Preferred Provider Certification and Services Manual

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Introduction

The Vermont Department of Health (VDH), Division of Substance Use Programs (DSU), in partnership with state and community–based public and private organizations, aims to create an accountable, comprehensive system of services and supports that empowers Vermonters to embrace resiliency, wellness, and recovery by becoming active participants in the management of their treatment and recovery. This system is composed of a continuum of timely, interconnected and coordinated components with multiple entry points that include the entire range of services from prevention, early intervention, and treatment through recovery.

On September 30, 2005, The Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Program. The Global Commitment to Health is a Demonstration Initiative operated under the Section 1115(a) waiver for Vermont's Medicaid program. The Legislature gave full approval for participation in the waiver on December 13, 2005.

The Global Commitment to Health Waiver provides the State with increased flexibility in the application of its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g. case rates, capitation, combined funding streams, incentive reimbursements) rather than individual fee-for-service payments, flexibility to pay for healthcare-related services not traditionally reimbursable through Medicaid, and investments in programmatic innovations. It is based on a managed care model that also encourages collaboration and consistency across programs.

The Center for Medicare and Medicaid Services (CMS) requires that all programs operating within Medicaid Waivers meet the requirements of 42 CFR 434.6, all applicable Federal and State laws, and regulations. Specific policies and procedures for communicating with plan members (persons served) are required, including grievance and appeals processes and their resolution, management of subcontracted providers, quality improvement, and data reporting.

The Department of Vermont Health Access (DVHA) has delegated responsibility of the state substance use authority to VDH for the administration of Medicaid funds to the Preferred Providers for the services outlined within this manual. In addition, VDH is responsible for dissemination and oversight of the federal Substance Use Prevention, Treatment, and Recovery Services Block Grant dollars to Preferred Providers.

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Definitions

ADMINISTRATIVE DISCHARGE: The process of withdrawing a client from services.

ADMISSION CRITERIA: Written specifications, which guide the need for, and placement of persons served within a continuum of treatment services.

ASAM CRITERIA: Clinical guidelines developed by the American Society of Addiction Medicine (ASAM) to improve assessment- and outcomes-driven treatment and recovery services

ASSESSMENT: The process of evaluating and documenting an individual's social, mental and physical past history and current status to determine if the person has a diagnosable condition and is in need of treatment services.

BUDGET: An itemized list of expected expenses and revenues for a given period of time.

CLINICAL DISCHARGE: The process of transitioning the client to another treatment provider.

CONTINUING CARE: Care that is ongoing through different phases of treatment.

CO-OCCURRING: Presence of concurrent substance use disorder and mental or physical illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

COUNSELING: The interaction between a counselor and a person served intended to result in a positive change in social, mental and/or physical status.

COUNSELOR or CLINICIAN: An individual who is deemed qualified by the hiring organization to provide counseling services.

COUNSELOR APPROVAL REGULATIONS: The administrative rules V.S.A. Title 3, Chapter 8 that define the standards and criteria for licensed alcohol and drug treatment counselors.

DIAGNOSIS: The process of identifying the specific nature and type of disease and/or problems of an individual based on an assessment of the person's social, mental, and physical past history and current status, and of documenting the opinion using the criteria and format of the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).

DATA 2000: means the federal Drug Addiction Treatment Act of 2000, which permits physicians who meet certain qualifications to treat individuals with opioid addiction by prescribing FDA-approved medications such as buprenorphine.

DATA 2000 Waiver: means an authorization for a licensed physician who has met the training and credentialing registration requirements of DATA 2000 to prescribe specified opioid addiction drugs to patients in settings other than Opioid Treatment Programs (OTP's).

DETOXIFICATION: Please see "Withdrawal Management".

DIVERSION: Illegal use of a prescribed controlled substance other than that for which, and to whom, it was prescribed

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DOCUMENTATION: A written record acceptable as evidence to demonstrate compliance with these standards.

DSU: The Division of Substance Use Programs of the Vermont Department of Health.

DVHA: Department of Vermont Health Access of the Agency of Human Services

EMERGENCY CARE: The provision of immediate diagnosis and care, as well as appropriate referral, to persons having acute substance abuse related problems.

EVALUATION: A systematic process by which treatment or program outcomes are assessed considering identified goals and objectives.

FOLLOW-UP: Contact with a person served after discharge for the purposes of determining post-treatment adjustment and assessing the impact of programming.

HEALTH HOME: A Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole-person" across the lifespan.

HUMAN SUBJECT RESEARCH: Scholarly or scientific investigation that involves the use of people served as subjects.

INFORMED CONSENT: The patient's agreement to participate in treatment based upon an understanding of the provider's rules, expectations and procedures involved in treatment after achieving an understanding of the relevant medical facts and the risks involved. This includes an understanding of medication risks and benefits.

INTERIM MAINTENENCE TREATMENT: Medication maintenance treatment provided in conjunction with appropriate medical services while a patient is awaiting transfer to a program that provides comprehensive Medication Assisted Treatment.

INTERPRETIVE SUMMARY: Central themes of the person that capture the relationships between sets of findings including the person's needs, strengths, and limitations. It should include a clinical determination regarding the patient's previous course of treatment, and treatment recommendations including appropriate level of care, length of care, and intensity of treatment.

INTENSIVE OUTPATIENT PROGRAMMING (IOP): As defined by ASAM, Level 2.1, IOP is comprised of 9-18 hours (6 or more hours for adolescents) of structured services per week, consisting primarily of individual, group, and family counseling, medication management, and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is psychiatrically and medically stable and requires only maintenance monitoring. (Services provided outside this programming must be tightly coordinated.) IOP services are not required to be provided in a single location and providers are expected to have the capability to tailor components of the program to meet each patient's individualized needs.

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INTERIM SERVICES: Interim services include counseling and education about tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that TB transmission does not occur, as well as referral for TB treatment services, if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

INTERN: An individual who, as part of matriculation toward a formal academic degree, has negotiated to work in an approved program for a specific period.

MAINTENANCE TREATMENT: Long-term MAT typically provided by an OBOT for an addiction lasting longer than one year.

MEDICATION FOR ALCOHOL USE DISORDER (MAUD): is a treatment approach that uses FDA-approved medications to help manage Alcohol Use Disorder (AUD). MAUD works by reducing cravings and withdrawal symptoms, making it easier for individuals to engage in recovery. Examples of medication that may be used for MAUD include naltrexone, disulfiram, and acamprosate.

MEDICATION FOR OPIOID USE DISORDER (MOUD): is a treatment approach that uses FDA-approved medications to help manage Opioid Use Disorder (OUD). MOUD works by reducing cravings and withdrawal symptoms, making it easier for individuals to engage in recovery. Examples of medication that may be used for MOUD include methadone, buprenorphine, and naltrexone.

HUB (Opioid Treatment Program also known as OTP): A regional addiction treatment center providing comprehensive addiction treatment, Health Home, and rehabilitation services for clinically complex patients with opioid use disorders who are receiving methadone maintenance therapy or buprenorphine maintenance therapy.

OUTPATIENT PROGRAM: ASAM Level 1 describes an outpatient program as an organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed alcohol and other drug treatment that are co-occurring capable and tailored to the individual's symptom severity and level of functioning. Outpatient treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week (6 hours for adolescents).

OUTREACH: The development and implementation of a plan to interact with a community or geographic area and its organizations to identify persons in need of services, inform individuals and organizations about the availability and location of services, encourage and assist persons to accept and enter treatment services, and develop organizational affiliations to facilitate the referral of persons in need of services.

PERSON SERVED: An individual who is receiving services that are governed by these standards.

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POLICY: A written and dated statement or course of action designed to determine and govern the decisions, activities, procedures and/or operations of an organization and its employees and representatives.

PREFERRED PROVIDER: Specialty substance use treatment service provider certified and audited by VDH.

PRIORITY POPULATION: groups defined by the Substance Abuse Prevention and Treatment Block Grant as having priority for access to services. Priority populations are pregnant women and intravenous drug users.

PROCEDURE: A series of activities designed to implement organizational goals or policy.

PROGRAM: An organizational entity, which provides treatment services to persons with substance abuse problems. A program may be an identified administrative unit within a larger organization; it may also consist of more than one component.

PROGRAM DIRECTOR: The person responsible for the technical and programmatic aspects of the program. This person should provide direct supervision of the day-to-day aspects of program operation.

PROGRAM EVALUATION: A written system designed and implemented to measure both the processes and outcomes of a treatment program.

PROGRESS NOTE: Written documentation of a person's clinical status and achievements during care which is part of the clinical record. Progress notes are individualized to each client and usually follow a standardized format, such as SOAP (Subjective, Objective, Assessment, and Plan) and include details of the client's symptoms, assessment, diagnosis, and treatment.

PSYCHOSOCIAL ASSESSMENT: Comprehensive evaluation of the psychological and social factors that are experienced by an individual or family as the result of addiction. The factors may complicate an individual's recovery or act as assets to recovery.

REFERRAL: The process by which a person served is directed to needed services not provided by the organization.

RESIDENTIAL PROGRAM: An organized service in alignment with ASAM Criteria 3rd edition 3.1 to 3.7 level of care that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to people served who reside on the premises during the course of treatment.

RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES: ASAM Level 3. 7 -WM: Medically Monitored Inpatient Withdrawal Management is an organized service delivered by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. These programs must comply with the requirements of ASAM, Third Edition.

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RISK MANAGEMENT PLAN: A document prepared to foresee risks, estimate potential impacts, and -define responses to issues

SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services.

SCHEDULE OF FEES: Maximum rate charged for each type of service a program provides.

SCREENING: A simple test performed using an evidence- based tool to identify those who are likely to have a specified disease and require further assessment.

SPECIAL POPULATION: A target group characterized by specific demographic, clinical and/or other unique features.

SPOKE (Office-Based Opioid Treatment Program also known as OBOT): A team of health care professionals providing ongoing care for patients receiving buprenorphine that is comprised of a designated prescribing OBOT provider and the team of collaborating medical and addiction treatment professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services.

SUPERVISION: A formal, systematic process that focuses on clinical skills development and/or integration of administrative procedures. Supervision that is clinical in nature must be provided by someone that is practicing within their scope.

TOXICOLOGY TESTS: Laboratory analysis of urine, oral mucosa, or serum blood for the purpose of detecting the presence of alcohol and/or various scheduled drugs.

TREATMENT: Planned and continuing services extended to the person served. Treatment includes screening for co-occurring health issues, a comprehensive assessment, appropriate services that meet the needs of the individual and linking ongoing support through recovery centers.

TREATMENT PLAN: A written document created to guide the course of treatment that is developed with the participation of the person served, which is appropriate to meet the person's needs, and which specifies goals, activities, and services determined through the process of assessment.

UNDERINSURED CLIENT: An individual who is enrolled in Medicare and/or a 3rd party payer insurance whose benefit does not cover the services provided and/or whose carrier does not cover the services when provided by an VDH Preferred Provider.

UNINSURED CLIENT: An individual who is not eligible for Medicaid and is not enrolled in Medicare or a 3rd party payer insurance coverage at the time services are provided.

UTILIZATION REVIEW: A process for monitoring the use, delivery, and cost-effectiveness of services.

VPMS: The Vermont Prescription Monitoring System, the statewide electronic database that collects data on Schedule II, III, and IV controlled substances dispensed in Vermont

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VOLUNTEER: A non-paid employee.

WAIT LIST: The unduplicated number of individuals assessed to need substance abuse treatment who are not yet receiving services

WITHDRAWAL MANAGEMENT SERVICES: the provision of medical and/or social services in a facility staffed 24 hours per day to persons served who are experiencing or are at risk for experiencing physical withdrawal from alcohol or other drugs. Social setting withdrawal management services take place in a non-medical facility, a unit of which has been specifically structured and staffed to provide the above services. Medical withdrawal management services are delivered by medical professionals and the symptoms of the person served are severe enough to require 24-hour inpatient care.

