

# PCPC FAQ

---

*The answers to the questions below serve as guidance only and do not supersede DDAP requirements outlined in the Grant Agreement.*

*Please click on the heading below to access the relevant questions:*

**PRINTING ERROR**

**TRAINING**

**PCPC APPLICATION/PROCESS**

**BEST PRACTICE/TREATMENT PRINCIPLES/DO & DON'T**

**EARLY INTERVENTION**

**VALIDATING A PCPC**

**SPECIAL POPULATIONS**

**LICENSING**

**FUNDING/PAYMENT/INSURANCE/MCO**

**PCPC & STAR**

**GAMBLING**

## PRINTING ERROR

1. My PCPC manual is missing level 1 on pages 9-10.

DDAP is aware of this printing error and it has been corrected. If you have a version of the PCPC manual with this error, simply reprint and replace pages 8-13 in your copy.

## TRAINING

1. What is the training and implementation schedule of the PCPC?

PCPC 3<sup>rd</sup> Edition Update Training is scheduled to begin early November 2014 and run through June 2015. This instructor-led training course lasts about 3 hours and will be offered in a morning and an afternoon session in various locations across the state every 2 to 4 weeks.

You can register for the PCPC 3<sup>rd</sup> Edition Update training through our Training Management System (TMS) found at <https://apps.ddap.pa.gov/TMS/>. Perform a Course Search for "PCPC 3<sup>rd</sup> Edition Update" to find the latest list of upcoming trainings being offered on this course. Please check back periodically for addition training dates and locations.

We are in the process of also developing a webinar on the PCPC 3<sup>rd</sup> Edition Update training. Details on the webinar will be provided once they become available.

Please note that we have discontinued offering the full PCPC 2<sup>nd</sup> Edition course at this time. We are now offering the the full PCPC 3<sup>rd</sup> Edition course in the mini-regionals and on-sites.

Similar to the release of the DSM, the PCPC 3<sup>rd</sup> Edition may be read and used as a reference for immediate implementation. However, SCAs and providers will not be monitored for compliance until July 2015.

2. Training requirements don't match Treatment Manual requirements. For example: treatment staff are not required to complete screening and assessment training, but they do PCPCs.

Training requirements in the Treatment Manual are being revised and will be aligned with the PCPC Training Principles with the start of the 2015-2020 SCA Grant Agreement.

3. For the requirements of the clinical supervisor signature, do the waiver approvals/grandfather of seasoned staff still exist and apply?

Yes. Anyone who has received PCPC 2<sup>nd</sup> Edition training by September 30, 2014 will be grandfathered and will not need to comply with the new training and signature requirements.

4. If a supervisor doesn't have PCPC training, can supervisor still sign off on summary sheet? If not, then who does it?

No. Another supervisor with training can sign off on the summary sheet for a supervisor that does not have the required training. If no supervisor has the required training, the authority to sign off on a PCPC summary sheet could be delegated to another qualified staff member.

The expectation is that a supervisor has experience and training relevant to the position(s) he or she supervises. All persons providing or supervising case management functions or adult treatment services must complete all required and applicable DDAP-approved core trainings within 365 days of hire. These requirements can be found in the DDAP Treatment Manual, Parts 8.00 and 9.08.

5. What if a supervisor has not had the updated PCPC training? Is that still the person who would sign off?

Yes, the supervisor would still be the person to sign off on PCPCs for those who have not met the requirements to administer the PCPC independently.

6. Who is training the insurance companies?

DDAP has offered to provide training to the HealthChoices Behavioral Health Managed Care Organizations.

7. If I have not attended a PCPC 3<sup>rd</sup> Edition update training by 6/30/15, do I have to do full 6 hour training again, must staff also re-do practical applications of PCPC?

If you were trained in the 2<sup>nd</sup> Edition of the PCPC and did not attend the PCPC 3<sup>rd</sup> Edition update training, you will need to attend the full 6 hour training. If you have previously taken Practical Application of PCPC, you are not required to re-take the course.

