

SUBSTANCE ABUSE SERVICES MEDICAID REIMBURSEMENT FREQUENTLY ASKED QUESTIONS (FAQS)

The 2007 Session of the General Assembly appropriated \$10.5 million (general fund and non-general fund, available since July 1, 2007) for Medicaid reimbursement of substance abuse treatment services for children and adults.

Community services boards have encountered several barriers to utilization of this funding source. The payment structure for substance abuse services is different from the structure for mental health services due to requirements of the Federal Centers for Medicare and Medicaid Services (CMS) for newly approved services. Given the different billing structures, some providers are opting to provide substance abuse services as part of covered mental health services. Although providing integrated substance abuse and mental health services is allowed under certain circumstances, this practice masks the provision of substance abuse services.

These Frequently Asked Questions (FAQs) may open the dialog regarding maximizing the utilization of Medicaid reimbursement for the provision of substance abuse services. DBHDS and DMAS remain available for technical assistance (TA) regarding SA Medicaid reimbursement.

Q1. Does Medicaid cover treatment for Substance Use Disorders?

A1. Yes, Medicaid covers the following Substance Abuse Services:

- Assessment and Evaluation (Community Mental Health Rehabilitative Services- CMHRS, Psychiatric Provider)
- Substance Abuse Crisis Intervention (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Intensive Outpatient (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Day Treatment (Community Mental Health Rehabilitative Services- CMHRS)
- Opioid Treatment (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Case Management (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Residential Treatment Services for Pregnant and Postpartum Women (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Day Treatment for Pregnant Women (Community Mental Health Rehabilitative Services- CMHRS)
- Substance Abuse Outpatient -individual, group, and family therapy (Mental Health Clinic, Psychiatric Provider)

Services provided outside the Managed Care Organization (MCO) that can be reimbursed by DMAS include: community mental health services (rehabilitative, targeted case management and the following substance abuse treatment services; emergency services(crisis); intensive outpatient services; day treatment services; substance abuse case management services; and opioid treatment services). For substance abuse services, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I Substance Use Disorder. American Society of Addiction Medicine (ASAM) criteria will be

used to determine the appropriate level of treatment. Please refer to the provider manuals for mental health eligibility criteria.

Substance use related lab work and medication for medication assisted treatment (Pharmacy, Independent Laboratory)

Substance use related services for adolescents (School Division, Early and Periodic Screening, Diagnosis and Treatment -EPSDT)

Information is provided in the Community Mental Health Rehabilitation (CMHR), Mental Health Clinic (MHC), Psychiatric Services, Pharmacy, Independent Laboratory, Physicians, and School Division Manuals:

The provider manuals can be located at

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual> through the drop down menu under Accessing Provider Manuals.

Q2. Are community services boards required to bill for Medicaid covered substance abuse treatment services? Yes

A2. Budget appropriation language requires that CSBs participate in billing for Medicaid covered SA treatment services or risk the termination of a like amount of state grant support. This stipulation can be accessed through: <http://leg1.state.va.us/cgi-bin/legp504.exe?071+bud+21-312> (Item E)

Q3. Is there an emergency Medicaid application process for recipients? No

A3. The Department of Social Services facilitates the Medicaid application process. There is no expedited process.

Q4. How can Medicaid regulation information related to substance use treatment services be accessed? DMAS Provider Manuals

A4. The Provider Manuals for substance abuse crisis intervention, substance abuse intensive outpatient, substance abuse day treatment, substance abuse case management and opioid treatment services can be accessed through several DMAS links. DMAS posts memos on their website, <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> , (provider services) regarding changes and updates. Please refer to DMAS' website for the most recent Provider information.

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual> (access all Provider Manuals through drop down menu)

Specific Provider Manuals or Supplements that may be helpful: Community Mental Health Rehabilitation Services, E, Mental Health Clinic and Psychiatric Services and EPSDT (Supplement B). Each manual provides information related to Provider Participation Requirements, Covered Services and Limitations, Billing Instructions and Utilization Review and Control.

Q5. Are substance use services that have been court referred, mandated, or are conditions of probation/parole, etc. eligible to be reimbursed by Medicaid? Yes

- A5.** When an individual is a Medicaid eligible recipient, Medicaid will pay for services that are medically necessary. The diagnosis must meet the criteria established in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I substance-related disorder. The American Society of Addiction Medicine (ASAM) patient placement criteria are used to determine the appropriate level of treatment. Eligibility requirements must be documented as medically indicated and clinically appropriate.