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Focus and Scope

This supplemental resource for the Preferred Providers does not replace the Department of Vermont Health Access (DVHA) Medicaid Program's *Green Mountain Care Provider Manual*. Preferred Providers are required to comply with all the requirements of the Vermont Medicaid program as outlined in the *Green Mountain Care Provider Manual* as these requirements apply to services covered under the Vermont Medicaid program.

This manual is intended to provide guidance to Preferred Providers regarding eligible service activity, reimbursement resources, and documentation requirements and is subject to change.

The contents do not represent an inclusive reference directory for all possible questions or clarifications that may be necessary to comply with Medicaid, Substance Use Treatment, Prevention, and Recovery Block Grant, or other State, Federal or VDH requirements. Providers are responsible for seeking clarification regarding services or activities and eligibility for reimbursement when services or billing is in question. **Questions regarding claims and billing issues should be directed to the Gainwell Provider Representative or the Provider Services Unit of Gainwell** at 1-800-925-1706.

Covered Entities

Medicaid payments for covered services are limited to VDH Preferred Providers that are certified by VDH for the purpose of providing substance use disorder treatment. Block grant payments are limited to VDH Preferred Providers that are certified by VDH for the purpose of providing substance use disorder treatment.

As a Preferred provider, in addition to VDH certification, you must also re-certify with Vermont Medicaid every three to five years depending on provider type and assigned risk level. Providers will be notified that they are required to revalidate prior to the revalidation deadline.

Preferred providers must comply with all parts of the Substance Use Disorder Treatment Certification Rule, Preferred Provider Substance Use Disorder Treatment Services Standards, all other relevant VDH grant/contract assurances and applicable laws.

If the Preferred Provider subcontracts services to be performed under the grant agreement it is the responsibility of the Preferred Provider to ensure that the subcontractor adheres to the requirements set forth in this manual as well as secure approval from VDH for the subcontractor, when so required. The subcontractor is then able to perform these services on behalf of the Preferred Provider.

For an entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards and procedures required by this manual.

The service must be provided, in accordance with the individual treatment plan, by:

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A Vermont Medicaid enrolled provider who is performing services consistent with their licensed scope of practice and who is employed by a Preferred provider, or a non-licensed staff member of the Preferred provider who, based on his/her education, training, or experience, is determined competent to provide the service by the Medical Director of the Preferred provider and whose work is directly supervised by a Medicaid Enrolled provider in adherence with the Supervised Billing Policy Health Care Administrative Rule (HCAR) 9.103 which can be accessed at http://humanservices.vermont.gov/on-line-rules/health-care-administrative-rules-hcar/health-care-administrative-rules/and is also reflected in *Section 8.5 – Supervised Billing for Behavioral Health Services* of the Vermont Medicaid Provider Manual.

Medicaid Enrollment

Providers must confirm Medicaid eligibility and other insurance information of the person seeking services. If the person served is not currently enrolled, but may be eligible for Medicaid, the Provider is expected to either assist the person with completing an application or support them through the application process.

The provider shall have an identified mechanism in place to track and monitor Medicaid eligibility and/or enrollment status for any person served. Providers are required to provide the applicable processes/procedures to VDH for review upon request.

Below are resources and tools to help with this process. These resources ensure that providers can efficiently verify eligibility and that members receive the public benefits they are entitled to under Vermont's Medicaid program.

Medicaid Eligibility Verification Tools

Providers can confirm Medicaid eligibility and access other insurance information through the following options:

- **Vermont Medicaid Provider Portal**:
  Access Medicaid-related information and verify eligibility at www.vtmedicaid.com.
- **Automated Voice Response System (VRS)**:
  Call **802-878-7871** for automated eligibility inquiries.

Medicaid Enrollment Process

The **Department of Vermont Health Access** determines Medicaid eligibility. Applications for Medicaid benefits can be submitted online:

- **Vermont Health Connect Portal**:
  Submit Medicaid applications.

Other Public Benefit Programs

In addition to Medicaid, applications for other public benefits in Vermont, such as food or fuel assistance, can be submitted through the **Department for Children and Families (DCF)**. Here are the ways to apply:

- **Online**: Apply for Benefits
- **By Phone**: Call the DCF Benefits Service Center at **(800) 479-6151**
- **In Person**: Visit a local DCF district office. Find office locations at http://dcf.vermont.gov/esd/contact-us/districts.

Statewide Beneficiary Support

For questions or assistance with Medicaid benefits, beneficiaries can contact the **Green Mountain Care Member Services Unit** at **1-800-250-8427**.

Provider Eligibility

Provider numbers are issued for the provision of specific types of services. Only services specifically allowed under a given provider number will be reimbursed. In cases where multiple provider numbers are issued to an entity, VDH staff will have access to reimbursement information under each number. Ongoing Medicaid review of activities by VDH will include verification that duplicate payments are not made under multiple provider numbers for the same service.

Medical Necessity

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule. 7103, medically necessary is defined as:

> *"Health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and A. help restore or maintain the beneficiary's health; or B. prevent deterioration or palliate the beneficiary's condition; or C. prevent the reasonably likely onset of a health problem or detect an incipient problem.*

VDH has adopted the American Society of Addiction Medicine (ASAM) *Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions* for use in the process of determining the medical necessity of substance use disorder treatment services. The ASAM Criteria provides criteria for a wide range of services for the care of addiction and substance-related conditions and establishes clinical guidelines for making the most appropriate treatment recommendations for people who demonstrate specific signs and symptoms of substance use disorders.

ASAM includes a comprehensive system of multidimensional assessment, broad and flexible continuum of care, interdisciplinary team approach to care giving; and clinical and outcome-driven treatment is expected to substantially reduce the consequences of substance use disorders. It also includes the conceptual framework of Recovery-Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented

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"chronic disease management" continuum, rather than repeated and disconnected "acute episodes of treatment" for the acute complications of substance use disorders; and/or repeated and disconnected readmissions to treatment programs that employ rigid lengths of stay into which members are "placed."

Adjacent Regulations

There are several inter-related agencies that oversee parts of the Preferred Provider network services.

Vermont Medicaid

Medicaid provides health coverage to many Vermonters—including those with low incomes, children, pregnant women, elderly adults and people with disabilities. Medicaid is run through a partnership between state and federal governments. After the Affordable Care Act was passed in 2010, Vermont expanded its Medicaid programs to cover more people. Medicaid pays for medically necessary health services provided by hospitals, physicians and other providers; rural health clinics; and community health centers.

The State of Vermont contracts with a fiscal agent, Gainwell, to enroll/re-enroll Vermont Medicaid providers, manage and maintain a Provider Call Center, manage and maintain the MMIS (Medicaid Management Information System), process Vermont Medicaid claims, pay enrolled health care providers and perform other duties.

Department of Health

The Department of Health promulgates rules related to medication for opioid use disorder and related topics. These rules include:

- Medication-Assisted Treatment for Opioid Use Disorder
- Prescribing of Opioids for Pain
- Safe Disposal of Unused Drugs
- Substance Use Disorder Treatment Certification Rule
- Vermont Prescription Monitoring System

Department of Vermont Health Access

- Substance Use Disorder Office Based Opioid Treatment Guidelines
    - All DVHA Procedures and Guidelines
- Health Care Administrative Rules

Department of Aging and Independent Living

- Therapeutic Community Residences Licensing Regulations

Vermont Certified Community Behavioral Health Clinics

- Certified Community-Based integrated Health Centers (CCBHCs) are community-based mental health and substance use disorder treatment providers that offer a wide range of services, including 24/7 crisis care, outpatient mental health and

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substance use disorder treatment, primary care screening and monitoring, and peer support services.

Office of Professional Regulation

Below is a partial list of the various professions regulated by the Vermont Office of Professional Regulation that are relevant to the services outlined in this manual. Each profession's page has more detailed information including contact information for the licensing administrator.

- Alcohol and Drug Counselors
- Allied Mental Health
- Psychological Examiners (Psychologists)
- Social Workers

National Correct Coding Initiative

The Patient Protection and Affordable Care Act (PPACA) mandates that all claims submitted on or after October 1st, 2010, must be filed in accordance with the National Correct Coding initiative (NCCI) guidelines. The NCCI was developed by CMS to promote the correct coding of health-care services by providers and to prevent improper payment when incorrect coding occurs. For the Medicaid NCCI Policy Manual that contains the NCCI rules, relationships, and general information, Medicaid NCCI FAQs, and the complete edit files, please refer to: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html. Code combinations are refreshed quarterly.

Certification Processes

The Department of Health's certification process is designed to evaluate substance use-related clinical programs across the continuum of care as aligned with the American Society of Addiction Medicine levels of care and criteria. Only organizations who are certified by the Department of Health can be eligible to take part in the enhanced reimbursement rates for appropriate clinical services.

Re-certification Procedure

Prior to the Site Visit

At least one month prior to the expiration of the certificate, the organization will be contacted with a list of possible days that are available for VDH staff to come out for a site visit.

Once a date has been confirmed, VDH will send the site the "VDH Recertification Application" as well as the expectations for the day (below).

One week prior to the site visit, VDH will send a list of client names/identifiers to the program contact in order to have the charts or EHR logins ready prior to the day of the site visit.

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The provider will complete and send the link to the Certification Application with the suggested agenda (below) prior to the site visit. VDH staff will review the application and attachments, the prior site visit report, and the VDH Preferred Provider Treatment Guidelines and grant language.

During the Site Visit

The following guidance is given to the providers in order to plan the day/process:

- Meet with leadership—if it's possible, VDH would like this to be the first meeting to kick-off the day. This is where general updates occur as well as challenges, successes, and sharing the vision for the upcoming years.
- Meet with 3-4 staff members who are not part of the leadership team—if they can't meet together, VDH can conduct shorter meetings of 15-20 minutes with staff individually
- Meet with 3-4 people receiving or who have received substance use services at the organization—can be individual or group conversations.
- Review client records—this activity would ideally be completed offsite using specific user credentials to access the provider's EHR remotely.
- Community partners interviews—VDH staff will reach out to community partners in the region of the provider to determine the nature of collaboration that occurs.
- VDH internal staff debrief
- Wrap-up session

After the Site Visit

After the site visit, VDH staff have 30 days to complete and send a draft of the site visit report. In the event that there is a delay in receiving documents or in speaking with staff, clients, or community partners, this timeline may be extended.

The program then has 30 days to send feedback, provide more clarification to the findings, or refute findings to VDH. If the provider does not respond by the deadline, a final report and certificate decision will be issued.

Then, VDH has an additional 15 days to decide to accept/reject the feedback, issue a final report, and send a certificate.

Corrective Action Plans

If the provider is not in compliance any of the standards, federal SUPTRS requirements, and/or any of the items outlined in their VDH scope of work, the provider will be required to submit a corrective action plan. This corrective action plan will outline the standards that the provider is out of compliance with, in addition to standards that were identified for recommended improvement.

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Procedure for Requesting Records Outside of the Site Visit

There may be instances outside of the site visit where VDH will request to review client records. The Substance Use Disorder Treatment Certification Rule 9.0 states:

> *"The Department may, without notice, perform an inspection and survey for compliance with these regulations, other applicable law and rules, VDH's Service Guidelines, and all other VDH grant/contract assurances at its discretion."*

VDH does not intend to request treatment records frequently or without purpose. If the need arises, VDH will communicate the following information:

- Who at VDH is requesting the records?
- Why are these records being requested?
- What will be the follow-up communication and when will it occur?

Methodology for Selecting Client Records

For organizations that have had over 250 admissions within the last 12 months, VDH will review 10% of the admissions. For organizations that have fewer than 250 admissions within the last 12 months, VDH will review 20 client charts.

Client chart selection will be completed using SATIS data submissions.

The client charts will have the following criteria:

- Admitted within the past 12 months or discharged within the past 12 months
- Medicaid as the payer

Each client will be assigned a random number, sorted in ascending order, and selected starting with the lowest random number assigned.

Decertification Process

Decertification is the process in which a Preferred Provider is significantly out of compliance with the treatment standards. There are several steps taken in order to determine whether the decertification process needs to continue and the provider has several steps to rectify any outstanding compliance items.

