FAQs: Substance Use Disorder Reform

Updated November 2018

* New questions from the November update

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I. 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. We are currently seeking federal approval to add Comprehensive Assessment, peer support services, withdrawal management, and treatment coordination to the Medicaid benefit set. This will include approval of rates for the services.

Q2. Where are SUD Reform WebEx presentations and resources located on the website?

Presentations will be posted on our website and shared by e-Memo. You can sign up for the e-Memo on our website.

Q3. Will billing for services be after CMS approval or July 1?

Billing for services will be after CMS approval (e-Memo #18-115). Systems work is in process and will also need to be in place. There are a number of variables that can impact the exact implementation date. DHS will provide more detail as we get closer to implementation.

Q4. When do we update our assurance statement? Before or after CMS approval?

After we have CMS approval AND after the internal work is completed with MHCP enrollment, we will notify providers through WebEx and e-memo communications.

Q5. How will the Chemical Health Assessment and Treatment Services (CHATS) system be utilized with SUD reform?

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 CCDTF services prior to direct access being fully implemented. An announcement will be released via e-memo communication when direct access has begun.
Q6. 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
- 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

Q7. How are we going to bill for co-occurring groups that combine CD with mental health? Are there special codes we can use for this?
245G Licensed programs must meet the criteria identified in 245G.20: License holders serving persons with co-occurring disorders, 254B.05 subdivision 5 ( c ) ( 4 ), and be approved by licensing. Programs will need to submit an assurance statement to MHCP to update the provider file.

Q8. What impact does SUD reform have on Tribal Nations?
Tribes will continue to be placing authorities during the two year parallel process for Rule 25 assessments and they will be eligible vendors for providing treatment coordination and comprehensive assessments. Tribal SUD programs will be eligible vendors of all treatments services.

Q9. 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 4, who would like to practice independent of a program, will need to enroll with MHCP. The enrollment application and necessary forms will be updated on the MHCP enrollment page when they are available. We will continue to provide updates through e-memo’s and future WebExs on how to access this information. Note: Prior to enrolling with MHCP, independent supervisor level alcohol and drug counselors will need to establish a National Provider Identifier (NPI) number.

Q10. Will service agreements be utilized outside of the Pilot program and Certified Behavioral Health Clinics?
Service agreements will continue to be used for authorization of services until systems are in place to utilize the comprehensive assessment for the purpose of direct access. Individuals who are not enrolled in medical assistance will likely still need a service agreement, but this is still being worked out.
Q11. If we are already contracted with/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 assurance statements to provide a SUD service that is not reflected on their current assurance statement. Certain providers are only eligible to provide certain services. 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. DHS will be amending its contracts with the MCOs, and providers will not be able to amend their contracts with the MCOs until DHS’s contract with them has been amended.

Q12. 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.

Q13. Were there any codes or rates proposed to CMS for withdrawal management?
   The department has not yet submitted a SPA for approval for withdrawal management, so no rates have been proposed yet.

Q14. Where is the application for the SUD 1115 waiver posted?
   The 1115 application was posted for 30 days on the DHS SUD state website and then posted federally on the Centers for Medicare and Medicaid website for 30 days, after which comments and input were provided to the State of MN and incorporated into our application which is awaiting approval from CMS.

   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.

   A Request For Proposals was released on May 21 for applicants. Two bidders conferences were held in May. Nine proposals were received and nine are moving forward with a contract once CMS approval is received. Currently, MN project staff are drafting an implementation plan, utilization management plan and an evaluation plan.

Q15. Will the state be eligible for federal Medicaid payment for clients attending an IMD pilot program?
   Yes, 1115 Demonstration project design, which has not been approved, would allow that Medicaid enrollees will be eligible for Federal Financial Participation (FFP). IMD’s that are not participating in the 1115 Demonstration project will not be eligible for federal Medicaid payment.
Q16. Are the providers that are identified in MN as IMDs aware of and participating in the 1115 Demonstration Project process?

DHS held public forums, issued e-memos and provided required CMS communications for a year and a half engaging stakeholders/providers. DHS published an RFP alerting all eligible applicants of this opportunity and this was also communicated via our e-memo.

Q17. *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.

Reimbursement for these services will not be available until eligible vendors are enrolled with MHCP and necessary systems work is in place.

**New vendors will need to:** enroll with the MN Health Care Programs.

**Existing enrolled providers will need to:** complete a new assurance statement and be approved to provide the service through MHCP prior to providing and billing for the new services.

DHS will be amending its contract with the Managed Care Organizations (MCOs) and once the DHS/MCO contract has been amended, providers who have contracts with MCOs will need to amend their contracts, prior to billing for the new services.

Please note that even as eligible vendors become enrolled to provide care coordination and peer recovery support services, clients can only access these following a Rule 25, until we have the systems in place to allow for direct access (using the comprehensive assessment for the purposes of placement).
Q18. *How do existing 245G residential programs enroll to provide care coordination and peer recovery support services outside of the residential program?

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.

• After approval from Licensing for non-residential services a new assurance statement will need to be completed and submitted to MHCP.

• If a residential program would like to only provide comprehensive assessments once direct access is in place, they can enroll to provide only this service without non-residential approval from licensing.

• Those completing a comprehensive assessment under the program license only need to meet the ADC qualification.

Q19. *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)

Individuals will need to enroll with Minnesota Health Care Programs since they are a new vendor (Website for forms).

Items to submit listed below:

1) DHS 4016 MHCP Individual Practitioner Provider Enrollment Application (Enrollment form has not yet been updated, provider will need to write in the provider type on the application. No fee required).

2) DHS 4138 Minnesota Department of Human Services Provider Agreement

3) Assurance Statement (Currently not available, it is being finalized by Provider Screening and Enrollment. We will let you know when it is available).

4) Submit proof that requirements are met. Meet criteria of 245G.11 Subdivision 4-Alcohol and Drug Counselor Supervisor.

• In addition to meeting the qualifications of an alcohol and drug counselor (245G.11 subd. 5) you also need to have at least 3 years of experience providing individual and group counseling to individuals with a substance use disorder and know and understand the implications of 245G, 245A.65, 626.556, 626.557, and 626.5572.

• After you are enrolled with MHCP you will need to get access to the Drug and Alcohol Abuse Normative Evaluation System (DAANES). If you will be seeking reimbursement from any MCO, you will need to be credentialed through them.
Q20. *How do Recovery Community Organizations enroll for the new services?*

RCOs will need to apply for an 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](#)).

