SUD Waiver Questions List as of 10/1/18

Q1: When reauthorizing for peer support, are you resubmitting under Tier 2 after 60 days?

A1: No, continued stay authorization requests remain at the Tier 1 data demand.

Q2: Can an agency provide Peer Support services throughout the entire spectrum of care?

A2: Yes, from Level 1 Outpatient services through Level 3.7.

Q3: Can an agency provide services during inpatient care or must it be strictly outpatient?

A.3 Services may not be provided while a member is receiving acute inpatient hospital care (Level 4.0)

Q4: Can FQHC Bill Peer Support?

A4: No, SUD services are only available to LBHCs.

Q5: Do Peer Support activities require documentation?

A5: Yes. Chapter 504, Appendix A, provides documentation guidelines and an example format. Additionally, Chapter 504.15.1 describes each required documentation component beginning on page 24.

Q6: Will Medicaid certify PHP?
A6: PHP is level 2.5 and not considered a Residential Adult Service program; therefore, it would not fall under the certification process.

Q7: Will the certification be the same process as other intensive service or intensive outpatient programs?

A7: No. Residential Adult Service (RAS) programs are not IS programs and do not have the same process. RAS programs submit the application located in Appendix B of Chapter 504 of the provider manual to begin the certification process for level of care found here: https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx.

Intensive service programs require submission of an application located in Appendix G of WV Medicaid Chapter 503 located here: https://dhhr.wv.gov/bms/Pages/Chapter503_LBHC_Services.aspx

Q8: If you are a LBHC, can you legally own and provide services at a recovery home?

A8: We are waiting a response from OHFLAC and providers will be updated on the next call.

Q9: Can any agency provide peer support in a car, at McDonald's or in the community?

A9: The Provider Manual Chapter 540.15.1 states: "Peer Support services may be provided in any location **except** for the Peer Recovery Support Specialist's home. However, Telehealth may be utilized for these services. A fundamental feature of Peer Support is that the services are provided in the natural environment as much as possible." Regarding a McDonalds or other public establishment, best practice would guide the PRSS to ensure a reasonable degree of confidentiality exists. Best practice might also caution that providing services while driving in a car would not be considered ideal due to safety concerns.

Q10: If a peer support specialist travels to a consumer's house, is mileage reimbursement available?

A10: No. The service is billed per unit of time spent engaged in provision of services.

Q11: How does the Peer Recovery Support Specialist (PRSS) prove 2 years of sobriety?

A11: As stated in Chapter 504.15.1:

a. The PRSS candidate must sign an Attestation Of Recovery statement in their application
b. The PRSS must submit three Letters of Reference along with their application
c. The PRSS candidate must not have received SUD treatment services within the preceding six months of applying for the certification.

Q12: Can PRS certified receive MAT while providing services?

A12: Yes, if the PRSS is stable on MAT and meets the two-year recovery requirements.

Q13: What are the specific skills training for consumers?

A13: The specific skills would be those determined to be medically necessary based on a comprehensive assessment of the member. Skills Training and Development information can be found in Chapter 503.18 beginning on page 26. https://dhhr.wv.gov/bms/Pages/Chapter503_LBHC_Services.aspx

Q14: If an individual is in a 3.7 LOC, and it is deemed necessary for psychological testing (96101), would the cost of the testing would be consumed by the 3.7 facility?

A14: Yes, since 96101 Psychological Testing with Interpretation and Report is included within the 3.7 level.

Q15: Can someone stay longer in the 3.7 than 28 days (i.e. 32 days)?

A15: As long as medical necessity is demonstrated for that level of care, yes.

Q16: Is the 3.3 population include TBI, IDD or co-occurring?

A16: If the TBI or co-occurring condition affects cognitive functioning such that the member is not able to benefit from the full service milieu of level 3.5 programs, and meets admission criteria, then yes. Regarding members with IDD diagnoses, if they also have a SUD diagnosis that meets medical necessity for high intensity residential adult services, and are assessed as able to benefit from the 3.3 program milieu, then yes. The deficits for members at this level of care are primarily cognitive (temporary or permanent), and members are able to effectively benefit from services that are provided at a repetitive and slower fashion.