The following is the process in which VDH will engage with the provider after a low compliance score:

1) After a Preferred Provider has a low compliance certification visit, a time-limited corrective action plan is issued with the most critical items to be addressed within 3-6 months. This is considered to be the first warning.
2) After the timeframe of the corrective action plan has elapsed, VDH follows up with the provider to obtain a status update on the identified items within the corrective action plan.

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3) If significant progress was not made (as determined by the State) of the identified corrective action items, VDH will issue a letter indicating the intent to decertify and the reasons for which decertification is being pursued. It includes the specific items that would need to be rectified to be issued a provisional certification—provide 30 more days. This will be considered the second warning.
4) If acceptable progress is not made within 30 days provided with step 3, VDH issues a letter indicating the end date of VDH-funded services (which must align with provider agreement). In the letter, VDH outlines the billing expectations for the provider. For instance, they can continue to provide services, but they need to use specific (or different) codes or provider IDs, etc.

The provider can submit another application in the future when items are fully resolved and a new certification visit will be scheduled.

Substance Use Prevention, Treatment, and Recovery Services Block Grant

Priority Populations and Service Provision

Priority populations are defined in the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant as pregnant women and intravenous drug users. The order of priority for services is:

a) Pregnant intravenous drug users;

b) Pregnant substance users;

c) Intravenous drug users; and

d) All other substance users.

Pregnant women must be served within 48 hours and must also be provided interim services during the 48-hour window, including a referral for prenatal care.

If a provider is unable to serve a pregnant woman within 48 hours, providers must refer the woman to a nearby facility or private practitioner that has capacity to serve her immediately. If no facility has capacity to serve her, providers must notify the VDH Clinical and Recovery Services Director or Manager of Clinical Services at 802-651-1550.

A person who uses substances intravenously must be served within 14 days. If treatment cannot be provided within 14 days interim services must be provided within 48 hours after the request for services and determination that the individual is appropriate for the services offered by the provider. Individuals must also be placed on a wait list. For those individuals who remain active on a wait list, they are to be admitted to treatment within 120 days.

If a provider is unable to serve an intravenous drug user within 14 days of the request for admission, the individual must be referred to other appropriate care located in a reasonable geographic area. If no treatment is available, the individual must be provided with interim services until such a time that treatment is available.

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Capacity of the Preferred Provider Network

VDH is responsible for and accountable to the Federal and State systems to monitor the health of the substance abuse system of care in Vermont as well as monitor the efficacy of the Preferred Provider network. In addition, VDH is required by the SUPTRS Block Grant, which allows VDH to grant funds to the Preferred Providers, to monitor the capacity of the Preferred Provider network.

The SUPTRS Block Grant requires VDH to monitor wait lists within the network as a condition of accepting the funding and to track Preferred Providers who are at 90% or above total capacity.

Access to Care

The provider is responsible for making information available to individuals, family members, other service providers, and the general community about the array of services the provider offers. The Provider will refer any individuals that they cannot serve or do not meet criteria to receive their health services to other appropriate service providers.

Preferred providers must offer referral appointments for non-urgent care within 30 days.

Routine care must be available in a timely manner consistent with the individualized treatment plan.

Waitlist & Waitlist Reporting

Preferred Providers are required to provide waitlist and/or census information to VDH. These requests may be regularly scheduled reports (typically months) or ad-hoc requests.

For the purposes of reporting to VDH, an individual is considered on a wait list once the individual has been screened **and/or** assessed **and** determined appropriate for the services/level of care offered by the provider the individual is seeking services from. These individuals must be prepared to enter treatment when it is available and therefore must be able to be contacted to set up an appointment.

The following individuals should not be reported as on a waitlist as they are **not considered waiting** for services for the purpose of waitlist reporting to VDH:

- Individuals who are incarcerated
- Individuals who are currently receiving services elsewhere (Preferred Providers are expected to coordinate)
- Individuals who have been screened/assessed and it is determined that the provider's services available/level of care is **not appropriate** for the individual (even if the program services/level of care may be appropriate for the individual at a future date after they receive services at a different level of care)

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- Individuals who have been screened and it is determined that their needs appropriately match the services/level of care provided and who **have been offered but declined** a treatment appointment.
- Individuals who have received an assessment and are scheduled for treatment services to begin within 10 days of the assessment
- Individuals who are not able to be contacted within a 30-day period (change of address with no forwarding information, disconnected phone, unreturned calls)

Women and Dependent Children's Services

VDH requires that Preferred Providers, when delivering services for parents and parenting people, should always ensure, either through service provision or appropriate referrals, that:

- The family is treated as a unit, and both women and their children are admitted to treatment, where appropriate;
- The availability of services for women and the fact that pregnant women are prioritized for treatment be publicized;
- Pregnant people or women with dependent children who request services must be admitted without limitation based on the person's pregnancy or parenting status;
- Care includes basic health screening; referral for prenatal care; monitoring and medication maintenance for chronic conditions; nursing intervention for minor injuries; physician care for acute illness; and emergency treatment as needed;
- Care includes postpartum check-ups for mother and infant at appropriate intervals; sufficient assistance with lactation if desired; and assurance of meeting nutritional needs of parent and infant;
- Pediatric care for children that includes primary health care such as:
    - Regular check-ups;
    - Basic health;
    - Vision screening;
    - Dental screening;
    - Monitoring of chronic conditions; and,
    - Acute and emergency care as required.
- Pediatric treatment for perinatal effects of maternal substance use that includes medical and other therapeutic modalities;
- Immunizations for protection against childhood diseases in accordance with schedules recommended by the state health office and commonly accepted medical practice; and
- Coordination with other state and federal social services designed to assure comprehensive care for the woman and her child(ren) such as Medicaid, Head Start, free and reduced school lunch programs, etc.

Treatment services must be provided in a gender specific manner, which includes:

- Education about the risks associated with substance use, developmental needs of children, community resources, appropriate discipline and health and safety issues;

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- Counseling on domestic violence and sexual abuse that includes information about the connection between substance use and violence, for both victim and perpetrator, conflict resolution techniques and information about local anti-violence resources including emergency shelter;
- Promotion of the appropriate involvement of the individual's family and other identified supports in the treatment and rehabilitation process and in the ongoing support system of the client;
- Family counseling about substance use that provides information to all age-appropriate members of the family about the addiction process, prevention, treatment, recovery, relapse, aftercare and effects on the family;
- Employment skill building including the importance of graduating from a secondary school or obtaining a G.E.D., education and vocational assessment, skills development and counseling related to seeking and maintaining employment;
- Reentry planning and counseling to support reentry into the community, both before and after discharge, which includes making referrals to any entities that provide services appropriate for women and their children

Providers must deliver appropriate therapeutic interventions for children who are in custody of people in treatment including:

- An assessment of the appropriate services for the client and children;
- Coordination of services that are beneficial to the family;
- Assistance in establishing eligibility for assistance under federal, state and local programs providing health, mental health, housing, employment, educational or social services for either the woman or her child(ren); and
- Where possible, coordination with other state and federal social services designed to assure comprehensive care for the woman and her child(ren) such as Medicaid, Head Start, free and reduced school lunch programs, etc.

Communicable Disease Services

Given the correlation of communicable disease and substance use disorders, and Vermont's rates of these diseases, the federal government has determined that there is a priority to screen for tuberculosis and HIV. Preferred Providers are required under the SUPTRS Block Grant requirements to:

- Comply with VDH Reportable and Communicable Disease Rule.
    - Health care providers and laboratories are required by law to notify the Health Department regarding patients with certain suspected or confirmed reportable diseases. Both laboratory-confirmed, and clinical diagnoses are required to be reported within 24 hours.
- Provide HIV and tuberculosis counseling for individuals who are waiting for admission to a substance abuse treatment program to include:
    - Information about signs and risks of infection;
    - Availability of testing and treatment services;

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    - Methods of transmission; and
    - How to avoid spreading the disease
- For individuals admitted for treatment, provide counseling that helps clients identify others in their households or families who are at risk of tuberculosis infection and who should also be tested and treated, including:
    - Information about the disease;
    - Modes of transmission;
    - Availability and necessity of testing; and
    - Options for treatment.
- Make tuberculosis services and testing readily available on site or by referral to all clients receiving treatment, ensuring that clients who are infected will receive treatment in order to reduce the spread of infection.
- Make HIV early intervention services readily available on site or by referral to clients receiving substance abuse treatment. Provide information about the types of services available, testing information and reporting requirements.
- Provide HIV counseling at the following levels:
    - Pre-test counseling: Give the client information about the testing process itself, including
        - Confidentiality protections;
        - Information about interpretation of test results;
        - Planning for consequences of a possible positive result;
        - Reporting protocol; and
        - Notification of other individuals who may be at risk of infection through contact with the client.
- Post-test counseling: Counsel clients regardless of the results of laboratory tests. Post-test counseling should include:
    - Education about risk behaviors;
    - Appropriate measures to avoid transmission and infection; and
    - For clients with positive test results, post-test counseling should include specific plans for protecting partners and family members from infection and notification of others at risk;
- Practice communicable disease protocols including standard infection control and bio-hazardous waste procedures.

Interim Services

In order to receive funding from VDH, Preferred Providers are required to provide interim Services as defined by the SUPTRS Block Grant when treatment services are not available for an individual in a priority population (pregnant women, women with dependent children and individuals who use intravenous drugs) deemed appropriate for the services/level of care offered by the provider. These services are designed to reduce the adverse health effects of substance abuse, promote the health of the client and reduce the risk of transmission of disease.

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Pregnant people must be able to be admitted to services within 48 hours or must be referred to another provider with capacity. During the 48-hour window, interim services must include, but are not limited to, referrals to prenatal care.

Individuals who use intravenous substances must be admitted to services within 14 days or have interim services within 48 hours of their request for services if treatment is not expected to be available by day 14. An individual may receive interim services for no longer than 120 days before beginning services. If a provider is unable to admit the individual within the required timeframe, the individual must be referred to another provider with capacity and if no such provider has capacity, the provider must notify the VDH Director of Clinical Services

Interim services include:

- HIV and tuberculosis counseling
    - Information about the risks of infection
    - Availability of testing and treatment services
    - Methods of transmission
    - How to avoid spreading the disease(s)
- Counseling on the effect of alcohol and/or drug use on a fetus
- Referral to primary or prenatal care

SUPTRS Block Grant Uninsured Funding

SUPTRS Block Grant uninsured/underinsured funds are the payer of last resort, after Medicaid and all third-party medical resources have been applied. If an uninsured/underinsured person seeks services from a preferred provider, the preferred provider is expected to assist the person in applying for Medicaid or other health insurance coverage.

VDH requires that each provider have a published fee schedule. If an individual has a high deductible, co-insurance or co-pay and meets criteria for the sliding fee, block grant dollars can be used to cover the cost to the individual of the service at the sliding fee rate. Block grant dollars cannot be used to make up the balance between the sliding fee rate and the rate set by the provider/agency for the service.

Sub-Contracting/Granting of Services

Preferred Providers may enter into sub agreements with qualified providers/entities for services to be performed under their grant agreements. All sub agreements must be in writing and specify procedures and criteria for terminating the agreement, including a requirement that the sub promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims. No sub agreement will terminate the legal responsibility of the sub to the Preferred Provider to assure that all activities under the sub agreement are carried out.

Sub agreements for services must:

- Specify the amount, duration, and scope of services to be provided
- Allow evaluation by VDH, DVHA and the U.S. Department of Health and Human Services, through inspection or other means, of the quality, appropriateness and timeliness of services performed under the agreement
- Require that the sub maintain an appropriate record system for services to the service recipient
- Require that the sub safeguards information about the individual
- Allow for inspection and auditing of any financial records of such contractor/ subcontractor.

The Preferred Provider is not required to contract with providers who do not meet its credentialing standards

In these instances, it is the responsibility of the Preferred Provider to ensure that the subcontractor adheres to the requirements set forth in this manual as well as secure approval from VDH for the subcontractor, when so required.

In order for an entity to be eligible for participation under the Medicaid State Plan, the subcontractor must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards and procedures required by this manual.

