# Chat questions – September 2024

**Q: That was my question about intensity and the answer wasn't clear. If someone misses a day and no documentation exists, the whole week should move to medium intensity? Sorry, low intensity.**
**Q: How about this - if a provider cannot produce documentation around an intervention for a missed day of treatment, how would they proceed with billing that day/week?**

Answer to both questions above: Minn. Stat. 254B.05, subd. 5 (j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

The statute change only includes an allowance to bill for the provider's usual and customary fee for the client's identified intensity level if the requirements are met. It does not include an allowance to bill a different way if those requirements are not met, such as billing at a lower intensity level for the week. A client's specific intensity level is determined by their needs and person-centered considerations and must be identified on the client's treatment plan. If the client's needs and considerations change, the client should be assessed to determine if a different intensity level is more appropriate; however, that is not something that would change for billing reasons. DHS is unable to provide guidance stating that a provider may bill the department if the required services for the intensity level were not provided and the program did not meet the statute requirements that allows them to still bill. See Minnesota Administrative Rules 9505.0450 BILLING PROCEDURES; GENERAL Subpart 1. A provider shall bill the department for the provider's usual and customary fee only after the provider has provided the health service to the recipient.

**Q: Is it permitted to schedule a 3-hour OP group with two 10-minute breaks? Or do we need to schedule separate groups?**

A: DHS is not aware of any regulations limiting a license holder's ability to schedule outpatient group treatment services or breaks in their treatment schedules. However, as indicated in the MHCP Provider Manual, the H2035 and H2035 HQ codes are based on a service provided "per hour" and not intended to allow providers to schedule units in less than 1 hour.

**Q: We provide large lectures, requiring multiple QP staff to be present to count the hours towards the old 30-hour requirement. It was a burden when documenting, so we are wondering if we need to document those services anymore since we offer other "daily skilled service".**
**Q: If we offer more than one service daily (defined as not a skilled service or not included in the provided daily skilled service), what standard of documentation are we held to, if any?**
**Q: If we are documenting a client's participation in the program but it is not a designated daily skilled service does that documentation still need to be client centered?**

Answer to three questions above: License holders are required to document all treatment services they provide under section 245G.06, subdivision 2a. If the lectures or other services are a treatment service as described in statute section 245G.07, they must be documented according to the requirements in that section, even if the program is exceeding the minimum services required for the ASAM level of care provided. Additional

documentation requirements are found in section 245G.06, subdivision 2b, including for significant events, appointments, and medication and attendance concerns. It's recommended that the program provide documentation sufficiently supporting continued stay medical necessity criteria in a high-intensity residential level of care. All documentation of a client's participation in the program should be client centered.

**Q: For the potential one rate for MA or BHF, will the different value 24 codes be combined or will the separate BHF only be eliminated? If I'm understanding the definition of this one rate portion.**

A: The BHF value codes will be eliminated. Once the programming for this change is finalized, everyone will begin using the value codes that were set up for the 1115 demo whether the client is enrolled with MA or OO.

**Q: With the approval of the unified rate, are providers able to reprocess claims that have already been submitted at the lesser rate?**

A: The programming for this change is still being developed. More information will be provided once the programming has been determined.

**Q: Would DHS ever consider a 30-minute code for individual counseling, to meet the patient where they are at for PHP, IOP and OP?**

A: DHS continues to explore more flexible claims coding structures for SUD treatment services.

**Q: Are there different procedure codes defined for Low Intensity, 15 or 5 hours? E.G. High Intensity Residential Mod is "TG". Medium was "TF" and Low was "UD"? Is that correct?**

A: Correct, these codes should continue to be used as follows:

| Intensity Level | HCPC + Modifier | Base Rate |
|---|---|---|
| 3.1 Low Intensity @ 5hrs per week | H2036 UD | $79.84 |
| 3.1 Low Intensity @ 15 hrs per week | H2036 TF | $166.13 |
| 3.3 High-Intensity @ Daily Skilled Tx Service | H2036 TG | $224.06 |
| 3.5 High-Intensity @ Daily Skilled Tx Service | H2036 TG | $224.06 |

**Q: The skilled service language was effective July 1, correct? If providers were moving clients to lower intensities based on not meeting 30 hours, would they be eligible to rebill at high intensity if they made it to 7 days of treatment but fell short of the 30 hours?**

A: The changes to the services were based on a July 1, 2024, effective date in state law and state plan. If a client received a daily skilled treatment service in a high-intensity residential treatment program according to the program's defined treatment week, the provider could bill the department for the usual and customary fee for that service.

**Q: Are there any hour requirements for 3.5 now? More than 15?**

A: Programs providing 3.3 and 3.5 high-intensity levels of care must have 24-hour staffing coverage and provide, at a minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan. The current requirements are based on the level of care standards in the ASAM 3rd Edition.

**Q: To clarify, 3.5 is not approved to observe the federal holidays, this is only 2.1 & 3.1, correct?**

A: Correct. Minn. Stat. 254B.05, subd. 5(k) states, "Hours in a treatment week may be reduced in observance of federally recognized holidays." Because 3.3 and 3.5 high-intensity residential levels of care require daily skilled treatment services seven days a week there is no allowance for hours in the treatment week to be reduced OBJ OBJ.

**Q: Can daily skilled services be provided via Telehealth? For example, if a rural program has a hard time staffing weekends, could the service be provided by a qualified staff remotely?**

A: Services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. Recent changes to requirements for telehealth services in 245G programs, including those specific to residential programs, are found in Minn. Stat. 245G.07, subd. 4

**Q: Do we have to have a QP in non-skilled services? For example, we offer a lot of programming and not all of it will be designated as a daily skilled service. If we are documenting that a client attended a group, but it is not a designated skilled service do we need to document what the client got out of that group?**

A: If any of the treatment services identified in section 245G.07 subdivisions 1 and 2 are provided, they must be provided by a person qualified to provide that service and must be documented according to section 245G.06, subdivision 2a. This applies to both skilled treatment services and other treatment services and to services that are provided beyond the minimum required for the ASAM level of care.

> Subd. 10. **Skilled treatment services.**
> "Skilled treatment services" includes the treatment services described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.
> 245G.06, Subd. 2a. **Documentation of treatment services.**
> The license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of each treatment service provided to a client and the client's response to each treatment service within seven days of providing the treatment service.

**Q: Could you repeat what was sent to the AA?**

A: Emails and phone calls have been made to Authorized Agents (AA) informing them of the requirement to submit paperwork attesting to an ASAM level of care no later than January 1, 2025. Section 256B.0759, Subd. 2(a).

**Q: One last thing - any idea what DHS is thinking around the rate study implementation? Will we see a staggered implementation, an increase proposed/supported by DHS next session?**

A: DHS continues to communicate support for the results of the rate study. However, any final decisions on what DHS will implement from the recommendations of the rate study will ultimately be determined during the upcoming legislative session.

**Q: Does the daily skilled service, rather than the specific hour requirement, also apply to the 1115 loc requirements?**

A: Yes, DHS will continue to update the Level of Care Requirements to align them with changes to state law.