Q17: Is there intellectual rule out for 3.3 such as mild, moderate, severe?

A17: No, the service is based on the individuals assessed need.

Q18: What is the base rate for 3.7 programs?

A18: The rate for 3.7 level of care is established between BMS and each individual program.

Q19: Can an extender be a Nurse Practitioner?

A19: Yes

Q20: Can a patient, in a residential adult service, be referred to a different level of care at any time or do they have to stay in the program for the allotted amount of time?

A20: Yes, a member may be referred to a different level of care to best meet the member's needs. No member must remain in a program for an "allotted" amount of time. Program lengths of stay should be considered estimates/average lengths of stay, and the member's assessed need should determine the medically necessary and appropriate level of care.

Q21. Are there time limits for service days?

A21. No, as long as the member continues to meet medical necessity for the level of care requested.

Q22. Is the H0004 (Supportive Counseling) billable for high school graduates?
A22. Yes, if the high school graduate has 2 years documented experience working in the behavioral health/substance use field.

Q23. Do you know what the reimbursement rate for Peer Recovery Support Specialist?

A23. The rate is $14.35 per unit, same as TCM.

Q24. Who do we contact about billing services when our program approval date was back dated?

A24. You may contact KEPRO regarding retrospective authorization requests that coincide with your back dated approval date. Please contact Molina if you need assistance with claim adjustments, etc.

Q25. Are CareConnections still required to be completed every 10 days? For what service?

A25. Each service authorization has start and end date. The adult residential levels 3.1, 3.3, and 3.5 have an initial authorization span of 20 calendar days and continued stay requests receive a span of 10 calendar days.

Q26. Do we have to submit a different authorization for Withdrawal Management?

A26. No. There is no authorization requirement for withdrawal management services.

Q27. When is it necessary to utilize sign in/out sheets?

A27. Every time the member exits the facility for any reason, whether accompanied by program staff member or not.

Q28. Does the physician extender have to lay eyes on the client?

A28. This depends upon the individual service requirement. There are different requirements according to the levels of care. Since a specific service is not mentioned in the question, providers should also consider whether telehealth is an available option.

Q29. How long after the verbal order, would the sign-off need to be?

A29. It has not yet been clarified whether a physician's order of admission to a program can be a verbal order. Sign-off time would be established if/when verbal orders are deemed acceptable by BMS.

Q30. What is the difference between capable and enhanced ability for co-occurring diagnoses?

A30. A co-occurring capable program has the ability to address both mental health and substance use disorders within their programming. The substance use disorder is the primary focus of treatment. In co-occurring enhanced services, the program has integrated both mental health and substance use disorder treatment. The primary focus is to integrate services for both conditions. More specific information can be found in the ASAM book, "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition" and website www.asam.org.

Q31. I provide services at a Day Report Center and wanted to verify if there was a billing code for SBIRT, separate from the initial intake.

A31. No, there is not a separate billing code. SBIRT has not been opened for billing purposes at West Virginia Medicaid. We require it for documentation purposes only. There are many different screening tools that can be used for SBIRT. SBIRT is a required documentation component, regardless of the suspected diagnosis, for the following CPT and HCPS codes for individuals age 10 and older:

- 90791 Psychiatric Diagnostic Evaluation (No Medical Services)
- 90792 Psychiatric Diagnostic Evaluation with Medical Services (Includes Prescribing of Medications)
- H0031 Mental Health Assessment by Non-Physician

The SBIRT is required ONLY for initial evaluations under these codes. Please refer to Chapter 504, Section 504.12 for the guidelines regarding SBIRT at https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx

Q32. Does the SUD Waiver reimbursement rate (for Adult Residential Treatment Services) cover counseling services also?

A32. Yes. Chapter 504 of the provider manual includes a complete list of the service array available to be provided in each adult residential program level of care. They include, but are not limited to:

- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO)
- Behavioral Health Counseling, Professional, Group (H0004HOHQ)

Q33. Does the way they bill for services change if a member in, for example, Traditional Medicaid qualifies for SUD? Is it a different funding source?

