07 identifies where services can be provided by a license holder. Please contact your licensor to determine if a secondary location will be required to be submitted.
Q25. *Where do we document the reason for providing services off site?*
   This could be identified on the treatment plan or the weekly review of treatment services documentation required under Minnesota Statutes Chapter 25G.06.

Q26. *Does 245G require daily documentation?*
   245G identifies throughout the various requirements what documentation is required and the timeframes with which they need to be met.

Q27. *What are the individual treatment plan timelines?*
   Individual treatment plan timelines are found in Minnesota Statutes, Chapter 245G.06, subdivision 1.

Q28. *If multiple staff members provide services, how do we complete the documentation of services?*
   Each staff person must document the service they provide. One person is not able to document the services provided by another. However, one individual can complete the review and summarize all of the provided services that occurred that week in the Weekly Review of Treatment Services.

Q29. *Can we bill for progress notes and weekly notes if they were prepared without the patient being present?*
   No. Progress notes are no longer a requirement in 245G. The language has been updated to reflect a weekly treatment plan review and documentation of treatment services.

Q30. *What additional clarification can you provide regarding the requirement for supervision of a student intern in 245G.11, subdivision 10? Also, does the Board of Behavioral Health and Therapy need to authorize each student intern?*
   Student intern is defined in Minnesota Statutes, Chapter 245G.01, subdivision 21. Depending on the board, supervision requirements may vary. Additionally, within a 245G program, a qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, progress note, and individual treatment plan prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

Q31. *What are the 245G requirements for what percentage of staff work time must be allocated to indirect care?*
   There is no longer a requirement in 245G that a percentage of time is allocated for indirect services. However, providers are responsible for meeting timelines and policies should outline how staff persons will be expected to meet these requirements within their scheduled work time.
Q32. *Does a discharge have to be complete within 5 days of an unplanned discharge, and no later than the discharge date of any planned discharge? (245G.06, subd. 4).

Minnesota Statutes, Chapter 245G.06, subdivision 4 identifies the timeline for when a discharge summary is to be completed.

Q33. *Will I be required to change my program to comply with 245G?

Yes the effective date for the new statute was January 1, 2018, and updates to 245G were effective July 1, 2019. All licensed 245G programs will need to follow the standards outlined in statute 245G.

Q34. *How do I get clarification on pieces of 245G?

Please visit our website. If you have questions after reviewing the FAQ’s, please contact your licensor.

Q35. *Does 245G require that electronic record keeping and electronic signatures be addressed in the provider policy and procedure manual?

245G.12 does not require that the license holder develop written policies and procedures regarding electronic record keeping and electronic signatures.

Q36. *If we provide a naloxone kit at discharge, as part of the Family Grant, does this need to be part of our policies and procedures, and noted in the clients clinical record? We already have policies and procedures for 245G.08, subd. 6, clauses (1) to (7).

It would not be a policy. It would most appropriately be documented in the resource area of the discharge summary.

Q37. *How does a County or Provider get enrolled in the Drug and Alcohol Abuse Normative Evaluation System (DAANES) in order to report?

Eligible vendors who are enrolled through Minnesota Health Care Programs Provider Enrollment, will need to contact the DAANES office at 651-431-2631 to obtain the necessary training and documents required to participate in DAANES. The DAANES Web User Manual is available on our website.
IV. Treatment Coordination

Q1. What is treatment coordination?
   The treatment service description can be found in 245G.07, subd. (1)(a)(6).

Q2. Does the license holder have to offer treatment coordination or is this something that the County can do if they refer the client?
   Treatment coordination is a required treatment service in 245G. The client may receive treatment coordination services from an eligible county or contracted provider if that best suits the client’s needs.

Q3. Is it correct that LADC's do not need the 30 hours of treatment coordination training?
   That is correct. All LADCs are qualified to provide treatment coordination since it is a treatment service. (245G.07 Subd. 1. (6) (i-vii)).

Q4. Without LADC’s what options are there for treatment coordination supervision in rural MN?
   Supervision is a required part of any clinical service. Treatment coordinators could be supervised not only by an LADC, but also by a clinician who meets the criteria in 245G.11, subd. 5. Supervision may also be delivered via an appropriate telemedicine arrangement. While some counties may choose to “leave it to the providers,” many counties or tribes may choose to provide Comprehensive Assessments and treatment coordination because funding will become available for providing these services.

   Rural workforce shortages, particularly for LADCs, remains challenging. We hope the new treatment coordinator requirements make these positions easier to fill than those of LADCs.

Q5. Why are the reimbursement rates and qualifications for treatment coordination lower than those for LADC's?
   Treatment coordination is an adjunctive, supportive service to assist the LADC, and many of the services that comprise treatment coordination do not need the scope of practice of an LADC. The rates we believe would be appropriate for a supportive, adjunctive service provided by a person with lesser credential would therefore be lower than the rates for a clinical service provided by a licensed professional.

Q6. Do clients need to be present to be reimbursed for "treatment coordination"?
   No, a client does not have to be present for a treatment coordination service to be billed.

Q7. Who do we contact to find out more information about the treatment coordination certification process: Alcohol and Drug Counselor, Level I, by the Upper Midwest Indian Council on Addictive Disorders?
   Treatment coordinators are not required to be certified.
Q8. Is a treatment coordination position going to be required for the Children’s Residential Facilities (CRF) programs?
   There is no requirement for a treatment coordination position for programs licensed under 2960. There are no current plans to amend the CRF program rules.

Q9. Will Counties be given first “right of choice” to provide treatment coordination?
   No. Clients will be able to access all treatment services that they are eligible for at the provider of their choice, which could be a SUD provider or a county/tribe, although individuals in a PMAP will be subject to any network requirements of their MCO.

Q10. How will a provider know that a client is currently receiving treatment coordination from another provider, so as not to bill for the service?
   A provider would ascertain if the client is receiving treatment coordination, or any other SUD services from another provider, and if so, contact them so the client’s care is coordinated and verification that there is no duplication of services.

Q11. Will billing be set up so that OTP’s can bill treatment coordination and peer support services separately? Would we need to re-write our contracts with the HMO's in order to bill separately?
   What options are there for billing “self-pay” clients with a per diem?
   Currently, there are no changes to the payment methodology for OTPs. There are some discussions relating to raising the daily reimbursement, but the per diem methodology will remain in effect, and will not permit the billing for any services above and beyond that per diem rate. However, we are trying to get approval to have peer support services billed concurrently because that service did not exist when the current rates where set. However, unless/until we have confirmation that this is permitted, our working position is that this is not billable concurrent with a per diem.

   If your program is accepting clients who are not Medicaid eligible because they have too high an income, and thus would not qualify for CCDTF either, your program can set up any payment plan that works for you and the client. Programs that accept Medicaid also take “self-pay” clients, and while services charged must be the same as Medicaid, the billing can be individually tailored.

Q12. Will the 2000 hours of ‘supervised’ practice for treatment coordination be waived for the current county Rule 25 assessors who are not licensed but have been doing assessments?
   No. But there is some consideration being given to looking at the amount of time the Rule 25 Assessor has worked as an assessor, if they have been supervised.

Q13. Can the treatment coordinator job responsibilities be added to the responsibilities of an LADC?
   Yes, treatment coordinator responsibilities are included in the scope of practice of an LADC.
Q14. *When will 245G be amended to reflect the name change of care coordination to treatment coordination?*
   This has been changed and is in effect as of 7/1/2019.

Q15. *Can a licensed social worker provide treatment coordination?*
   As long as the individual meets the qualifications noted in 245G.11, subd. 7 they are eligible to provide the service within a 245G/tribal SUD program, county, or tribe. In order to bill for treatment coordination as an independent provider, you would need to meet the qualifications of an alcohol and drug counselor supervisor as identified in 245G.11, Subdivision 1 and 4.

Q16. *What are the specific qualifications for treatment coordination supervision? Is this supervision required to be provided by a LADC?*
   Supervision for a treatment coordinator needs to be completed by an alcohol and drug counselor who meets the criteria in 245G.11, subd. 5, which may be an LADC. If the individual providing the treatment coordination meets the criteria of an alcohol and drug counselor themselves, they are not required to have supervision.

Q17. *Who can be an eligible vendor to provide treatment coordination services?*
   Substance use disorder (SUD) licensed programs are required to provide treatment coordination. Nonresidential substance use disorder programs are eligible to bill for the service when authorized. SUD licensed professionals in private practice and counties and tribes are eligible vendors to provide this service. The individual providing treatment coordination must have staff qualifications identified in 245G.11. Please note that an alcohol and drug counselor (as defined in 245G.11, subd. 5) meets these qualifications as this credential exceeds the qualification requirements of a treatment coordinator.

Q18. *Will reimbursement for treatment coordination/case management only be for individuals who are eligible for the Consolidated Chemical Dependency Treatment Fund (CCDTF)?*
   Treatment coordination for SUD is reimbursable to individuals who access CCDTF and those enrolled in an MCO as long as they meet medical necessity for the service and the provider has a contract in place with the MCO to provide this service.

