DEPARTMENT OF HUMAN SERVICES

DBT IOP FAQ

Q. Where is best place to get information about MN DBT IOP?

A. There are two places to get information about Dialectical Behavior Therapy. One is the *Dialectial Behavior Therapy* page and the other is the *DBT IOP Department of Human Services webpage* which provides both information and access to applications. Questions can be sent to *dbt.certification@state.mn.us*

Q. Can multiple sites be certified as one program?

A. Yes. This allowance is made when teams are housed in multiple locations. For these programs only the main program is certified and the satellite offices are allowed to deliver components of the services when there isn't a large enough team to certify each location as a separate program. For an alternate location to be considered a satellite office, all members must be part of the same consultation team and therefore, operating as part of one program under the same NPI. This allows for multiple sites to be certified as one program.

Please note that when more than one consultation team exists at various locations, each program must be certified individually.

Q. How many people do you have to have for a team?

A. A minimum of three members are required to be considered a team. All members must be trained in DBT treatment and may include persons from more than one agency as long as professional and clinical affiliations with the DBT team are delineated as employees, affiliates, or contractors of the DBT program.

Q. What is the process of becoming certified?

A. The process for certification of DBT programs in Minnesota involves completing the official certification application and submitting supporting documentation. DHS will review applications and supporting documentation against the evidence-based standards of DBT as described in Minnesota Rule 256B.0671 subpart 6. You will find more information about the requirements of the DBT IOP in the MHCP Provider Manual- DBT IOP. Teams may apply for certification by submitting an application with the required attachments which can be accessed thru the DBT IOP Department of Human Services webpage.

Notification of certification status will be sent by email no more than 60 days after a completed application and supporting documentation has been received. If all requirements are met satisfactorily, certification will be approved for one year from the date of certification approval. Certified programs and their affiliated team members will be designated to use DBT-specific reimbursement codes and will be listed on the DHS website as approved certified DBT providers.

Q. What does it cost for MN DBT IOP Certification?

A. There is no cost to apply or maintain certification.

Q. How long is the certification period?

A. With the exception of the initial certification period which lasts for one year, the certification period varies 1 to 3 years for those teams who are certified only from DHS, the certification will last 1-3 years depending on treatment fidelity. For those teams who have certification from accepted national board which is currently Linehan Board of Certification, the DHS certification will follow the same timelines.

Q. What is the certification process for professionals in private practice or affiliate team members?

A. It is possible for an individual therapist to be part of a certified team even if they do not work for the same agency. Individual clinicians in private practice must be contracted or affiliated with a certified DBT program. As documented in each team's provider manual, individual clinicians in private practice must sign an Outside Provider Contract.

At the time of applying for certification, a DBT program should clearly identify all qualified staff considered to be a part of the DBT treating team whether employed by, contracted by, or otherwise affiliated with the program. This includes any DBT groups that are provided or operate in satellite offices outside of the main office. All team members of a certified team are required to follow all standards within this rule part.

Once a team is certified, all members who are enrolled Minnesota Healthcare Programs providers will be assigned a DBT specialty code on their provider profile, which will authorize them to bill claims through their own NPI number outside of the clinic or entity certified. The delivery of fee-for service individual DBT therapy and group skills training requires prior authorization. Provider names and national provider identification number (NPI) for each service (individual DBT and group skills training) must be designated at the time of prior authorization in order for those providers to use DBT procedure codes.

If the status of a team member changes at any time, DHS must be notified by filling out the Program Staff Update Application and submit it along with the required staff credentials to the DBT-IOP Database.

Q. What is the financial benefit to an agency who decides to pursue certification?

A. Teams are able to bill at a higher rate or enhanced rate, which takes into consideration the comprehensive nature of the treatment and the additional expenses of providing DBT services (consultation team, phone coaching and additional clinician training). The fee-for-service (FFS) rates are available on the DHS rates table. Certified DBT teams will be authorized to bill FFS rates for individual DBT therapy (H2019 U1) and a second code for group skills training (H2019 U1 HQ) for eligible recipients. As a certified team, you may bill with DBT-H codes Billing Code Grid for increased rate for Medicaid clients for individual therapy and skills group. There is not a specific rate increase for phone coaching. The increased rate is for therapy and skills group. Phone coaching is considered part of therapy and therefore included within the rate increase.