Co-occurring Substance Use and Mental Health Disorders

A co-occurring disorder is the presence of substance use, physical health and/or mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Members who are experiencing co-occurring substance use and mental health or physical health disorders may experience greater impairments in functioning. Thus, providers who are trained and practicing within the scope of their practice, in working with members with co-occurring disorders should ensure all conditions are addressed in treatment. If a provider is not trained in treatment of co-occurring disorders, or the combination of disorders falls outside their scope of practice, individuals must be referred to an appropriate service provider. With current signed consent and authorization to exchange/disclose personal health information, both providers should collaborate to coordinate effective treatment.

For people with co-occurring conditions, providers are expected to integrate the services provided for the substance use disorder, medical and/or mental health treatment needs. There may be concurrent authorizations for psychiatric, physical health and substance use services if medical necessity criteria are met for the requested services. Collaboration and coordination of care among all treating practitioners shall be documented.

Hard copies of this document are considered uncontrolled.
If you have a printed version, please refer to the VDH website www.healthvermont.gov for the official version.

Providers shall incorporate the goal of identifying independent co-occurring disorders into their multidimensional assessment or service specific provider intake (whichever is required for the service) for all members entering treatment. Providers shall utilize ASAM Criteria as a component of the assessment.

Telemedicine

The Vermont Medicaid benefit includes select telemedicine services. Telemedicine is defined in Act 64 as "…the delivery of health care services… through the use of live interactive audio and video over a secure connection that complies with the requirements the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. More information about audio-only services, including which codes need a prior authorization, can be found on the Department of Vermont Health Access website.

Client medical records must document the telemedicine encounter consistent with the service documentation requirements. The documentation is to specifically reference telemedicine as the means for conducting the service and use the appropriate procedure code modifier, as appropriate.

For additional information, including billing rules, see the Vermont Medicaid Provider Manual.

Documentation Standards

Clinical Record

Each provider must keep written documentation for all medical services, actual case record notes for any services performed, or business records that pertain to members for services provided and payments claimed or received. Providers must document all services provided on the same day of the encounter or within a reasonable time. A "reasonable time" means within one week of providing the service, unless extenuating circumstances prevent the provider from documenting a service within that time. If extenuating circumstances prevent a provider from documenting a service within one week of providing the service, the provider must also document those extenuating circumstances. All documentation must be legible, contain complete and adequate information and applicable dates.

In accordance with the Vermont Medicaid Manual for Psychotherapy Services, each client must have an individual client record. All documentation must be legible, contain complete and adequate information and applicable dates. Providers may use any format for documentation, such as a SOAP, BIRP, or DAP notes, as long as minimum documentation standards are met. The Medicaid documentation requirements in a mental health/substance use health record are the following:

1. Identifying data

- Name, unique ID, date of birth, and other demographic information as needed.

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2. Dates of service

- Documentation by the primary treatment provider of all dates and the amount of time clinical services were provided.

3. Comprehensive clinical assessment (e.g., biopsychosocial, medical history, etc.)

- Evidence that a comprehensive clinical assessment has been completed, with documentation of a presenting problem.
- Evidence of ongoing reassessment as needed.

4. Treatment and continued care planning

- Documentation of treatment plan, including the following:
    - Prioritization of problems and needs.
    - Evidence that goals and objectives are related to the assessment.
    - Evidence that goals and objectives are individualized, specific, and
    - measurable, with realistic timeframes for achievement.
    - Specific follow-up planning, including but not limited to anticipated response to treatment, additional or alternative treatment interventions, and coordination with other treatment providers (e.g., PCP).

5. Progress Notes

- Documentation supporting continued need for services based on medical necessity, including the following:
    - Dated progress notes that link to initial treatment plan and goal(s).
    - Updates or modifications to treatment plan.
    - Interventions provided and client's response.
    - Printed staff name, qualification, and signature or electronic equivalent.
    - The specific title or code of the service rendered;
    - Location in which the service occurred;
    - Specific plan for ongoing treatment; and
    - Start and stop time must be documented.

Providers are responsible for ensuring that documentation for any service that was billed is readable, maintained, and available for audit upon request for at least seven years.

Each reimbursed service must be documented in the individual's medical record. This documentation may be in another provider's files but must be available to VDH auditors and identified with the individual's name and/or record number.

For paper records, the use of white-out in the paper clinical record is prohibited. The use of cross-outs to alter information that has been entered into the clinical record is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alterations, date and time.

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For electronic records, all documentation should be locked when complete. If a change is needed after an electronic note has been locked, the agency should assure compliance with its policies regarding this and be able to identify change, time of change, and signature of person making the change.

Checklists by themselves are not acceptable as clinical or support notes. Additional narrative is required to explain the information that has been "checked off".

Person-Centered Treatment Plan

Every individual must have an authorized Person-Centered Treatment Plan (Plan) in their chart no later than the end of the 4th visit for outpatient and intensive outpatient programs (including hubs) or the end of the 7th day for residential and withdrawal management programs. The Plan must be directly related to the individual's current assessment.

The Plan reflects a partnership between providers and the enrolled individual. It is expected that the individual will take a central role in the development of the goals, objectives, and expected outcomes in the Plan, and that the Plan is completed with the collaboration of the individual and any identified family and/or support persons as requested.

The plan identifies service expectations and all planned services to address the client's treatment goals including the frequency and intensity of services to be provided for the purpose of treating the client's diagnosis and symptoms, as well as any collaborations, and anticipated outcomes in support of the individual's goals.

The services included in the plan are a subset of the total available array of program services, depending on clinical need and individual choice. Individuals are only entitled to the clinically appropriate services included in their plan.

The lead clinician signing the Plan will work with the entire treatment team, including external providers, to coordinate care.

The Plan must contain the following components:

Goals: *What are the desired outcomes of services?* Statements that identify the treatment needs and desires of the person served, expressed in their own words, and reflective of their informed choice. These self-stated goals are clinically interpreted with input from the person served into SMART goals that are specific, measurable, attainable, results-oriented, and time-bound.

Objectives: *What are the steps to getting to the desired outcome(s)?* Objectives are what the client will do to meet their related goal. Describe the specific measurable changes in behavior, function and/or status that the individual will achieve as a result of participating in treatment services and working on their recovery. Objectives are written in language that is understandable for the person served. Objectives include specific time frames for achieving/assessing progress.

Interventions: Actions of the clinician designed to help the person served complete the objectives listed in their plan.

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- Who? What the clinician will do to help the client complete the objectives.
- What? Actions of the clinician – the specific service(s) to be provided to the client.
- When? How often, how much time, and duration. It is acceptable to identify a range of treatment frequency for planned services or interventions. PRN or "as needed" frequency may only be used for emergent or episodic service delivery. See table below.
- Where? The location of service delivery.
- Why? The purpose of doing this intervention or action. Link the intervention back to the goal.

Outcomes: The anticipated outcomes resulting from the treatment and/or services provided for the identified. Outcomes tend to reflect short-term or incremental goals.

Plan Necessity

- Plans will be required following new admissions (or re-admissions) to the agency and/or programs
- Documentation of a holistic assessment, clear clinical formulation, and presence of a Plan with the signature of a clinician operating within their scope. If the clinician signing the Plan is a non-licensed clinician, Apprentice Addiction Professional (AAP) or Certified Alcohol and Drug Counselor (CADC), the treatment plan must be cosigned by a licensed behavioral health professional practicing within their scope.
- Any other team member providing treatment should be encouraged to review and sign the Plan.
- Whenever possible, the individual who is the focus of treatment should also sign the Plan. If this is not possible, a reason must be documented, i.e., client refusal.
- Treatment and service modalities, with the exception of emergent treatment needs and services, must be authorized in the Plan or subsequent revisions for the period in which the treatment and service modalities are provided to be eligible for reimbursement. Emergency treatment needs, and services may be delivered and do not need to be identified as planned services.
- Plans must identify services that the treatment team intends to deliver (not every possible option).
- If plan is a shared responsibility, the role or roles of other agencies and the staff designated as responsible for the coordination and integration of services must be identified.

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Plan Review and Revision

A clearly documented review including a determination of whether a revision of a treatment plan is required when there is a significant change in life circumstances for the individual that the clinician feels requires a sustained intervention or a revised plan. Treatment planning decisions are governed by the individual and their team working together. Examples of the types of circumstances that trigger the need for a review of whether changes need to be made to the Plan include, but are not limited to:

- When there are significant changes in a person's life
- When there are changes to the treatment modality, frequency and/or amount of treatment services
- Development of new goals
- Failure to progress over a period of six months
- When there is a transition between levels of care

Client Involvement

It is expected that the treatment plan is completed with the collaboration of the client, guardian and/or family and any significant person(s) that the client, guardian and/or family designates. Providers must document if a family member or caregiver was involved in the development of the plan or if assistance was provided if the client's condition required such. Clients must be offered a copy of the plan upon completion and document as such.

Progress/Service Notes

Service documentation shall support the medical necessity criteria and how the individual's needs for the service continue to match the level of care criteria. Progress notes shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures.

- Progress notes must be documented and comprehensive for each service that is billed and shall include the following, at a minimum:
- Name of the individual receiving services
- Name of the service rendered;
- Date of the service rendered;
- Signed and contemporaneously dated by the person who rendered the service and prepared the notes including credentials of the person;
- Amount of time or units required to deliver the service;
- Setting in which the service was rendered;
- Content of each progress note shall corroborate the time/units billed;
- Signature of the person who rendered the service. If co-therapists are involved in treatment, the provider who bills must also sign the progress note
- Clinical intervention used;
- Current issues discussed or addressed;

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- Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment; If indicated, the involvement of family and/or significant others in treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Specific plan for ongoing treatment or follow-up

VDH shall not reimburse for services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences specific to the individual's circumstances, treatment, and progress. Claim payments may be subject to recovery of expenditures if the supporting documentation does not demonstrate unique differences specific to the individual.

Transitions of Care and Discharges

Transition Plan

Anticipated transition plans are documented at the start of treatment. Transition plans are developed with the person served and are kept current and specific to the needs of the individual. The transition plan shall include steps for transitioning through appropriate levels of care until the individual reaches a point where they may exit the continuum of care and resume daily activities without the need for any intervention.

When an individual is transitioning between levels of care/providers/agencies, the lead clinician is responsible for ensuring that, with the proper release, the receiving agency/provider receives the most recent assessment. In addition, with consent, the treatment team will document coordination of care with the individual's Primary Care Provider and/or other prescribing professionals regarding what, if any, medications are prescribed and the purpose of the medication.

Transition plans must be written and developed to ensure a seamless transition to another level of care or discharge from treatment, and must include, at a minimum:

- The signature of the person served and/or legal guardian
- Identification of recovery supports and/or other services to assist the individual in continued recovery and reintegration into the community
- Referral information with date and time of the appointments, contact name for the provider or service or recovery entity, telephone number, physical address
- Recommendations for self-help and contact information for local peer recovery support services

Discharge Summary

Discharge summaries are to be completed within seven days of the agency/program discharging the individual discharging from a program and/or agency. Discharge summaries are to include, at a minimum:

- dated signature with credentials of the clinician completing the summary;
- dates of admission and discharge from the program and/or agency;
- presenting condition;
- description of services provided;
- description of progress toward treatment goals and objectives;
- reason for transition/discharge;
- identification of unmet needs;
- recommended aftercare supports and services;
- medications prescribed during the course of care; and
- diagnosis at the time of discharge/transfer

The SATIS discharge date does not have to be the same as the agency discharge date. The agency discharge date should be after re-engagement attempts are made, if applicable. Discharge date may vary depending on whether the discharge was planned, unplanned, or lost to contact.

Billing and Claim Processing

Allowable Reimbursement

Reimbursement is allowed for services provided by:

- Qualified staff that are employed by a preferred Provider practicing within their scope.
- Students/interns, provided that the student/intern is supervised by a qualified staff of the preferred provider, is subject to all policies and procedures, and that the preferred provider assumes responsibility for the work performed.

Instructions for Claims Submission

Claims, either paper or electronic, need to be submitted to the "fiscal agent", Gainwell.