Q19. *Will programs be able to bill in 15 minute increments for LADCs that perform treatment coordination for their assigned caseload or does this have to be an additional added staff position?*
   If a person is receiving non-residential services from a 245G licensed program, tribally licensed program or eligible independent professional, the answer is “Yes.” However, the answer is “No”, when an individual is in a residential program, these services are already reimbursed in their bundled residential rate.
Q20. *What meets the qualifications of the required 30 hours of classroom instruction on treatment coordination for an individual with a substance use disorder?*

There is not a particular training program required. However, the amount of training must be equal to 30 hours, be specific to treatment coordination for an individual with a substance use disorder and review topics identified in 245G.07 subdivision 1 (6). The classroom instruction is not limited to being presented in person. The classroom instruction may be provided by an agency, college or university, or private training consultant.

Q21. *Will DHS revisit providing reimbursement for the required training or weekly clinical supervision for treatment coordinators?*

We are not currently planning a rate adjustment. The SUD rate study report that was completed and provided to the Minnesota legislature in 2018 may impact the rate in the future.

Q22. *If an outpatient program and provider are assisting a client with different needs, can they both bill for treatment coordination and/or peer recovery support services on the same date?*

Yes, if a person is receiving non-residential services from a 245G or tribally licensed program or eligible independent professional and is receiving treatment coordination from a county and peer support from an RCO, unduplicated services can be billed on the same date. However, there is a maximum number of billable units per day, per client for each service: 8 units for both treatment coordination and peer support.

Q23. *How many minutes for treatment coordination do we need to bill for 1, 15 minute unit. Does anywhere between 1 -15 minutes make a unit? Is a 2 minute phone call billable?*

A unit of time is attained when the mid-point is passed. With this said, for a 15-minute unit to be billed the service would need to be at least eight minutes. The treatment service must last a consecutive 8-15 minutes in order to bill one unit. A 2-minute phone call alone is not billable. A treatment coordinator may make a couple phone calls, complete paperwork, and/or meet with the client within one period of time, which must be more than eight minutes to bill for one unit and more than 23 minutes to bill two units.

Q24. *Can an occupational therapist in private practice bill for outpatient treatment?*

All providers of SUD treatment services must meet requirements in 245G.11, subdivisions 1 and 4 (Minnesota Statutes, 254B.05, subdivision 1, paragraph (b)) AND be enrolled with Minnesota Health Care Programs (MHCP).

Q25. *Where would our UA’s and the referrals for testing fall under the definitions of care coordination?*

Urine Screens or other drug screens are not a covered benefit under the CCDTF. SUD reform does not change vendor eligibility for services other than the substance use disorder services funded by the CCDTF, i.e. those found in MN §254B. To determine whether a program or a professional is an eligible vendor for non-CCDTF services, consult the Minnesota Health Care Programs provider manual or your MCO contract.
V. Peer Recovery Support

Q1. What are peer support services?
Peer support services are provided one-on-one by an individual in recovery. These services include: education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying the client to appointments that support recovery, assistance in accessing resources to obtain housing, employment, education, and advocacy services, and nonclinical recovery support to assist a person in the transition from treatment into the recovery community.

Q2. Is phone support recognized for peer recovery support?
No.

Q3. Are there ethical concerns with an LADC having a dual relationship as a peer recovery specialist?
Yes. Dual relationships are not desirable for clients or providers, and can lead to confusion and burnout. An alcohol and drug counselor who has also been trained as a recovery peer cannot act as a peer in the same program where they are concurrently employed to work as a counselor.

Q4. Can a LADC provide "Peer Recovery Support" services without the certification credential as they are the one supervising the peer recovery support staff?
No. An LADC who is employed as an alcohol and drug counselor, cannot work in a dual role to provide peer support services. In addition, while an alcohol and drug counselor is qualified to supervise peer support staff, an alcohol and drug counselor who would like to seek employment as a peer must meet all of the qualifications of a peer specialist, including the certification requirement.

Q5. Can a counselor provide peer recovery support services for clients at the agency they work at for clients that are not on their caseload and not have a dual relationship?
No. That LADC/Counselor would still be part of the counseling team even for clients of the agency not on their own caseload.

Q6. Can peer recovery support be billed in group hours?
No. Minn. Stat. 245G.07, paragraph (a), subdivision 5 states that peer recovery support services are to be provided one-to-one by an individual in recovery. However, a recovery peer could attend recovery and other support groups with a client and bill for that time.

Q7. Are clients required to attend peer support services, or may they decline?
Clients may decline peer support services, as they can refuse to participate in other SUD treatment services.
Q8. *Who can be an eligible vendor for peer support services?*

Peer support services will be reimbursable when provided by a Recovery Community Organization that has a certification from Association of Recovery Community Organizations (ARCO), and by licensed SUD treatment or withdrawal management programs that provide the service utilizing recovery peers.

Peer recovery support services must be provided by a person who has received certification from the Minnesota Certification Board (MCB), Upper Midwest Indian Council on Addictive Disorders (UMICAD), or NAADAC, the Association for Addiction Professionals. Peers must receive ongoing clinical supervision in areas specific to the domains of their role from a licensed professional.

Q9. *If peer support services are provided by a Recovery Community Organization (RCO), will medical necessity need to be met? Will people need to have an active SUD diagnosis and will RCO's be expected to engage in "clinical charting"?*

RCOs are not licensed programs, but are potential eligible vendors of peer support services. Providing a Medicaid reimbursable service will require that some documentation of the services they are billing for exists, so yes they will be expected to engage in documenting their services. In order for a Recovery Community Organization to provide peer support services, the individual must have received an assessment completed by a qualified professional that indicates the need for peer recovery support services. Once the assessment is complete and referral is made to the RCO, the RCO can begin providing billable services. The peer providing the service must complete an Individual Recovery Plan with the client that is reviewed weekly. In addition, all services provided must be documented in a progress note.

Q10. *Is there a specific assurance statement for recovery peers?*

Recovery peers cannot enroll as eligible vendors. Recovery Community Organizations (RCO’s) can enroll as eligible vendors. RCO’s will not need to complete an assurance statement.

Q11. *Can you please provide more information about Recovery Community Organizations?*

Recovery Community Organizations (RCO’s) are eligible vendors of peer support services and are defined in section 254B.01, subdivision 8, and described in the resource on our website titled: peer recovery support in the SUD Reform area. These are organizations that provide not only training and supervision of recovery peers, but are now also able to provide and bill for peer support services. There are currently six Recovery Community Organizations within the state of Minnesota.

Certifications from the following certification bodies are approved for Recovery peer specialists:

1. Minnesota Certification Board, an affiliate of International Certification & Reciprocity Consortium
2. National Association for Alcoholism and Drug Abuse Counselors
3. Upper Midwest Indian Council on Addictive Disorders
Q12. *Do I need a certification from DHS in addition to the training I received from Minnesota Recovery Connection to provide and bill for peer support services?*

Peer support staff are not eligible to bill. Peer staff are paid by the eligible vendor they are employed by or contracted with. See 254B.05 Subd 1 (a) and (d) [https://www.revisor.mn.gov/statutes/cite/254B.05](https://www.revisor.mn.gov/statutes/cite/254B.05)

MN Statute 245G.11, subd 8, (3) states that a recovery peer must: “hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support;”

If you receive certification from a DHS commissioner approved certification body, you will not need an additional certification from DHS. Individual peers cannot bill directly for services.

Certifications from the following certification bodies are approved for Recovery peer specialists:

1. Minnesota Certification Board, an affiliate of International Certification & Reciprocity Consortium
2. National Certification Commission for Addiction Professionals
3. Upper Midwest Indian Council on Addictive Disorders

Q13. *What are the documentation requirements to be able to bill for Treatment Coordination and Peer Recovery?*

Treatment coordination is defined at 245G.07, subdivision 1, paragraph (a), clause (6) and includes documentation of the provision of treatment coordination services in the client's file (item vii).

A treatment service provided to a client must be provided according to the individual treatment plan.

Q14. *Can treatment coordination be billed for clients waiting to get into residential programs?*

Yes, if need has been determined by the Rule 25 or Comprehensive Assessment, AND there is a service agreement with the payer for this service.

Q15. *What is the criteria or symptom severity level that corresponds with medical necessity for Peer Support Services to be provided and reimbursed through Medicaid?*

At this time, an individual needs to have a severity level of at least a 2 in dimensions 4, 5, or 6 in order to be eligible to receive this service.

Q16. *Are there any updates on the criteria for Recovery Community Organization certification?*

Recovery Community Organizations must be certified by the Association of Recovery Community Organizations (ARCO) or the Council on Accreditation of Peer Recovery Support Services.
VI. Withdrawal Management

Q1. What are Withdrawal Management Services?
Standards were enacted in 2015 in Minnesota Statute 245F that lay out two different levels of care, depending on the severity of the client’s need for medical intervention. The more severely impaired clients need a higher level of nursing care and physician involvement. Withdrawal Management services also include the provision of treatment services, including treatment coordination and peer support services. This is to build linkages for clients to recovery resources and increase the likelihood that the client will be able to either receive further treatment or improve their connection to support in their community. Withdrawal management services will be reimbursable July 1, 2019, or upon federal approval, whichever is later.

Q2. Who can be an eligible vendor for withdrawal management?
In order to be an eligible vendor of withdrawal management services, providers must maintain a current 245F license and be enrolled with Minnesota Health Care Programs.

