SUD Questions submitted up to 3/6/19

Q1. We will be a residential behavioral health facility working with 3.1 and 3.5 ASAM levels. Do these members need to be on MAT Treatment to meet the qualifications or can they come in without having MAT as part of their treatment plan? Example (if a person were to suffer from alcohol or marijuana use) would this person be eligible?

A1. Members do not have to be on MAT treatment before entering a program. The program can offer MAT treatment if they choose, provided they have an authorized prescribing physician. Opioid Treatment Programs are the only facilities that can prescribe methadone in the state. So if the program accepts someone who is on methadone, or any other MAT, they must be able to continue to receive their current MAT medications. Second, any person admitted to your program must meet medical necessity. If someone has a substance use diagnosis and meets the medical necessity for treatment, you can admit them into your program.

Q2. Does a member have to be present for every discussion regarding them or does this only apply when there is a change or discussion to their treatment plan?

A2. No. Members are required to be a part of the treatment planning team. But members do not have to be present for every discussion regarding them (e.g. Targeted Case Management).

Q3. When we bill with the residential bundle code, do we have to include each CPT code that was used within the bundle?

A3. No, you are not required to line item bill CPT codes under the H2036 residential per diems. CPT codes are included in the bundle unless they are billed by other providers.

Q4. As a Federal Qualified Health Center, are we eligible for PRSS reimbursement, or is PRSS reimbursement restricted to entities with CCMHC status? We are, of course, credentialed with Medicaid and receive reimbursement at the FQHC rate.

A4. An FQHC may only provide PRSS services if they are also a Licensed Behavioral Health Center.

Q5. This question is regarding OTP therapy participation: I have a member with a four-month-old child, who has all drug free urines and was short a half an hour of counseling last month. We would normally discharge a member if they did not meet Medicaid requirements for counseling, but can we make an exception for them?

A5. The OTP medical director can make a program decision and allow the participant to make up the missed therapy.

Q6. If we need an admission physician order for admission, do we need an order before discharge on non-MAT participants?

A6. Yes, good practice standards are that any patient, MAT or not, would need a discharge order and discharge plan.

Q7. How do we handle a doctor who orders 3.5 when a participant does not meet criteria via the psychosocial assessment?

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A7. You would need to have an internal discussion/treatment team meeting and discuss why the physician feels that level is needed. Patients for Level 3.5 must have a substance abuse diagnosis and meet the admission criteria listed under Chapter 504, Section 504.18.3. If, upon a retrospective review, a program was found to have not followed proper procedure, they could lose and/or repay monies.

Q8. Who accepts the order for admission if our staff completing the assessment is a MA therapist?

A8. You should follow your facility's rules about admission. The treating physician should review the therapist's assessment.

Q9. Can a standing physicians order be used to satisfy the requirement of the written order for a member to enter ASAM Level 3.5 or does the physician need to write individual orders for each member?

A9. You must have an individual order for each member. Standing physician's orders should not be utilized.

Q10. Is there a mandated staff to patient ratio for 3.5?

A10. No, programs just need "safe & appropriate oversight."

Q11. What is the policy for the members to keep medications, specifically MAT medications, in their Residential Adult Services residence/apartment? Project Hope has an 18-apartment site. The members keep all medication in their home-unlocked and with children. They are unsure if this is a fair expectation or do they need to be stricter.

A11. Self-Administered Medicine - Self-Administration of a patient's medicine is accomplished by having a nurse or other identified staff member observe the member taking their own medication. The program must ensure that all medication for patients are kept in a secure area and only given to the patient during times for self-administration of their medicine. Medications should be kept behind three locked units (e.g. locked office door, locked cabinet, locked medication box) as required by OHFLAC regulations.

Q12. They also would like to know if an RN is the only person to help regulate medication.

A12. Any staff can observe the individual self-administering their medication and kept in a locked unit as of now (unless this changes in the plan developed by Dr. Becker).

Q13. When trying to bill pregnant women the difficulty is when they go into labor, they are in the program for three days and go into labor and are at the hospital for the last four- can they bill for the first three days because they have not met the 21hour week requirement.

A13. Yes, you can bill for the days they participated in the program prior to hospital admission even if they don't meet their required hours for the week.

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Q14. This next section is from the Adult Residential Substance Use Disorder Treatment Program Certification Tool used by KEPRO as they complete their on-site review of your RAS program. On Page 7 of Appendix B of Chapter 504, The Residential Adult Services Application, there are questions asking for facility regulations, visitation guidelines, search/contraband protocol, drug testing policy, etc. This is the information being gathered in review of your RAS application.

A14.

Section Therapy and Services

0	10.	Verify that the following policies/procedures are in place: • Patient Handbook/Rights and Responsibilities Handouts for Patients • Visitation Policy • Search and Seizure Policy and Procedure—do you ever do clothing or body searches? • List of prohibited items and substances--contraband • Drug Testing Policy, Relapse Policy (and/or failed drug test policy) • Treatment Contract, Program Expectations, and/or Program Guidelines (Rules/Regulations)
		Policy # TS-22 Visitation, # TS-10 Illicit Drugs and Impaired Patient, #TS-23 Contraband on Premises, TS-01 Patient Rights, Non Discrimination of Services and Grievance Procedures, Observed the drug testing policy, relapse policy, treatment contract in the Project Hope Admission Handbook.

Q15. I am wondering if the SUD waiver includes fees associated with primary care medical services? I am asking because we are considering having primary care physicians provide services at the center, and we weren't sure about reimbursement.

A15. A physician may bill Evaluation/Management codes for RAS levels 3.1, 3.3 & 3.5. E/M codes are included in the RAS Level 3.7 residential bundled per diem.