Ambulatory Frequently Asked Questions (FAQ)

Below is a compilation of questions received throughout the planning of the 1115 Demonstration Waiver along with responses that we hope assist you as we transition into implementation. Please note, the State has made efforts to ensure that the provider standards does not conflict with any Department of Public Health (DPH) licensing regulations (see §19a-495-570 of the Regulations of Connecticut State Agencies) or Department of Children and Families (DCF) licensing regulations (see §17a-20-11 to 17a-20-61 of the Regulations of Connecticut State Agencies). In some instances, the provider standards exceed what is required within the licensing regulations. If now, or in the future, the licensing regulations exceed the standards, providers should ensure compliance with the higher expectation. New questions and responses not present in previous versions of this document appear in red font.

Questions Applicable to All Intermediate Levels of Care (IOP, PHP, 1-WM & 2-WM)

1. **Is there a way for a clinic not included in the original provisional certification application to receive a provisional certification at this time?**
   A. Yes, new sites can still request provisional certification. The provisional certification timeframe will end 24 months after the start date for the provider type/specialty cohort regardless of when the new sites obtain provisional certification. So for example, the provisional certification period for BH Clinics, ECCs and Outpatient Drug and Alcohol Abuse Centers is 11/15/2022-11/15/2024. A new site obtaining provisional certification on 2/15/22 would have a 21 month provisional certification period with an end date of 11/15/2024 in alignment with this provider type/specialty cohort.

2. **What is the process for completing a staffing waiver request- is there a form?**
   A. A request to the Departments (DSS, DMHAS and DCF) via email would initiate the process; there is no form at this time. Depending on the nature of the waiver request additional information and/or documentation may be requested for submission.

3. **Are hospitals, specifically those that provide dual-diagnosis ambulatory behavioral health treatment required to complete this application and if not, how would this impact our services?**
   A. If a hospital provides ambulatory behavioral health treatment to Medicaid beneficiaries with a primary SUD diagnosis in the following levels of care: ASAM 1-WM, 2-WM, 2.1 (Intensive Outpatient) or 2.5 (Partial Hospitalization), then certification under the 1115 SUD Demonstration is required. Electing not to participate in the certification process would bar the hospital from accessing the associated SUD billing codes and potentially increase the likelihood of improper Medicaid payments. If under audit, it is determined that these services were provided without certification it is likely that these errors would result in the recoupment of these payments.

Questions Applicable to Ambulatory Withdrawal Management (1-WM & 2-WM)

1. **Is it required for the staff completing the individualized progress note to include their credentials?**
    A. Yes, standards have been updated to reflect that credentials of the completing practitioner is required.

2. **Is there an expectation for a particular discipline to complete any of the following documents (biopsychosocial assessment, individualized treatment plan, discharge summary)? Is there an expectation for a full biopsychosocial assessment, or a briefer summary?**
    A. Staff completing any interventions and associated documentation should be operating within their scope of practice; unless specifically identified in the standards there is flexibility in which practitioners complete these tasks.

3. **Is there an expectation for a full biopsychosocial assessment or a briefer summary?**
    A. The expectation is that there be "sufficient biopsychosocial screening assessments to determine the level of care in which the person should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6."

4. **Is there a need for documentation in the standards about medication administration, such as:**
    - **The need for an individual medication record**
    - **The requirement that medications are administered only upon written and signed orders by a practitioner operating within their scope of license**
    - **The need for policies for safe prescribing and administration of drugs and recording of medication administration**

    A. The items identified are standards outlined by the Department of Public Health for licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons (§ 19a-495-570). As indicated in the standards, "All Providers must adhere to state licensing requirements for their respective level(s) of care."

5. **Are methadone clinics (08/096 Provider Type/Specialty) permitted to bill ambulatory WM services in addition to the methadone daily rate for purposes of an opiate taper?**
    A. Ambulatory WM is not a separately billable service for Methadone Clinics. The billing guidance outlined in PB 2017-22, *Methadone Maintenance Reimbursement Guidelines,* remains in effect along with existing rates for methadone clinics. The Behavioral Health Clinic Regulations referenced in the bulletin includes § 17b-262-822 which states:

    "Services shall be billed as chemical maintenance treatment when the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder. The induction phase of treatment, the maintenance phase and any tapering of treatment dosage downward, even to abstinence, shall be billed as chemical maintenance treatment."