Items to submit listed below:

1) DHS-4016A MHCP Organization Provider Enrollment Application (Enrollment form has not yet been updated, provider will need to write in the provider type on the application). Fee required ($569.00).

2) DHS-4138 Minnesota Department of Human Services Provider Agreement

3) DHS-5259 Disclosure of Ownership and Control Interest of an Entity

4) Assurance Statement (Currently not available, it is being finalized by Provider Screening and Enrollment. We will let you know when it is available.)

5) Certification documentation
   
   - RCOs will need to enroll with the Drug and Alcohol Abuse and Normative Evaluation System (DAANES) at a later date once direct access systems are in place. Information will be provided at a later date.

Q21. *Where can I find the assurance statement?*

The assurance statement document is not yet available, it is being finalized by Provider Screening and Enrollment. We will let you know when it is available.

Q22. *Will DHS be providing training on the billing process?*

Provider Screening and Enrollment will notify providers of training opportunities.

Q23. *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.
II. Substance Use Disorder Treatment Program Standards
MN Statutes, Chapter 245G

Q1. Will I be required to change my program to comply with 245G?
The effective date for the new statute is January 1, 2018. ADAD will continue to provide training on an ongoing statewide basis in a way that is convenient and that will promote clear and consistent information to stakeholders directly from DHS related to compliance expectations.

Q2. How do I get clarification on pieces of 245G?
The best way to get clarification on 245G is to attend the monthly WebEx’s. WebEx’s include a Q&A session. WebEx login and topic information is provided by e-Memo. Please visit our website to subscribe to the Alcohol and Drug Abuse Division e-Memo. You may also email questions to YourOpinionMatters.DHS@state.mn.us and leave the question so that it can be answered. Another resource for clarification is the Rule 31 to 245G Table of Legislative Changes that is available on the website.

Q3. What 245G templates are posted on the DHS Licensing Website?
The following 245G templates 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

Q4. When will a checklist for 245G be available?
Please contact your licensor to obtain the 245G checklist.

Q5. 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.
Q6. What are the staff qualification requirements for alcohol and drug counselors in the new program license requirements?

Alcohol and drug counselor qualification requirements are noted in 245G.11, subdivision 5.

(a) An alcohol and drug counselor must either be licensed or exempt from licensure under chapter 148F.

(b) An individual who is exempt from licensure under chapter 148F, must meet one of the following additional requirements:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, 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 a staff member;

(2) completion of at least 270 hours of drug counselor training in which each of the core functions listed in chapter 148F is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

(c) An alcohol and drug counselor may not provide a treatment service that requires professional licensure unless the individual possesses the necessary license. For the purposes of enforcing this section, the commissioner has the authority to monitor a service provider's compliance with the relevant standards of the service provider's profession and may issue licensing actions against the license holder according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's determination of noncompliance.
Q7. What additional information can you provide about the group size limit of 16 noted in Minnesota Statutes, 245G.10, subdivision 4?

Minnesota Statutes, 245G.10, subdivision 4, states that it is the responsibility of the license holder to determine an acceptable group size based on each client’s needs except that treatment services provided in a group shall not exceed 16 clients. ADAD and DHS Licensing have agreed to approve a variance for therapeutic recreation and educational groups allowing for group size to exceed 16 through June 30, 2020. For more information on the variance please view e-Memo #18-28.

ADAD and DHS Licensing are currently working on standard conditions that would apply for license holders if they choose to apply for such a variance. To apply for a variance: Licensing requirements- Variance request form DHS-3141

Education is one of the required treatment services.

If it is not a treatment service the size limits do not apply (e.g. DWI education ordered by a court).

The statute is not met if a group education lecture with more than 16 patients has two LADC’s attend.

The presentation of educational material in a setting of larger than 16 by a guest speaker or staff member (e.g. LADC or other professional license), is not a billable service, but this would not prevent a group of 16 or less from meeting later to process the information from the lecture and that would be billable.

In cases such as an unexpected event, a client showing up beyond the 16 members, a staff member calling in sick at the last minute, it would be appropriate to provide services to those there. The idea is that this would not be a regular occurrence, but an unexpected event.

Unless you have a variance, all groups are limited to 16 clients. If you are creating a meeting event with both day and evening groups, and family members, it could be done but would not be a reimbursable event if the group was a Family Program group session which was over 16 clients. The group size does not refer to family members in attendance, only to clients.

Q8. How do I get a list of all variances that have been approved for our licenses?

Providers please contact your licensor for a list of current variances.
Q9. Can an RN, psychologist or an addiction psychiatrist provide the education for an educational group? Or does it need to be an LADC?

A licensed alcohol and drug counselor must be present during an educational group as noted in 245G.07, subdivision 1, paragraph (a), clause (2). Present means to be in the room where the group is being held and having meaningful awareness of the educational event and to be able to intervene or contribute when needed to ensure the group is of educational value to the clients attending. An alcohol and drug counselor must either be licensed or exempt from licensure under chapter 148F. An individual who is exempt from licensure under chapter 148F, must meet one of the following additional requirements noted in 245G.11, subdivision 5, paragraph (b).

245G, as in Rule 31, requires that a treatment service must be provided by an alcohol and drug counselor, unless the individual is specifically qualified according to the accepted credential to provide the service. Since treatment groups, whether focused on a specific educational topic or not are limited to 16 or less, the RN, psychologist, or addiction psychiatrist must have the scope of practice to provide counseling to persons with substance use disorder. If it is an “education group” or lecture event that is being referred to, of larger than 16, which is not a billable activity, and the program plans to process the lecture in small groups afterwards, having an alcohol and drug counselor present in the event would be advisable.

Q10. Does 245G.07, subdivision 1(a) (2) refer to all educational groups or just educational groups that pertain to the subject matter indicated in this clause?

The language contained in 245G.07, subdivision1 (a)(2) is only applicable to that clause, however, the scope of what the clause identifies as education is very broad and not intended to be limited to a narrow scope of topics.

Q11. Please provide clarification on what services, and under what circumstances services can be provided off-site without having to get a separate license?

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 requested and approved by the Commissioner prior to services begin. The secondary location request form is posted on the DHS Licensing website.