## PCPC APPLICATION/PROCESS

1. What do you do for an AMA or Administrative Discharge or other unusual type of discharge?

If an individual leaves any level of care AMA, a continued stay PCPC should be completed because the individual still meets criteria for that level of care. It should be documented that although the individual meets continued stay criteria, he/she chose to leave the facility against advice.

2. If client comes into IOP and then goes to OP, an admission PCPC is completed. What do you do if they go from OP to Medication-Assisted Treatment maintenance with fewer contact hours? Do you complete an admission PCPC or a continued stay PCPC?

Medication-Assisted Treatment is a type of service that can be offered in conjunction with any level of care. Any treatment 5 hours per week or less is considered Outpatient. Completion of a PCPC would not be necessary because the individual is not changing his/her level of care.

3. How should the following scenario be addressed? The SCA does admission PCPC on July 1 but individual does not enter treatment in 3B until July 5. Technically client did not admit to facility until 7/5 so is sending the admission PCPC to the provider with the original date is incorrect? Should they complete a new Admission PCPC for 7/5?

The date of the admission PCPC should be the date the level of care was recommended. The actual admission date to the level of care should be documented in the client record and via the Admission form in STAR.

4. If I recommend 3C level of care for a 3B client, how often do I submit PCPCs – 7 days or 30 days? Do I continue to complete 3C admission PCPCs for every submission? How do I submit an admission for lower level of continued care?

If an individual is recommended for a different level of care than he/she receives, the reason why the recommended level of care was not received must be documented. Once the individual has been admitted to any level of care, continued stay PCPCs should be completed to maintain the individual in the level of care to which he/she has been admitted. In your example, an admission PCPC would be completed for 3C because that is the level of care recommended. If the individual is admitted to 3B, then continued stay PCPCs should be completed for 3B because that is the level of care in which you are requesting the individual be maintained. You should document that although the most appropriate level of care for the individual is 3C; he/she is unable to access the recommended level of care and is receiving 3B as an alternative. Continued stay reviews are to be conducted within the parameters for the level of care the individual is receiving.

5. What are your recommendations for individuals who do not want the PCPC recommended level, but want something lower (ex: meet 3B criteria, but want 1A)?

The admission PCPC should always be completed for the clinically appropriate level of care. If an individual does not wish to participate in the recommended level of care and is referred to an alternative, the reason for the referral to a level of care different from that which was recommended must be documented. In this scenario, the reason for not receiving the recommended level of care is client choice.

6. Will the level of care assessment required components be changing?

At this time, there is no intent to change the components of the Level of Care Assessment.

7. Will DDAP not be looking for discharge or non-treatment needs in charts?

Through case coordination, SCAs and their contracted providers are required to address both treatment and non-treatment needs. This requirement has not changed. DDAP will only be monitoring for a discharge PCPC for the Outpatient level of care.

8. Continued stay (pg. 10) wording for time frame for 1A – continued stay is due once every 60 days, every 180 days, or anytime in between 60-180 days?

Continued stay reviews may be conducted at any time during the range provided for each level of care, or anytime deemed clinically appropriate, depending on the individual's needs.

9. What are the reasons an individual may not receive the recommended level of care?

Reasons may include: funding, capacity issues, provider staffing concerns, proximity, lack of appropriate service, legal issues, client choice.

10. How should criteria for an MAT referral be documented? Should that be 3A due to withdrawal risk or another level of care because medication would mitigate withdrawal? Does this change given the lag that may occur until the individual can receive the medication?

MAT can be provided at any level of care. Services should be specific to the individual's needs and the recommended level of care should match those needs.

11. How do we utilize DSM-5 and .5 Early Intervention and 1A Outpatient in order to correctly differentiate correct LOC? How does moving SUD criteria to a continuum affect our ability to diagnose and therefore admit individuals to treatment?

An individual who meets PCPC criteria for .5 Early Intervention does not meet DSM-5 criteria for a Substance Use Disorder diagnosis. For the purposes of billing, an appropriate code would be the DSM-5 V-code 65.40 Other Counseling or Consultation. This code is also being used by other states for early intervention services to obtain payment from third party billing. Each level of care is differentiated by the PCPC criteria specific to that level. Early Intervention is not considered to be SUD treatment.