Payments and Conditions of Reimbursement

Preferred Providers must have an executed grant agreement as well as an active certification in place with VDH in order to bill for substance use disorder treatment services using the VDH allowable codes. The following conditions of reimbursement shall apply to all substance use disorder Medicaid covered services:

- Payment for Medicaid services will be made at the lower of (1) the actual charge or (2) the Medicaid rate on file. The provider must accept, as payment in full, the amounts received from Medicaid;
- According to Federal Law, all clients must be treated similarly in terms of billing for all services. For example, if a non-Medicaid enrolled client is being transported with other clients whose services are being reimbursed by Medicaid, the non-Medicaid

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enrolled client must also be billed. This does not preclude the use of sliding fee scales.

- The Federal Government (Medicaid – Title XIX) will not reimburse for services to a Medicaid enrolled individual if a non-Medicaid enrolled individual receives the same service free of charge. This does not preclude the use of sliding fee scales.
- Fee-for-Service Medicaid services may be provided and reimbursed on the same day prior to the time of admission, or after discharge, to an Institution of Mental Disease.
- VDH retains sole authority to set payment rates for the VDH Preferred Provider network.
- Errors must be adjusted immediately upon realization that a billing error has occurred.

Exclusions and Prohibitions

The following exclusions and prohibitions are in effect for billing for substance use disorder Medicaid services:

- Preferred Providers may not bill VDH, 3rd party payors, or Medicaid for any services provided by the Department of Vermont Health Access Blueprint for Health funded spoke staff.
- Any individuals, including physicians, serving as Preferred Provider agency staff members may not concurrently provide private services of a similar nature to their Preferred Provider agency clients and bill for those services under the Medicaid program.
- Activities with the primary purpose of teaching clients the vocational skills needed for a specific job (i.e. vocational trainer/job coach activities) or other vocationally-related services:
    - Vocational Placement
    - Work Adjustment Training
    - Job Placement/Performance evaluation
    - Vocational Workshop
    - Vocational Counseling
    - Vocational Support Group
    - Vocational Program Administration
- Activities with the primary purpose of education, such as academic instruction or tutorial, typically provided in an educational setting by professional educators.
- No other substance abuse Medicaid reimbursement shall occur for any client receiving:
    - Private Non-Medical Institution (PNMI) services, for services that are included in the PNMI rate for that facility. For the purposes of this manual, PNMI services include: adolescent residential substance use disorder treatment services.

Timely Filing of Claims and Adjustments

Claims over six months old that have not already been billed to Gainwell will not be approved for filing except in the following instances:

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- Gainwell is at fault (documentation required) for the claim and/or adjustment not being processed in a timely manner
- Retroactive Medicaid eligibility
- Other insurance – an explanation of benefits was received after the year filing time and documented attempts were made to receive the denial with the year
- The preferred provider has been over paid, and a recoupment is needed
- Re-submissions – all re-submissions should be received by Gainwell within 6 months, but cannot exceed two years from the service date. Proof of the original submission must be attached to the claim.

Claims and/or adjustments meeting the above criteria, and not more than two years old, will be reviewed on a case-by-case basis. Please be advised that any claims and/or adjustments over two years old cannot be considered for payment in accordance with federal regulation.

Third Party Liability

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the recipient for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid. It then becomes an issue of recovery. Some examples of third party resources are:

- Medicare
- Health insurance, including health and accident, but not that portion specifically designated for "income protection" which has been considered in determining recipient and veteran programs, workers' compensation, etc.
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

Reimbursement Updates and Communications

The Vermont Medicaid Banner is the first page of the Remittance Advice (RA), a weekly report that details the status of each claim and any related financial information. Messages on the Vermont Medicaid Banner are a key resource for providers, as they contain important updates regarding policy changes, billing procedures, and other critical information. In some cases, the Vermont Medicaid Banner may be the only or the first notification of changes that affect billing or policy.

It is the provider's responsibility to review the Vermont Medicaid Banner each week and stay informed of any updates to VDH and/or DVHA policies or procedures. Missing or overlooking this information can lead to compliance issues or delays in reimbursement.

Accessing the Vermont Medicaid Banner:

- The Vermont Medicaid Banner is posted online weekly and can be accessed on the Vermont Medicaid Portal.
- Archived banners are also available at the same location for reference.

Email Subscription for Updates:
Providers can receive the Vermont Medicaid Banner and other important communications directly via email by joining the communications email distribution list. To subscribe, send your email address to vtpubs-comm@gainwelltechnologies.com.

By staying connected to the Vermont Medicaid Banner, providers can ensure they are up to date on all essential changes impacting their participation in the Medicaid program.

Reimbursement Trainings
Gainwell periodically provides trainings related to reimbursement processes. Recorded webinars of past presentations can be found at the Vermont Medicaid Portal. For specialized training or questions, contact the Gainwell Provider Representative.

Grievances
The Preferred Provider must have a grievance process for resolving service disagreements/complaints between service recipients and/or their representatives and the Preferred Provider. The overall goal of the grievance process is to resolve disputes fairly, to enhance individual and public confidence in the equity and integrity of the service system, to ensure the rights of those served to clinically indicated, covered benefits, and ensure providers' clinical decision-making roles.

Providers must adhere to Vermont Medicaid regulations regarding grievance procedures.

Staff Qualification Requirements for Clinical Services
All clinical covered services including clinical assessment, treatment planning, and individual, group and family counseling/psychotherapy must be completed by one of the following types of providers who is operating within their scope of education and training. Licensed providers must be actively enrolled with Vermont Medicaid:

- Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the Provider
- Licensed psychiatric nurse practitioner directly affiliated with the Provider
- For non-licensed Psychiatric Nurse Practitioners refer to the *Supervised Billing for Behavioral Health Services* in the Vermont Medicaid Provider Manual
- a staff member of the Provider who holds one of the following credentials:
    - Licensed Alcohol and Drug Counselor
    - Licensed Psychologist
    - Licensed Marriage and Family Therapist
    - Licensed Clinical Mental Health Counselor
    - Licensed Independent Clinical Social Worker; or

- A qualified provider described above, who is sub-contracted by the Provider, and who, based on his/her education, training, and licensure, or in adherence with Supervised Billing policy is authorized by the Provider's Director as competent to provide the service.

For new hires that do not have any behavioral health credentials, they need to be rostered while pursuing their AAP or CADC. If someone is an AAP or CADC, they do not need to be on the roster in addition to the credential. For more information, refer to *the* *Supervised Billing for Behavioral Health Services Manual,* the *Apprenticed Addiction Professional Billing Manual,* and the in the *Certified Alcohol and Drug Abuse Counselor (ADC) Billing Manual*.

Use of Mental Health Clinicians

Licensed Clinical Mental Health Counselors (LCMHCs) and Licensed Clinical Social Workers (LCSWs) who provide addiction treatment services within the Preferred Provider network **do not** need to have a Licensed Alcohol and Drug Counselor (LADC) co-sign for clinical documentation if substance use treatment is within their scope of practice. It is the responsibility of the agency to ensure that the licensed clinician has the appropriate training and experience to be providing the service. All staff providing billable services are expected to have regular supervision with a qualified supervisor with the appropriate experience and scope to encompass the breadth of the services provided.

Supervision Requirements

All staff who provide billable substance use disorder treatment services must be supervised by a qualified, licensed clinician practicing within their scope (LADCs, LCMHCs, psychologists, LMFTs, LICSWs) or American Board of Addiction Medicine (ABAM) certified physician at a minimum of twice per month. OPR may have different supervision requirements—providers should review the latest requirements. Supervision must be documented.

Correct Coding and Accurate Reporting of Procedure Codes

VDH requires strict adherence to coding guidelines based on the Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases-10 Clinical Modification (ICD-10-CM). This section outlines the rules for billing time-based procedure codes and untimed codes to ensure compliance with state and federal requirements, but providers should always use the most current CPT/HCPCS/ICD-10-CM guidance.

Providers must ensure accurate and compliant billing for time-based and untimed services under the Vermont CCBHC program. For more detailed information, refer to the Vermont Medicaid General Provider Manual or the Medicare Claims Processing Manual.

Time-Based Codes

Several procedure codes for therapy modalities, procedures, and tests specify direct (one-on-one) time spent with the patient in 15-minute increments. For time-based billing, follow these guidelines:

- Services must be billed using the appropriate procedure code and the number of 15-minute units of service delivered within a single calendar day.
- Services lasting less than 8 minutes should not be billed.
- Only the time spent actively delivering the service counts towards billing. Pre- and post-service activities (e.g., setup, charting) should not be included.
- When multiple 15-minute timed services are performed in a single day, the total number of minutes determines the units billed.

Note: Each service performed should be submitted as a separate line item for each date of service. Claims must reflect accurate reporting of time spent, or they will be rejected.

While the following guidance outlines general practices, providers must always consult the most current coding manuals and official code books for definitive billing information. Be especially mindful of codes that deviate from standard billing practices, such as those using a 15-minute unit but requiring specific guidance beyond the typical mid-point rule. Ensuring accuracy by referencing the official code books is essential to avoid billing discrepancies or non-compliance.

Untimed or Minimum Unit Codes

For untimed procedure codes, units are reported based on how many times the procedure is performed as described in the HCPCS code definition (often once per day). When reporting service units for codes where the procedure is not defined by a specific timeframe (untimed codes), a 1 should be entered in the unit's field on the claim form.

Note: Always ensure that untimed codes are reported accurately, as time spent does not affect the units billed.

Procedure Code Modifiers

A medical coding modifier is two characters (letters or numbers) appended to a CPT or HCPCS code. The modifier provides additional information about the procedure, service without changing the meaning of the code. Providers use modifiers to specify additional details for a particular encounter.

For instance, a modifier may be used to indicate a service did not occur exactly as described by a CPT or HCPCS code descriptor, but the circumstance did not change the code that applies. A modifier also may provide details not included in the code descriptor, such as the education level of the provider. Some programs may have modifiers that apply only when you're reporting codes in connection with those programs (e.g. Hubs).

Some additional examples of when a modifier may be appropriate:

- More than one provider performed the service or procedure.

- More than one location was involved.
- The service or procedure was provided to the patient more than once (e.g. case management).

Proper use of modifiers is important both for accurate coding and because some modifiers affect reimbursement. Omitting modifiers or using the wrong modifiers may cause claim denials that lead to rework, payment delays, potential reimbursement loss, or recoupment.

Clinical Assessment (Diagnostic and Evaluation Services)

Procedure Code: H0001

Per day limit: 1 unit (encounter)

Clinical assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments at the onset of treatment and as an ongoing process throughout the course of services. A clinical assessment identifies the extent of an individual's condition and their treatment needs.

Clinical assessment or reassessment must be conducted as a face-to-face contact or in accordance with the telemedicine policy—audio only assessment is currently not allowable. For more information, refer to the Vermont Medicaid Provider Manual and the Audio Only Telehealth Services information.

A clinical assessment or reassessment that extends over several services should be entered into the individual's record as one cumulative assessment with the dates and lengths of service outlined at the beginning of the written assessment.

VDH requires a multidimensional assessment utilizing the ASAM Criteria which shall be completed and documented by a credentialed addiction treatment professional within the scope of their practice. The multidimensional assessment shall be maintained in the member's medical record by the provider.

The multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions:

- Acute intoxication or withdrawal potential, or both;
- Biomedical conditions and complications;
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change;
- Relapse, continued use, or continued problem potential; and
- Recovery/living environment

Medical necessity for all ASAM levels of care shall be based on the outcome of the individual's multidimensional clinical assessment that reviews risk ratings across the 6 dimensions in the ASAM criteria. The multidimensional assessment documentation shall

support an individualized, person-centered biopsychosocial assessment performed face-to-face or through telemedicine, in which the provider obtains comprehensive information from the individual and collateral sources of information once appropriate consent and authorization has been obtained in writing from the client (such as family, other natural supports, previous or current treatment providers, probation officers, etc.). Assessments shall include the following information:

- Presenting Problem (reason for seeking care)
- Family history, including parenting status;
- Developmental history, including education;
- Evidence-based screening for trauma;
- Alcohol, tobacco, and other drug use history;
- Evidence-based screening for pathological gambling;
- Legal history and involvement with the Department for Children and Families;
- Psychiatric history;
- Medical history, including any known allergies and/or adverse drug reactions;
- Risk ratings across the 6 dimensions in the ASAM criteria;
- Mental status exam, including risk of harm to self and/or others;
- Current physical examination;
- Survey of assets, individual strengths, vulnerabilities and supports, including employment;
- Cultural considerations;
- Interpretive Summary and diagnoses; and
- Treatment recommendations.