Note: Section 1905(a)(24)(A) of the Social Security Act excludes from Medicaid coverage payments for care and services rendered to any individual who is an “inmate of a public institution” unless that individual is a patient in a medical institution. There are no stipulations for persons under community supervision of the criminal justice system or the purview of the court. Certain mental health and substance abuse residential services are not allowed by the Social Security Act. Generally, services cannot be reimbursed if provided in programs that have 17 or more beds for persons 22 to 64 years of age.

Information can be accessed at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> Provider Services- Provider Manuals (CMHRS- Chapter III- Member Eligibility, revised December 1, 2011)

Q6. Can a clinician bill exclusively for substance use services? Yes

- A6.** Under the provisions for Medicaid billing, substance use services can be exclusively billed. The Mental Health Clinic option can also bill for services provided by their employed licensed substance abuse treatment practitioners, if the mental health clinic has a valid Medicaid provider agreement.

The professional services may be billed separately as outpatient psychiatric or substance abuse services by a qualified, enrolled Medicaid provider. Prior authorization of the professional services may be required.

Refer to Medicaid Memo “Medicaid Coverage of Substance Abuse Services”,- Effective July 1, 2007 (dated 6/12/07)

Q7. Why are the reimbursement rates in 15- minute time increments? Requirement of Centers for Medicare and Medicaid Services (CMS)

- A7.** The Centers for Medicare and Medicaid Services (CMS), the federal Medicaid oversight agency, requires DMAS to use 15-minute time increments and different rates for different levels of qualifications for community SA services. The Community SA rates were based on rates for existing Community Mental Health Rehabilitation (CMHR) services

Q8. Does Substance Abuse Case Management require KePro pre-authorization? No

- A8.** Substance abuse case management does not require pre-authorization. List of services requiring no pre-authorization can be found at <http://www.dmas.virginia.gov/downloads/pdfs/mm->

[Substnc Abuse Serv.pdf](#) To check if authorization is required for other SA services the Medicaid HELPLINE is available at 1-800-552-8627.

Substance abuse case management is subject to a maximum service limit of 52 hours or 208 units annually. Starting August 1, 2009 and each July 1st thereafter, all service limits will be set to zero.

Q9. Are there substance abuse services that require prior authorization (PA)? Yes

A9. The substance abuse outpatient or clinic treatment sessions are separate from psychiatric services. When medically necessary, there may be concurrent authorizations for substance abuse treatment and psychiatric services. For persons with co-occurring psychiatric and substance abuse conditions, providers are encouraged to integrate the treatment. The most appropriate service, either psychiatric or substance abuse treatment would require prior authorization. (Psychiatric Providers manual)

Under the Mental Health Clinic and Substance Abuse outpatient option, outpatient psychiatric and substance abuse services require prior authorization after 26 sessions in the first year of treatment. During the first year of treatment, an additional 26 sessions may be authorized. The initial 26 sessions can be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 sessions in subsequent years, but these sessions require prior authorization. (Mental Health Clinic manual)

A separate PA request is required for SA and MH if the plan is to provide these services intermittently.

Medicaid MCOs establish their own prior authorization (PA) criteria and perform authorizations.

MEDICAID AND ADOLESCENT SUBSTANCE USE REIMBURSEMENT

Q10. How can Early and Periodic Screening, Diagnosis and Treatment (EPSDT) be used to provide treatment for child/adolescent substance use services?

A10. EPSDT is the benefit package for Medicaid/FAMIS Plus enrollees under 21 years of age. EPSDT includes a range of services including individualized health care, diagnostic services, and "treatment" - as noted in the Federal Medicaid statute. EPSDT criteria indicate that each substance use services are medically necessary. Children under the age of 21 who receive Medicaid through FAMIS Plus and are enrolled in a Managed Care Organization (MCO), MEDALLION or Fee-for-Service (FFE) are eligible to receive the full scope of Medicaid/EPSDT services. This includes specialized services such as residential substance abuse treatment, if they are deemed medically necessary. Outpatient substance use services are provided as a component under the general Medicaid system.

A specific EPSDT manual supplement is utilized to determine eligible services. Information can be obtained through the following links

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual> (drop down menu EPSDT), or

http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_fs.pdf (fact sheet)

Q11. What are the eligibility requirements for adolescents to receive EPSDT substance use services?