12. Does SCA always start the PCPC/referral to a treatment provider or does the provider initiate PCPC?

The entity completing the level of care assessment is responsible for completing the admission PCPC. Therefore, a PCPC could be initiated at either an SCA or a provider.

13. Because STAR is only used for SCA funded clients, not MA funded clients, can we use the unique client number instead of the UCN# on the PCPC?

If an individual is not SCA funded, a provider may use their own unique client number on the PCPC.

14. Please provide clarification of discharging clients from 1A to 1B. Is a PCPC discharge required or do we just complete an admission PCPC?

A discharge PCPC is only done when an individual completes 1A treatment. If a person requires a higher level of care than the one he or she is currently in, an admission PCPC for the most appropriate level of care would be completed. In this example, an admission PCPC for IOP would be completed by the OP provider to show that the individual meets criteria for a higher level.

15. Why the spread in timeframes for continued stay review? Why not make it a specific number of days?

DDAP wanted to allow providers and SCAs flexibility in the timeframes for completion of continued stay reviews.

16. Does the client need a psychiatric evaluation or previous official diagnosis to be dual/co-occurring? Do these diagnoses have to be done with documentation or is it just based in the data gathered at the biopsychosocial?

Level of care assessment data is obtained from the individual and other sources that could indicate whether it is appropriate for the person to be referred for specialty services. If specialty services are appropriate, a referral should be made to a program capable of addressing the needs.

17. If a referral comes from an emergency room, does the emergency room have to prepare the PCPC?

No, the emergency room would not complete a PCPC, because they are not required to complete a level of care assessment.

18. In dimension 1 of PCPC if recommending detox, do we give specifics about use, given 255.5?

4 Pa. Code § 255.5 applies to all dimensions of the PCPC and communication between the provider and the payer. The DDAP Confidentiality Guide is available on our website and describes permissible disclosures in compliance with 255.5.

19. Should the ASAM or the PCPC be used for 18 year old in school and involved in children's services?

The PCPC should be used for all individuals age 18 years and older.

20. If someone is placed on county funding in the middle of treatment, does a new PCPC start on the date they switch to county funding or do you carry on with the original admission PCPC date?

PCPC is not based on funding; however, payers may have requirements that current documentation be provided to justify the level of care.

## **BEST PRACTICE/TREATMENT PRINCIPLES/DO & DON'T**

1. Is the 90-day involvement in treatment limited to inpatient? Is DDAP saying we should send individuals to 3C because of the research to back that up?

No single treatment is appropriate for everyone. Within the continuum of treatment services, treatment placement recommendations and length of stay need to be based on a comprehensive assessment that includes a review of the severity and biopsychosocial impact of the individual's substance use as well as the individual's clinical, social and recovery status (e.g., mental health status, social functioning, health status recovery capital, family and legal status). Treatment must last long enough to produce stable behavioral changes. For those who are appropriate for outpatient, a similar 90 day minimum is required for best outcomes, this also reflects that time is needed to establish rapport and to engage in the work of treatment.

2. With appropriate releases in place, can the PCPC 3 Summary Sheet be released to a Probation Officer or other group/individual who falls under 255.5 restricted access to information?

Although 255.5 allows for the release of specific information to a payer, probation officer or other criminal justice entity, providing a clinical document such as the PCPC Summary Sheet is not the most appropriate method of communicating this information.

3. How can legal organizations (e.g., probation, parole) dictate LOC and length of stay?

Placement decisions should always be based on a comprehensive level of care assessment. Collaboration with legal organizations is beneficial to ensuring an individual receives the clinically appropriate level of care. Length of stay decisions are made at the time of continued stay review and depend on the individual's progress in treatment.

4. What happens when level 2A PCPC is the last completed level of care and no more care is needed?

Best practice indicates that an individual should move through the continuum of care and be stepped down to the next lower level of care.