A33. No, the funding source doesn't change. They may have any form of Medicaid, even MCO coverage. However, when a member switches to SUD Waiver services, the provider requests prior authorization from

KEPRO for the appropriate code for the program's level of care, and receives a daily bundled rate that covers all services that can be provided in the program's level of care.

Q34. What provider NPI number should be used for SUD? Do they need to get another one? If so, how do they do it? What's the process and who do they contact to do it?

A34. The same NPI number may be used. These are just additional services providers can bill.

Q35. If a member currently receives charity care through BHHF, then qualifies and moves to SUD waiver, then will they still bill charity care or is it a different funding source? Again, how do they bill?

A35. Providers should contact the Bureau for Behavioral Health to discuss charity care coverage.

Q36. Can a dually diagnosed member who qualifies for and receives Withdrawal Management in CSU be transferred to "regular" CSU to receive MH services after the SUD Waiver withdrawal management services? Would that qualify as a new admission?

A36. No. The CSU should be capable to handle the crisis requiring admission. If there is both withdrawal and a MH condition, both should be addressed.

Q37. I see a public notice for Residential Services application. Is there a due date for these to be completed and sent to you?

A37. No, there is no specific date. You can begin to fill them out and submit them now. This application will remain the same even after July 1, 2018.

Q38. I am on a fact-finding mission in trying to help my daughter (and myself). We live in Mineral County, WV. She has been getting Methadone treatment in Cumberland, MD she lived in Cumberland for a while, but has moved back home to Mineral County. Since she moved back home I have had to pay out of pocket for her continued treatment at the Cumberland facility. I have been paying out of pocket, $440/month and I can no longer do that. Is there a treatment center in Mineral County that could provide her Methadone treatment? I have heard information about the new waiver and I am wondering if that might help her. I would appreciate any assistance you could offer?

A38. Through the new SUD Waiver, WV Medicaid began reimbursing for Methadone treatment for our members beginning this past January. If your daughter is a WV Medicaid member, she would be eligible for treatment at any of the WV Methadone Treatment Centers. There is no treatment center in Mineral County. Depending on where you are located, there are three possible centers where she could receive treatment. Med-Mark of Morgantown (214-379-3398), the Martinsburg Institute (304-263-1101), or the Clarksburg Treatment Center (304-462-2648). I would suggest her Cumberland, Maryland treatment center to make a referral to whichever of these centers she chooses to attend.

WV Medicaid pays a weekly bundled rate for methadone, its administration and the related counseling and labs. It also covers the initial dosing and monitoring to make sure the medication can be tolerated. Unfortunately, this coverage is only for WV Medicaid members.

Q39. On behalf of our member hospitals, I hope this is a simple question. Within the SUD training materials, the code H0050 HF appears to be a referral to treatment. If the referral occurs in the ER or hospital outpatient setting, may the hospital bill the service?

A39. No, the code H0050 is only billable by EMS responders and is a pre-hospital service. This is a code used for what we termed a "Warm Handoff" where the EMS responders provide information such as a pamphlet or handout brochure about treatment available from local SUD providers or refer them to the 1-844-HELP4WV helpline to assist them with a referral to treatment. It is not a billable code for anyone other than EMS responders. Please refer to Chapter 504 SUD Manual located here: https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx

Q40. Is drug testing bundled in for the Residential Adult Treatment Services?

A40. Yes. We added three drug testing codes to the Residential Bundle: 80305, 80306, and 80307.

Q41. Who has been approved to supervise Peer Recovery coaches in WV? Do they get reimbursed under the Medicaid 1115 waiver?

A41. According to Chapter 504, Section 504.15.1 Peer Recovery Support Specialists, "Must be supervised by a Master's degree individual that is employed by the same provider." Please refer to Chapter 504 SUD Manual located here: https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx

Q42. Will the Health Plan pay for adults over the age of 21 in a substance abuse unit?

A42. Based on the individual member's medical necessity and screening for SUD treatment, effective July 1, 2018, all WV Medicaid members can receive SUD treatment.