Q. Can I use DBT H-codes while working on certification process?

A. DBT H codes may only be used once a program has been certified and provider enrollment has been given necessary information to enroll all individual providers and the program together. While working for certification the Psychotherapy code 90832 would be used for therapy and Group code 90853 for skills group.

Q. When can H codes be billed?

A. H codes can only be billed after the service has been determined to be necessary based upon a comprehensive evaluation that includes a diagnostic assessment and functional assessment of the client, and review of the client's prior treatment history. Treatment services must be provided pursuant to the client's

individual treatment plan and provided to a client who meets eligibility criteria, including commitment to the treatment. For example, this means that H codes cannot be billed despite completion of a diagnostic assessment yet continuing pre-commitment strategies and/or waiting for the client to enter a group.

The following information* must be completed to substantiate the client's treatment need and client's readiness for DBT IOP:

- The client's most recent diagnostic assessment (DA) or diagnostic update conducted by a mental health professional or a mental health practitioner working as a clinical trainee and reviewed by the DBT program.
- The client's most recent functional assessment (FA). The FA:
  - Must address domains of life areas (mental health symptoms, mental health service needs, use of drugs/alcohol, vocational functioning, educational functioning, social functioning, interpersonal functioning, self-care and independent living skills, medical health, dental health, financial, obtaining and maintaining housing)
  - Should not be based on historical or predicted functions
  - Must be completed every six months
  - May be completed by another service provider within the last six months as long as the information it contains reflects current functioning
- The client's personal commitment/contract to enter the DBT program
- The client treatment plan that includes goals for stage one DBT treatment (inclusive of individual and group interventions)
- The Level of Care Assessment approved by the Commissioner, (if available)

*For Fee-for-Service individuals, the prior authorization must be approved with supporting documentation attached to support medical necessity for DBT IOP.

Q. Where can I find out the rates for DBT H codes?

A. Rates can be found on this website: *Medical Assistance Rates*

Q. Where can I find out what the DBT H codes and modifiers are?

A. They can be found in the MHCP Provider Manual- DBT IOP under Billing.

Q. What insurance is covered for enhanced rate?

A. Medicaid clients who pay straight fee for service. It does not cover Prepaid Medical Assistance Project (PMAP) insurance plans or private insurance plans. However, these insurance plans may require certification of DBT programs. Each plan would need to be contacted individually due to the complexity of insurance coverage.

Q. What can I do if claim denied?

A. You may call the provider helpline at 651 431 2700 or toll free 1-800-366-5411. If you feel it may be related to a provider being authorized with a clinic you may contact dbt.certification@state.mn.us or 651 431 2225 and ask for the DBT program consultant

Q. Does MN DBT IOP cover adolescents?

A. DBT IOP covers cover both adolescents and adults. See the FAQ for adolescent services for additional information.

Training Competencies (return to top of the page)

Q. What kind of training do I need to meet DHS required competencies for DBT?

A. All team DBT team members should have skills and competency in the following areas within six (6) months of joining a team:

- Bio-Social Theory and Framework for DBT
- Validation
- Dialectics
- DBT Mindfulness
- DBT Consultation Team
- Suicide risk assessment/intervention
- Skills training (understanding and application of principles of skill acquisition, strengthening and generalization, and in-session teaching)
- Exposure-based procedures
- Cognitive Modification
- Contingency Management
- Behavioral Analysis

A person's competency upon completion of training should be determined by the person responsible for the training. Examples of competency evaluation may include, but are not limited to: tests, observations, skills demonstration, discussion, or attestation statements.

Q. What kind of training is available to meet DHS required competencies for DBT?

A. DHS encourages teams to seek out trainings using the required competencies as direction and also support the evidenced-based research by treatment developer Marsha Linehan, of the University of Washington Behavioral Research & Therapy Clinics (BRTC). DHS does not endorse or require any specific training or certification. The expectation is that clinicians meet the minimum competencies described above.