The source of the information contained in the assessment must be identified. Assessment "write-up time" is not service time that is reimbursable. This time is indirect service time and already allocated in administrative costs. Clinicians should consider client preference and functioning in order to make the process as low-barrier as possible while ensuring a high-quality assessment. Assessments should be completed in the manner least onerous to clients and in consideration of ensuring the client is able to begin accessing treatment services in a timely manner.

A single clinician need not necessarily be the collector of all the data, but documentation should reference and assimilate all pertinent data of other qualified clinicians. If referenced data (i.e. psychosocial history, medical history etc.) is used, there must be an update from the date of the most recent referenced material (if older than six months).

If a client is referred from another Preferred Provider or licensed clinician and there is an assessment from the referring provider, the receiving provider may not require the client to undergo an assessment before entering services. The receiving provider is expected to accept the referring provider's assessment and, if necessary, complete only an addendum to the assessment with the client.

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Only time spent by a qualified clinician collecting assessment information may be reimbursed as clinical assessment. Information obtained by non-qualified staff in face-to-face contact for a clinical assessment or re-assessment and signed off by a qualified clinician may not be reimbursed as clinical assessment service. Assessment information obtained in this manner may be reimbursed separately as community support service.

Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other service (e.g. billing community support services rather than Diagnosis and Evaluation).

Administratively required assessments (e.g. assessment ordered by a judge or social agency) that do not meet clinical assessment and service prescription requirements are not reimbursable.

Clinical assessment may be conducted as a face-to-face contact. If it is through telemedicine, it will need a prior authorization.

Individual Therapy/Counseling (Psychotherapy)

Procedure Code: H0004

Per day limit: 6 units (15 minute)

Individual Therapy is specialized, formal interaction between a behavioral health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a disorder, psychosocial stress, and difficulties in coping in the social environment.

Attributes

- Each session requires a discrete note.
- Must be authorized in the treatment plan.
- Only one charge may be made for any service regardless of the number of clinicians present.
- Must be delivered by a clinician who meets the requirements listed in the *Staff Qualification Requirements for Clinical Services* of this manual.
- Must be provided face to face or by telemedicine in accordance with section *10.3.54 Telemedicine Services* of the Vermont Medicaid Provider Manual.

Family Therapy/Counseling (Psychotherapy)

Procedure Code: T1006

Per day limit: 1 unit (encounter)

Family Therapy is an intervention by a therapist with an individual and/or his/her family members considered to be a single unit of attention. Typically, the approach focuses on the

whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members.

Attributes

- Couples therapy sessions will be reimbursed as family therapy.
- Can only be billed for only one family member per session
- Each session needs a discrete note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes.
- Must be authorized in the treatment plan.
- Must be delivered by a clinician who meets the requirements listed in the *Staff Qualification Requirements for Clinical Services* of this manual.
- Must be provided face to face or by telemedicine in accordance with section *10.3.54 Telemedicine Services* of the Vermont Medicaid Provider Manual.

Group Therapy (Psychotherapy)

Procedure Code: H0005

Per day limit: 1 unit (encounter)

Group therapy is an intervention strategy that treats individuals simultaneously for emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy may focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couples' therapy.

Attributes

- Sessions may not exceed a 1-to-10 clinician ratio.
- Group therapy for less than 15 minutes is not reimbursable.
- If two or more clinicians lead a group, only one can bill.
- Must be authorized in the treatment plan
- Must be delivered by a clinician who meets the requirements listed in the *Staff Qualification Requirements for Clinical Services* of this manual.
- Must be provided face to face or by telemedicine in accordance with section *10.3.54 Telemedicine Services* of the Vermont Medicaid Provider Manual.

Case Management

Procedure Code: T1016

Per day limit: 8 units (15 minute)

Substance use case management service activities include the following:

- Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
- Making collateral contacts with the person's significant others with properly authorized releases to promote implementation of their Person-Centered Treatment Plan (Plan) and community adjustment;
- Linking the person to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the person as developed in the Plan;
- Assisting the person directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.
- Providing follow-up instruction, education, and counseling to guide the person and develop a supportive relationship that promotes the Plan;
- Advocating for the person in response to their changing needs, based on changes in the Plan;
- Planning for transitions in the person's life;
- Knowing and monitoring the person's health status, any medical conditions, medications and potential side effects, and assisting the person in accessing primary care and other medical services, as needed; and
- Understanding the capabilities of services to meet the person's identified needs and preferences and to serve the person.

Attributes

- Substance use case management services are not reimbursable for people while they are residing in institutions, including Institutions for Mental Diseases (IMDs).
- Providers are required to identify during the intake process whether the person is already receiving case management services from other provider and obtain permission to contact other involved case management providers person's request for service and notify the other provider that it must stop billing for case management services.

Substance Use Case Management Exclusions

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- Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking people to determine potential service needs that do not meet the requirements for billing.
- Substance use case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible person has been referred.
- Substance use case management does not include activities for which a person may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) consistent with § 1903(c)of the Social Security Act.
- Does not include supervision of the staff providing the substance use case management services.

Time/Unit Definitions for Services

Limits: Maximum service provision is 8 units per day. The following units of time may be used.

T1016 is a 15 minute, unit code.

Time spent for Individual Community Supports, Group Community Supports, and Service Planning and Coordination will be aggregated and will not exceed the allowed time for service provided for an individual on the same day.

Any combination of services may be provided to a client, not to exceed the maximum allowed amount per day. Services cannot be duplicated or provided simultaneously.

When there are meetings to provide services for an individual that involve multiple clinicians/case managers, only one may bill for services.

Intensive Outpatient

Procedure Code: H0015

Per day limit: 1 unit

ASAM Level 2.1 states that intensive outpatient programming is comprised of between 9 and 18 hours (6 or more hours for adolescents) of structured services (outlined below) per week. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside this programming must be closely coordinated.) IOP services provided by audio-only telemedicine need a prior authorization for reimbursement.

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If you have a printed version, please refer to the VDH website www.healthvermont.gov for the official version.

Intensive outpatient service providers must meet the ASAM Level 2.1 service components. Service components are part of an all-inclusive per diem rate and may not be billed separately. If the person served is enrolled in an IOP program but does not receive services for the minimum of 9 hours in the week, only then can the service components be billed separately. The following service activities included in the per diem rate shall be provided at least once weekly or more frequently as directed by the treatment plan and based on the member's treatment needs identified in the multidimensional assessment and should be provided within the 3 service days per week:

- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral.
- Psychiatric and other individualized treatment planning.
    - Individual therapy
    - Group therapy
    - Family therapy
    - Case management
    - Psychoeducation
    - Psycho-pharmacological consultation.
    - Addiction medication management provided on-site or through referral.
    - 24-hour emergency services available.
    - Withdrawal management services may be provided as necessary by qualified staff either on site or through referral. Providers should refer to the ASAM Criteria text for Intoxication/Withdrawal Management guidelines.

Attributes

- The billing unit for intensive outpatient is per encounter.
- Staff travel time is excluded.
- One unit of service is one day with a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for people under 18 years of age.
- Intensive outpatient services may not be billed concurrently with other type of substance use disorder treatment services without approval by VDH regional management staff.

Concurrent Hub and IOP enrollment Parameters

Concurrent Hub and IOP/OP enrollment is allowable for an individual's mental health needs when mental health needs exceed the expertise of the Hub clinicians as determined by the Hub provider OR a client would benefit from an evidence-based treatment modality not otherwise offered by the Hub (e.g. EMDR or DBT).

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Concurrent Hub and OP/IOP enrollment is allowable for treatment of an individual's SUD needs when:

- Hubs are in a temporary staffing lull and either there is a lack of available staff for individual counseling or a need for off-hours services (ex. an individual's hourly work schedule requires a very early morning or late afternoon/evening/weekend counseling) service-
- During a transition period from an existing therapist prior to enrollment at a Hub with a maximum allowable 3-month transition period.
- The client is exhibiting a stable Opioid Use Disorder and need for specialty evidence-based IOP programming for other SUDs that is not available within the Hub (e.g. cocaine and MATRIX program)

- Allowable concurrent Hub and OP/IOP/PHP enrollment must demonstrate:
    - The need was determined by the Hub provider and documented within the client chart;
    - the individual was in agreement with a referral to the IOP/OP/PHP program;
    - the Hub staff made the referral to the IOP/OP/PHP program; and
    - care coordination between the Hub and IOP/OP/PHP is occurring and documented throughout the treatment episode

Residential Care

A residential program must be staffed with face-to-face support 24 hours per day, seven days per week with telephone and/or in-person consultation with a prescribing health care provider and emergency services available 24 hours per day, seven days per week. Treatment services are provided at least four hours per day, seven days per week and services are provided in the evenings as well as typical working hours.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1)

Procedure Code: H0019

Clinically managed low intensity residential services (ASAM Level 3.1) provide a minimum of at least five hours of clinically directed program activities per week. This service shall not include settings such as sober houses, boarding houses or group homes where treatment services are not provided.

Clinically managed low intensity residential services (ASAM Level 3.1) required service components include:

- A face-to-face multidimensional assessment performed no later than the end of the 4th day after admission by a credentialed addiction treatment professional acting

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within scope of their practice and shall determine and document a DSM5/ICD-10 diagnosis.

- Person-Centered Plan (Plan) to be completed no later than the 5th working day after the individual's admission
- Services for the member's family and significant others, as appropriate to advance the member's treatment goals and objectives identified in the Plan.
- Weekly face to face meetings with the member and the treatment team will be required to review, discuss and document treatment progress and progress toward discharge. A week is defined as Sunday through Saturday.
- Clinically directed program activities by appropriately credentialed addiction treatment professionals, constituting at least five hours per week of professionally directed treatment designed to stabilize and maintain substance use disorder symptoms, and to develop and apply recovery skills, utilizing motivational enhancement and engagement strategies.
- Counseling and clinical monitoring to support initial or re-involvement in regular productive daily activity and reintegration into family or community living with health education.
- Relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery. Services shall promote personal responsibility and re-integration of the member into the network systems of work, education, and family and community life.
- Allied health professional staff, such as counselor aides or group living workers, who are available on-site 24 hours a day or as required by licensing regulations.
- Physician consultation and emergency services, which shall be available 24 hours a day and seven days per week.
- Arrangements for medically necessary procedures including laboratory and toxicology tests, which are appropriate to the severity and urgency of a member's condition.
- Arrangements for pharmacotherapy for psychiatric or medication assisted treatment medications and drug screenings.
- Arrangements for higher and lower levels of care and other services. Direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as intensive outpatient, vocational assessment and placement, literacy training, and adult education.
- Regular monitoring of the member's medication adherence.
- Education on benefits and potential side effects of medication assisted treatment and referral to treatment as necessary. Opportunities for member to be introduced to the potential benefits of addiction pharmacotherapies as a long-term tool to manage addiction.
- Biomedical enhanced services are delivered by appropriately credentialed medical staff who are available to assess and treat co-occurring biomedical disorders and to monitor the member's administration of medications in accordance with a physician's prescription.
- Coordination with community physicians to review treatment as needed.

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- Appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the member's scheduled discharge date.
- Substance use case management is included in this level of care.

Services that are in scope:

- a minimum of five hours of clinical programming, individual, and/or group counseling sessions per week;
- a daily schedule of activities designed to facilitate member participation in, and transition to, the community and to promote recovery;
- individualized case management services;
- coordination with and/or referral to Medications for Addiction Treatment and Medications for Opioid Use Disorder providers;
- medication management services;
- for pregnant members, provide coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies; and
- facilitate access to recovery support navigator services and peer recovery coach services either directly or through referral.