The intent of the reform is to increase access to services for clients, particularly in settings such as a recovery school, a jail, or a primary care/Office Based Opioid Treatment (OBOT) site, where clients in need of services are already convened, and measures to ensure the safety of the clients, especially vulnerable adults or minors, are already in place.

The intent of the reform is not intended to have comprehensive components of a treatment program take place outside of the facility, but rather to allow a program to contract with a recovery school, for example, to do individual sessions when appropriate, comprehensive assessments, and periodic groups for
adolescents on site at the school, either before, during or after school. This will greatly increase access to services for this population that is not always able to access services outside of the school setting, for a variety of reasons.

A residential service can only be provided at the location for which the program is licensed. Residential programs that desire to provide non-residential services at a location other than their licensed site must describe each service in their policies and procedures manual and on their assurance statement.

Q12. Do we need to request a variance to our license to be able to do off site treatment?
You do not need a variance but you will need to submit the secondary location request form located on the [DHS Licensing website](https://www.dhs.state.mn.us/Licensing). 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 requested and approved by the Commissioner prior to services begin. The secondary location request form is posted on the [DHS Licensing website](https://www.dhs.state.mn.us/Licensing).

Q13. Where do we document the reason for providing services off site?
If services are provided off site from the licensed site, the reason for the provision of services remotely must be documented. Complete records of the provision of services are still required for services provided off-site. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry.

The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

Q14. Is a Rule 31 license required for a new off site location for outpatient programs?
The provision of your normal group counseling services at a site other than your licensed 245G location depending on the schedule and frequency could require that the organization acquire an additional license. The provision of services off site is meant to be based on intermittent need, not simply locating some of the programs services at an additional location.

Q15. 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](https://www.dhs.state.mn.us/Licensing).

Behavioral Health Division November 2018
Q16. Does 245G require daily documentation?

245G does not require daily documentation.

Q17. What are the individual treatment plan timelines?

Individual treatment plan timelines are found at 245G.06, subdivision 1. An individual treatment plan example is available through the DHS Licensing website.

Q18. Do Counselors document on the treatment plan review and other staff document in the client file as events occur, or are multiple people documenting on the treatment plan review?

Yes, usually the counselor assigned to the client documents the treatment plan review and other staff, including other counselors, document in the client file as events occur, and as services are delivered. Multiple people do not need to document on the treatment plan review, but the provision of any treatment service must be documented by the person who provided the service.

Q19. If multiple staff members provide services, how do we complete the documentation of services?

Each staff person must document the service they provide. This can be done on the day of service or at the end of the week, but 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.

Q20. 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.

Q21. 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?

Supervision means that a clinician is responsible for and overseeing and reviewing the work of a supervisee. In the case of a student intern, the supervisor must also review and sign off each assessment, progress note and individual treatment plan prepared by the intern. The supervisor does not need to be present each time an intern is providing a treatment service, but does need to review and sign off on it.

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 (2), and (7).
Qualified staff would be determined by what kind of intern they are. An alcohol and drug counseling intern must be supervised by an alcohol and drug counselor, a psychologist, professional counselor, or social worker must be supervised by individuals qualified to do so under their respective boards.

There is no requirement for the Board of Behavioral Health and Therapy (BBHT) to specifically authorize each student except that they are involved in such a program and are supervised by a licensed professional.

**Q22. 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. During the implementation phase of 245G, existing staff will be able to seek this additional training, or programs could offer it as in-services.

**Q23. 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.

**Q24. 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.
Q25. Under Rule 31, 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.

Q26. When you talk about medical necessity, are Payors going to be held to Parity?

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

Q27. 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).

Q28. 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.

Q29. 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.

Q30. Is the 16 clients per group limit strictly for outpatient, or residential treatment groups as well?

The 16 client limit refers to all therapy groups, outpatient or residential.
Q31. What are the consequences with CMS for not billing the additional people above 16 people in a group, if the situation arises? Example: There is someone who is out sick and two groups need to be combined into 1 due to LADC coverage. This creates a total of 20 clients in the therapeutic group. Can a program still bill for 16 of the 20 clients?

The situation described is a program dealing with an uncommon situation, and a program should bill for all the attendees, even if there are more than 16 in the group. However, this is non-compliant with 245G, unless a variance is in place that permits this.

Q32. 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.

Q33. 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.

Q34. 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 you licensor for variance questions.

Q35. *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)

The summary must be completed within five days of the client’s service termination or within five days from the client’s or program’s decision to terminate services, whichever is earlier. In a planned discharge the summary must be completed within 5 days of the decision to discharge. In an unplanned discharge the summary must be completed with 5 days of the client no longer receiving services. The discharge summary timeline is not based on the discharge date. The timeline is based on when the client is no longer receiving services or when the program decides to terminate services.
Q36. *Does the Initial Services Plan and the VA determination have to be all one form/assessment?*

There is no required form for the Initial Services Plan. 245G.04, paragraph (b) requires that the initial services plan must include a determination of whether a client is a vulnerable adult as defined in section 626.5572, subdivision 21. An Initial Services Plan & VA Determination Example is provided by DHS Licensing.

Q37. *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.

Q38. *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.

Q39. *What are the 245G requirements for what percentage of staff work time must be allocated to indirect care?*

Counselors serving adult clients are not required to devote any minimum percentage of their time to indirect care.

For license holders serving adolescents, 245G.18, subd. 4, requires that at least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties for license holders serving adolescents.

For student interns, 245G.11, subd. 10, 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.

Q40. *Can we bill for progress notes and weekly notes if they were prepared without the patient being present?*

No.
III. Treatment Coordination

Q1. What is treatment coordination?

245G.07, subd. (1)(a)(6):

- Assistance in coordination with significant others to help in the treatment planning process whenever possible;
- Assistance in coordination with and follow-up for medical services as identified in the treatment plan;
- Facilitation of referrals to substance use disorder services as indicated by the client’s medical provider, Comprehensive Assessment, or treatment plan;
- Facilitation of referrals to mental health services as identified by a client’s Comprehensive Assessment or treatment plan;
- Assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client’s needs;
- Life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed, and
- Documentation of the provision of care coordination services in the client’s file.

Q2. Who can be an eligible vendor to provide treatment coordination services?

Substance use disorder (SUD) programs, individuals eligible for direct reimbursement, withdrawal management programs and counties would be eligible vendors of treatment coordination services.

Minnesota Statutes, chapter 245G identifies staff qualifications for treatment coordinators. However, 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 exceeds the requirements of 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.