Q3. Is it necessary for the "Medical Director" to be on site 7 days a week (withdrawal management), or does the statute just require a physician on site daily?
The statute requires that the program have a medical director. The two clinical levels have different requirements: “clinically managed” needs to have a “qualified medical professional” available by telephone or in person for consultation 24/7- and that could be the medical director or a different medical professional (physician) used by the program; “medically monitored” not only needs the same, but also the ability to be seen within 24 hours or sooner if needed by a qualified medical professional and the ability for on-site monitoring of patient care seven days a week by a qualified medical professional.

Q4. *Can withdrawal management programs be an eligible vendor for Peer Support on July 1, 2018 or upon CMS approval?*
Withdrawal Management programs are not projected to be implemented until July 1, 2019, or upon CMS approval, whichever is later. All withdrawal management programs are required to offer peer support services as part of their per diem rate. Licensed 245F programs cannot bill separately for peer support services under their 245F license.

Q5. *Were there any codes or rates proposed to CMS for withdrawal management?*
The approved code for level 3.2 clinically managed withdrawal management is 0900, with the rate being $400 per diem plus $75 for room and board. The approved code for level 3.7 medically monitored withdrawal management is 0919, with the rate being $515 plus $75 for room and board.
VII. Comprehensive Assessment

COMPREHENSIVE ASSESSMENT TEMPLATE

Q1. Will there be a new tool/template to be used for the assessments, similar to the rule 25 form that will be used at all assessments?
   No, there will not be a required form. See the linked handout on Comprehensive Assessment.

Q2. Is there an example Comprehensive Assessment and Assessment Summary?
   Comprehensive Assessment and Comprehensive Assessment Summary examples are posted on the DHS Licensing website.

Q3. Where do we get the software needed for the Comprehensive Assessments?
   No software is needed for the Comprehensive Assessment. There is a sample template posted on the DHS Licensing website. The template is a resource available to license holders, but the template is not required to complete a Comprehensive Assessment.

Q4. Can a combined Rule 25 and Comprehensive Assessment/Assessment Summary be used for placement?
   No. Counties, Tribes and MCOs may continue use of the Rule 25 Assessment during the parallel process through June 30, 2020. The limited Hennepin county pilot project uses a form approved by the commissioner that serves as both a Rule 25 Assessment and comprehensive assessment. Use of this tool is not available for the purpose of direct access.

ELIGIBLE VENDOR

Q5. Is an LADC that meets the qualifications of an alcohol and drug counselor supervisor an eligible vendor for reimbursement for Comprehensive Assessments and treatment services?
   Yes, if an LADC meets the alcohol and drug counselor supervisor requirements and is in private practice.

Q6. If we have not done Comprehensive Assessments, how do we start? Or can we continue to provide Rule 25 assessments?
   Rule 25 assessments must continue to be administered by placing authorities (Counties, Tribes, MCO) during the parallel process until June 30, 2020 if a client requests an assessment. Licensed SUD treatment programs, counties, and licensed professionals eligible for direct reimbursement are identified as eligible vendors for providing comprehensive assessments, and will not be required to have a substance use disorder program license to provide an assessment. Eligible vendor requirements for providing comprehensive assessments can be found in Minnesota Statutes 254B.05, subdivision 1. Eligible providers for comprehensive assessments will need to be enrolled with MHCP in order to bill for this service. Contracts with MCOs will also need to be established or updated in order to bill for this service.
Q7. *Do I need a license to contract with someone to provide comprehensive assessments? How about individual therapy?*

A 245G license is not required for a licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4. A licensed professional in private practice is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

Also, please see 254B.05 Sub. 1 (a) (b) (c) https://www.revisor.mn.gov/statutes/cite/254B.05 for vendor requirements for providing Comprehensive Assessment/Assessment Summary AND other SUD treatment services.

**TIMELINE**

Q8. Can a Comprehensive Assessment update be done if a Comprehensive Assessment is over 45 days old but less than 6 months old?

Yes, in some cases. Since the treatment plan is developed from the comprehensive assessment, it is prudent to base it on the most up-to-date and accurate data. If there is sufficient accurate, timely data, coming from the update of an assessment to create, update, or revise a treatment plan, that is fine. However, this would not be billed as a comprehensive assessment, it would be billed as an individual treatment session.

Q9. Is collateral information needed on the same day as the Assessment Summary when authorizing treatment?

Collateral information is not required when doing a Comprehensive Assessment if there exists enough information to create a placement recommendation. If the alcohol and drug counselor believes the Comprehensive Assessment cannot be completed without some specific collateral information being gathered first, treatment cannot be authorized until it is gathered, so the comprehensive assessment can be completed. If the alcohol and drug counselor believes the collateral information would assist in creating a better treatment plan, the treatment could be authorized based on a completed Comprehensive Assessment and completed Assessment Summary, and the collateral information, once gathered, could be added as a separate chart note.

Q10. Do we need to provide another assessment within 21 days of admission to an OTP, following the comprehensive assessment?

No. 245G does not include a requirement for another assessment to be done within 21 calendar days of admission.
Q11. *If the Comprehensive Assessment is completed during the initial session for non-residential programs, and since this is replacing the Rule 25, will the assessment already be complete once the client arrives at the provider?*

If a non-treating provider performs the comprehensive assessment, the treating provider needs to review the comprehensive assessment for compliance with 245G and whether it needs updating.

Q12. *Can a person be admitted to treatment prior to having the Comprehensive Assessment and knowing the level of care?*

With the exception of the Rule 25 Assessment during the 2-year parallel process, if the Comprehensive Assessment is the first contact with a potential client, they cannot be “admitted to treatment”, or begin services until it is completed, or at least started. The “level of care” is determined by the Comprehensive Assessment, not before. If treatment has been authorized by a Rule 25 assessment, the person may be admitted to a treatment program.

Q13. *Is the comprehensive assessment required in the initial group session, or the initial individual session for an outpatient program?*

If the comprehensive assessment is completed via direct access, it must happen prior to treatment services. If the comprehensive assessment is started at the initial outpatient session it should be completed prior to the provision of any groups, and if it is not able to be completed, there must be a client centered reason for the delay documented in the client file and the planned completion date. However, if the client enters treatment following a Rule 25 Assessment, then the timeline requirements in 245G for a comprehensive assessment must be followed.

Q14. *Does the Assessment Summary need to be completed on the same day as the Comprehensive Assessment? And will both of these be sent to the treatment provider?*

If the Comprehensive Assessment is being done to make a recommendation for treatment, the Comprehensive Assessment and the assessment summary must be done on the same day, and the completed Comprehensive Assessment and assessment summary must be forwarded to the receiving/treating provider at that time. If it is not being done to make a recommendation for treatment, an alcohol and drug counselor must complete an assessment summary within three calendar days after service initiation for a residential program and during the initial session for all other programs.

ACCESS

Q15. Can Comprehensive Assessments be used for placement?

Yes, once direct access is implemented, it can be used to identify the appropriate SUD treatment for eligible persons.
Q16. Should we do Rule 25’s and Comprehensive Assessments or only Comprehensive Assessments?
There is no requirement to complete a comprehensive assessment for purposes of placement instead of a Rule 25 assessment. However, Rule 25 assessments will become obsolete 7/1/2020 and a comprehensive assessment will be required for the purposes of placement. Rule 25 assessments are not a reimbursable service under CCDTF. Until 6/30/2020, placing authorities will be required to continue completing Rule 25 assessments for CCDTF clients who seek them. A comprehensive assessment may be used to authorize placement by eligible vendors once direct access has begun.

Q17. Please explain why we cannot do comprehensive assessments and Rule 25 assessments if they are being implemented in parallel?
Once direct access systems are in place, vendors eligible to complete comprehensive assessments for the purposes of placement and/or Rule 25 assessments can do so. Each method has its own requirements and procedures.

Q18. How will you ensure rural Minnesota will have access to these programs (i.e. Primary care set up critical access hospitals)?
CMS requires access statewide. We expect that additional reimbursable services will improve flexibility and access in our rural communities by attracting more providers to serve rural areas of our state.

Q19. Who will provide oversight to the sole providers of assessments and treatment services?
The expectations provided by SUD licensing standards and the process to become licensed as a substance use disorder program are required to protect consumers of SUD treatment program services.

Oversight of private practice providers has always been provided and will continue to be provided by the individual’s Professional Licensing Board. In addition, now that Private Practice providers can enroll as eligible providers and be reimbursed by the CCDTF, they will also be subject to the Surveillance and Integrity Review Section (SIRS) that investigates possible fraud relating to reimbursement and billing, under the Office of the Inspector General.

Q20. How is DHS going to track the quality of evaluations and recommendations from different providers? Has there been a consideration of the problem of people shopping around for the recommendation they want?
The SUD Reform requires DHS to develop a Utilization Review process. The selection of a health care provider for any health condition should reside with the patient. Barring a commitment, we support client choice in choosing the treatment program or individual clinician they would like to seek services from, provided it meets medical necessity requirements and is part of the client’s benefit set and provider network, even if it does not comply with what a particular professional would prefer for the client.
Q21. Will there be a limit to how many Comprehensive Assessments clients can request in a time period?
   No, there is no limit to the number of comprehensive assessments that may be provided, however there is a limit as to the number of comprehensive assessments that will be able to be reimbursed within a time period. Two Comprehensive Assessments may be reimbursed in any 6 month period.

Q22. What if the client wants outpatient and they need inpatient? Does the client choose?
   Yes. The SUD Reform does permit a client to choose a lower intensity level of service than from the assessor’s recommendation. If the level of care they choose and the level of care identified by the assessor are different, helping the client get necessary services may be part of the treatment plan.