Attributes

- Members must be discharged from this service when other less intensive services may achieve stabilization or the member requests discharge.
- Residential treatment services may be provided concurrently with opioid treatment services.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Staff travel time is excluded.
- Medicaid does not pay for room and board.
- One unit of service is one day.
- There are no maximum annual limits.

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5)

Procedure Code: H0018

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) are residential treatment services which shall include:

- Telephone or in-person consultation with a physician or physician-extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week.

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- Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.
- Arrangements for needed procedures including medical, psychiatric, psychological, lab and toxicology services appropriate to the severity of need.
- A physical examination, performed within a reasonable time, as determined by the patient's medical condition.
- Arrangements for addiction pharmacotherapy.
- Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the member into the network systems of work, education, and family life.
- Program activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- Daily clinical services to improve organization, daily living skills, recovery, personal responsibility, personal appearance and punctuality. Development and practice of prosocial behaviors.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the member in initial involvement or re-engagement in regular productive daily activities including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the member's understanding of substance use and mental health conditions.
- Counseling and clinical interventions to facilitate teaching the member skills needed for productive living and successful reintegration into family living to include health education. Daily treatments to manage acute symptoms of biomedical substance use or mental health disorder.
- Planned clinical interventions to enhance the members' understanding of substance use and mental health disorders.
- Daily scheduled professional services, interdisciplinary assessments and treatment, designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of social network supportive of recovery. Such services would include member and group counseling, psychotherapy, family therapy, recreational therapy, art, music, physical therapy, vocational rehabilitation, educational and skill building groups,
- Planned community reinforcement designed to foster improved community living skills.
- Motivational enhancements and engagement strategies appropriate to each member's stage of readiness and desire to change.
- Counseling and clinical monitoring to assist the member in initial involvement or re-involvement in regular productive daily activity such as work or school, with successful re-integration into family living with health education.

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- Services for family and significant others, as appropriate, to advance the member's treatment goals and objectives identified in the Person-Centered Plan.
- Withdrawal management services may be provided as necessary. Providers should consult the ASAM Criteria for Intoxication/Withdrawal Management requirements.
- Case management, which includes coordination of related addiction treatment, health care, mental health, and social, vocational, or housing services (provided concurrently0; and the integration of services at this and other levels of care.

Family engagement shall be provided in addition to family therapy/counseling as appropriate. Family engagement shall be provided as outlined in the Person-Centered Plan (Plan) and the family or legally authorized representative shall be part of the family engagement strategies in the Plan. Family engagement activities are considered to be an intervention and must occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative.

Services that are in scope:

- management of mild medical complexities;
- coordination with and/or referral to Medications for Addiction Treatment and Medications for Opioid Use Disorder providers;
- multidimensional biopsychosocial evaluation and treatment planning either performed by, or reviewed and signed off by, the clinical director or the clinical director's independently licensed designee;
- facilitate access to treatment of mental health co-occurring disorders either directly or through referral;
- individual and group counseling;
- psychoeducation on the disease of addiction;
- case management;
- transition planning and coordination of services;
- for pregnant members, provide coordination with OB/GYN, pediatrics, and any other appropriate medical and social services providers, and state agencies; and
- facilitate access to recovery support navigator services and peer recovery coach services either directly or through referral.

Attributes

- Members shall be discharged from this service when other less intensive services may achieve stabilization or the member requests discharge.
- Residential Treatment Services may be provided concurrently with opioid treatment services.
- Residential treatment services **may not** be provided concurrently with partial hospitalization services, intensive outpatient services and/or outpatient services.
- One unit of service is one day.
- There are no maximum annual limits.

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- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the treatment plan needs of the members served.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal car, habilitation, or academic-educational needs of the member.

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7)

Procedure Code: H0018

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) shall meet the following service components:

- Clinical staff shall be able to provide a planned regimen of 24 hour professionally directed evaluation, care and treatment including the administration of prescribed medications.
- Addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians or physician extenders shall perform physical examinations for all members who are admitted within 24 hours of admission; or a review and update by a facility physician within 24 hours of admission of the record of a physical examination conducted no more than 7 days prior to admission. Staff shall supervise addiction pharmacotherapy, integrated with psychosocial therapies. The professional may be a physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment. Physician monitoring, nursing care and observation shall be available. A physician shall assess the member in person within 24 hours of admission and thereafter as medically necessary.
- A registered nurse (RN) or licensed practical nurse (LPN) under direction of either a supervisory RN or Physician Medical Director, shall conduct an alcohol or other drug focused nursing assessment upon admission. The RN or LPN shall have the competencies and experience in conducting an alcohol or other drug focused nursing assessment. The nurse (whether RN or LPN) performing the alcohol or other drug focused nursing assessment shall report the results to the attending physician, who then directs initiation of the medical-monitored protocol based on the results of the focused assessment. A licensed registered nurse or licensed practical nurse shall be responsible for monitoring the member's progress and for medication administration duties. A registered nurse conducts an alcohol or other drug focused nursing assessment upon admission. A registered nurse or licensed practical nurse is responsible for monitoring the member progress and for medication administration duties.
- Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group and family therapy services.

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Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the member's level of understanding and assist in the member's recovery.

- Planned clinical activities to enhance understanding of substance use and/or mental disorder. Planned clinical program activities to stabilize acute addictive or psychiatric symptoms.
- Activities may include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and adapted to the member's level of comprehension.
- Counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable. Counseling and clinical monitoring to promote re-involvement in or skill building in regular productive daily activities such as work or school and successful re-integration into family living if applicable.
- Random drug screens to monitor use and strengthen recovery and treatment gains.
- Regular medication monitoring.
- Health education associated with the course of addiction and other potential health related risk factors including Tuberculosis, HIV, Hepatitis B and C, and other sexually transmitted Infections.
- Evidence based practices such as motivational interviewing to address the members readiness to change, designed to facilitate understanding of the relationship of the substance use disorder and life impacts.
- Daily treatments to manage acute biomedical symptoms of substance use or mental illness.
- Services to family and significant others as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Additional medical specialty consultation, psychological, laboratory and toxicology services shall be available on site, either through consultation or referral.
- Coordination of necessary services shall be available on-site or through referral to a closely coordinated off-site provider to transition the member to lower levels of care. Substance use case management is included in this level of care. Substance use case management services (T1016) are not reimbursable for members while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period.
- Psychiatric services are available onsite, through consultation or referral when a presenting problem could be attended to at a later time. Such services are available within 8 hours by telephone and 24 hours in-person.
- Medication education and management shall be offered.

Services that are in scope

- medically managed withdrawal management;
- management of mild to moderate medical complexities;
- induction onto maintenance treatment;

- coordination with and/or referral to Medications for Addiction Treatment and Medications for Opioid Use Disorder providers;
- multidimensional biopsychosocial evaluation and treatment planning either performed by, or reviewed and signed off by, the clinical director or the clinical director's independently licensed designee;
- facilitate access to treatment of mental health co-occurring disorders either directly or through referral;
- individual and group counseling;
- psychoeducation;
- case management;
- transition planning and coordination of services;
- for pregnant members, coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies; and
- facilitate access to recovery support navigator services and peer recovery coach services either directly or through referral.

Services that are out of scope (can be managed/billed outside of the residential setting)

- Diabetes management
- Cardiac-specific
- Specialty care
- Infection management
- High intensity wound care
- Specialty or complex psychiatric care (e.g. medication specific initiation)

Attributes

- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge or the member leaves the facility
- Residential Treatment Services may be provided concurrently with opioid treatment services.
- One unit of service is one day.
- There are no maximum annual limits.
- Group counseling by credentialed addiction treatment professionals shall have a maximum limit of 10 individuals in the group. Such counseling shall focus on the needs of the members served.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- Residential services may not be billed concurrently with other type of substance use disorder treatment services except the Hub bundled monthly rate for individuals concurrently enrolled in a Hub MAT program.

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Medication for Opioid Use Disorder

Medication for opioid use disorder (MOUD) is the use of medications in conjunction with counseling and behavioral therapies in the treatment of an opioid use disorder.

Opioid Treatment Program (OTP also known as "Hub")

Procedure Code: H0020

All providers who are prescribing MOUD must hold a valid Vermont license to practice.

OTPs, in addition to the regulatory requirements of 42 CFR, Part 8, are required by Vermont to follow the *Rules for Governing Medication-Assisted Therapy for Opioid Dependence*.

OTP service components include the following activities. Providers shall document the provision of the following activities, as rendered, in the member's medical record:

- Provide individualized, patient-centered assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
- Link the member to psychological, medical, and psychiatric consultation as necessary to meet the member's needs.
- Ensure access to emergency medical and psychiatric care through connections with more intensive levels of care.
- Ensure access to evaluation and ongoing primary care.
- Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Ensure appropriately licensed and credentialed prescribers are available to evaluate and monitor use of methadone, buprenorphine products or naltrexone products and of nurses to dispense and administer these medications.
- Ensure medication for other physical and mental health conditions are provided as needed either on-site or through collaboration with other providers.
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the member on an individual, group, or family basis.
- Refer members for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

OTP risk management shall include the following activities which must be clearly and adequately documented in each member's record:

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- Random urine drug screening for all members, conducted at least eight times during a twelve-month period.
- Opioid overdose prevention education including the prescribing or distribution of naloxone.

Attributes

Hubs are reimbursed through a bundled case rate for services. Unless otherwise stated, all services related to an individual's care for a substance use disorder is included in the monthly bundled rate and may not be billed separately. These services include:

Medical Services

- Methadone
- Medical Exams as they related to OUD
- Dispensing of medication: daily or as determined by clinical need and the patient's treatment plan, includes a health impairment screening
- Dose Adjustments
- Nursing Services

Lab Services

- 8 observed UAs per year. The frequency beyond the federal minimum of 8 annually should be driven by clinical need and patient stability

Psychosocial Services

- Psychiatric consultation as needed
- A minimum of one counseling/psychosocial contact per month. This can include group and/or individual contact
- Co-occurring capable treatment services
- Treatment planning

The following services have been identified as billable by Hubs outside of the approved bundled rate:

- Intensive Outpatient Programming (IOP)-the Hub must document the individual as meeting criteria for ASAM Level 2.1 services and must document ongoing coordination with the IOP provider for purposes of care coordination and monitoring of the individual's readiness to transition from IOP services.
- Residential care - the Hub must document the individual as meeting criteria for ASAM Level 3.1-3.7 services and must document ongoing coordination with the residential provider for purposes of care coordination and monitoring of the individual's readiness to transition back to the Hub.

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- Outpatient therapy for specialty services related to a co-occurring mental health diagnosis such as an eating disorder that fall outside the scope of a co-occurring capable program and beyond the scope of the clinicians at the Hub.
    - The Hub must document the justification for the service being provided outside the Hub bundle in the medical record and must coordinate care with the therapist.
- Non-methadone Opioid Use Disorder maintenance medications (i.e. Buprenorphine, Naltrexone)
- Phlebotomy upon admission to screen for infectious disease and/or co-occurring medical conditions that are likely to impact treatment
- Electrocardiograms (EKG) under the following conditions:
    - upon admission if person has a documented current or family history of cardiac arrhythmias or
    - if the individual has a documented history of syncope or
    - prior to initiation of high dose methadone (>100 mg)
- Quantitative urine analysis **only** under the following conditions:
    - In the event a result is contested by the patient and the result of such test could have a significant negative impact on the patient's treatment (i.e. program discharge)
    - If there are reasonable clinical indications that a patient's pattern or substance of use is not adequately detectable in available testing (i.e. tracking a Benzodiazepine taper or requiring a norbuprenorphine ratio due to concerns about take-home dosage diversion or misuse)
    - Peak and Trough levels for Methadone to determine rapid metabolizing requiring "split dosing" protocol

  Under these circumstances, program prescribers could order confirmation testing which would be billable outside the Hub bundled rate with the clinical rationale, including the potential for impact on treatment, documented clearly within the patient record. The documentation should also include the clinical follow up as a result of the confirmation testing. Documentation must be made available for audit upon request.

