

DDAP ASAM Technical Assistance Series
Questions and Answers
February 7, 2022

1. Does Substance Use D/O need to be primary with secondary M/H, or it does not matter?

The ASAM Criteria, 3rd Edition, 2013 terms of co-occurring capability, co-occurring conditions and co-occurring disorders de-emphasize the focus on the question of which disorder is primary and which is secondary. Rather, ASAM Criteria encourages SUD and MH treatment systems to design continuums of care that can address concurrent SUD and MH symptoms and diagnoses in all patients. The chart on page 30 of the text clearly illustrates this continuum that can effectively screen, refer/consult and/or begin to treat MH and SUD conditions concurrently. Further in the definition of co-occurring disorders on page 416 ASAM states “Use of the term carries no implication as to which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.”

DDAP recommends reaching out to payors for requirements related to diagnosis and reimbursement.

2. Since we are seeing clients all across the state for residential treatment and the MCO's that are covering their BHMCO services are not accepted by providers in our area, how is this being addressed across the system for integrated care even regarding BH insurance coverage?

Each BHMCO may contract with any licensed and credentialed provider that they choose and do contract with most residential treatment providers in their area as many members prefer to receive care close to their home communities. BHMCOs also have contracts with providers outside of their area and are encouraged to contract with providers across the Commonwealth to ensure access to care for their members. Providers may also approach any of the BHMCOs across the Commonwealth to initiate a contract and begin the credentialing process. Many BHMCOs prioritize contracting with providers that demonstrate quality care and positive outcomes for those in care.

3. If there becomes a COD regulatory body, will that mean more audits? We are dual licensed, and the audits are lengthy processes. I don't know that we could handle one more audit. Is there a way they (MH, DDAP) can align?

DDAP and DHS are currently working on an update to the 2006 Co-Occurring Disorders Bulletin, and more information about co-occurring enhanced programs will be released shortly. When possible and appropriate, DDAP and DHS do coordinate licensing visits, so

they occur on the same day (s), and at the same time (s). DDAP and DHS are continuing to work among program offices to make audits less burdensome for providers.

4. I understand from our PA HealthChoices funder that a therapist working with COD requires a master's degree. Is that a funder or state reg? We are COD enhanced and for that reason, only employ master's level therapists.

Pennsylvania regulations **do not** outline educational requirements required for therapists working with co-occurring disorders specifically.

Pennsylvania regulations **do** outline staffing requirements for counselors specific to if they are working in a licensed SUD [28 Pa. Code Chapter 704. Staffing Requirements For Drug And Alcohol Treatment Activities \(pacodeandbulletin.gov\)](#) or in a licensed MH facility. MH Facilities in the Commonwealth are licensed and guided by regulations written for each specific level of care. MH facilities must follow the regulations for the level(s) of care they provide. As defined by [55 Pa. Code Chapter 1153. Outpatient Psychiatric Services \(pacodeandbulletin.gov\)](#) a Mental Health Professional is a person who meets one of the following:

(I) Has a graduate degree from a college or university that is accredited by an agency recognized by the United States Department of Education or the Council for Higher Education Accreditation (CHEA) in a generally recognized clinical discipline in which the degree program includes a clinical practicum.

(II) Has an equivalent degree from a foreign college or university that has been evaluated by the Association of Credential Evaluators, Inc. (AICE) or the National Association of Credential Evaluation Services (NACES). The Department will accept a general equivalency report from the listed evaluator agencies to verify foreign degree or its equivalency.

(III) Is licensed in a generally recognized clinical discipline that includes mental health clinical experience.

DDAP and DHS recommend reaching out to specific payors for requirements related to the diagnosis of SUD and MH conditions. BHMCOs may have their own more stringent requirements for the credentialing of staff and programs that they contract with. For example, a BHMCO may require that a Mental Health Professional be licensed.

5. In the one slide it stated that the Master level clinician could diagnose a MH condition...I thought that a MH and/or a SUD diagnosis was only binding AFTER the medical director signed off on it...Are MH diagnosis's binding when a Master level clinician assigns it?
- 1) There is nothing in the Pennsylvania regulations requiring a physician signature to make a diagnosis "binding."
 - 2) The core competencies for the Pennsylvania Certification Board's (PCB) Certified Advanced Alcohol and Drug Counselor (CAADC) include diagnosing for an SUD or co-occurring disorder.
 - 3) PA Regulations do outline various practices employed by Licensed Professional Counselors, Licensed Marriage and Family Therapists and Clinical Social Workers including assessment, diagnosis and treatment in 2018 Act 76 - PA General Assembly (state.pa.us) and define diagnosis.

"(1) A clinical social work assessment, a marriage and family therapist assessment or a professional counselor assessment.

(2) The utilization of currently accepted diagnostic classifications by a clinical social worker, a marriage and family therapist or a professional counselor, including, but not limited to, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as amended and supplemented, but only to the extent of the clinical social worker's, marriage and family therapist's or professional counselor's education, training, experience and scope of practice as established by this act."

DDAP and DHS recommend you reach out to your specific payors for requirements related to the diagnosis of SUD and MH conditions.

DDAP and DHS recognize that agencies may require a medical sign off, as the practitioners in that agency are not functioning independently.

Providers must maintain policies and procedures as required by regulation. Further, DDAP recommends that agencies develop policies and procedures related to the diagnostic process and related topics (supervision, training etc.) and ensuring that staff function only within the competency areas for which they are qualified by education, training, and experience – including diagnosis.

6. Are any of the co-occurring trainings that popped up on the slide available on the TrainPA site, or in another virtual format?

DDAP recently announced a new virtual training opportunity, Co-Occurring Conditions: Promising Practices and Approaches Part 1 and 2. Information about this training is available here: [Virtual Training - Co-occurring Disorders.pdf \(pa.gov\)](#)

7. Wondering if increased COE rates apply to outpatient/IOP?

The XYZ rate setting process only applies to inpatient non-hospital residential providers: 3.1, 3.5, 3.5 Enhanced, 3.7, 3.7 Enhanced, and 3.7WM.

8. What is being referred to when we talk about medication education? I am hesitant to encourage our staff to be providing information that could be construed as practicing medicine without a license or practicing outside the scope of our individual knowledge area.

ASAM Criteria 3rd Edition, 2013 states that “Ongoing education to patients about the medication they are prescribed (p.27)” is one of the indicators for co-occurring capability and should be addressed through policy, procedure, practice improvement, and workforce development over time. Another indicator is that is “**All staff**, including addiction counselors, nurses, mental health clinicians, and residential aides, are supported and assisted to be ‘co-occurring competent’, so that all staff work as an integrated team to help patients with multiple issues make progress towards their goals” (p.28).

In co-occurring capable programs individuals with co-occurring mental health and addiction symptoms are welcome in the program and encouraged to discuss all issues – including medications--- in treatment to get help with managing mental health and addiction issues.