Q23. Currently we do 4X as many Rule 25s as clients entering treatment. If clients have the choice of treatment and we utilize an LADC for paperwork (walk in Comprehensive Assessments) how will this streamline the process?
   Since the goal is for Comprehensive Assessments to be reimbursable this will be a source of revenue that many programs have not had. If your program does many assessments, you may find that the additional revenue will allow you to add another assessor to ease the burden.

Q24. With "other medical services" the provider/doctor does not do the admission paperwork. The Provider does care/treatment. What support for SUD admissions paperwork will be available?
   “Each treatment program has a current business model that includes admission paperwork for clients entering the program, and it is up to an individual program as to what type of staff person completes this responsibility. It will be up to individual programs to determine whether SUD reform would indicate a change in admission practices. A comprehensive assessment is not “admission paperwork,” but is part of the treatment planning process.

Q25. Who will have the responsibility to find treatment options for those hard to serve individuals? For example: Someone shows up for a Comprehensive Assessment at a facility that does not take someone with a sex offense which that treatment center does not serve. Who assists?
   This has always been a challenging task and has usually been achieved by working with and collaborating with the County Social Services/Chemical Health units. Even under SUD Reform with the new role of counties, they still have the role of providing case management to their residents, and often possess deep knowledge about resources in their areas that many providers have never had. It would be highly recommended that providers and counties continue to collaborate on the care of these difficult-to-place clients.
Q26. Under direct access, who will be responsible for ensuring those incarcerated are being given a comprehensive assessment within 10-days? There are numerous barriers present in the jail system that make it difficult to open the doors to more vendors.

SUD regulations do not require that a Comprehensive Assessment be completed within 10 days. Rule 25 requires counties to assess within 20 days of request and to make a determination within 10 more.

Q27. How do we become involved in giving input to the outline of the utilization review process?

This has not yet been started, but development of a utilization process is also part of the 1115 Demonstration Project.

Q28. If someone is given a “downward deviation” and this is included in their treatment plan, then could they be referred to a higher level of service based upon justification such as continued use etc.? Court ordered?

An individual should, after an assessment, receive a recommendation to the appropriate level of care. If a subsequent reassessment indicates need for a different level of care, the person should be encouraged to get services at that different level of care. The client may disagree, and may receive a lower level of care than the one recommended. If the person is court-ordered or civilly committed, the court may not allow such deviation from the clinical recommendation, and may require the individual’s return to court.

Q29. How do the Rule 25 and comprehensive assessment timelines differ?

Please view Minnesota Statutes 9530.6615 for Rule 25 assessment timelines. Comprehensive assessment timelines can be found by viewing Minnesota Statutes 245G.05.

Q30. Do providers have to continue using the Rule 25 form for DWI/DUI clients?

Until 6/30/2020, the Rule 25 assessment form will continue to be available for this purpose and to authorize treatment services. The procedure after this date has yet to be determined.

Q31. Can a comprehensive assessment be administered if a program has a waitlist?

Yes. We encourage getting clients into a treatment service at the earliest opportunity, bearing in mind federal admission preference requirements.

Q32. Does the client need a new assessment to go to out-patient treatment after they complete in-patient treatment?

No. However, since the treatment plan is developed from the comprehensive assessment, it is prudent to base it on the most up-to-date and accurate data. If the client attends out-patient treatment with a different provider, then the out-patient treatment provider is responsible for having a comprehensive assessment on file for the client that meets the standards identified in 245G.05.
Q33. *What services can an LADC located in a small rural community, who does not work in a 245G program provide?

An individual who meets the qualifications of an Alcohol and Drug Counselor supervisor according to 245G.11, Subdivisions 1 and 4, is an eligible vendor of Comprehensive Assessment and Assessment Summary according to section 245G.05, and other treatment services according to sections 245G.06 and 245G.07. Individuals qualified as an alcohol and drug counselor supervisor who want to bill the CCDTF directly will need to be an enrolled provider with the Minnesota Health Care Program (MHCP) and contact managed care organizations to become credentialed as an ‘in-network’ provider.

Q34. *Does the assessor need to facilitate a client getting into treatment?

It would be good clinical practice to facilitate the client getting into treatment, but the assessor has no obligation to assist the client in completing entry into treatment. Treatment coordination services may be used to assist people needing help pre-treatment, as they may help people during or after treatment.

Q35. *If the treatment center is 3 to 6 weeks out with an opening, who will be responsible to help the person coming in for a Comprehensive Assessment, if they need to get in right away?

Under SUD reform, once the client has had a Comprehensive Assessment, the program can offer treatment coordination and/or Peer Support to keep the client engaged while they wait for the opening, and thus not “fall through the cracks”. The individual may need to enter treatment with a different provider. In addition, the continued and expanded utilization of Fast-Tracker is expected to expedite client access to treatment openings.

Q36. *Are treatment centers going to be responsible for calling other treatment centers to find an open bed?

Treatment centers will vary in the extent to which they will help their clients find space in another treatment program. Through use of Fast-Tracker, treatment centers will be able to use the online searchable tool to locate open beds. But yes, it will be up to the treatment centers to locate open beds. Treatment coordinators could provide support for this task.

Q37. *Is it ethical for an OTP to self-refer a client to their program following a comprehensive assessment?

Yes. It is ethical for an assessor to refer to the program where they work, including OTPs, if the individual client is assessed as needing what the program provides. It is the client’s choice as to what program the client will attend, and a client may choose to attend the same or different OTP program, to obtain treatment elsewhere, or to risk going without treatment entirely.
Q38. *What is DHS doing to get more LADCs into the field for completing Comprehensive Assessments?

With the passing into law of M.S. 245G, a LADC, a person with Upper Midwest Indian Council on Addictive Disorders (UMICAD) certification, or a person with another license and a scope of practice to work with SUD are able to do a comprehensive assessment. SUD reform provided new ways to offer SUD treatment as part of health care and by becoming more mainstream, reach more people, earlier. DHS partnered with Metropolitan State University and others in 2018 on a workforce summit, and continue to work on workforce development in 2019.

STAFF QUALIFICATIONS

Q39. Are ADC Temporary and interns able to complete Comprehensive Assessments?

Yes, ADC-T’s and interns will be able to complete a Comprehensive Assessment, just as they can now, at the location of the licensed program where they receive supervision. In the case of interns, all their work must be signed off on by an LADC who is supervising them.

Q40. Are ADC-T/interns billable if an LADC supervisor approved their work?

Intern services in this case are billable as long as the service is approved and signed off on by the ADC/LADC supervisor.

Q41. Can a Licensed Addiction Counselor (LAC) complete a Comprehensive Assessment or would they need to have both a LADC and LAC? An LAC is a credential from North Dakota.

Individuals need to have a scope of practice in Minnesota to complete a comprehensive assessment. The credential of “LAC” must be equivalent or reciprocal to an “LADC”, so this will need to be assessed by the Board of Behavioral Health and Therapy as to whether this provides someone a scope of practice in Minnesota, and if not, the necessary steps for this to happen.

Q42. Can a LPCC complete a comprehensive assessment?

Yes. If the Licensed Professional Clinical Counselor (LPCC) meets the requirements for an Alcohol and Drug Counselor Supervisor in 245G.11 Subd. 1 and 4.

Q43. Who is qualified to do a Rule 25 Assessment?

Please see the existing MN Rules 9530.6615, subpart 2, listing the criteria, which include three sets of criteria, one of which is that the person must have successfully completed 30 hours of classroom instruction on chemical use assessments and have at least 2000 hours of work experience, either as an intern or an employee.
Q44. If a Rule 25 is completed by a staff with qualifications to complete a Rule 25, and they are referred to treatment, does the provider need to also complete a Comprehensive Assessment?

What if the Rule 25 was done by a LADC?

Yes, all clients admitted to treatment under Rule 31, and later under 245G must receive a Comprehensive Assessment for treatment planning purposes, as required by M.S. 245G. If an LADC does a Comprehensive Assessment for placement and refers a person to treatment, the receiving program can accept the Comprehensive Assessment but will need to confirm that it meets the requirements of 245G, but will not need to do a new assessment.

Q45. What training is required for a mental health professional to be eligible to provide the Comprehensive Assessment?

A Comprehensive Assessment must be completed by an alcohol and drug counselor. Please see M.S. 245G.11, which lists the staff qualifications for an alcohol and drug counselor in subd. 5. A mental health professional would fall under paragraph (b), an individual who is exempt from license under chapter 148F, meaning that they have a license under another chapter, and that they meet one of five additional requirements such as: (1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in chapter 148F is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member. Please review 245G.11 for additional options.

Q46. Must a LADC do all of the assessment or could other professionals such as a RN for Dimensions 1 & 2 or addiction psychiatrist for Dimension 3 and Diagnosis?

An Alcohol and Drug Counselor must complete the Comprehensive Assessment. However, the Alcohol and Drug Counselor may use current information from another source, or referring agency as a supplement. So the assessor could include information from an RN or addiction psychiatrist as supplemental information.

Q47. Is a Comprehensive Evaluation done by a LPCC, LICSW, and LP?