Q43. Will the Health Plan pay for adults over the age of 21 in the 7-10 day detox before they go into the 28-day unit?

A43. If there is a medical necessity for withdrawal management, WV Medicaid members can receive these services as described above. The only type of Withdrawal Management provided in a residential treatment setting is WM 3.2 and it is included in the services provided in a Level 3.7 Residential Treatment unit.

Q44. Will the Health Plan pay for adults over the age of 21 for IOP services once they are discharged from the 28-day unit?

A44. It is anticipated that individuals will receive follow-up after care/recovery once being discharged from a residential treatment unit. Discharge planning begins upon admission. Again, if the member's treatment plan, and the member's SUD screening and medical necessity indicates it, they may transition into some kind of outpatient treatment. If IOP is indicated, and they qualify for these services, WV Medicaid members may receive IOP services. MCO's will continue to pay for IOP's as they do now since that is a state plan service, not a SUD Waiver service.

Q45. If someone does not have the capacity to consent for this level of treatment (low IQ, APS, etc.), can a guardian consent for them and still be Medicaid eligible for reimbursement?

A45. Yes, if someone has legal guardianship of a WV Medicaid member, they could sign them into

treatment.

Q46. If someone was court ordered to this program (which we think may happen although we are not seeking it out), would they still be eligible for Medicaid reimbursement?

A46. If you are in jail, you lose Medicaid eligibility. If you were out of jail up until sentencing, you could still have a Medicaid card and go into treatment. The Medicaid member would have eligibility until the day they go into Corrections' custody. Services after then become the Department of Corrections responsibility.

Q47. On the SBIRT, if someone comes from detox, and already had an SBIRT upon admission there, must we do it again, and if so, can we bill for it again? I would think that there was some frequency related to billing?

A47. SBIRT is only required for documentation on the initial assessment using those three codes. All three of those codes are included in the residential bundle. We are not reimbursing for SBIRT, only requiring it for documentation purposes on the initial visit.

Q48. What if someone was ordered by mental hygiene or court ordered treatment as a result of an evaluation after mental hygiene?

A48. If they are court ordered, that does not determine Medicaid payment for a service. But if the person meets Medical Necessity for the service, we would then pay based upon the medical necessity of the individual.

Q49. Regarding the Variance for Peer Recovery Support Specialist: Can an employee bill Medicaid while the request for a variance is pending?

A49. No. They must receive clearance from WVCARES before billing for services.

Q50. If we submit the Residential Adult Services application now based on the current configuration of our programs, will we be able to submit an appended application or program description based on changes due to the Ryan Brown funding?

A50. Yes, you would just report the changes on the Residential Adult Services application and re-submit it.

Q51. Must you provide every service covered in the bundled per diem rates for Residential Adult Services?

A51. No, but you cannot bill for any service covered in the bundled per diem rates outside of the bundle.

Q52. As we've been reaching out to the Medicaid MCOs regarding contracting for the residential SUD treatment, we've been told by one that the MCOs will not be covering this service until a later date, maybe January, that it will only be covered by traditional Medicaid. Is this true? If so, can you provide any insight into how this will work for those Medicaid members who are enrolled in an MCO?

A52. All new services under the SUD Waiver, when implemented, will be billed as Fee-for-Service (FFS) for all members.

- KEPRO is the FFS utilization manager

- Molina is the FFS fiscal agent

The MCOs will begin covering these services at a later time.

Q53. I was reading the Peer recovery application form and realized that it requires direct personal recovery. We have individuals who we have hired already who do not have personal recovery, but instead have indirect experience through family members. These persons would be eligible for the IC&RC Peer Recovery Certification through the WV Certification Board for Addiction and Prevention Professionals once they reached the training and time required for those certifications. How will they fit into the application process?