Treatment coordinators must have either a bachelor’s degree in one of the behavioral sciences or related fields OR certification as a Level I alcohol and drug counselor from UMICAD, and:

1) At least 2,000 hours of supervised experience working with persons with SUD, and
2) Complete a 30 hour training on treatment coordination with people with SUD.
Q3. Please clarify “Treatment coordination” vs. “Service Coordination”?
Service Coordination has been described as efforts to help the client obtain the services and to support the client’s need to establish a lifestyle free of the harmful effects of substance use disorder and is a service provided by an alcohol and drug counselor. This description, without the label, is found in 245G.07, subdivision 1, paragraph (a), clause (1). Treatment coordination, which is described in 245G.07, subdivision 1, paragraph (a), clause (6), is a service that can be provided by a person who is not an Alcohol and Drug Counselor, but has lesser credentials. The main differences are 1) service coordination can only be done by an alcohol and drug counselor, and 2) treatment coordination activities are mainly directed at assisting and facilitating the implementation of the treatment plan.

Q4. What are the specific qualifications for treatment coordination supervision? Is this supervision required to be provided by a LADC?
A Treatment coordinator must have had at least 2000 hours of supervised experience in working with individuals with substance use disorder. While it is not required that the supervision be done by an LADC, it must be done by a clinician who meets the criteria in 245G.11, subd. 5, clause (b).

Q5. Does a County LADC that is providing treatment coordination need to have weekly supervision by an LADC?
Please refer to 254B. 05. If the LADC, themselves, is providing the treatment coordination, no; but if the county has people meeting the qualifications of a treatment coordinator on staff that are the ones actually providing the treatment coordination, yes.

Q6. 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.

Q7. Has the 30 hour treatment coordination training been developed?
We are aware that a 30-hour classroom training on treatment coordination for persons with SUD is being offered at some Minnesota college LADC training programs and from a training consultant. There is not a particular training program required, but staff must have training in the identified topics.

Q8. 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).
Q9. What is the 30 hours of training needed for treatment coordination, who is doing the training and when will it be?

Once treatment coordination is added to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later, care for treatment coordination will need to meet the requirements of 245G.11 Subd. 7 (3): 30-hours of classroom instruction on treatment coordination for an individual with substance use disorder, and will need to meet the requirements of 245G.07 Subd. 1 (6) (i-vii) care coordination services.

Please see the answer to question 6 above.

Q10. Is one hour a week supervision with an alcohol and drug counselor required for treatment coordination?

Yes. A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from and alcohol and drug counselor weekly. Please see 245G.11 Subd. 7 (b).

Q11. Does the requirement for a bachelor’s degree for treatment coordinators begin in July 2018? Does this requirement also begin in July 2018 for anyone making treatment service recommendations?

Reimbursement of treatment coordination won’t start until July 1, 2018, or upon federal approval, whichever is later, and then there is the two year parallel process to aid in implementation. Individuals making recommendations for care after a Rule 25 or as part of their role with the county will be able to operate as they do now. For someone who is not an alcohol and drug counselor, it is required that they have either a bachelor’s degree in one of the behavioral sciences or related fields OR certification as a Level I alcohol and drug counselor from UMIAAD, and at least 2,000 hours of supervised experience working with persons with SUD, and complete a 30 hour training on treatment coordination with people with SUD.

Q12. 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 may choose to provide Comprehensive Assessments and treatment coordination because funding will become available for providing this service.

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.

Q13. Can we use outside sources for treatment coordination that are already providing these services in the community?

Yes, if these outside sources meet the treatment coordination provider qualifications in 245G.11, subdivision 7.
Q14. 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.

Q15. Will reimbursement for treatment coordination/case management only be for individuals who are eligible for the Consolidated Chemical Dependency Treatment Fund (CCDTF)?
   Once treatment coordination/case management is added to the state’s Medicaid benefit set, it will be reimbursable to individuals who access CCDTF and those enrolled in a PMAP.

Q16. 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?
   The goal is for Treatment coordination to be a billable service in 15 minutes increments but the details of the new service will not be known until the CMS approval process is complete.

Q17. 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.

Q18. Will Peer Recovery Specialist and Treatment coordinators be included in the definition of “psychotherapist” in MN Statutes 604.20, subdivision 5?
   No. Neither provides psychotherapy.

Q19. 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. However, there are several qualifications identified in Minnesota Statutes 245G, subdivision 7 that a treatment coordinator must meet, including that an individual must have either a bachelor’s degree or current certification by Upper Midwest Indian Council on Addictive Disorders (UMICAD) as a level 1 alcohol and drug counselor. You can contact UMICAD at their website www.umicad.com. Note that all the other requirements, including the 30 classroom hours of education on treatment coordination working with persons with substance use disorder, and the 2000 hours of supervised experience are in addition to the requirement to have UMICAD Level I certification or bachelor’s degree in behavioral science or related field.
Q20. 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.

Q21. 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, although individuals in a PMAP will be subject to any network requirements of their MCO.

Q22. 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.

Q23. 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 were 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.

Q24. 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.
Q25. What is an appropriate salary for the treatment coordination and peer recovery support positions?
Each program will be in the position to make its own determination of salaries. However, if it is of interest, please view e-Memo #18-47 for the proposed rates for treatment coordination and peer recovery support services.

Q26. 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.

Q27. If peer support and treatment coordination services are not reimbursable by July 2018, are 245G programs exempted until the billing issues are resolved?
Because the funding for the new services will not be available until July 1, 2018, or upon federal approval, whichever is later, and the state recognizes, too, that these are new services and there will need to be a period where new staff are trained and the services are integrated into the programs’ workflows, we will be discussing and determining timelines for beginning the reviewing for these new services.

Q28. Are providers expected to offer treatment coordination services prior to the 30 hour treatment coordination course becoming available?
Individuals providing treatment coordination services must have completed 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder, but there is no particular course that is required.

Q29. What type of documentation will provider enrollment require to enroll as a provider of SUD Treatment Coordination?
Providers of treatment coordination will need to meet the staff qualifications identified in chapter 245G.11 subdivision 7. 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.
Q30. 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.

Q31. Are residential programs able to bill for treatment coordination and peer support?
Currently, residential programs are paid a per diem rate, so they will not be able to bill for treatment coordination and peer support. Peer support is being reviewed for concurrent billing with the per diem.