5. Can we get a link to the Villanova study?

DDAP currently does not have access to an electronic copy of the Villanova study.

## EARLY INTERVENTION

8. Is the SCA required to establish a contract for Early Intervention?

SCAs are not required to contract with providers of Early Intervention services. However, before the SCA expends Department of Drug and Alcohol Program funds, an Early Intervention services contract with the provider must be fully executed.

9. What are the training requirements/METs for staff running an early intervention class or group?

Please reference page 21 of the PCPC manual regarding staffing requirements for Early Intervention. METs have not been defined for persons providing Early Intervention services; however, some examples of who may deliver this service include Certified Recovery Specialists, counselor assistants, counselors, case managers, or other skilled human service professionals.

10. Would there be a discharge PCPC on .5 LOC?

No. Discharge criteria only apply to level 1A, Outpatient.

5. Is Early Intervention reported under activity 72 Intervention or is there a new activity code?

Yes, Early Intervention is reported under activity 72.

6. Is there "criteria" to meet for level .5?

Yes, see level .5 Early Intervention in the PCPC Manual.

7. Once assessed for the .5 LOC, what is the provider obligated to do with an adult individual?

Each SCA will need to determine what resources it has available for the provision of Early Intervention services.

8. What resources do we have for .5? Will we (SCA) fund for DUI classes?

DDAP funds allocated for treatment and intervention may be utilized to fund Early Intervention; however, each SCA will need to determine what resources it has available for the provision of Early Intervention services.

Under the Patient Protection and Affordable Care Act, insurers are to fund for "any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force," which would include SBIRT screening and educational services.

Although an SCA may choose to fund DUI classes, by state law, DUI courses are required to be paid for by the offender.

9. Is there any required charting for .5 LOC individuals?

If an individual is assessed and determined to need this level of care, SCAs and their contracted providers must comply with Part 9.05 of the DDAP Treatment Manual, Case Management File Content. It is always best practice to document all client contact.

## VALIDATING A PCPC

1. If an SCA receives an admission PCPC for detox, does the case manager have to validate the PCPC?

PCPC validation is done at the provider level to ensure individuals are being referred to the clinically appropriate level of care. The SCA's role is to review the PCPC for appropriate placement and to approve the level of care admission from a funding perspective.

2. If you receive an admission PCPC for the level of care you are providing and you verify it, does the receiving facility have to do another PCPC?

No. If you are providing the level of care for which the individual has been referred and concur that the admission PCPC that level of care is valid, you do not need to complete another admission PCPC. The intent of the verification process is to eliminate duplication of effort.

3. If the SCA does the level of care assessment and the provider needs to validate PCPC, do we need to pay them for another assessment or can they do this during evaluation process?

PCPC validation may be completed once the provider has enough information to determine the appropriate level of care. This may be done through review of the biopsychosocial from the referring provider or through the admitting provider's own biopsychosocial evaluation. A new Level of Care Assessment does not need to be completed in order to verify a PCPC.

4. There is no prompt on the PCPC Summary Sheet to initial for the receiving provider to validate the PCPC. Do they just need to place a checkmark?

Yes. A case note would be the appropriate place to supplement with additional information if necessary.

5. How does the validation process affect intra-agency transfers? Ex: IOP to OP within same provider.

The validation process remains the same when an individual moves from one level of care to another, whether it is within the same provider or separate providers. When an individual changes level of care, an admission PCPC for the recommended level of care must be completed.

## SPECIAL POPULATIONS

1. Was there any consideration for including overdoses as a special population?

Not at this time. Overdose Survivors are currently identified as a priority population, in conjunction with the federally identified priority populations.

2. What standards are used to determine “severity” of co-occurring disorders?

Severity of co-occurring disorders should be based on clinical judgment.

3. In the DSM-5, no diagnosis is given if there has been no substance use for 1 year, but in the new PCPC, criminal justice looks at 6 months prior to incarceration. Do we also give diagnosis for 6 months prior to incarceration?