6. **In the State Standards, it says an RN or NP must be on-site at all times during hours of operations. It also states that a request to waive that criteria can be submitted to the Department for review. Can a provider- such as an APRN, PA, or MD/DO- take on this role and/or would we be required to fill out a waiver in order for a provider to be able to fill this role?**
    A. Individuals with credentials higher than those identified in the State's Standards may perform the duties outlined so long as these duties are within the practitioner's scope of practice. Any time allocated to the Ambulatory WM program must be spent in the program performing duties as outlined in the Standards. Covering the Ambulatory WM program while performing duties at another program/level of care at the same site or vice versa would not be permitted. Clarifying language will be added to our Standards to note that providers of higher credentials can perform these duties so long as they are working within their scope of practice.

7. **Can the intake appointment for withdrawal management be done via telehealth?**
    A. While agencies may opt to screen for admission eligibility and scheduling admission by phone, this is not a separately billable service. Intake assessments, including but not limited to, the medical history and physical examination, addiction-focused history, biopsychosocial screening and withdrawal measures should be completed during the in-person service provision.

8. **Is a certified peer required as part of the staffing?**
    A. Ambulatory WM (both ASAM 1-WM and 2-WM) require a certified peer as part of the staffing.

9. **What is the treatment plan frequency?**
    A. As outlined in the standards, the individualized treatment plan "shall be initiated at the time of admission and reviewed and modified as needed until the individual is discharged." This aligns with the facility licensing expectations per DPH.

10. **For Ambulatory Withdrawal Management (ASAM 1-WM) are the clinical hours required every day? the auditors thought that clinical hours were required every day. Can this be clarified? We currently do one individual session and one group session per week.**
    A. Individuals assigned to outpatient ambulatory withdrawal management (ASAM 1-WM) should be receiving up to 4 hours of services per day as outlined in the Treatment Services section of the State Standards. There should be evidence in the medical record of some type of service each day e.g., nursing notes, care coordination. Individual and group sessions would also count towards service hours. There are no minimum daily clinical hours at this level of care. This question has been reviewed with the auditing teams.

11. **Are prior-authorizations for ambulatory withdrawal management programs required? Our finance staff state that authorizations are not required for this LOC although the auditors were looking for them.**
    A. Prior authorization is not required for 1-WM and 2-WM programs. This has been reviewed with the auditing teams.

Questions Applicable to Intensive Outpatient (IOP) and Partial Hospitalization (PHP)

1. **Will the policies be revised to align with the recent revision made to the residential levels of care to change the language "….a Master's prepared behavioral health practitioner with a minimum of an associate license" to "an independently licensed or associate licensed behavioral health practitioner, or graduate-level intern"? Will use of graduate-level interns be allowed in the PHP and IOP levels of care?**
   A. The state updated the IOP and PHP standards and posted them to the dedicated website. Graduate level interns were also included in this update.

2. **Are the standards for IOP and PHP applicable to adult and youth programs?**
   A. Yes. ASAM does outline adolescent-specific considerations, however, and these are noted in the standards document, where applicable.

3. **For PHP, what is the timeframe in which a physical examination needs to be completed? Is completion via telehealth permitted?**
   A. Our state standards, which align with ASAM, do not have a specific timeframe for completion of a physical and note that they should be completed "within a reasonable time, as determined by the individual's medical condition." Additionally, our standards note reliance on the client's personal physician whenever possible. The standards do not specify telehealth or in-person as it would depend on the telehealth policy in effect and the preference and policies of the physician/practice completing the physical. PHP providers should ensure they are assessing clients' biomedical conditions (ASAM Dimension 2) as part of their multidimensional biopsychosocial assessment and document any findings. When a need is identified, a goal to address this need should be incorporated into the individual's treatment plan. providers should assist clients

4. **For PHP, what is the timeframe in which a psychiatric evaluation needs to be completed?**
   A. Our standards state that the necessary support systems for PHP include "Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral. **Psychiatric and other medical consultation is available within 8 hours by telephone and within 48 hours in person**." These identified timeframes are specific to when a need is identified to ensure that an expeditious connection to these specialty services is facilitated by the PHP program.