Q32. Will DHS revisit providing reimbursement for the required training or weekly clinical supervision for treatment coordinators?
We are not currently planning a rate adjustment. A SUD rate study report will be completed and provided to the Minnesota legislature by December 15th, 2018. This may impact the rate in the future.

Q33. When will 245G be amended to reflect the name change of care coordination to treatment coordination?
The next opportunity is the 2019 legislative session. We are recommending this change in our legislative proposal.

Q34. 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 4.

Q35. What will be the process to get reimbursed for treatment coordination, peer support and comprehensive assessments?
The eligible provider will need to be an eligible vendor, meet qualifications identified in statute, be enrolled with MHCP, and update necessary contracts with MCOs, as applicable. Processes for billing these services will depend on the payer.

Q36. Can treatment providers contract out for peer recovery support services and treatment coordination?
Yes. The treatment plan should reflect who is providing the service.

Q37. Will travel time be a billable activity under treatment coordination?
No. Medicaid/MA does not reimburse providers for their travel time.
Q38. Is there a state approved training for treatment coordination?
   There is not a specific training that is “state approved.” We encourage attendees and trainers to verify that
   the classroom instruction includes the relevant criteria listed in Minnesota Statutes, 245G.07, subdivision 1,
   paragraph (a), clause (6), and Minnesota Statutes, 245G.11, subdivision 7, paragraph (a).

Q39. Why is the treatment coordination training so costly, when Adult Mental Health Targeted Case
   Management training is at no cost and provided by DHS, yet is still an MA billable service?
   The trainings/classroom instruction for treatment coordination are independent of DHS and we do not
   regulate the cost of these.

Q40. *Can previous school coursework count towards the 30 hours of classroom instruction needed
   for treatment coordinators?
   Individuals who completed coursework would need to verify that their coursework covered the relevant
   components from 245G.07, subdivision 1, paragraph (a), clause (6) and 245G.11, subdivision 7, paragraph
   (a). Please see e-memo #18-99 for additional information.

Q41. *Is there a specific assurance statement for treatment coordination services?
   Eligible vendors for treatment coordination services (Counties, Tribes, licensed professionals in private
   practice, and withdrawal management programs), will need to complete assurance statements. This form is
   not yet available. We will let you know when it is available.
IV. 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. 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 that is designated by the commissioner, and by licensed SUD treatment or withdrawal management programs that provide the service utilizing program peer support staff.

Peer recovery support services must be provided by a person who has received certification from a program approved by the commissioner. Peers must receive ongoing supervision in areas specific to the domains of their role from either an alcohol and drug counselor or an individual with a certification approved by the commissioner.

Q3. Is phone support recognized for peer recovery support?
No.

Q4. Are Peers able to provide services for people prior to them getting into treatment and be reimbursed for this?
This is our goal, but it depends on our negotiations with CMS.

Q5. 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 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 training and supervision of recovery peers. There are two existing RCOs that are currently funded with grant dollars, but this does not mean new RCOs may not be created over time, as peer support services will be a new Medicaid service that can be provided through an RCO. New RCO’s will have to meet the definition in the statute. DHS is in the process of designating the RCO certification needed to become an eligible vendor.
Q6. According to 245G.07, subdivision 1, clause (5) peer recovery must be provided one-to-one although able to attend support groups, which is not one-to-one. Please clarify what one-to-one means?

Peer Recovery services are mostly provided via the relationship of the peer and the client through their face-to-face interactions. Peer services can also be provided to that individual in a group setting, in addition to assisting clients in their attendance in self-help or other support groups. If a Peer Recovery service is provided in a group setting, the peer support service is only reimbursable for one client per peer.

Q7. 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.

Q8. 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, credential or not. 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.

Q9. 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?

Please see the answer to question #23 on page 16.

Q10. 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. It is not clear what having an “active” SUD diagnosis means in the context of SUD being defined as a chronic illness, but peer support services are to be provided to individuals dealing with their own SUD issues. As far as the determination of “medical necessity”, the RCOs themselves, unless they contract with a qualified alcohol and drug counselor do not have a way of determining medical necessity, and will have to rely on a comprehensive assessment that was completed by a qualified alcohol and drug counselor, and the comprehensive assessment must indicate the symptom severity level that corresponds with medical necessity for peer support services to be paid for.
Q11. Can peer recovery support be billed in group hours?
   No.  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.

Q12. Your Q and A indicates that a LADC/counselor should not provide peer recovery support services as to not have a dual relationship, however, can a counselor provide peer recovery support services for clients at the agency they work at for clients that are not on their caseload?
   No. That LADC/Counselor would still be part of the counseling team even for clients of the agency not on their own caseload.

Q13. *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 need to complete an assurance statement, however, this form is not yet available. We will let you know when it is available.

Q14. *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.
V. Withdrawal Management

Q1. What are Withdrawal Management Services?

Withdrawal Management services are provided to individuals who are intoxicated or in withdrawal in order to stabilize them, and prepare them to receive further services. Withdrawal management services include medical monitoring and management of the client’s status by providing necessary care.

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 addition to freestanding withdrawal management programs, opportunities for programs to provide 245F services in 245G licensed and other appropriate settings will be explored.

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. Here again, this could be the medical director or an additional medical professional (physician) used by the program.

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. Once they are in existence, yes, they will be an eligible vendor. By definition, there are no withdrawal management programs in Minnesota, because none are licensed as such. Existing detox programs, licensed as Rule 32, are not eligible vendors.
Q5. *Were there any codes or rates proposed to CMS for withdrawal management?*

We are working to identify appropriate codes and rates. There is an approval process for codes with the Administrative Uniformity Committee which is a group that represents both public and private payers. This work needs to be completed before we can post the State Plan Amendment (SPA) for public comment and before the SPA can be submitted to CMS.
VI. 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 yet available for the purpose of direct access.

ELIGIBLE VENDOR

Q5. Who can be an eligible vendor to provide comprehensive assessments?
   Comprehensive Assessments will be reimbursable when provided for placement purposes, instead of the Rule 25 assessment. Programs, counties, and licensed professionals eligible for direct reimbursement will be eligible vendors for providing Comprehensive Assessments, and will not be required to have substance use disorder (SUD) program license.

Q6. 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?
   Upon CMS approval or on July 1st, 2018, whichever is later, yes, if an LADC meets the alcohol and drug counselor supervisor requirements and is in private practice.
Q7. 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. 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.