The term Comprehensive Assessment is defined in 245G.05, subdivision 1. Nothing at 245G.05 has an impact on other assessments/evaluations that may exist, nor does 245G.05 have an impact on qualifications for any assessment/evaluation that may exist other than the comprehensive assessment at 245G.05.
Q48. Why is an LADC supervisor qualification required to provide comprehensive assessments at the county?

An “LADC” supervisor qualification is NOT required to provide comprehensive assessments at the county; rather, an individual must meet the staffing qualifications of an alcohol and drug counselor supervisor under 245G.11, subdivisions 1 and 4, which can include those other licensed professionals as well. With that said, an individual working outside of a licensed program, either for a county or independently, is required to be at the supervisor level to ensure they have sufficient experience to work independently and are aware of the laws governing their practice. For those with current licensure but who are going back to school to become an LADC or to otherwise meet the qualifications of an alcohol and drug counselor under 245G, their years of experience as an assessor while licensed can count toward the three years’ experience for purposes of doing comprehensive assessments at the county.

Q49. Has there been any consideration for allowing Rule 25 assessors who have recently obtained their LADC and do not have the LADC supervisor qualification to administer comprehensive assessments for the county?

Previous experience as a Rule 25 assessor counts towards the three years of experience needed to qualify as an Alcohol and Drug Counselor supervisor when that assessment experience was as a licensed professional. There has also been conversation about potential changes to allow an individual qualified as an alcohol and drug counselor to provide assessments at the county under the supervision of an individual qualified as an alcohol and drug counselor supervisor, but this is a continuing conversation and we are continuing to work with counties and other stakeholders on this. Legislative action by the 2019 Legislature directed DHS to address this issue, and work is ongoing.

Q50. Does my LADC license need to be in active status to conduct comprehensive assessments at the County?

A Comprehensive Assessment is an alcohol and drug counseling service. According to the LADC licensing statute, 148F.07, a licensee must not practice alcohol and drug counseling while the license is inactive. So yes, to perform a Comprehensive Assessment, you would need to reactivate your license, per the statute, as well as meet the additional requirement of an alcohol and drug counselor supervisor.

Q51. Can a person qualified to complete a Rule 25 assessment have an LADC Supervisor review and approve a Comprehensive Assessment?

No. As of January 1, 2018, 245G.05 states a Comprehensive Assessment must be completed by an alcohol and drug counselor, so an individual who does not meet these qualifications cannot conduct a Comprehensive Assessment. If the person is completing a comprehensive assessment outside of a 245G or tribally licensed program, they need to meet the requirements of an ADC supervisor (245G.11 Subdivision 1 and 4).
Q52. *What are the staff credentials to complete a Comprehensive Assessment?*

The comprehensive assessment must be completed by a staff member who is an “alcohol and drug counselor”. The credential requirements for “alcohol and drug counselor” in a program licensed by 245A and regulated by 245G are found at 245G.11, subdivision 5.

Q53. *Please clarify what Comprehensive Assessments need to be done by an alcohol and drug counselor supervisor?*

Comprehensive Assessments provided within a 245G or tribally licensed program may be provided by an ADC. Comprehensive Assessment provided outside of a 245G or tribally licensed program need to be provided by a someone who meets the requirements for an Alcohol and Drug Counselor Supervisor in 245G.11 Subd. 1 and 4.

OFF SITE

Q54. Is a letter of need required to provide a comprehensive assessment at a government building?

No, but if a program is providing services off site, they will need to have a policy in their manual covering whatever services they plan to provide off site. Pursuant to Minnesota Statutes, Section 245G.07, subdivision 4, the Commissioner may grant approval for a license holder to identify a secondary suitable location where select services may be provided. These locations may be a school, government building, medical office, behavioral health facility, or social service organization, but must be approved by the Commissioner prior to services beginning. The secondary location request form is posted on the DHS Licensing website.

Q55. When referring to doing assessments off site are you talking about a Rule 25 or Comprehensive Assessment?

We are referring to Comprehensive Assessments. Since the Rule 25 assessment is not a treatment service, it has been done outside of treatment facilities at a variety of locations for years, by counties and their contractees.

Q56. What additional information can you provide about mobile assessor qualifications?

Staff qualifications for completing Comprehensive Assessments are that of an Alcohol and Drug Counselor as noted in 245G.11, subd. 1 and 5. In addition to meeting those qualifications, a provider or professional desiring to offer mobile assessments must get approval of the commissioner as referenced in 245G.07, subd. 4 regarding location of service provision. Comprehensive Assessments offered by a professional in private practice must meet the qualifications in 245G.11, Subd. 1 and 4, which are for a Counselor Supervisor and require more experience.
COMPREHENSIVE ASSESSMENT BILLING

Q57. Will there be a different rate for Comprehensive Assessments vs. an individual session? Would a provider be able to use 2 sessions to complete a Comprehensive Assessment?

There will be a separate rate and billing code for comprehensive assessment, which must be used when doing a comprehensive assessment for approval of treatment services.

Q58. If a Comprehensive Assessment is done, and a client with a Prepaid Health Plan (PPHP) is referred, and then discharged from treatment, should the next facility refer to the level of care they need or back to the Rule 25 assessor?

If a Comprehensive Assessment is done, and a client is referred to treatment, and then discharged, the next level of care the client would need would be based on the Comprehensive Assessment, which may need to be updated. If the client was covered by a PMAP or PPHP, the facility would need to verify continued insurance coverage and then work with the PPHP/PMAP for the next step, referring to the level of care that is clinically indicated. There would be no rationale to involve a “rule 25 assessor”, as the client is covered by insurance.

Q59. How does an LADC obtain funding from the consolidated fund for an eligible client?

On July 1, 2018, or upon federal approval, whichever is later, allows a licensed professional in private practice who meet the staffing requirements for an alcohol and drug counselor supervisor to become eligible vendors for direct reimbursement from the Consolidated Chemical Dependency Treatment Fund. The clinician will need to be enrolled with Minnesota Health Care Programs and Managed Care Organizations and follow their billing procedures.

Q60. Can a person who is not an alcohol and drug counselor supervisor do a comprehensive assessment and it not be billable?

If it is within the professional scope of the individual to complete the comprehensive assessment, such as a licensed alcohol and drug counselor they can complete the assessment. In order to bill for the assessment, the clinician does need to meet the qualifications of an alcohol and drug counselor supervisor.

Q61. Are we currently able to use the Comprehensive Assessment for the purposes of placement without billing for having done it?

No. Currently for all publically funded treatment placements, the Rule 25 is the required tool to determine placements in treatment. Once the state system can accept the required comprehensive assessment information, a Comprehensive Assessment will be able to be used for placement in treatment, alongside the Rule 25 Assessment, which will be available until June 30, 2020.
Q62. How will a provider know that the limits of Comprehensive Assessments have been met and there is no further reimbursement for future assessments?

There are no limits to how many comprehensive assessments can be performed on a specific person, but there will be limits set for how many are reimbursable within a given time frame. At present, payments for only two comprehensive assessments will be made in a rolling 6-month period. Also, once a person has received a comprehensive assessment it generally can be updated, but an entire comprehensive assessment does not need to be redone and the time spent updating the information should be billed as an individual treatment session.

Q63. Would I bill on the MN-ITS system or do I use another outside billing system like MN E-connect for billing for the Comprehensive Assessment?

Once providers are enrolled and systems are in place, the comprehensive assessment would be billed according to each payer’s process.

Q64. Can Rule 32 programs bill directly for comprehensive assessments?

Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors for Comprehensive Assessments (Minnesota Statutes 254B.05, subdivision 1, paragraph (e)).

Q65. *How would the assessor bill for an assessment for an adolescent who is not eligible for MA?

The adolescent will need to meet the same income eligibility requirements as MA, but would not need to be enrolled in MA to be eligible for a CCDTF reimbursed comprehensive assessment. Under certain circumstances, adolescents’ income alone may be considered, and they may constitute a household size of one.

Q66. *Can LADCs who provide Rule 25 assessments in a hospital bill for comprehensive assessments?

Is a hospital an eligible vendor?

A rule 25 assessment cannot be billed as a comprehensive assessment. A hospital is not an eligible vendor of SUD treatment services unless the hospital has a licensed 245G program. If the LADC (or ADC) is a staff member of a 245G program, the program can bill for a comprehensive assessment. If the individual meets the criteria for an alcohol and drug counselor supervisor and chooses to enroll as a licensed provider in private practice, they may complete comprehensive assessments at the hospital, but would bill independently of the hospital.

ADCs who are employed by a 245G program could provide a comprehensive assessment and the 245G program could bill for the service if they have the variance in place to provide the service off-site.

Q67. *Is the comprehensive assessment that is completed following a Rule 25 reimbursable?

If a Rule 25 assessment indicates a need for treatment, a comprehensive assessment would be required for treatment planning, as it is now. The comprehensive assessment is not yet billable for placement purposes via direct access to CCDTF-funded treatment. Currently only the Rule 25 Assessment authorizes treatment
for CCDTF-funded individuals, so if the Service Agreement authorizes a comp assessment, then the provider can bill for the comp assessment when completed for treatment planning purposes.

Q68. *If a client has completed a comprehensive assessment twice within the last rolling 6 month period, and a provider completes an updated assessment, can the provider bill the service as “treatment coordination”?*

The time spent updating a comprehensive assessment could be billed as an individual treatment session.

