EXECUTIVE SUMMARY
DHHS ADVISORY COMMITTEE ON PROBLEM GAMBING
PROBLEM GAMBLING TREATMENT WORKGROUP
RECOMMENDED CHANGES

February 7, 2012

INTRODUCTION: One of the tasks specified in the Problem Gambling Treatment Strategic Plan was to conduct a review of the gambling treatment program standards and revise as needed for use in year two (Page 8). In order to meet this objective, the ACPG Treatment Strategic Plan Work Group was reconvened in January 2012 to review Appendix A of the plan and offer recommended changes. As a starting point, the Work Group reviewed proposed revisions based upon the Frequently Asked Questions (FAQ) document that DHHS compiled during the first two quarters of FY12. During the course of the Work Group meetings, additional improvement areas were identified with accompanying recommendations. The recommended edits in their entirety are presented below, along with a brief description of identified issues and recommended resolutions.

Recommended revisions to Appendix A of the Problem Gambling Treatment Strategic Plan are provided below with new language in **bold and** deleted language shown in ~~strikethrough~~.

APPENDIX A

NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROBLEM GAMBLING TREATMENT PROVIDER GUIDE

I. Definitions

1. *Issue:* Providers had different understanding of what constituted "aftercare."

   Resolution: Add "aftercare" to definitions.

   "Aftercare" shall mean the stage following discharge, when the client no longer requires services at the intensity required during primary treatment.

2. *Issue:* In order to determine client eligibility, the providers needed to determine the client's primary diagnosis. Confusion emerged as to what constituted a "primary diagnosis."

   Resolution: Add "primary diagnosis" to definitions.

   "Primary Diagnosis" shall mean the main condition treated or investigated, during the relevant episode of healthcare. The reason for admission in and of itself does not constitute the primary diagnosis. A primary diagnosis for

Pathological Gambling, or other eligible client diagnoses, may only be made by CPGCs and mental health professionals qualified to make DSM-IV diagnoses as specified in their license or certification scope of practice.

3. *Issue:* Per Page 16 of the Strategic Plan, provider claims may be approved for up to $1,500 per treatment episode. Confusion arouse as to what constituted a "treatment episode."

   Resolution: Add "treatment episode" to definitions.

   "Treatment Episode" shall mean the period beginning with the service date reported on the first encounter claim to the submission date of the discharge form.

II. Performance Standards

4. *Issue:* Providers expressed confusion as to what data was being used to assess performance standards.

   Resolution: Add clarifying language to "Performance Standards" introduction (**in bold**).

   "Providers funded through this Agreement must meet the performance standards below. These performance standards are imposed and assessed on individual Providers **and based exclusively on required data submitted by Providers to the UNLV International Gaming Institute, the current Information Management Contractor for DHHS gambling treatment services.** If DHHS determines that a Provider funded through this Agreement fails to meet the specified performance standards, Provider will be required to submit a corrective action plan to DHHS's satisfaction. Repeated inability to meet the performance standards below may result in discontinuation of grantee funding. Providers are also subject to requirements imposed by DHHS in other documents attached to the Notice of Grant Award."

5. *Issue:* Client satisfaction data will be gathered once to twice per fiscal year during defined two-week periods. This method did not correspond to the requirement that client satisfaction surveys must be collected by not less than 50% of total enrollments.

   Resolution: Delete requirement that satisfaction surveys must be collected by not less than 50% of total enrollments.

   "Client Satisfaction: The percent of problem gambling affected individuals receiving services funded through this Agreement who complete a problem gambling client satisfaction survey would positively recommend the Provider to others must not be less than 85%. ~~Client satisfaction surveys must be collected by not less than 50% of total enrollments."~~

IV. Grant Award Calculation and Disbursement Procedures

6. *Issue:* Providers varied in the proportion of clients for whom they requested benefit extensions; leading to possible inequities between providers.