To meet DSM-5 criteria, the individual must meet the criteria in a 12-month period. Once diagnostic criteria are met, that diagnosis continues to apply; however, the specifiers will change over time (e.g., in a controlled environment, early remission, sustained remission).

4. Will questions need to be added to the LOC assessments to address special populations and considerations?

The PCPC has always recommended the inclusion of assessment questions which target special needs and populations. DDAP requires a level of care assessment to identify the need for drug and alcohol treatment and any other needs an individual may have that affect placement decisions. Assessment requirements and components are outlined in Part 9.03 of DDAP’s Treatment Manual.

5. Why aren’t men with children included if they are the custodial parent?

The Special Populations section is not all-inclusive. Please reference the response to the question above regarding identification of needs during the level of care assessment process.

## LICENSING

1. Can a sole private practitioner obtain a facility treatment license?

Yes, please visit DDAP's website for licensing information at [www.ddap.pa.gov](http://www.ddap.pa.gov). Click on "For Professionals and Stakeholders" on the left-hand side of the page, and link for "Drug and Alcohol Treatment Licensing" will be displayed directly below or call the Licensing Division at 717-783-8675.

2. DDAP Licensing Division currently does not review the PCPC during licensing review. Will this be changing 7/1/15?

No.

3. Does the elimination of PCPC discharge criteria change the discharge summary requirement for licensed treatment providers?

No. A discharge note/summary and a discharge PCPC are two different things. Refer to DDAP regulation for discharge summary requirements.

## FUNDING/PAYMENT/INSURANCE/MCO

1. How do you propose case managers deal with Managed Care Organizations that define inpatient levels of care strictly by length of stay? For instance, MCO X identifies any length of stay greater than 28 days as 3C, long term inpatient; therefore, I need to justify admission under 3C criteria for any client needing additional treatment time.

HealthChoices BH-MCOs are required to follow PCPC. PCPC does not define levels of care according to length of stay. Level of care criteria are clinically based. Medically Monitored Short Term Residential treatment is designed for individuals who are in acute distress, in which rehabilitation is the treatment goal. Medically Monitored Long Term Residential treatment is designed for individuals in chronic distress with severe impairment in social, occupational, or school functioning, and habilitation is the treatment goal. For continued stay in any level of care, the individual must meet continued stay criteria for the level of care they are receiving. An individual who meets criteria for 3B will not meet criteria for 3C, and vice versa.

2. If a provider does a continued stay for another level of care, does the payer have to provide (pay for) that service?

There are many reasons someone may not receive the level of care that was recommended. If an individual does not receive the recommended level of care, the reason must be documented in the client record.

3. If recommended to place to next highest level of care when the preferred is not available, what happens if 3<sup>rd</sup> party or facility is unwilling to accept?

The PCPC guides you to give first consideration to the next higher level of care if the recommended level of care is not available. Sound clinical judgment is what is most important when making your recommendation. If a payer refuses to pay for the recommended level of care, the reason should be documented in the record. In this instance, the payer's appeal process should be followed.

4. For principle 7, is any work being done to address declining length of stay for county, managed care, and private funding?

Yes, Department leadership is always looking for ways to emphasize the importance of treating individuals with clinical integrity. This means making treatment available at the appropriate level of care for the length of time needed by each individual. Part of the role of the provider is to employ the appropriate appeal procedures when individuals are not given the care they require.

5. Where is the funding coming from when an SCA runs out of Act 152 funds?

Please discuss with your SCA the various funding streams available.

6. Will an individual still qualify for funding if they refuse the recommendation?

This scenario should be discussed with the funding source.

7. Will managed care companies begin following the continued stay review timeframes now or after July 1, 2015?

Managed care companies are being trained in the PCPC. July 1, 2015 is the deadline for full implementation of the new PCPC.

6. What is the state doing to curtail the aggressive practices of MCOs to get confidential information that is illegal to disclose?

With the release of the PCPC 3, all BHMCOs have been offered the PCPC Update training, which reiterates the need to follow all state and federal confidentiality regulations and to not deny claim, solely based upon the provider's compliance with state and federal law.