OTHER

Q69. Can the Comprehensive Assessment and Assessment Summary be combined into one document, encompass the criteria of both, and be labeled the Comprehensive Assessment and Summary?

Yes, the comprehensive assessment and the assessment summary can be combined into one document, but should be labeled as such.

Q70. How can we obtain client signatures with electronic medical records (EMRs) without having to print and scan all these documents?

Many providers with EMRs have created a one page “signature” page, that the client can sign which attests to the fact that the client is in agreement with the treatment plan, for example, and then that page can be scanned into the record.
VIII. Direct Reimbursement

Q1. What are the proposed reimbursement rates for the new services?
   All current services and fees are available at: https://edocs.dhs.state.mn.us/lfserv/Public/DHS-7612-ENG.

Q2. How would treatment coordination and peer services be reimbursed in residential?
   Residential treatment services are currently reimbursed with a per diem, which is an “all-inclusive” rate.
   Additional reimbursement for treatment coordination, or other treatment services, are not allowable.

Q3. Will experienced Licensed Alcohol and Drug Counselors be able to bill for direct reimbursement for services?
   Individuals who meet the requirements of 254B.05, subdivision 1, paragraph (b), including the staffing requirements for an alcohol and drug counselor supervisor (245G.11, subdivision 4) will be eligible for direct reimbursement.

Q4. With direct access implementation will CCDTF eventually be phased out and MA be billed directly by providers?
   The current plan is to retain the CCDTF, and there are no plans to “phase out” the CCDTF.

Q5. What will be the new process for adolescents that have a household above CCDTF limits (i.e. in the past the state has advised us to get a letter from parents if they are unable or unwilling to pay for treatment so that the fund can be used for them)?
   The adolescent client, even if their household is above CCDTF limits, is eligible for treatment on their own merits, and a letter is not necessary. Please contact the Behavioral Health Division for clarification if this is your practice.

Q6. Does the LADC or ADC need to be enrolled with MHCP for the testing laboratory to be reimbursed for urine screens?
   Urine Screens or other drug screens are not a covered benefit under the CCDTF. SUD reform does not change vendor eligibility for services other than the substance use disorder services funded by the CCDTF, i.e. those found in MN §254B. To determine whether a program or a professional is an eligible vendor for non-CCDTF services, consult the Minnesota Health Care Programs provider manual or your MCO contract.

Q7. Will the GT modifier be required after 1/1/2018? Place of Service (POS) = 02 was in effect on 1/1/2017, does DHS not use this POS?
   The GT modifier will continue to be required after 1/1/18. The Place of Service (POS) code “02” is currently being looked at, and it will be used on some types of claims after March 1, 2018.
Q8. Who will approve the CCDTF?

Access to the CCDTF will be based on two determinations 1) financial eligibility, done by the county, and 2) clinical eligibility, done by the provider of the Comprehensive Assessment. The Comprehensive Assessment will drive what services the client will get, but there is no “approving” or “placing” entity; the treatment is driven by the provider and the client after July 1, 2020.

Providers have to confirm individuals coverage/benefit set and eligibility from the county/MCO, it will not be the provider’s responsibility to determine the eligibility.

Q9. How will providers know that a client has been verified as CCDTF eligible?

Providers may need to work with their counties to confirm CCDTF eligibility. But we are exploring other options that may be available once the client has entered treatment, it should be standard practice for programs to reconfirm eligibility via MNITs monthly.

Q10. Without the county being the placing authority, will treatment centers then provide all approval for additional days? Will there be any checks and balances on this process?

Yes, treatment centers will provide services needed by the client without needing outside approval. SUD reform requires a “utilization review” process to be set up to oversee how this is going, and the process is still in development.

Q11. Does a contracted provider of treatment coordination services bill Medicaid/CCDTF directly, or would we bill for their services and reimburse them per our contractual agreement?

If you contract with an outside provider to provide treatment coordination, they would have to be eligible vendors of that service to bill for it. You would not be able to bill for a service you did not provide.

Q12. Will a licensed professional in private practice need to obtain a NPI Number to bill?

Yes.

Q13. *Can an LADC have an office in a hospital and bill the CCDTF without having a rule 31 license?

Please contact Provider Enrollment for the current process at 651 431 2700.
Q14. *Will all individuals referred for a Rule 25 assessment have to go through the comprehensive assessment by a licensed professional? For example, criminal court cases or child protection cases. Also, in many situations the court referrals don’t qualify for CCDTF so who would be paying for their assessment when they go to a licensed professional?*

Since the comprehensive assessment is replacing the Rule 25 assessment, the answer to the first part is “yes”. If a criminal case or a child protection case is requiring an assessment, it is because there is a question regarding whether a substance use disorder has a bearing on the case and the outcome to be decided. Whether an individual is seeking treatment, often they are not, this information is often very important to the adjudication of a case, or the disposition of a child protection case. The last part of the question is more difficult. Depending on the funding, the professional who does the comprehensive assessment will be able to bill either the CCDTF or a health plan. Also, if the person is MA eligible and has insurance that doesn’t cover 100% of treatment costs, including co-pays and/or deductibles, the CCDTF could cover these costs. If the person does not qualify for CCDTF, and does not have insurance due to simply not enrolling, the person would be financially responsible for the assessment, as they are currently.
IX. Counties

Q1. I've heard about a parallel process for assessments, what is this?
   The current process for accessing treatment is for a person to get a Rule 25 assessment from a placing authority (MCO, county or tribe), who then authorizes a treatment placement. SUD Reform does not immediately repeal this process. However, it creates the legal framework to implement a parallel, concurrently operating, direct access process, i.e. where a person can go to any provider for a Comprehensive Assessment, which is billable for the provider and which recommends and approves a level and nature of treatment service, thus paving the way for an individual to then directly enter treatment. So basically, we will be running both access processes while we build up to the capacity to do direct access statewide. Comprehensive Assessments were approved for Medicaid reimbursement 7/1/2019 and Comprehensive Assessments for treatment planning, but not direct access, were implemented and reimbursable starting on January 1, 2019, because, the technology to facilitate the direct access process is not yet operational. Once needed DAANES retooling and billing systems work is complete to support direct access we will communicate this to stakeholders.

Q2. What happens in 2020? Do counties continue to complete chemical use assessments as a choice?
   After July 1, 2020, the only counties that will still be providing chemical use assessments will be those who have elected to become a vendor of Comprehensive Assessments. Counties who do not choose to become a vendor will not be authorized to complete assessments for approval of treatment services. However, a county can choose to permit a credentialed professional to provide comprehensive assessments on-site at a county if the professional bills directly for providing the service.

Q3. What role will the county still provide?
   Initially, as we run the Rule 25 process parallel to the new direct access process, some counties will continue to provide Rule 25 assessments with service agreements. During that time, we will also be implementing the new services, and counties will be eligible vendors for Comprehensive Assessments and treatment coordination. Each county will be in a position to make its own determination to what extent it will provide these new services. In addition, counties will continue their role in supporting individuals accessing CCDTF and enrolling in medical assistance.

Q4. Will County Social Service/Human Service Agencies need to have LADCs on staff to perform Comprehensive Assessments?
   Yes, under current system design, if a County Social Service/Human Services Agency wishes to become an eligible vendor of comprehensive assessments, the county would have to have qualified alcohol and drug counselors on board. Alternatively, the county could contract with qualified individuals in private practice to provide comprehensive assessments at a county office.
Q5. Will there be a training for County employees who are LADCs to learn to use the Comprehensive Assessment tool?
LADCs are qualified to provide the Comprehensive Assessment. LADCs employed by a County would need to meet the qualifications of an eligible vendor, 254B.05, Subd.1 (c), including at least 3 years or more experience, to bill for providing a Comprehensive Assessment. Comprehensive Assessment and Comprehensive Assessment Summary examples are posted on the [DHS Licensing website](https://www.dhs.egov.us.hs).  

Q6. Will the county still be paying a share for services when the Comprehensive Assessment is used for placement?
The County will continue to be responsible for a share of the cost of SUD services when the Comprehensive Assessment is used for placement of individuals not enrolled in a managed care organization. In 2020, counties will pay no share for SUD treatment for people enrolled in Medical Assistance.  

Q7. Does the client still need to go through a financial review with the County prior to admission?
To access publically funded SUD services, a person must get a determination of financial eligibility, enrollment in Medical Assistance, or approval of Consolidated Chemical Dependency Treatment Fund (CCDTF) eligibility. The process for doing this is unaffected by the reform. As we move forward, DHS will work with counties and providers to identify a streamlined process for clients to obtain enrollment in medical assistance to support quicker access to treatment and to support clients being able to obtain health care coverage for all of their medical needs.  

Q8. Will county workers be assigning clients PMI numbers that are not on MA but qualify for CCDTF?
Counties have the same roles in assessing financial eligibility as they have always had; this hasn’t changed under the reform. Since counties assigned PMI numbers to individuals who did not have MA, but qualified for CCDTF in the past, they will still do so. In most circumstances, counties and programs are encouraged to assist individuals enroll in Medical Assistance rather than simply accessing the fund. This will ensure that individuals have a full array of health care available.  

Q9. Can the assessor bill DHS directly or would it be part of the Client Placement Authorization (CPA)?
The assessor would need to be an enrolled provider under [Minnesota Health Care Programs](https://www.dhs.egov.us.hs), or working under a licensed treatment program or county that has chosen to be a provider of Comprehensive Assessments. Then the enrolled provider would use their normal billing procedures.
Q10. Will there be a utilization review by the county?