A11. Children under the age of 21 who receive Medicaid through FAMIS Plus and are enrolled in a Managed Care Organization (MCO), MEDALLION or Fee-for-Service (FFE) are eligible to receive the full scope of Medicaid/EPSDT services. Children under EPSDT can receive specialized treatment services not routinely covered through Medicaid. If deemed a medically necessary treatment, children can receive substance abuse residential treatment and intensive or cognitive rehabilitation as an EPSDT specialized service. Outpatient substance use services and community-based rehabilitation services are provided as a component under the general Medicaid system.

Information can be accessed through: http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_fs.pdf (fact sheet);

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/General/epsdt_supplement_gen.pdf (Supplement B-EPSDT revised December 23, 2008), or

http://www.dmas.virginia.gov/downloads/pdfs/mm-transition_EnrolleesMemo.pdf (Medicaid memo- Outpatient Substance Abuse Services that will transition to KePRO for Fee-for Service Enrollees)

MEDICAID REIMBURSEMENT FOR RESIDENTIAL SUBSTANCE USE SERVICES

Q12. Does Medicaid cover substance abuse residential treatment services? Yes,

A12. Medicaid covers only SA residential treatment services for pregnant and recently post partum women and as a component of EPSDT for children under 21 years of age.

Postpartum women are covered for 60 days after delivery. In order to be eligible for reimbursement, the treatment program must meet the specific Medicaid regulations addressed in their Community Mental Health Rehabilitative Services manual

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/CMHS/Chapter4_cmhrs.pdf (Community Mental Health Rehabilitative Services, Covered Services and Limitations, revised September 23, 2010).

For children, service needs that do not meet existing program criteria are considered for approval by the Specialized Services Unit at DMAS using EPSDT criteria. Information can be accessed at:

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/CMHS/Chapter4_cmhrs.pdf (Community Mental Health Rehabilitative Services, Covered Services and Limitations, revised September 23, 2010).

http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx EPSDT (fact sheet)

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/General/epsdt_supplement_gen.pdf (Supplement B-EPSTD revised December 23, 2008).

MEDICAID REIMBURSEMENT FOR WOMEN'S SERVICES

Q13. If the community services board (CSB) receives SAPT-BG Women's Set-Aside funds and/or State General funds that support Project LINK services, is there a conflict in billing Medicaid case management services for pregnant women?

A13. No, there is not a conflict. The Project LINK funds are allocated to support staff positions and program expenses. The SAPT-BG Women's Set-Aside funds are allocated to support defined services to pregnant and post-partum women and women with dependent children, as well as to the dependent children. Medicaid can be billed for services provided to Medicaid enrolled women. There can be no duplication of case management services.

MEDICAID REIMBURSEMENT FOR SCREENING AND ASSESSMENT

Q14. Does Medicaid provide coverage for screening? Yes

A14. The Department of Medical Assistance Services (DMAS) has authorized reimbursement for two substance abuse screening codes for both Fee-for-Service and Managed Care Medicaid clients, including MEDALLION and FAMIS Plus enrollees. The Common Procedural Terminology (CPT) codes are 99408 and 99409. These new codes reimburse providers for structured screening for substance abuse and brief interventions. Information about Screening and Brief Intervention (SBI) and screening instruments for adults, adolescents, and perinatal can be located at: <http://www.dbhds.virginia.gov/screeners.htm> . No prior authorization is required.

Additional information can be accessed at: http://www.dmas.virginia.gov/downloads/pdfs/mm-SAS_Screen_CDs.pdf (Medicaid Memo updated May 23, 2008)

Q15. Can a community services board bill for Screening and Brief Intervention (SBI) related to substance abuse services? Yes

A15. Many CSBs provide substance abuse screening and brief intervention services in settings such as medical clinics, local departments of social services, the courts, WIC offices, etc. If the services meet Medicaid regulations regarding the provision and documentation of SBI services, the CSB may bill Medicaid. The CSB may also consider contracting with medical providers to provide SBI services and allow the provider to bill for the service.

Q16. Can a clinician bill utilizing the assessment codes if there is a pending definitive diagnosis? Yes

A16. Common Procedural Terminology (CPT) code 90801 can be billed with appropriate documentation indicating a rule out or presumptive diagnosis. Guidance for the assessment and evaluation and outpatient therapy (individual, family, and group) services can be found in the Mental Health Clinic and Psychiatric Services Manuals.