5. **For Adolescent PHP, is an education professional required to be part of the staff?**
   A. The standards state "For adolescents, partial hospitalization often occurs during school hours; such programs typically have access to educational services for their adolescent patients. Programs that do not provide educational services should coordinate with a school system in order to assess and meet their adolescent patients' educational needs." It is not required that an educational professional be a part of the PHP staffing. However, when programs do not provide educational services, the program has a responsibility to coordinate with the member's school system to assess and ensure that their educational needs are being met. Additionally, per CT State Department of Education (CSDE), a school schedule has to be worked out with the student's school district. The member's treatment record should note how the member's educational needs are or are not being met, the source of this information and any identified plans and responsible parties for addressing any educational gaps.

6. **Number 3 in the admission criteria section states "Emotional, behavioral, or cognitive conditions and complications: None to moderate." Does that mean individuals with serious and/or pervasive mental illnesses should not be admitted to an SUD IOP or SUD PHP program?**
    A. Individuals with serious and/or pervasive mental illnesses should not be excluded from receiving treatment in an SUD or IOP or SUD PHP program. While emotional, behavioral or cognitive conditions are not required for admission to SUD IOP or PHP, such programs should be co-occurring capable such that individuals presenting with these concerns are able to receive concurrent treatment appropriate to their mental health condition. Treatment associated with these conditions or concerns should be reflected in the member's individualized treatment plan.

    Co-occurring capable addiction treatment programs generally serve a diverse population. Some individuals in the program may have no mental health condition or trauma history. For those individuals, addiction-focused treatment is all that is necessary. Usually the majority of individuals, however, will have a range of mental health conditions, cognitive/learning issues, and/or trauma issues that should be screened for in a co-occurring capable program. Most of these individuals will have symptoms and impairments that are mild to moderate in acuity and/or severity.

    The typical co-occurring capable addiction treatment program will be able to manage a small percentage of individuals who have more serious psychiatric conditions (e.g., a person with schizophrenia who is on disability, a person with a more severe personality disorder). The same is likely true for managing individuals who may intermittently have flare-ups of acute symptoms (e.g., flashbacks or panic attacks), but do not need acute mental health treatment. Such patients are still interested in receiving addiction treatment and, with support, are capable of succeeding in the addiction program.

7. **Is a new biopsychosocial required for someone who is stepping up/down into IOP? How recent does it need to be?**
    A. Yes, a new assessment should be completed for any individual entering an IOP program. To the degree that an agency has information from the previous treatment episode, this can be integrated into the updated assessment with verification with the member that the information is still applicable. The biopsychosocial guides the development of the individualized treatment plan.

8. **Can the biopsychosocial be done by telehealth?**
    A. Procedure code 90791 (psychiatric diagnostic evaluation) can be billed for separately prior to admission to IOP or PHP to assess the member's appropriateness for the level of care. Procedure code 90792 (psychiatric diagnostic evaluation with medical services) can be billed separately once during a treatment episode. Both may be conducted via telemedicine if permitted under current telehealth policy.

9. **What capacity can LADC's be used? Are they included in the group to provide clinical hours (independently licensed or associate licensed masters level behavioral health practitioners)?**
    A. LADCs are considered independently licensed behavioral health practitioners and can be used within their scope of practice, including the provision of clinical hours.

10. **For the physical, can we use one that we have on file either completed by our organization or received from another organization? How recent does it need to be?**
    A. Our standards indicate "within a reasonable time, as determined by the individual's condition. Such determinations are made according to established protocols, which include reliance on the individual's personal physician (or NP/PA) whenever possible." In addition to the State's standards, all Providers must ensure adherence to state licensing and funding requirements for their respective level(s) of care.

11. **Does any of the time spent doing service coordination count towards the total hours?**
    A. Service coordination does not count towards the clinical hours. To the degree that service coordination involves the member and helps advance their treatment goals as outlined in their individualized treatment plan, service coordination activities may count for the non-clinical hours of weekly programming. For example, if a member has an identified need to further develop skills in scheduling, managing and maintaining appointments and there is a treatment plan goal that corresponds to this need, the service coordinator may facilitate the development of this skill through service coordination activities. It is anticipated, however, that some of the service coordination activities (e.g. referrals and linkages to other community-based resources) will be in addition to the weekly programming that members receive.