There is not a utilization review for direct access developed yet, but this is required by the statute. Until the process is developed, we are unable to answer specific questions about the process. However, we will be working with counties and providers to develop a utilization review process that monitors for appropriate client-centered placements that meet medical necessity and does not create barriers to access.

The utilization review process required by the statute will not involve any form of “pre-authorization”, but will review patterns of assessments to ensure that they comply with the standards. The only role for counties will be the determining of financial eligibility, which would include identifying the county of fiscal responsibility.

Q11. What are the options for current Rule 25 assessors?

Current Rule 25 assessors have a number of options depending on their current level of training, background and licensure. If they are not an LADC now, but meet the requirements in 245G.11, subd. 5, for licensed professionals in other disciplines who have the necessary SUD training, they can continue to provide Comprehensive Assessments and treatment coordination if their county elects to become an eligible vendor of those services. If they do not meet the qualifications to provide Comprehensive Assessments, most Rule 25 assessors would still meet the qualifications to provide treatment coordination.

Q12. Does the experience of Rule 25 assessors count towards the 3 years of experience needed for LADC’s working in a County?

254B.05, subdivision 1, clause (c) requires that an LADC working for the county have at least 3 years or more experience, to meet the qualifications, and further, if a non-LADC went to school and became an LADC, they would still have to wait for 3 years before they could provide a Comprehensive Assessment.

Counting the experience of the Rule 25 Assessor in doing assessments is reasonable if the individual was an LADC while doing the assessments since clearly individual counseling occurs during the completion of an assessment when done by a licensed individual. Even though there would likely be no group counseling experience, there would still be individual counseling experience demonstrated. However, if a Rule 25 Assessor goes back to school to become an LADC, that assessor would need to acquire the three years of experience post-licensure, since a Rule 25 assessment provided by an unlicensed individual is not utilizing the same knowledge and techniques that a licensed LADC is trained and licensed to provide.

Q13. Can a Rule 25 LADC assessor who does not have the qualifications of an alcohol and drug counselor supervisor be reimbursed for Comprehensive Assessments? Also, could they provide treatment services?

A current Rule 25 LADC assessor would not be eligible to get reimbursed for the Comprehensive Assessment unless they had the three years of experience, but a county could bill for treatment coordination that the individual provides if the county has enrolled as a provider of that service. And once the individual meets the qualifications of an alcohol and drug counselor supervisor, they could provide services on behalf of a county that is a vendor or as an individual practitioner for direct reimbursement.
Q14. Would DHS consider staffing regional LADC’s for counties to use?
Not at this time.

Q15. Will Rule 25 assessments still need to be reviewed by consolidated teams at the county for those individuals without health insurance or on straight MA?
Comprehensive assessments will not need to be reviewed by consolidated teams at the county, because the role of determining clinical need will not be the county’s responsibility. But the county or tribe will need to determine financial eligibility for those individuals without health insurance or who are on fee-for-service, or “straight MA,” so counties and tribes will use their normal procedures for determining that.

Q16. Will there be a grandfathering period for county workers that have completed Rule 25’s?
No “grandfathering” is anticipated. The current Rule 25 assessment process will continue to operate in parallel with the new direct access process for up to two years while we phase in the new process.

Q17. Can an LADC B.S., with less than three years’ experience still complete Rule 25 assessments or will an LADC with supervisor qualifications have to do them?
A person with a B.S. and an LADC is able to complete a Rule 25. This will continue to be true in programs licensed under 245G as we move to Comprehensive Assessments. However, if a county decides to become an eligible vendor of Comprehensive Assessments, an LADC who works for them must meet the qualifications in 245G for an Alcohol and Drug Counselor Supervisor to be able to complete a Comprehensive Assessment.

Q18. Can a certified Addictions Registered Nurse provide care?
To provide substance use disorder nursing treatment, you are already qualified. To provide substance use disorder treatment as an “alcohol and drug counselor”, you would have to meet the criteria in 245G.11, subdivision 5, if you are not an LADC.

Q19. Can mobile comprehensive assessments be provided outside of a physical Rule 31 setting if performed by a Rule 31 employee?
Assessments can be provided “mobile” either by a 245G staff person with appropriate credentials, or by an appropriately credentialed individual who is enrolled as a vendor and eligible for direct reimbursement.

Q20. Are counties eligible vendors for Peer Recovery Support?
No, the SUD reform changes do not include or authorize counties to be vendors of peer recovery support services.

Q21. Can a County contract with a private community provider to provide the alcohol and drug counselor weekly supervision for treatment coordination?
Yes.
Q22. Does a county LADC or Rule 25 Assessor require 2000 hours of supervision for treatment coordination?
   If you are an LADC at the County, no. If you are a Rule 25 Assessor who is not an LADC and meets the criteria in 245G.11 subd. 7, yes. Although the hours of experience as a Rule 25 Assessor would apply.

Q23. Can an LADC at the county do treatment coordination without the 1 hour weekly supervision requirement?
   An LADC has the scope of practice to do treatment coordination, so “yes”.

Q24. Will LADC’s need to complete the 30 hours of training in order to provide treatment coordination?
   LADC’s will not need to complete the 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder as required in 245G.11, subdivision 7, paragraph (a), clause (3), as it is already part of an LADC’s core functions. Discussions with schools will be held to confirm that treatment coordination curriculum completed by non-LADC’s covers the necessary information.

Q25. As a county Rule 25 Assessor I have already completed a 30 hour course with a private trainer, are you going to make it mandatory for us to attend this 30 hour course DHS is working on developing?
   We are not requiring anyone to have a particular approved program, only that they have 30 hours of classroom training in treatment coordination for individuals with SUD as required in the statute. The 30 hour course on Rule 25 assessments has different course content and learning objectives, so would not serve as substitute.

Q26. Does an LADC who is providing treatment coordination for the county need to do weekly documentation?
   There is no requirement of weekly documentation. There is a requirement that treatment coordination is documented in the client’s file, and for individuals in treatment, that the documentation of services must be weekly or after each service, whichever is less frequent. Since a client receiving treatment coordination from a county LADC will likely not be in a formal treatment program, it would be after each service, unless the client was being seen more frequently than once a week, at which point it would be weekly.

Q27. Will there be a certification process, similar to the MN Choice Assessment Training, for the comprehensive assessment for county personnel?
   No. This is a clinical service, which must be provided by a person who meets the requirements of an alcohol and drug counselor supervisor under 245G.11, subdivisions 1 and 4.
Q28. How can counties prepare the courts of their decision to not provide comprehensive assessments? What alternatives are available for this transition (e.g. comprehensive assessments by Vidyo)?

If a county chooses not to become an eligible vendor for comprehensive assessments, there is a two year parallel process where they would continue to provide the same Rule 25 services they do now, and they could inform the county courts that they would not be providing Rule 25 assessments after July 1, 2020. The county could work with the court system to identify local providers, and comprehensive assessments could also be provided via telemedicine, if a comprehensive assessment provider was not locally available.

Q29. Will the County Assessor and Treatment Coordinators also have to enter information into the Drug and Alcohol Abuse Normative Evaluation System (DAANES)?

Counties who are eligible vendors for providing treatment coordination will need to enter this information into DAANES. Counties who are providing Rule 25 assessments will not need to enter this information into DAANES.

Q30. How do County’s become an authorized provider for Comprehensive Assessments? Will we be operating under our current MA authorization number with the added service of Comprehensive Assessments?

Counties will need to complete an assurance statement and submit it to Minnesota Health Care Programs. The county is responsible to verify that staff completing a comprehensive assessment is qualified to do so, according to 245G.11, Subdivision 4.

Q31. What if a county plans to utilize their current Rule 25 assessor who has a BS and make contacts with LADCs in the area? Is that appropriate?

During the parallel process Rule 25 assessments must continue to be available. Comprehensive Assessments being done at the County need to be administered by an individual with the qualifications of an alcohol and drug counselor supervisor.

Q32. Can a certified County Rule 25 assessor who has been grand parented in, provide treatment coordination services without the 30 additional hours of training?

No “grandparenting” is currently in place. The current Rule 25 assessment process will continue to operate in parallel with the new direct access process until 6/30/2020. A treatment coordinator must meet the staff qualifications set-out in Minnesota Statutes, chapter 245G.11, subdivision 7.

Q33. Do counties have to have treatment plans in order to bill for treatment coordination?

Yes, as a plan of care, indicating a need for this treatment service. This is not required to be a treatment plan as described in 245G.
Q34. *Will the counties continue to “authorize payment” with direct access?*

When the direct access process is implemented it will go away with the “placing authority” role of the county, so the county will not “authorize payment.” The counties will still determine financial eligibility for services, but the placement decisions are clinical, not financial, and will be based on the results of the comprehensive assessment which must be completed by a qualified clinician. There is no need for providers to send comprehensive assessment results to a county for review or approval.

Q35. *Will access be delayed if counties are still determining financial eligibility?*

A determination of eligibility is required for everyone not already enrolled in Medical Assistance.

Q36. *How will the County providers bill for Treatment Coordination and Comprehensive Assessments? Will there be codes added to MMIS?*

Counties will bill for treatment service coordination, and comprehensive assessment with a MMIS Service Agreement (SA). Providers may submit claims for these services provided as of 1/1/2019.