Q8. *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.

TIMELINE

Q9. When will the Comprehensive Assessment change go into effect? And, who can complete the Comprehensive Assessment during the two year, implementation parallel process?

Our timeline goal is to have Comprehensive Assessments for placement purposes Medicaid reimbursable by July 1, 2018. After July 1st, all Comprehensive Assessments will need to be completed by an Alcohol and Drug Counselor, a designation that includes LADCs. We are projecting that some providers and counties will be poised to be early implementers beginning almost immediately after this date. However, we also recognize that other counties and providers will be in different circumstances and this timeline might be too ambitious. So even while the existing placing authority system continues in place, the new process will be gradually phasing in.

Initially, as we run the Rule 25 process parallel to the new direct access process, some counties will continue to provide Rule 25 assessments. 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. The
County will continue to be responsible for a share of the cost of SUD services when the Comprehensive Assessment is used for placement.

After 2020, the only counties who will still be providing assessments to approve treatment are 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 an assessment for authorization of treatment services because the Rule 25 will no longer be in use. 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 the service. Current Rule 25 assessors will be able to continue completing Rule 25s during the 2-year parallel process.

Q10. How will providers know that a person is financially eligible for the CCDTF when they enter their door seeking a Comprehensive Assessment and treatment?

If a client comes to you and is not already on an MCO or Medical Assistance, then the provider will have to check with the applicable county, tribe, or MCO to check benefits and financial eligibility. The goal is to ensure that when a person is assessed and meets need, that they will be able to start treatment when there is an opening.

As we move forward in the future, we 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. Increased use of navigators is one route discussed to do this, as well as looking to Recovery Care Organizations to support this need.

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 the Comprehensive Assessment is completed by the provider who is offering the services, no. If it has been completed at another site by a different provider, it would merely need to be reviewed for compliance with 245G and updated if needed by the treating provider.

Q12. 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 within three sessions for all other programs.
Q13. 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.

Q14. 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, since 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.

Q15. 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.

Q16. 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.

Q17. 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, during the two-year parallel process, if the client enters treatment following a Rule 25 Assessment, then the timeline requirements in 245G for a comprehensive assessment must be followed.
Q18. After July 1st, 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.

ACCESS

Q19. 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.

Q20. Who will provide oversight to the sole providers of assessments and treatment services?

The minimal 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) who investigates any fraud relating to reimbursement and billing, under the Office of the Inspector General.

Q21. 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 if the assessor also has treatment coordination services available, it wouldn’t necessarily need to be the assessor assisting the client in getting entry into a program.

Q22. Will health care plans and private insurance companies be required to have LADC’s review the Comprehensive Assessment when they approve funding for treatment?

Since the placement in treatment should be primarily driven by clinical needs, the primary decision will need to come from the alcohol and drug counselor who has completed the assessment. Pre-authorization decisions and utilization review decisions must meet the guidelines laid down by the Federal Parity laws. It will be important to work to ensure that individuals who need care are getting the appropriate care at the right time, in the right dose and at the right place.
Q23. 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. As for people “shopping around” for the recommendations they want, we do not see this as a concern. 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.

Q24. Will there be a limit to how many Comprehensive Assessments clients can request in a time period?

No. There will likely be a limit as to how many Comprehensive Assessments will be able to be reimbursed within a time period, but not how many they can receive. We are working to have two Comprehensive Assessments available for reimbursement in any 6 month period.

Q25. 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, this can be part of the treatment plan.

Q26. 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.

Q27. What is DHS doing to get more LADCs into the field for completing Comprehensive Assessments?

There does need to be an LADC or person with another license and a scope of practice to work with SUD to do the Comprehensive Assessment. SUD Reform has the goal of providing a new model of care that sees SUD as part of health care and thus more mainstream. In addition, DHS, along with others, partnered with Metropolitan State University to host a Workforce Summit on May 11, 2018.
Q28. 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?
A comprehensive assessment is not “admission paperwork.” 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. Likewise going forward, it will be up to individual programs to determine whether SUD reform would indicate a change in admission practices.

Q29. 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 and treatment coordination services to keep the client engaged while they wait for the opening, and thus not “fall through the cracks”. In addition, the continued and expanded utilization of Fast-Tracker is expected to expedite client access to treatment openings.

Q30. Are treatment centers going to be responsible for calling other treatment centers to find an open bed?
With the addition 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. Fast-Tracker will make this task easier. Treatment coordinators could provide support for this task.

Q31. 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.

Q32. 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 Reform does not require that a Comprehensive Assessment be completed within 10 days, that is a Rule 25 requirement and it will continue to be a requirement for Rule 25s completed during the two year parallel process.
Q33. How do we become involved in giving input to the outline of the utilization review process?
   This has not yet been started.

Q34. What services can an LADC located in a small rural community, who does not work in a 245G program provide?
   After July 1, 2018, or upon federal approval, whichever is later, 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 directly will need to be an enrolled provider with the Minnesota Health Care Programs (MHCP) and file an Assurance Statement with MHCP.

Q35. 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?
   The concept of “downward deviation” relates to a client choosing a lesser level of service than the highest intensity level of service indicated by a comprehensive assessment. Certainly the clinical plan should be responsive to the client’s response to the treatment plan, and if the client is experiencing difficulty in the level of care they are receiving, it would be prudent for them to be offered a higher level of care. The issue of whether a downward deviation “is given”, or is “allowed” implies that a provider has some power to make a client do something they do not want to do. When a client is ordered by the courts to “complete a chemical health assessment and follow all recommendations”, it is assumed that the client will be accurately and appropriately assessed, and that the level of care the assessor believes is indicated would be stated. While the client can disagree and ask for a downward deviation from that, the client should also understand that the courts may disagree with the choices made by the client, and there could be ramifications. Essentially, while client-centered choice is a hallmark of reform, some choices have repercussions.

Q36. 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, and this includes OTPs. It is the client’s choice as to what program the client will attend, and a client may choose to attend the same or a different OTP program.
Q37. 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.

Q38. 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.

Q39. *How do I choose rather to provide a Rule 25 assessment or comprehensive assessment? How do the timelines differ?
Prior to direct access, the only option is to complete a Rule 25 assessment for the purposes of placement. When direct access is available and systems are in place to implement this process, the client can choose which process for accessing services to use until 6/30/2020. After July 1, 2020 direct access via the Comprehensive Assessment will be the only option.