A53. Unfortunately, to become a Peer Recovery Support Specialist and provide Peer Recovery Support Services, you must be a Peer, which is defined in Chapter 504 of the WV Medicaid Providers Manual located here: https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx

Unless you are a peer, you cannot become a PRSS and cannot provide PRSS services. A peer is an individual who shares the direct experience of addiction and recovery. A Peer Recovery Support Specialist (PRSS) is a person who uses his or her own lived experience of recovery from addiction, in addition to skills learned in a formal training, to deliver services in substance use disorder settings to promote mind-body recovery and resiliency. A PRSS is professionally qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of substance abuse disorders, to provide peer support as a self-identified individual successful in the recovery process with lived experience with substance use disorders, or co-occurring mental health and substance use disorders, and to offer support and assistance in helping others in the recovery and community-integration process.
The Peer Recovery Support Specialist (PRSS) requirements include:

a) Self-identify as an individual with life experience of being diagnosed with a serious mental illness or substance use disorder which meets Federal definitions,

b) Must be well established in their own recovery; currently in recovery for a minimum of two years and not have received SUD treatment, except for MAT, for the preceding six months. MAT is considered a part of recovery.

Q54. What is the reimbursement rate for Peer Recovery Support Services? How many units can be provided per day?

A54. Peer Recovery Support services are reimbursed at the rate of $14.35 per unit. A unit is up to 15 minutes. A member may receive up to 16 units of Peer Recovery Support services per day. A member must have a SUD or a SUD and mental health diagnosis to receive Peer Recovery Support services. A Peer Recovery Support Specialist may serve no more than 20 members at a time. Group Peer Recovery Support Services are not reimbursable.

Q55. What is the medical necessity for Peer Recovery Support services?

A55. A member must have a SUD diagnosis or a co-occurring SUD and mental health diagnosis to receive Peer Recovery Support Services.

Q56. We are receiving denials for the H0031 for the members that get placed in the Methadone program. We complete this assessment as part of the admission process. What is causing the denials?

A56. H0031 – Mental Health Assessment by Non-Physician is a service contained in the bundled billing code H0020 – Methadone Weekly Bundled Code, and cannot be billed separately outside of the bundle.

Q57. What is the address to mail Appendix B, the application for Residential Adult Services?

A57. Mail it to: Jeffrey S. Lane
SUD Waiver Program Manager
350 Capitol Street, Room 251, D15
Charleston, WV 25301-3706
You may also scan and email it to BMSSUDWaiver@wv.gov

Q58. Can more clarification be provided regarding what will count towards fulfilling the Daily Progress Summary requirement?

A58. We will review the daily summary template during the site visits.

Q59. Can the physician's order for placement in program's LOC be a verbal order, and/or done via telehealth?

A59. Yes, it can be completed through telehealth.

Q60. Can there be a standing physician's order, for instance that all members with a diagnosis of ____ are ordered into the _____ program's LOC?

A60. No.

Q61. Do physician's orders for placement have to specify the services to be provided, (as physician's orders for admission into crisis units currently require)? If so, can it be check box format? And if so, can it be the same for most members; i.e., mirroring the available & required services for the particular program's LOC?

A61. It must be individualized; it would be difficult to do so with check boxes.

Q62. If a member receives physician's order to enter a 3.5 program (for example), completes that level of care, and is ready to step down to a level 3.1 offered by same agency, is another physician's order required to place the member in that same agency's step down service?

A62. Yes, another physicians order is required for moving up or down in a level of care.

Q63. If members leave AMA, but return within a few days (less than a week), since a new comprehensive assessment would not be warranted in this instance, would another physician's order be required? Does the Physician's Order have to come from a physician/extender utilized by the program or its home agency, or can physicians/extenders from other programs/facilities provide an order for admission to another program's LOC?

A63. Yes, another physician order is required. The order should come from the program's physician.

Q64. If programs currently have a process in place that documents every exit from the facility for every member; however, it is kept as one running log of all members rather than a separate log for each member, would this fulfill the requirement, or will they need to switch to one sheet for each program member?

A64. No. They will need to switch to one sheet per member.

Q65. If program members are leaving the facility with staff members for a regularly scheduled program activity, such as a 12-step meeting, is it still required that all members sign out for each of those activities?

A65. Yes

Q66. Do Residential Adult Service programs have to become OBMAT certified to provide MAT on site?

A66. The OBMAT rules may be located on the OHFLAC webpage: https://ohflac.wvdhhr.org/

Q67. Will BMS ever "cap" length of stay for a particular level of care?