The DDAP Confidentiality Guide is available on our website and describes permissible disclosures in compliance with 255.5.

7. Appendix T of the HealthChoices legislation and Program Standards Requirements identified PCPC 2 as the medical necessity criteria to be used by the BHMCOs. When will this be changing to the PCPC 3?

DDAP did not confirm whether or not the HealthChoices written documentation has been updated; however, the DHS website indicates that PCPC 3 is the appropriate tool for drug and alcohol. Specifically, according to the DHS website:

“Drug and alcohol reviews must be conducted in accordance with the Pennsylvania Client Placement Criteria for adults issued by the Department of Drug and Alcohol Programs found at:

[http://www.portal.state.pa.us/portal/server.pt/community/pcpc\\_edition\\_3/21898](http://www.portal.state.pa.us/portal/server.pt/community/pcpc_edition_3/21898)”

*COMMONWEALTH OF PENNSYLVANIA  
HealthChoices Behavioral Health Program  
Program Standards and Requirements -Primary Contractor  
January 1, 2015*

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p\\_003130.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p_003130.pdf)

## PCPC & STAR

1. How does a supervisor sign a PCPC in STAR?

Since there is no electronic signature capability in STAR, supervisory review should be documented through a case note. STAR will be updated to accommodate changes in the PCPC, but the timeframe for that is still to be determined.

2. Should providers wait to use the new PCPC until it is changed in STAR?

Individuals may begin using the new PCPC immediately. July 1, 2015 is the deadline for full implementation of the new PCPC. DDAP has begun the process of requirements gathering for incorporating the necessary changes into STAR, but has not yet determined the timeframe for the changes in STAR to be available.

3. What should I do if I'm using the PCPC in STAR and am recommending .5 Early Intervention (which is not in STAR) as the level of care for an individual?

Until STAR is updated with the new PCPC, DDAP recommends the following:

- Level of Care tab
  - The “Indicate the level of care recommended” field is an open-text field; enter “Early Intervention” into this field.
  - Early Intervention will not be an option in the drop-down boxes that correspond to each of the PCPC dimensions (i.e., Levels of Care). Leave those items set to the “\*\* Please Select \*\*” option.

- CMRR tab
  - For the question “Based on the Level of Care Assessment, along with the PCPC what level of care do you recommend for this client?”, choose “Intervention”
  - For the question “To which level of care was the client referred?”, choose “Intervention”

4. When the PCPC is required in STAR (no paper form accepted) can the PCPC be accepted with no electronic signature?

Yes. There is currently no capability in STAR for electronic signatures.

5. Can you provide an electronic form of the PCPC Summary Sheet to use until STAR is updated?

Yes, an electronic version of the PCPC Summary Sheet is available on the PCPC webpage.

[http://www.ddap.pa.gov/portal/server.pt/community/pcpc\\_edition\\_3/21898](http://www.ddap.pa.gov/portal/server.pt/community/pcpc_edition_3/21898)

6. Are we able to use the STAR PCPC printout in charts or must we use a handwritten updated summary sheet instead until STAR PCPC is updated?

Yes, you may print the PCPC Summary Sheet in STAR to keep in the client chart. You do not need to do a handwritten summary sheet on the updated form if the PCPC is completed in STAR.

## GAMBLING

1. Is there a list of the specially trained gambling addictions counselors in PA? We do not have any in our county.

Information on gambling providers in Pennsylvania can be accessed at the following links:

[http://www.ddap.pa.gov/portal/server.pt/community/need\\_help\\_now\\_/20933](http://www.ddap.pa.gov/portal/server.pt/community/need_help_now_/20933)

<http://www.paproblemgambling.com/find-help/>

2. Should the PCPC be utilized for Gambling Tx LOC?

While Co-Occurring Substance Use and Gambling Disorder has been added as a special population in the PCPC, the PCPC is not intended to be applied for an individual with only Gambling Disorder. The Gambling Patient Placement Criteria (GPPC) is designed for level of care placement of those with Gambling Disorder without co-occurring Substance Use Disorder.