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

Q40. *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.

Q41. *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.

Q42. *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.
Q43. *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.

**STAFF QUALIFICATIONS**

Q44. **What are the staff credentials to complete a Comprehensive Assessment?**

The comprehensive assessment must be completed by 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.

Q45. **Please clarify what Comprehensive Assessments need to be done by an alcohol and drug counselor supervisor?**

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

Q46. **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.

Q47. **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.

Q48. **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, what steps would need to be taken for this to happen.

Q49. **Can a LPCC complete a comprehensive assessment?**

If the LPCC meets the requirements for an Alcohol and Drug Counselor Supervisor in 245G.11 Subd. 1 and 4.
Q50. Can a person qualified to complete a Rule 25 assessment have an LADC Supervisor review and approve a Comprehensive Assessment?
   As of January 1, 2018, 245G.05 states that 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.

Q51. 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.

Q52. 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, as they have always been required to have. 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.

Q53. 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. 245G.11 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.
Q54. 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.

Q55. 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.

Q56. 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.

Q57. Why is an LADC supervisor qualification required to provide comprehensive assessments at the county?

First, it’s important to differentiate between an alcohol and drug counselor supervisor under 245G, and an LADC, i.e. LADCs are ONLY those individuals licensed by the Board of Behavioral Health and Therapy, while an Alcohol and Drug Counselor under 245G could be an individual with different licensure that includes a scope of practice to work with individuals with addiction, as long as the licensed individual has also completed a minimum amount of concentrated coursework related to substance use disorder and has completed an internship for individuals with substance use disorder. 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.

Q58. 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?
There has been discussion about accepting previous experience as a Rule 25 assessor to count 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, and would most likely require legislative action.

OFF SITE

Q59. 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 requested and approved by the Commissioner prior to services begin. The secondary location request form is posted on the DHS Licensing website.

Q60. 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.

Q61. 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

Q62. 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.
Q63. 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, that is, are they still covered, 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.

Q64. How would the assessor bill for an assessment for an adolescent who is not eligible for MA?

The assessor would bill the CCDTF.

Q65. How does an LADC obtain funding from the consolidated fund for an eligible client?

254B.05, subdivision 1, paragraph (b). 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.

Q66. Can LADCs in Rule 32 Programs bill for Comprehensive Assessments in July of 2018?

LADCs working in a Rule 32 Licensed program, which is not an eligible vendor, will only be able to bill for a Comprehensive Assessment if they qualify as a licensed professional in private practice, and can bill independently, and then they could work as a contractor for the Rule 32. But the LADC would have to bill under their own license/provider number.

Q67. 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.

Q68. Are we currently able to use the Comprehensive Assessment for the purposes of placement without billing for having done it?

No. Currently for all publicly funded treatment placements, the Rule 25 is the required tool to determine placements in treatment. Upon federal approval of the comprehensive assessment and implementation of direct access, a Comprehensive Assessment will be able to be used for placement in treatment, and until June 30, 2020, the Rule 25 Assessment will be available as well.
Q69. 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. Our working number at the present time is two comprehensive assessments 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.

Q70. Can LADCs who provide Rule 25 assessments in a hospital bill for comprehensive assessments? Is a hospital an eligible vendor?
   If the hospital is not a licensed 245G program, no. But the LADC could enroll as a private practitioner, 254B.05, subd. 1, paragraph (b), and contract their assessments to the hospital, and then the LADC would have to bill for the assessments themselves.

Q71. 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.

Q72. 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)).

Q73. *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, as it is now. Such an assessment would be used for treatment planning, as it is now. A comprehensive assessment, performed for the purpose of authorizing treatment and instead of a Rule 25 assessment, would be reimbursable.

Q74. *Are comprehensive assessments reimbursable yet?
   Comprehensive assessments can NOT be used for placement until direct access is implemented. We will continue to keep you updated on this.
Q75. 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.

Q76. 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.
VII. Direct Reimbursement

Q1. Will there be a process in place to become an eligible vendor if all qualifications are met? Also will there be training on ways to be reimbursed once you become an eligible vendor?

The process for enrolling as an eligible vendor will be in place after July 1st, 2018, or upon federal approval, whichever is later. Once available, individuals who meet the criteria to be an eligible vendor will find detailed instructions as to how to enroll on the Minnesota Health Care Programs website.

Q2. What are the proposed reimbursement rates for the new services?

We will not know the rates for these new services until CMS gives final approval. It is likely that this could take some negotiation—our hope is to have this information earlier than July 1, 2018. Currently, two pilot sites are testing the new services, we are reimbursing these services at $157.50 per encounter for the Comprehensive Assessment, $11.38 per 15 minutes for peer support services, and $17.50 per 15 minutes for treatment coordination. However, the rate for treatment coordination in the pilot was based on a credential that is higher than the credential we require in the bill, so that will likely be a consideration when that rate is established. Update: The current rates being proposed are $162.24 per encounter for the Comprehensive Assessment, $15.02 per 15 minutes for peer support services, and $11.71 per 15 minutes for treatment coordination.

Q3. 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.

Q4. Would the assessor have to have a contract to bill a PMAP?

Yes. See handout on direct reimbursement update.

Q5. Can an LADC have an office in a hospital and bill the CCDTF without having a rule 31 license?

Yes. See handout on Comprehensive Assessment/Direct Access and Direct Reimbursement.

Q6. 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.

Q7. 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.
Q8. 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 Alcohol and Drug Abuse Division for clarification if this is your practice.

Q9. Will direct billing & mobile assessments be available on January 1, 2018?

No. July 1, 2018 is the earliest date that this will be available. Please see the implementation timeline at this link: https://mn.gov/dhs/assets/sud-reform-legislative-timeline_tcm1053-302071.pdf

Q10. 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.

Q11. 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.

Q12. 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.

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.

Q13. How do we become a Vendor?

Once the new statutes and new statutory changes become effective, which occurs on July 1, 2018, or upon federal approval, whichever is later, organizations who desire to become vendors will need to enroll through Minnesota Health Care Programs Provider Enrollment.
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. 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.

Q15. 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.

Q16. 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.

Q17. 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.

Q18. Will a licensed professional in private practice need to obtain a NPI Number to bill?