Hub Staffing Methodology and Minimum Staffing Requirements

The methodology for Hub staffing requirements is based on key health professionals required to provide Health Home Services. The model requires **6 FTEs for every 400 patients** served. In the case of lab technician staffing, a Hub can opt to include the costs of standard qualitative urine analysis testing conducting through a sub-contracted lab instead of providing this service on site.

While flexibility in staffing is permissible within the recommended staffing model, caseloads for counseling staff are recommended to **not exceed** 60 patients per 1 FTE counselor.

Hubs as Health Homes

Hubs must function and become certified as Patient Centered Medical Health Homes. Regardless of whether National Center for Quality Assurance (NCQA) accreditation has yet been achieved, Hubs must provide opioid treatment services in compliance with the 11 core components:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate;
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Health Home Service Documentation

Health home service documentation shall support the individual's needs for the service and the connection of the provided service to the individual's person-centered plan. Health home service notes shall disclose the extent of service provided and corroborate the enhanced bundled rate billed. Claims not supported by corroborating health home service notes may be subject to recovery of expenditures.

Health Home service notes must be documented and comprehensive for each service that is billed and shall include the following, at a minimum:

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- Name of the individual receiving services
- Name of the service rendered;
- Date of the service rendered;
- Signed and contemporaneously dated by the person who rendered the service and prepared the notes including credentials of the person;
- Setting in which the service was rendered;
- Content of each progress note shall corroborate the enhanced bundled rate billed;
- Signature of the person who rendered the service.
- Health home service provided;
- Specific plan for ongoing treatment or follow-up

VDH will not reimburse for health home services in which the health home service notes are not individualized and case-specific. Duplicated health home service notes shall not constitute the required case-specific individualized notes. Each health home service note shall demonstrate unique differences specific to the individual's circumstances and needs. Claim payments may be subject to recovery of expenditures if the supporting documentation does not demonstrate unique differences specific to the individual.

Health Home Enhanced Rate Methodology

Hubs are expected to function as Health Homes as a requirement of their Preferred Provider agreement. Health home services are considered a right of Medicaid beneficiaries and these services are to be provided, Health Home Services that go beyond the required/typical Opioid Treatment Program services have been incentivized using a rate enhancement. This service can be conducted by any Hub staff person if the person is working within their scope of practice and the activity meets criteria. One documented health home eligible service per patient per month is required to bill at this enhanced rate.

Enhanced services include (but are not limited to) assertive care coordination with social service or medical providers on behalf of the patient, assertive (active) referrals, educational activities that relate to skill building outside the scope of standard substance abuse counseling activities, active communication across providers to facilitate transitions of care, support for the client via an empaneled team such as LIT or a Pre/Postpartum Community Response Team. The patient need not be present for the enhanced rate health home service to occur but the activity must directly relate to an identified, documented individual need (ideally as it relates to their treatment plan).

Any activity **required** or **expected** by state or federal regulation for the certification of Opioid Treatment Programs **cannot** be counted as an enhanced rate Health Home Service. Health Home services as identified by the Health Home quality measures in Hub grants cannot be used to justify billing the enhanced rate.

Program Integrity and Special Investigations

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Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided and claims should be submitted for only those days that were authorized. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Medicaid than other providers
- Coding billing records to receive more reimbursement than what is appropriate
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Medicaid will pay more for services

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit via website submission, telephone (802) 879-5900, or the Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone (802) 828-5511.

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, their provider agreement with Vermont Medicaid, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

VDH is responsible for monitoring activities covered under this manual, for the purpose of detecting potential fraud and abuse of Title XIX of the Social Security Act. If an instance of possible fraud or abuse is identified, VDH will notify the Medicaid Program Integrity Unit.

For additional information please see the provider manual.

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is a covered service for members enrolled in traditional, Primary Care Plus (PC Plus) Medicaid and the Dr. Dynasaur programs. NEMT is a statewide service, providing transports for eligible members to and from medically necessary medical services that are Medicaid billable.

For further NEMT information and requirements go to the DVHA transportation website.

Interpreter Services/Limited English Proficiency

Providers are required under Federal and State laws to provide interpreters for patients with limited English proficiency (LEP) and for those who are deaf or hard of hearing.

- Title VI of the Civil Rights Act of 1964
- Title VI regulations, prohibiting discrimination based on national origin
- Executive Order 13166 issued in 2000
- Vermont's Patients' Bill of Rights (18 VSA 1852)
- Vermont Public Accommodations (9 VSA 4502)

For additional information please see the Medicaid Provider Manual.

Provider Subcontracts

VDH Preferred Providers unable to provide the clinically necessary covered services to the individual through its service programs may elect to provide services through subcontracts.

All sub-contractual arrangements must be in writing and specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims. No subcontract will terminate the legal responsibility of the contractor to the Preferred provider to assure that all activities under the contract are carried out.

Sub-contracts for services must:

- Specify the amount, duration, and scope of services to be provided
- Allow evaluation by VDH, DVHA and the U.S. Department of Health and Human Services, through inspection or other means, of the quality, appropriateness and timeliness of services performed under the contract
- Require that the contractor maintain an appropriate record system for services to the service recipient
- Require that the contractor safeguards information about the individual
- Allow for inspection and auditing of any financial records of such contractor/ subcontractor.

Sub-contract arrangements that provide clinically necessary, covered services which are included in the Preferred Provider's case rate, per diem rate, or encounter rate, to the individual (and therefore included in their Plan) will be supported with funds from the Preferred Provider who is sub-contracting for the services. Sub-contract arrangements that provide clinically necessary, covered services which are stated in this manual as permissible to bill outside the Preferred Provider's case rate, per diem rate, or encounter rate, are expected to be billed directly to the individual's insurer or VDH if the individual is uninsured or underinsured and covered under the Block Grant Uninsured/Underinsured definition.

Preferred Providers are not required to sub-contract and/or pay for services that are not required in the individual's Plan.

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Coordination with Primary Care Providers

Each Preferred Provider is responsible for making every effort to secure the individual's release of information (ROI) to support sharing appropriate clinical information between the primary healthcare provider and the treatment program.

Additionally, Preferred Provider case managers are encouraged to develop and maintain joint comprehensive treatment plans, when possible, to provide for maximum integration of physical and mental health services. Toward this end, the following requirements must be met:

- Each clinical record at the Preferred Provider must contain the name of the primary care provider (PCP).
- For those individuals without a primary healthcare provider, the Preferred Provider must make every effort to assist with the selection of a PCP. The Case Manager or other Preferred Provider designee must also take steps to encourage that individuals are seen by their PCPs at least once annually.
- The Case Manager or Preferred Provider designee must also take steps to assure that individual's addiction medication management including changes in medications or dosage is, with consent, routinely shared with the primary healthcare physician; and if not, to document the ongoing efforts made and barriers preventing this coordination of care.

Reporting Requirements

Preferred Providers are expected to submit additional reporting to the state. These reporting requirements are outlined in their provider agreements and at a minimum include the following:

Monthly	Quarterly	Annually
• Wait Times and Service Requests Summary Form • SATIS Data	• Block Grant Progress Report	• Financial Report (within 45 days of fiscal year end) • If applicable, audited annual financial report

SATIS

The Substance Abuse Treatment Information System (SATIS) is the VDH client data system which contains individual-level records of services provided by Preferred Provide. Data must be submitted to VDH via SATIS according to the requirements outlined in the VDH provider agreement.

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Critical Incident Reports

The Vermont Department Health, Division of Substance Use Programs Clinical and Recovery Services Director must be notified in writing of any critical incidents within 24 hours. The provider must fill out the Critical Incident form.

Critical incidents include:

- Serious illness and/or injuries resulting in medical care as a result of services delivered or on the premises.
- Death
- Alleged or confirmed assault, including sexual assault by staff or other
- Medical errors
- Unlawful activity perpetrated on the property by staff or other
- Any incident, marked by seriousness or severity that is likely to result in attracting negative public attention or lead to claims or legal action against the State or reporting entity

The form must be faxed to 802-652-2019 or securely emailed to AHS.VDHSUDClinicalTeam@vermont.gov. No other form or method of submission will be accepted.

Providers are expected to conduct timely, thorough and credible root cause analyses of critical incidents and will develop action plans to implement improvements to reduce risks. Providers will monitor the effectiveness of improvements.

Medical Records

For individuals or families who require treatment intervention or support beyond consultation, education and population-based strategies, the following items must be present in the client file:

1. Participant Name & Medicaid ID
2. Referral & Intake information
3. Screening Tools or information
4. Evaluation Tools & on-going assessment information (including assessment provider name and dates completed)
5. Person-Centered Plan of Care (including time frame of the plan, service type and frequency, responsible providers name, individual or parent/guardian and licensed clinician signature, dates completed)
6. Progress notes to include:
    a. Summary of major content or intervention themes consistent with treatment goals;
    b. Clear relationship to assessment data;
    c. Description of services and interventions that reflect those listed in the treatment plan;
    d. Observations made of the individual or responses to interventions;

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e. Assessment of progress toward treatment goals;
f. Signature by lead service coordinator

7. Ongoing needs for continued intervention and next steps.
8. Performance goals/outcomes for individual clients served.
9. A log of services provided and dates (this log may be electronically available as part of the EHR and does not need to be duplicated as a separate document each month)
10. Transition or discharge plan

Clinical Documentation

Clinical Documentation is the foundation of all other documentation requirements. Meeting ongoing patient needs, such as furnishing and coordinating necessary services, is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between professionals. Records not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. The outcome can cause unintended complications.

Quality Oversight

VDH supports the practice of quality management at each Provider and requires that processes are in place. Services and assessment of client needs shall undergo ongoing quality review for improvement opportunities. Quality management practices typically consist of three types of activities:

1. **Quality Assurance**

   Quality Assurance is the process of oversight of services provided within the system of care, where deficiencies and/or weaknesses are identified, while ensuring that services meet minimum standards. Providers will generate data internally to review use of their resources. Each Provider will provide documented evidence of its internal monitoring, review, and utilization of service data and outcomes to better meet the needs of those individuals served and fulfill minimum standard requirements.

2. **Quality Monitoring**

   Quality Monitoring consists of the collection and review of data and analysis and aggregate reporting. The Department of Health, Division of Substance Use Programs requires the management of service utilization data and corresponding outcomes to ensure provision of quality services. To ensure compliance with this standard, programs are required to have utilization and outcomes management practices for measuring and responding to the needs of those receiving services described in this manual and evaluating practice outcomes.

   Each Provider shall maintain utilization review activities to assess, monitor, and maintain effective, efficient, and appropriate utilization of resources. The utilization review process will include consideration of service use for potential patterns of

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underutilization, overutilization, or inefficient use of services and to assure that they are delivered in an appropriate, effective and efficient manner, that individual. Individual service documentation must meet Preferred Provider standards, requirements and ensure that Provider resources are used efficiently. Review of monitoring activities and achievements must occur at least quarterly and will be reviewed by VDH during the Certification processes.

3. Quality Improvement

Quality Improvement is a systematic approach to improve and enhance the way care is delivered. A variety of approaches—or QI models—exist to help collect and analyze measurable data and test change to achieve desired outcomes and goals, while utilizing best practices.

The Provider shall employ a continuous evaluation process coupled with coordinated plans to improve and build meaningful and effective services. Provider structures a measurable quality management or improvement plan to make changes that will lead to better care. Providers identify individual needs and preferences, collect information through needs assessments, monitor quality, and manage outcomes to promote improved quality of service. Community collaboration and systems improvement can likewise be forged through greater levels of individual and service provider participation in the Quality Improvement process.

Program effectiveness, efficiency, and satisfaction by service users are priority objectives for system measurement. Provider structures must support monitoring of priority initiatives through timely information and review activities. Review activities must include consideration of service quality, appropriateness of service, and service trends.

The Provider will generate and review service use data internally and review use of their resources. Each Provider will provide documented evidence of its internal monitoring, review, and utilization of service data and outcomes to better meet the needs of individuals served. Review of outcomes management activities and achievements must occur at least quarterly and will be reviewed by VDH.

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