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/mhc/chapterIV_mhc.pdf
(Mental Health Clinic Provider Manual, Covered Services & Limitations, revised August 26, 2009)

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/psych/chapterIV_psy.pdf
(Psychiatric Services Provider Manual, Covered Services & Limitations, revised May 21, 2009)

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/psych/chapterV_psy.pdf
(Psychiatric Services Provider Manual, Billing, Instructions, revised January 26, 2011)

Q17. If a consumer has been screened for both mental health and substance use but identified to be at risk for problems in only one of these areas is there a need to address both areas of functioning when the assessment is completed? Yes

A17. Providers should address all areas of need because screenings are not diagnostic. Additional exploration may flush out denial, minimization or other defenses; it may also help individuals achieve a different perspective or increase their awareness.

MEDICAID SUPERVISION REQUIREMENTS

Q18. When is physician oversight required? Oversight is required in Mental Health Clinics (Federal law- section 1905(a)(9) of the title of the Social Security Act)

A18. A mental health clinic that has clinical outpatient services must have a physician to oversee the services. Physician oversight is required for outpatient services as it is a clinic option services. The patient care protocols for treatment of Medicaid recipients must reflect the role of the physician. The physician does not have to be a psychiatrist and does not have to be on the premises when the patient is receiving covered services. The physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Under this policy, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, psychiatric nurse practitioners, and clinical nurse specialist-psychiatric may render reimbursable services without the direct personal supervision of a physician present. Licensed Substance Abuse Treatment Professionals may provide substance abuse services only. However the physician must have a face-to-face visit with the recipient, prescribe the type of care provided, and periodically review the need for continued care. The patient's medical records must document that the physician has ordered the plan of care and is reviewing the need for continued care at least every six months.

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/MHC/chapterIV_mhc.pdf
(Mental Health Clinic manual, Covered Services and Limitations, revised August 26, 2009)

Q19. How is "directly working" with a client defined and how does the provider bill for the services?

A19. "Directly working" refers to monitoring and face to face support provided by a Qualified Substance Abuse Provider (QSAP), a CSB certified pre-screener, or a paraprofessional. A certified pre screener is employed by the community services board (CSB) or its designee and is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services (DBHDS). A

paraprofessional or unlicensed individual must work under the supervision of a QSAP and may provide certain services in accordance with the plan of care. (Please see service descriptions for the services that allow paraprofessionals.) Each substance abuse treatment session must be dated and signed by the paraprofessional and co-dated and signed by the supervising provider on the date of service indicating that the note has been reviewed.

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/CMHS/Chapter4_cmhrs.pdf
(Community Mental Health Rehabilitation Services, Covered Services and Limitations, revised September 23, 2010)

http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/psych/ChapterII_psy.pdf
(Psychiatric Services Provider Manual, Provider Participation Requirements, revised October 4, 2010)

The provider should bill for the level of provider actually providing monitoring or face to face with the client. For Example: The Qualified Substance Abuse Professional (QSAP) is providing supervision, the paraprofessional is directly working with the client, the paraprofessional level of service is billed.

MEDICAID REIMBURSEMENT FOR CO-OCCURRING DISORDERS

Q20. How an Individualized Service Plan (ISP) is appropriately established for a consumer with multiple providers?

A20. There must be an ISP from each provider rendering services to the recipient. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs from multiple providers help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specify short-term objectives in measurable terms. An ISP can identify goals that address either an MH or SA issue in order to have an integrated plan. Each ISP should be signed by the provider and the client.

Q21. How are services billed for consumers who have co-occurring mental health and substance use disorders?

A21. Substance abuse treatment and psychiatric services are distinct services. The consumer may be eligible for both outpatient substance abuse and psychiatric services. When medically necessary, there may be concurrent authorizations for substance abuse treatment and psychiatric services. Medicaid encourages clinicians to provide integrated treatment to individuals who have co-occurring substance use and psychiatric disorders. When providing integrated treatment, the most appropriate service, either psychiatric or substance abuse treatment, would require prior authorization.

Q22. How are Medicaid case management services billed when a consumer is receiving both substance abuse and mental health case management?