Yes.
VIII. 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. Our timeline goal is to have Comprehensive Assessments for placement purposes Medicaid reimbursable by July 1, 2018. We are projecting that some providers and counties will be poised to be early implementers beginning almost immediately after this date. However, we also recognize that other counties and providers will be in different circumstances and this timeline might be too ambitious. So even while the existing placing authority system continues in place, the new process will be gradually phasing in. We are predicting that it could take up to two years for full implementation to occur, with the caveat that the current process is possible as a result of a waiver from CMS, and there is no guarantee that the waiver will continue to be approved. Also, we ask for your patience in this process as there are several variables that are not solely under the control of DHS, so timelines are not entirely predictable. During the process to transition to a person-centered process of accessing treatment, we are committed to preventing and addressing any barriers or delays to any individual in the state who is needing services during this period.

Q2. What happens in 2020? Do counties continue to complete chemical use assessments as a choice?

After 2020, the only counties who will still be providing chemical use assessments will be those who have elected to become a vendor of these 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 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. 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, if a County Social Service/Human Services Agency wishes, going forward, to become an eligible vendor and provide these services once the parallel process, two year implementation period is over, the county would have to have qualified alcohol and drug counselors on board. Or the county could contract with outside qualified staff.

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.

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.

Q7. Does the client still need to go through a financial review with the County prior to admission?
To access publically funded SUD services, as with the rest of publically funded health care services, a determination of financial eligibility and enrollment in Medical Assistance or approval of Consolidated Chemical Dependency Treatment Fund (CCDTF) funding must be obtained. The process for doing this is unaffected by the reform at this stage. As we move forward in the future, we 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. Increased use of navigators is one route discussed to doing this, as well as looking to Recovery Care Organizations to support this.

Q8. Will the counties continue to “authorize payment” with direct access?
The direct access process does 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.
Q9. Will access be delayed if counties are still determining financial eligibility?
There is always the potential that this could cause a delay, although we hope that counties will efficiently complete the enrollment process for all individuals seeking publically subsidized health care, including substance use disorder services.

Q10. Will county workers be assigning clients PMI numbers that are not on MA but qualify for CCDTF?
All the details of the roles of counties is still being clarified. Counties have the same roles in assessing financial eligibility as they have always had, this doesn’t change 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. However, it is worth noting that in most circumstances counties and programs should be assisting the individual to enroll in Medical Assistance rather than simply accessing the fund. This will ensure that individuals have a full array of health care available.

Q11. 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, 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.

Q12. 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 questions about its specificities. 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.

Q13. 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. Because there is a two year parallel process, Rule 25 assessors also will have close to three years from the posting date of this answer to update their training.
Q14. 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, technically, 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.

Q15. 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.

Q16. Would DHS consider staffing regional LADC’s for counties to use?

Aside from the LADCs who work for the Community Addiction Recovery Enterprise (CARE) programs, DHS does not provide staff to counties to provide clinical services.

Q17. 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.

Q18. 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.
Q19. 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 has always been 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.

Q20. 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.

Q21. 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.

Q22. 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.

Q23. Can a County contract with a private community provider to provide the alcohol and drug counselor weekly supervision for treatment coordination?

Yes.

Q24. 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, yes. Although the hours of experience as a Rule 25 Assessor would apply.

Q25. 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”.
Q26. 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.

Q27. 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.

Q28. For treatment coordination, if the person coming into that position was a Rule 25 certified assessor for 5+ years, would there still need to be weekly supervision by LADC?

If the person coming into the position of treatment coordinator was not an LADC, yes.

Q29. 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.

Q30. Can the public or providers attend the ITV sessions at DHS?

ITV session refers to the already existing ITV’s that DHS has with counties. These are not open to the public or to providers (unless the county invited the provider to be present at an ITV session).

Q31. 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.
Q32. 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.

Q33. How does a County file an assurance statement in order to become an enrolled provider?

The assurance statement is a document that attests that the eligible vendor is providing a service(s) in accordance with statutory requirements. It is completed and submitted to Minnesota Health Care Programs. We will provide information and updates as to how a county can access the assurance statement document via e-memo and future WebExs.

Q34. How will the County providers bill for Treatment Coordination and Comprehensive Assessments? Will there be codes added to MMIS?

Enrollment and billing procedures will be announced once the systems are modified to support them.

Q35. 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.

Q36. 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 complete an assurance statement and submit it to Minnesota Health Care Programs. The county is responsible to verify the staff completing a comprehensive assessment is qualified to do so, according to 245G.11, Subdivision 4.

Q37. 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.
Q38. 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.

Q39. 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.
XI. Telehealth

Q1. 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 by means of submitting the new Assurance Statement, and follow 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.

Q2. Can Rule 25 assessments be provided by telemedicine?
Rule 25 assessments cannot be provided by telemedicine and will not be Medicaid reimbursable, and will not be eligible to be delivered via telemedicine.

Q3. Can Comprehensive Assessments be provided by telemedicine?
Once the Comprehensive Assessment has been approved as a reimbursable service by CMS or on July 1, 2018, or later, it can be provided by an eligible vendor via telemedicine by appropriately credentialed individuals over approved telemedicine connections.

Q4. What substance use services can be provided via telemedicine and what credentials do providers need to have?
Individual counseling, including Comprehensive Assessments, can be provided via telemedicine. The credentials needed to provide substance use disorder services are unaffected by whether the service is delivered via telemedicine. Requirements for providing telehealth services are found in the MHCP manual.

Q5. 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. There are no plans to change this for 2018.

Q6. Can a County contract with another County for an LADC to provide a Comprehensive Assessment via telemedicine?
Yes. The County providing the LADC will need to file an Assurance Statement with MHCP to amend their provider profile. The County will also need to be an eligible vendor for Comprehensive Assessments. An LADC who works for a County that provides Comprehensive Assessments must meet the qualifications of an Alcohol and Drug Counselor Supervisor according to 254B.05, subd. 1, paragraph (c). Both counties will need to have the appropriate telemedicine technology.
Q7. What is the limit for individual sessions for telemedicine?
   The limit is three sessions per week per individual.

Q8. 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.

Q9. 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.

Q10. Is Vidyo equipment approved as appropriate equipment for telemedicine?
   Yes, it is one of the approved platforms.

Q11. 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.

Q12. 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.

Q13. Can a treatment coordinator who is an LADC bill for treatment coordination via telemedicine?
   Yes, if they are enrolled with MHCP to provide telemedicine.
Q14. 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.

Q15. 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.

Q16. 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.
X. Stay Informed

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

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