   Resolution: Add language that established parameters as to what is an allowable proportion of clients, per provider, eligible for benefit extensions. The 10% figure was chosen arbitrarily. Additional discussion is requested following the availability of data as to what proportion of clients are obtaining benefit extensions.

   C. Prior Authorization. DHHS may grant the following exceptions with prior authorization.
      1. The maximum allowed reimbursement per treatment episode may be exceeded, **but the annual limit for each treatment provider is 10% of the total number of client enrollments.**

7. *Issue:* Providers asked for clarification as to how to request extension for client benefit limits. They asked what information is needed, to whom and how should it be submitted, and when it must be submitted. Early requests included clinical information that was not required as DHHS approves or denies a request based only on grant conditions and fiscal considerations. Clinical need is established by the agency following a defined protocol. One of the grant conditions was that DHHS is the payer of last resort for problem gambling treatment; however, it was unclear how DHHS could monitor this condition so new language was needed to specify documentation requirements regarding alternative sources of paying for treatment.

   Resolution: Revise language to reflect current protocol and to clarify what information is not desired and what information is needed.

   D. Procedure for requesting prior authorization.

      ~~**1.** Provider requests for prior authorization exceptions may be submitted in once monthly batches of individual requests and include the following:~~ **Provider requests for prior authorization exceptions may be submitted via email to Laurie Olson (lolson@dhhs.nv.gov) with copy to Jeff Marotta (problemgamblingsolutions@comcast.net), Bo Bernhard (bo.bernhard@unlv.edu), and Sarah St.John (sarahastjohn@yahoo.com). Providers' prior authorization requests should not contain the name of the client or clinical information relating to the client as DHHS management role in this process is solely related to fiscal and contract considerations and not clinical case management. Prior authorization requests must include the following:**

   a) Name of agency requesting the exception;

   b) Client identification code **(please do <u>not</u> include client name);**

c) Description of the exception request **(if requesting funds in excess of benefit limit, must provide the specific dollar amount);**

d) Statement indicating that the exception request was reviewed and approved by the agency's gambling treatment clinical team or clinical supervisor. Date of the exception request clinical review must be included in the statement.

e) If requesting funds in excess of benefit limit, statement indicating what other resources the client might have to pay for the additional service. Requesting state funds to pay for additional services should only occur if the client and/or agency have no other means to pay for continued services. Clients who have insurance but refuse to allow the provider to contact their insurance company are not eligible for benefit limit extensions.

2. Documentation must be placed in the client's clinical record describing the clinical review of the exception request including the clinical justification for requesting the exception.

a) If requesting funds in excess of benefit limit, a needs statement signed by client and clinic director must be placed in the client's clinical record documenting (a) the client does not have third-party insurance to cover the costs of continued care, (b) the client is experiencing financial hardship and is therefore unable to afford out-of-pocket payment for the full costs of continued services, and (c) the treatment agency is not in possession of charitable contributions earmarked for covering the costs of care for those without treatment payment means.

Exhibit 2

Gambling Treatment Provider Standards

8. *Issue:* Providers asked: "For residential gambling treatment, what level of documentation is required to support a claim?"

   Resolution: Add language to include documentation requirements needed to substantiate a claim for a residential treatment bed day and clarify how often progress notes needed to be written.

IV. Accountability – Providers shall deliver the services in accordance with the following standards:

B. DOCUMENTATION

The individual's progress and current status in meeting the goals set in the treatment plan shall be documented within 72 hours of all clinical contacts. All progress notes shall be dated, indicate type and length of service, location of service, contain data from the session, clinical assessment, a clinical plan, and be signed by the person providing the service. **Within a residential treatment setting, the use of weekly summary notes is sufficient to document clients' progress. Additionally, providers of residential gambling treatment services must document each per-diem treatment claim by asking clients to sign and date a residential gambling treatment log.**

EXHIBIT 4

Nevada DHHS Problem Gambling Services
Procedure Codes and Reimbursement Rates

9. *Issue:* Providers asked: "What if a residential client obtains a 24-hour pass; can we bill for that day?" As day and weekend passes are frequently viewed as a therapeutic component of residential treatment (e.g., opportunity to assess readiness for discharge) and a client's bed could not be forfeited or used during a 24-hour or weekend pass, it was determined that providers should be able to obtain reimbursement for use of that treatment bed when clients are on pass.