A22. In an effort to maximize Medicaid coverage for consumers with co-occurring disorders, providers are encouraged to bill for substance abuse case management services first. SA services that are

provided are generally more intense early in treatment. Substance abuse case management providers can bill for all case management services, including, face-to-face contacts, contacts or communication related to treatment planning, as well as providing, coordinating and monitoring of services. Substance abuse case management services are billed in 15 minute units (not to exceed 52 hours or 208 units annually-all service limits set to zero each July 1st) while mental health case management services are billed by the month with prior authorization (PA). Only one type of case management can be billed at a time. The consumer must meet the Medicaid service description.

SUBSTANCE USE PROVIDER OPTIONS

Q23. How are substance use services integrated under Community Mental Health Rehabilitative Services (CMHRS)?

A23. Mental Health Support, Mental Health Case Management, Mental Health Crisis Intervention, and Mental Health Crisis Stabilization- If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance use disorder is intended to positively impact the mental health illness. The impact of the substance abuse condition on the mental health condition must be documented in the assessment, the ISP, and the progress notes.

The following codes can be utilized: SA Crisis Intervention (H0050), SA Intensive Outpatient (H2016), SA Day Treatment (H0047), Opioid Treatment (H0020). If an individual has co-occurring mental health and substance use disorders integrated treatment for both disorders is allowed.

Q24. How are substance use services provided through the Mental Health Clinic option?

A24. Mental Health Clinics that have a valid Medicaid provider agreement and employee licensed SA Treatment Practitioners may bill for substance abuse services. All psychiatric and substance abuse services must be medically prescribed treatment and documented in an active written treatment plan. A separate plan is required for psychiatric services and substance abuse services when prior authorization is requested separately. The primary diagnosis should indicate the focus of treatment. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed with the expectation the clinician will bill for the primary presenting problem.

LEVEL OF CARE (ASAM)

Q25. Has DMAS endorsed a patient placement instrument to be utilized in conjunction with the ASAM assessment tool that facilitates the process to logically consider treatment recommendations or level of care?

A25. DMAS has approved the use of LOCADTR (Level of Care for Alcohol and Drug Treatment Referral) as a guideline for level of care determination (there are no ASAM specific documentation requirements). DMAS requires that each of the six ASAM dimensions be documented. It is suggested that each dimension be documented with at least a notation of "none" and when

appropriate with a note of the area or level of risk as well as an explanation for the chosen level of care. Documentation need not differ in format from standard clinical records.

LOCADTR (Update) [LOCADTR.pdf](#) sample of the form.

Q26. What services require completion of ASAM patient criteria prior to beginning treatment services?

- A26.** Substance Abuse Intensive Outpatient services
Substance Abuse Day Treatment
Opioid Treatment
Substance Abuse Residential Treatment for Pregnant Women
Substance Abuse Day Treatment for Pregnant Women

Q27. Are there e-learning or web ex courses available for ASAM?

- A27.** There are currently no e-learning or web ex courses available for ASAM training or refresher. There are proprietary online and DVD trainings available (1-800-844-8948). Additionally, training DVDs and a manual with statewide site licenses have been purchased and are available for all our CSBs and facilities. These can be utilized (copy freely) to train any staff who are not familiar with ASAM.

MEDICAID REIMBURSEMENT FOR CRISIS SERVICES

Q28. Does Medicaid classify Crisis Management as an emergency service?

- A28.** Medicaid covers Crisis Intervention and Crisis Stabilization, these services are considered emergency services.

Q29. Under a crisis admission, are there services provided outside of the global rate?

- A29.** If an individual is admitted to a hospital, no other charges are allowed, except professional services. Please refer to the chart in the Community Mental Health Rehabilitation (CMHR) manual under Covered Services and Limitations.

DOCUMENTATION REQUIREMENTS FOR MEDICAID

Q30. What documentation is required by Medicaid when reviewing the Plan of Care (POC) every six (6) sessions or 90 calendar days?

- A30.** The Plan of Care (POC) must be reviewed by the provider every 90 calendar days or every sixth session, whichever time frame is shorter, from the date of the provider's signature. The review may be incorporated into the progress notes, but must be identifiable as a review of the POC. This

requirement is to ensure quality. Please refer to the manual for requirements related to the Plan of Care (POC).

Q31. Are there specific provisions for substance use services that are required in order to bill Medicaid for Substance Abuse Case Management?

A31. Currently, the CMHRS manual does not list specific substance abuse services that must be provided, but the expectation is that monitoring, linking, and coordination will occur for any service that the case manager identifies as medically necessary. For example, this could mean monitoring a consumer's attendance at 12 step support programs.