Add the new services as a line item on the SA. Multiple providers can be on the same SA. Residential is per diem.

DHS has scheduled Web-ex trainings for specifics on entering this info into SAs. You may take (or retake) CH101i CCĐTTF MMIS Applications for specific details. See E-Memo #19-5 on our website for details and training schedule.

Counties do need to complete documentation to MHCP in order to have these codes added to their provider file and to be able to bill.

These are the rates that have been approved by CMS in the State Plan Amendment.

- **T1016**- Treatment Coordination- proposed rate: $11.71 per 15 min unit
  - Must be billed with modifiers U8 and HN
  - 8 Units/per client/day billable
- **H0038**- Peer Recovery Support- proposed rate: $15.02 per 15 min unit
  - Must be billed with modifier U8
- **H0001**- the Comprehensive Assessment- proposed rate: $162.24
Q37. *When a person has been deemed eligible for CCDTF by their county, does the client’s county continue to generate a PMI number and a Service Agreement number for the client in order for the provider to be able to bill and process DAANES?*

If a client receives a Rule 25, counties will continue to generate a PMI number and service agreement. If the client receives services through the direct access portal, (when direct access is implemented in Phase II), with comprehensive assessment provided by the eligible licensed professional, the County will need to be contacted for the PMI number OR to enroll the person in MA if eligible.

Q38. *Do Counties who are enrolling for new services, need to select DAANES on the Provider Enrollment forms?*

Yes, please select it on the form, and please note that DAANES has not yet been re-tooled for this purpose. Counties will be informed when the re-tooling of DAANES is completed.

Q39. *Do Counties who are enrolling for new services, need to select that they will provide HIV and TB education on the Provider Enrollment forms?*

Only if the county has a 245G program license. See 245GA.12 (2) https://www.revisor.mn.gov/statutes/cite/245G.12

Q40. *If an individual is on MA, is it the county’s role to enter in a service agreement for all providers requesting to provide comprehensive assessment, coordination, or peer support? If yes, does the county have any responsibility to assure the required forms are submitted to DHS?*

Yes, new services need to be billable against a Service agreement during Phase I. Comprehensive assessments can be billed by nonresidential providers (or qualified independent professionals when Phase II direct access is implemented), if authorized. Licensed residential substance use disorder treatment providers will not be enrolled to provide/bill these services separately as residential programs receive a per diem rate to provide the services. Residential 245G sites will be eligible to provide a comprehensive assessment for the purposes of placing (direct access-Phase II), which is not part of this upcoming rollout (Phase I).

Currently, 245G residential programs could bill for a comprehensive assessment for treatment planning as an individual session treatment code (H2035).

Q41. *If the county has already provided a Rule 25 and the provider wants to complete a comprehensive assessment should the county authorize a service agreement for the assessment even though it would be a duplication of the Rule 25 just completed by the county?*

Yes, if the individual is participating in 245G non-residential treatment (or with an eligible independent professional when direct access is implemented).
Q42. *If a client is not on MA and meets eligibility for CCDTF, should the county enter a service agreement for all requested new SUD services?*

Yes, if the Rule 25 or Comprehensive Assessment has determined that the individual is eligible for these services.
X. Managed Care Organizations

Q1. How long will it take to amend the MCO contracts?
   The contracts between DHS and Managed Care Organizations are reviewed twice annually, in July for mid-year amendments and in the autumn for the following year.

Q2. Will health plans be including treatment coordination and peer recovery services in their coverage?
   Pre-paid medical assistance plans will be required to include coverage of treatment coordination and peer recovery services in their contracts.

Q3. Will health care plans and private insurance companies be required to have LADC's review the Comprehensive Assessment when they approve funding for treatment?
   Managed care organizations (MCO) are required to meet the standards of their contracts with DHS, which include making enrollee placements according to the process available to other Medical Assistance recipients.

Q4. Would the assessor have to have a contract to bill a PMAP?
   Yes. See handout on direct reimbursement update.

Q5. *If a client is on a PMAP that a SUD provider does not have a contract with, does the client need to choose a different facility?
   Yes. To be reimbursed for a service the provider must be contracted with the MCO, and be in their network.
XI. Telehealth

Q1. Will telemedicine include reimbursement for services other than individual, non-residential treatment services in 2018?
   The only services that can be provided via telemedicine currently are individual services.

Q2. What is the limit for individual sessions for telemedicine?
   The limit is three sessions per week per individual for any service, not solely SUD services.

Q3. Does the telemedicine originating site need to be a licensed site?
   The “originating site” is a federal term meaning where the patient or client is when they are receiving services. It does not have to be a licensed site, but does have to be covered in your telemedicine policies. The place where the provider is, is called the “distant site”, and usually would be a licensed site, but could, if the program is providing some services off site, be one of the off site locations, which would not be licensed itself, but would, of course, need to have the appropriate two-way televideo technology set up.

Q4. What states are currently providing SUD services via telemedicine?
   Forty-six states are currently reimbursing some form of telemedicine. The NFAR ATTC (National Frontier and Rural Addiction Technology Transfer Center) has information on their website, however, it will say that each state has its own laws and rules as to what they allow.

Q5. Is Vidyo equipment approved as appropriate equipment for telemedicine?
   Yes, it is one of the approved platforms.

Q6. Can a Licensed Professional Clinical Counselor (LPCC) who is also an LADC provide telemedicine from an office location without a Rule 31 license?
   Providers need to be enrolled with MHCP and file a new Assurance Statement to provide telemedicine. A licensed professional in private practice is an eligible vendor for comprehensive assessment, assessment summaries and treatment services if they meet the requirements of 254B.05, subdivision 1, paragraph (b). An eligible vendor in private practice who meets these requirements does not need a 245G license.

Q7. Can couples counseling be conducted by telemedicine?
   There are many questions relating to this question: Where is the couple? Are they both at an approved originating site? Is one of them, and the other at the distant site with the provider? Who is the identified patient? Is this a mental health service or an SUD service? “Couples Counseling” is not a reimbursable service, in itself, but the patient can receive counseling with a family member present. The short answer is yes, if the people being counseled are at an appropriate originating site, and the counseling being done is within the scope of practice of the provider.
Q8. When a client is at home, under what circumstances do you not need a "presenter"? Seems remote areas need services and even getting a "presenter" would be challenging?

It is only the rare and exceptional circumstance that would suggest the appropriateness of a client receiving telemedicine services at home without a presenter. In all cases, the use of telemedicine when a client is at home would need to be set up ahead of time and would require appropriate interactive telecommunications equipment. A presenter, or staff member accompanying the client is necessary in the event that the client is unable to utilize the equipment independently or needs emotional support and/or assistance following the telemedicine encounter.

Q9. What funding source is available for comprehensive assessments provided by telemedicine for inmates with no insurance?

Telemedicine has the same funding sources that are available for comprehensive assessments that are provided face-to-face. If the person has no insurance but is non-MA CCDTF eligible- the CCDTF could provide coverage once an eligibility span is created by the county of financial responsibility; if they exceed income guidelines, they would be self-pay as they are now.

Q10. *Do we need to file a new telemedicine Assurance Statement for SUD treatment services if our agency already has one for Mental Health?

Yes, a new Assurance Statement must be submitted, which will cover both. The previous Assurance Statement has now been revised to cover Substance Use Disorder.

Q11. *Can we now utilize Telemedicine and will it be reimbursed?

Yes, once a program, or individual provider, has enrolled with Minnesota Health Care Programs (MHCP) Provider Enrollment-telemedicine by means of submitting a telemedicine assurance statement and follows all the requirements. There is no separate reimbursement for telemedicine itself, only for the services delivered via telemedicine, and they are reimbursed at the same rates they would be if delivered in person. If you plan to provide services via telemedicine you will need to complete the necessary assurance statement (edoc DHS-6806-ENG) and submit it to MHCP.

Q12. *What substance use services can be provided via telemedicine and what credentials do providers need to have?

Non-residential individual counseling can be provided via telemedicine. We are waiting on federal approval for the comprehensive assessment to be completed via telemedicine. The individual providing the telemedicine service needs to meet the qualifications identified in 256B.0625 Subd.3b (e). Requirements for providing telehealth services are found in the MHCP manual.
Q13. *Are Peers able to provide services for people prior to them getting into treatment and be reimbursed for this?*

Recovery Community Organizations are able to provide peer services at any time when the client has been determined eligible for the service, the provider is enrolled with Minnesota Health Care Programs, and a service agreement has been issued by the placing authority. Licensed SUD treatment programs must admit the client to their program before providing any treatment service, including peer recovery support.

Q14. *Can Comprehensive Assessments be provided by telemedicine?*

Pending federal approval, it can be provided by an eligible vendor via telemedicine by appropriately credentialed individuals over approved telemedicine connections. The individual or program providing this service via telemedicine needs to have the proper assurance statement (DHS-6806-ENG) submitted to MHCP Enrollment.
XII. Stay Informed

Q1. How do I stay informed as this progresses? Find upcoming trainings and PowerPoints?

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Visit our website: to learn more about substance use disorder policies and procedures, initiatives, workgroups, training and conferences, grant announcements, view Webex presentation (pdfs), access forms and more!

We want to hear from you about YOUR substance use disorder system. Send input to: YourOpinionMatters.DHS@state.mn.us