12. **Can LPN's and/or RN's provide clinical hours?**
    A. No, clinical hours must be provided by an independently licensed, associate licensed masters level behavioral health practitioner or graduate-level intern whose placement and clinical training is in the provision of behavioral health services (please see the limits outlined for the intern in the standards). RNs and LPNs may work within their scope of practice to provide the non-clinical hours of programming (e.g. psychoeducational group on the importance of medication adherence).

13. **Under Service Coordination, the last bullet says, "service coordination may be performed by licensed, unlicensed and certified practitioners…" What do you mean by "certified practitioners"?**
    A. Certified Peers or Certified Alcohol and Drug Counselors (CADCs) are both certified practitioners who would be appropriate to fulfill the service coordination activities.

14. **Does a discharge summary need to be completed if the individual is continuing care in our agency (would a transfer of treatment note- be acceptable noting goals/recommendations for continued care).**
    A. A discharge summary is required within 15 working days of the individual leaving the program. Please refer to the standards for additional information on what is required in this document.

15. **Will there be any additional review of the IOP and PHP rates or are these the final rates?**
    A. After a comprehensive review of the IOP and PHP rates that are proposed in our current substance use disorder state plan amendment, DSS has confirmed that the IOP and PHP rates will remain as is.

    DSS has confirmed that the IOP and PHP rates include sufficient physician time to align with requirements in outpatient hospital programs for physician direction. Outpatient

hospital services are governed by the Outpatient Hospital State Plan Amendment. The approved rehabilitative state plan for non-hospital providers transitions IOP and PHP from the clinic authority to rehabilitative authority. However, this does not affect outpatient hospital service provision authority. Services in an outpatient hospital setting must remain under the outpatient hospital authority under the direction of a physician. Rehabilitative services in a non-hospital setting must be recommended by a licensed practitioner of the healing arts but do not have to be physician directed.

16. Is psychoeducation included as part of the 2.5 clinical hours required for IOP or 3.5 clinical hours required for PHP?

A. No, psychoeducation is considered non-clinical.

Please note that with the approval of State Plan Amendment (SPA) 22-0020 and 22-0021, SUD services were moved to the Medicaid Rehabilitative Services Category and are no longer under the authority of the Behavioral Health Clinic Regulations. Regulations for rehabilitative services are under development. In the interim, providers should continue to follow any guidance outlined in the SPAs, Provider Bulletins and State Standards as agreed to in the Addendum to Provider Enrollment Agreement for Substance Use Disorder (SUD) Providers – Outpatient and Residential Levels of Care.

17. Are the clinical hour requirements in effect as of 11/15/2022?

A. The total minimum number of treatment hours need to be in place as of 11/15/2022. Clients need to be prescribed and scheduled for these treatment hours. There is some flexibility during the provisional certification period which is 24 months post implementation as to what staff can provide these hours and at what percentage. The State Partners recognize that it may take some time for agencies to meet the total number of hours required to be provided by clinical staff due to current labor issues.

18. Are medication management services permitted to be billed for separately?

A. As outlined in PB 2022-86, medication management is a treatment component of the IOP and PHP programs and are included in the per diem IOP and PHP rates. Such services are not permitted to be billed for separately.

19. How much time can elapse between the completion of the biopsychosocial (BPS) assessment and the client beginning ambulatory services before a new BPS must be completed?

A. Agencies should consult with their medical and clinical leadership when there is gap between assessment and the individual receiving treatment in ambulatory levels of care to ensure it is clinically appropriate. If the individual does not begin services within 30 calendar days of assessment, a clinical note at admission that re-assesses the six ASAM dimensions for any significant changes is indicated.

1115 SUD Demonstration Treatment Plans, Biopsychosocial Assessments and Discharges Completion Questions

1. **When are Treatment Plans, Biopsychosocial Assessments and Discharges considered completed under the Demonstration?**

A. Once the treatment plan/biopsychosocial or discharge plan is completed and signed by an independently licensed practitioner as defined by the Demonstration's State Plan Amendment it is considered completed and in final status. If it is completed and signed by any other qualified practitioner, it would need to be reviewed and signed by an independently licensed practitioner to be considered in final status. For certification purposes auditors will give partial credit for the treatment plan/biopsychosocial or discharge summaries that are completed by a qualified practitioner within the timeframes outlined in the standards and will give full credit for documents that are subsequently reviewed and signed by an independently licensed clinician for final status within the following timeframes:

<table>
<tr><th>Documentation Type</th><th>ASAM Level of Care</th><th>Completion Timeframe</th><th>Final Status</th></tr>
<tr><td rowspan="3">Biopsychosocial Assessment</td><td>3.1,
3.3</td><td>Within 72 Hours of Admission</td><td>5 Calendar Days</td></tr>
<tr><td>3.5,
3.5PPW,
3.7R,
3.7RE,
3.2WM,
3.7WM</td><td>Within 48 Hours of Admission</td><td>5 Calendar Days</td></tr>
<tr><td>2.1
2.5
1-WM
2-WM</td><td>Initiated for level of care determination prior to admission and completed within 72 Hours.</td><td>15 Calendar Days</td></tr>
<tr><td rowspan="4">Initial Treatment Plan</td><td>3.1,
3.3,
3.5,
3.5PPW</td><td>Within 72 Hours of Admission</td><td>5 Calendar Days</td></tr>
<tr><td>3.7R,
3.7RE</td><td>Within 48 Hours of Admission</td><td>5 Calendar Days</td></tr>
<tr><td>3.2WM,
3.7WM,
1-WM
2-WM</td><td colspan="2">Completed within 48 hours of admission</td></tr>
<tr><td>2.1
2.5</td><td>Within 72 Hours of Admission</td><td>30 Calendar Days</td></tr>
<tr><td>Discharge Summaries</td><td>All ASAM Levels of Care</td><td colspan="2">Within 15 Working Days from Discharge Date</td></tr>
</table>

- Agencies should continue to utilize clinical discretion and comply with all applicable licensure timelines regarding the completion of these documents

2. **At clinics where clients are dually enrolled in MOUD or MAUD programs and ambulatory levels of care e.g., intensive outpatient are separate treatment plans required or can the facility utilize an integrated treatment plan?**

A. Integrated plans are acceptable provided there is clear delineation of when the subsequent episode began and that the services identified are aligned with an updated dimensional assessment and level of care determination e.g. start dates, updated signatures etc. Plan should be updated to reflect the goals associated with each LOC. Timeframes for treatment plan reviews and discharge plans should be met for the respective levels of care being provided and progress appropriately noted.

3. **Nursing Assessment – Our physicals are completed by APRN which includes a detailed substance use assessment. Can this count as a nursing assessment or does it need to be a separate form?**

   A. If completed within the appropriate timeframes outlined in the Connecticut State Standards, this would meet the requirement.

1115 SUD Demonstration Supervision Questions

1. Can the supervision hours be reviewed and updated to incorporate feedback from the providers over the first 18 months of the Demonstration?

A:

Changes to Supervision Expectations under CT 1115 SUD Demonstration January 2024
Agencies should consult State Plan Amendment 22-0020 for definitions of practitioner qualifications and supervision guidelines. The following guidance pertains only to the expectations of the 1115 SUD Demonstration and does not replace or supersede any other regulatory or professional licensure expectations. It is recommended that agencies utilize their clinical and professional discretion in setting additional supervision expectations for personnel. State Plan Amendment 22-0020, the Connecticut Substance Use Disorder Services Policy and Clinical Assumptions Grid and other provider resources can be found at https://portal.ct.gov/DSS/Health-And-Home-Care/Substance-Use-Disorder-Demonstration-Project/Provider-Resources.

ASAM Level of Care	Professional Discipline	Current Standard	Updated Standard
ASAM 2.1 Intensive Outpatient Treatment (IOP) ASAM 2.5 Partial Hospitalization (PHP)	Independently Licensed Clinical Staff	Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month.	No Change
	Associate licensed or Unlicensed staff	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
	Certified Peers	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
ASAM 3.1 ASAM 3.3 ASAM 3.5 ASAM 3.5 PPW ASAM 3.7 ASAM 3.7RE ASAM 3.2 WM ASAM 3.7WM	Independently Licensed Clinical Staff	One hour per week. Group supervision may be utilized once per month.	Two hours per month for independently licensed clinical staff. Group supervision may be utilized once per month.
	Associate licensed or Unlicensed staff	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
	Certified Peers	One hour per week. Group supervision may be utilized once per month.	One hour per week for associate licensed and unlicensed staff. **Group supervision may be utilized twice per month**.
	Technicians	Technicians receive supervision 30 minutes for every 40 hours worked. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month).	No Change