A67. No. Medical necessity indicates lengths of stay for a particular level of care.

Q68. Can a continuation auth be submitted before current approved auth runs out of units? If so, how many days in advance?

A68. EP Response: The answer depends upon the duration of the service authorization. For example, RAS at the 3.5 level receive an initial 20-day authorization. Continued stay requests would be appropriate around day 16. If the service were of a shorter duration, such as the 3.7 level of care (initial authorization duration of 5 days), continued stay authorization request could be submitted around day 3.

Q69. Can programs continue to receive any types of grant funding while receiving reimbursement through SUD W codes/bundled rate? If so, what grants are/are not excluded?

A69. Yes, although you may not receive payment for duplicate services (i.e. use grant money for a treatment component since you are receiving Medicaid reimbursement for it).

Q70. How do the MCOs fit in to the SUD Waiver Program? What is meant by the "carve out?" Will providers ever have to obtain prior authorizations for any services from MCOs for members who fall under the SUD Waiver?

A70. SUD Waiver services are not carved into MCO's at this time.

Q71. Does it negatively impact certification for a level 3.5 if the program chooses not to do physical exams or 90792s?

A71. You must complete the appropriate assessments for admission into program.

Q72. Can PRSS staff work in crisis stabilization units?

A72. Yes. Providers may elect to have PRSS staff in crisis stabilization units although no reimbursement is available for their services.

Q73. Do all IS programs, 2.1 and under regardless of whether it has a BH and/or SUD treatment focus need to submit a new IS Description at this time, and if so when is the deadline to have them in?

A73. Yes as quickly as possible to be compliant with policy.

Q74. We were informed that [due to certification effective date being back-dated] we need to roll back [claims for] current members in our program's level of care with the old service code, and resubmit with new service codes. Is this correct? If so:

a. When we request the first set of authorizations going back to date of program approval, do we request them as a retro request or regular request with a backdated service start date?
b. If a commercial insurance carrier is going to pay for the service, with or without authorization, can we go ahead and bill according to carrier's specifications?

A74. a. Yes, retrospective authorization requests will be permitted to the program's identified start date. Any existing authorizations for the services will be terminated and authorized under the appropriate SUD code. b. Yes, commercial insurance should be utilized before Medicaid.

Q75. If an OTP is receiving the daily bundle for a member in their program, can an RAS program also bill and receive the daily bundle for the same member concurrently?

A75. Yes.

Q76. Do we have to get a separate auth for Withdrawal Management (2.0) that will be done on our Crisis Unit, or will the auth we get for the Crisis Unit (H0036) cover it and we just use the admission criteria specific for WM2.0?

A76. Request the H0036 authorization, as there are no codes specifically for withdrawal management. Use admission criteria for Level 2WM, for members admitted who need detoxification services (withdrawal management).

Q77. How do we bill Peer Support Services (Recovery coaching) outside of residential services under SUD Waiver. We have many clients with addiction issues that could benefit from peer support services pre/post residential treatment.

A77. Request authorization for code H0038 through KEPRO and bill Fee-for-Service.

Q78. How will we bill the BHHF (OBHS, Charity Care) clients for SUD Waiver services? We cannot use the rehab provider number for a BHHF client, because they wouldn't have a Medicaid number to use, only a "19" number. Bundled as a per diem or unbundled as we currently bill?

A78. Please refer all questions concerning charity care to BBH.

Q79. If a client is in an approved residential SUD Waiver program, and has to go to the emergency room or to a PCP, do we have to pay for those services out of our per diem? Or will the treating entity bill for those services separately since the manual states that all E&M codes are excluded for reimbursement and are included in the bundle?

A79. Only 3.7 level of care has the E/M codes in the bundle rate.

Q80. The manual states we can use recovery coaching for co-occurring. If a client who is in outpatient could benefit from recovery coaching under SUD Waiver, can we request auths for both the therapy and recovery coaching at the same time, since they will both be billed under the rehab provider number.

A80. Yes. PRSS services may be requested for members receiving outpatient addiction treatment services.