   Resolution: Add language to the service criteria for residential gambling treatment that clarifies claims can be made for residential gambling treatment services while a client is on a therapeutic pass.

Code	Description	Upper Payment Amount*	Service Criteria
G2013	Residential gambling treatment service, per diem	$96 *($88)*	Services provided within a licensed inpatient mental health facility or residential alcohol and drug treatment facility designated as a residential gambling treatment program and intensively staffed 24-hour for which treatment includes an appropriate mix and intensity of assessment, medication management, individual and group therapies and skills development to reduce or eliminate the acute symptoms of the disorder and restore the client's ability to function in a home or the community to the best possible level. **A claim for residential gambling treatment services can only be made for those days where the client is occupying a bed during sleeping hours or a client has been provided a therapeutic pass for up to 48 hours. With pre-authorization, exceptions to the 48 hour rule may be made with reasonable justification.**

10. *Issue:* Providers pointed out that they don't know if a client meets eligibility criteria for DHHS funded gambling treatment services until after they have completed their intake. The question was asked: "Will DHHS pay for all problem gambling assessments?" Specifically, if a client is court referred for an assessment but denies a gambling problem over the phone is this client eligible for state-supported problem gambling assessment services?

    Resolution: A policy clarification is needed to clarify that client eligibility criteria do not apply to Intake Assessment (procedure code G2200 & G2200i). A person is eligible for state-supported intake assessment services if the provider submitting a claim has reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS funded gambling treatment services. A court referral for a gambling treatment assessment would be considered reasonable cause.

G2200	Intake Assessment per activity	$125 *($115)*	Service provided by a CPGC. Biopsychosocial clinical assessment containing a DSM IV diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. **Eligibility based on provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS funded gambling treatment services.**
G2200i	Intake Assessment per activity	$62.5 *($57.50)*	Service provided by a CPGCI. Biopsychosocial clinical assessment containing a DSM IV diagnosis with supporting documentation, level of risk of harm to self or others, financial risk, recommendations for the type and intensity of treatment and any referrals given to another treatment provider. **Eligibility based on provider's reasonable cause to believe the person requesting the intake assessment may be eligible for DHHS funded gambling treatment services.**

11. *Issue:* Providers appeared to be providing aftercare or continuing care services but utilizing different approaches. Some providers were keeping clients enrolled while clients participated in "aftercare" while other providers were offering continuing care group services to clients without being reimbursed. As relapse prevention or continuing care fits within the Strategic Plan's goal to create a recovery oriented system of care, it seemed an oversight to not financially incentivize the use of continuing care services.

    Resolution: Creating new billing codes for continuing care group services would help to create a more uniformed approach toward a recovery oriented system of care by incentivizing providers to engage clients for extended periods of time. Cost efficiency is accomplished by utilizing a flexible group modality and limiting the benefit to 12 months following discharge from treatment.

G2300	**Continuing Care Group Services, per 15 min for gambler and/or family member**	**$4.50** ***($4.50)***	**CC Group Services are provided by CPGC to clients who have completed problem gambling treatment within the past 12 months and are utilized to facilitate continued recovery. Services can be provided within an existing therapy or psycho-educational group being provided to current clients or to a group of previous clients meeting on a regular basis for aftercare.**
G2300i	**Continuing Care Group Services, per 15 min for gambler and/or family member**	**$2.25** ***($2.25)***	**CC Group Services are provided by CPGI to clients who have completed problem gambling treatment within the past 12 months and are utilized to facilitate continued recovery. Services can be provided within an existing therapy or psycho-educational group being provided to current clients or to a group of previous clients meeting on a regular basis for aftercare.**