Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 9

July 28, 2017

1. **What should the patient to counselor ratio be for group counseling provided in a residential SUD treatment for adults program? With larger groups the documentation requirements become burdensome.**

   Therapeutic group activities for adult residential SUD generally consist of no more than 12-14 individuals with one staff member. All clinical services must be documented in each individual record when facilitated by a licensed professional. Residential programs should be diverse in their therapeutic activities.

2. **Can a recovery coach, peer support, or direct care worker conduct a group as part of the weekly hourly service requirement?**

   A clinical group may only be led by individuals outlined in COMAR 10.09.59 (http://www.dsd.state.md.us/comar/comarhtml/10/10.09.59.04.htm). Additional types of groups may include relapse prevention to provide guidance on making choices, educational, occupational, recreational therapies, art, music, movement therapies, and vocational rehabilitation. Peers are a part of the treatment milieu and can provide groups related to their scope of practice.

3. **Are clients in ASAM Level 3.3 or 3.5 permitted to work while in treatment and still have Medicaid pay for their treatment?**

   It is up to the program to determine if the individual is able to maintain recovery while employed. The individual would need to be assessed as having no/low risk factors across all six ASAM dimensions and still meet MNC for this level of care in order for it to be appropriate for them to work while in treatment. Employment does not necessarily preclude someone from receiving a residential level of treatment. However, for Medicaid to reimburse for therapeutic services the individual must meet medical necessity criteria for that level of care and they must medically require the level of programming that is required for each of the levels of care.

   For ASAM level 3.3 at least 20-35 hours weekly (of combined treatment and recovery support services) are required and for ASAM level 3.5 a minimum of 36 hours weekly of therapeutic activities are required. These service requirements for the level of care must still be met by the program if the individual is employed. Based upon the ASAM criteria, it would be difficult to foresee situations where an individual would need this level of programming and be able to continue to work. Once an individual stabilizes, outpatient treatment and recovery housing is a more appropriate level of care.

4. **We understand that audits will require demonstration of competence in delivering the EBP attested to during the application process. We understand that we should document CEUs, but we need some guidance on how fidelity measurements of EBP implementation should be demonstrated.**

   Please find the list of approved EBPs below:
   a) Acceptance and Commitment Therapy (ACT)
   b) Cognitive Behavioral Therapy (CBT)
   c) Medication Assisted Treatment (MAT)
   d) Motivational Enhancement Therapy (MET)
   e) Motivational Interviewing (MI)
   f) Psychoeducation
   g) Psychotherapy
   h) Relapse Prevention (RP)
   i) Solution-Focused Group Therapy (SFGT)
   j) Supportive Expressive Psychotherapy (SE)
   k) Trauma Informed Treatment

   The program should have in its policies and procedures the types of EBP utilized for service delivery. The progress notes and treatment plan should provide evidence that the EBPs are being applied in clinical services. For example, if a provider is facilitating CBT, then it would be expected that in the chart there would be specific references to problematic thinking patterns, behaviors related to those thinking patterns, how this relates to the individuals' recovery process and ways to challenge these thinking patterns and behaviors. For a provider that is utilizing motivational interviewing, it would be expected that the charts will include discussions on the individuals' stage of change, motivators, and specific enhancement techniques that are being utilized to move the individual within the stages of change. Additionally, the personnel files of staff must contain evidence of Continuing Education training.

5. **Client John Doe enters treatment at our program, ASAM Level 3.3 on June 18 under grant funds. Grant funds expired June 30 and he was approved for Medicaid to fund Level 3.3 treatment for 30 days starting July 1. Since Level 3.3, under grant funding, did not require him to have a medical evaluation at the time of his intake on June 18, it was not done. Medicaid requires an initial medical evaluation on Medicaid-funded clients, but at the point Medicaid began paying for his treatment, he had been in ASAM Level 3.3 for 12 days. Does John Doe need a medical evaluation now to comply with Medicaid requirements?**

   Yes, an initial medical evaluation is required for Medicaid reimbursement. For patients that were in care prior to July 1st, providers should close the authorization and open a new one beginning July 1. With a new authorization a medical evaluation is required.

6. **Since all clinical treatment happens in our program from Monday-Saturday, there are no clinical notes entered on Sundays. Our clients are still in group, but no clinical notes are**

entered. Can we bill just the room and board charge or do we need to have a clinical note in conjunction with the room and board?

Providers must document for the dates on which the service occurred and can never be backdated. Although the daily rate is billed for therapeutic services and room and board, the service hours are based on a weekly minimum and documentation should reflect a service array that contributes towards that minimum. Service arrays include combinations of counseling led by licensed or certified providers, as well as symptom reduction activities which may be led by certified and/or experience based providers and recovery activities that assist individual in moving through the continuum of care towards treatment in their community environment. Programs must document in each individual's chart to indicate that the minimum number of service hours per level of care has been met in order to bill for the therapeutic services.

7. **I need some clarification for claims submissions. What is the difference between a PT 54 and a PT 55? What forms do we use to submit claims? What place of service do we use to bill?**

Programs enrolled as provider type 55 render residential SUD services for individuals under 21 and are covered under COMAR 10.09.23. This provider type bills revenue codes on a UB-04 form. The PT 55 has been a provider type under Medicaid for several years. No changes were made to this provider type.

The adult residential SUD benefit is Provider type 54. This provider type uses HCPCS codes on a CMS 1500 form. A PT 54 may use either place of service (POS) 54 or 55 depending on their classification. POS 54 is for Intermediate Care Facility. POS 55 is for Residential Substance Abuse Treatment Facility. Both places of service are accurate and it is up to the provider to select which place of service applies to your facility.