At this time, DHS certifies teams, and not individual clinicians. Teams who wish to pursue National and/or Individual Accreditation may find information about the National Program Accreditation and Individual Clinician Standards available the University of Washington. Certification as an individual conveys to the public that the therapist has been examined and designated as having a special proficiency in the delivery of DBT, this however is not a requirement for certification with the Department.

Effective 10/17/2022, DHS will require 30 hours of training every two years for staff based on the hire date. MN Statute 245I.05 provides additional guidance on what is required for initial and subsequent training of staff.

A training plan is required at the agency level and must describe how the program evaluates training needs, provides trainings, and evaluates competency. The training plan must describe how the program determines when a staff needs additional training. An annual performance evaluation of a staff person can indicate the staff person's additional training needs.

For individual staff, a record of trainings attended must be recorded in the individual's personnel file.

DHS Requirements (return to top of the page)

Q. As a certified program, why do I have to notify DHS of program/staff changes and how do I do it?

A. Eligible team members of certified DBT programs are designated as approved providers with Minnesota Healthcare Programs' Provider Enrollment office. These providers are approved to receive enhanced rates for prior authorized services. The fee-for-service rates are available on the DHS rates table. It is also important for DHS to ensure DBT services are being provided with fidelity to the model by confirming that incoming team members and mental health practitioners are receiving the proper orientation and supervision. You can complete the Program Staff Update Application and submit it along with the required staff credentials to the DBT-IOP Database. Questions can be sent via email to dbt.certification@state.mn.us

Q. What is needed in a Functional Assessment (FA)?

A. The Functional Assessment must be completed after the completion of a diagnostic assessment and be done via a collaborative process with the client and the client's family and other natural supports. It must include referral sources, and if not included the reason the provider did not collaborate with previous providers of the client's natural supports. The FA must also include information on how the client's symptoms impact function in all ten areas and how the recommended treatment will improve functioning. Client's strengths, resources and areas of functional impairment should be included in the narrative summary. The FA must be completed before the individual treatment plan and be updated every 180 days. The MHCP Provider Manual DBT section includes the requirement to complete FAs as a part of prior authorization for DBT IOP (initial admission and every 6 months thereafter). The MHCP Provider manual also has a section specific to the requirements of a functional assessment. There is also an online training on the topic of FA that will be useful to understand the expectations for completing an FA. Checklist versions of FAs are not acceptable.

Q. What is the MHIS online data-reporting system?

A. The Minnesota Department of Human Services (DHS) requires regular reporting of client outcomes information for publicly funded mental health services using the Mental Health Information System (MHIS).

MHIS focuses on key client status points during treatment service: at start, at end of service and at the six month anniversary of the start date.

Definitions:

- **New Client** – a person who either (1) has not previously received a service and has now started receiving services from Public Funding, OR (2) has previously received a service from a private payer and now started receiving services from Public Funding, OR (3) had previously received a service from Public Funding and during the reporting period resumed receiving services after being previously discharged or after an extended period of inactivity (see discontinuance).
- **Continuing Client** – a person who continues to receive services 180 days after the start date (anniversary date) and has not completed treatment.
- **Client Completed Treatment** – a person who received services and completed services during the reporting period.
- **Discontinuance** – a person who received services and then, an extended period of inactivity occurred during the reporting period.

- In order to report meaningful outcome measures, agencies are encouraged to observe best practices in data collection such as:
- collecting client status at time of completing treatment;
- judicious and timely implementation of agency discharge policy, including administrative discontinuances;
- consistent and frequent update of client status (consider a quarterly update)

Reporting is required once every 6 months and falls into two reporting periods. Data is collected on clients served Jan – June and reported by July 31st. Clients served July – December are reported on by Jan 31st. For more information on data collection and reporting timelines visit the MHIS Technical Assistance Webpage or the MHIS User Manual.

For DBT services, persons who should not be reported*:* persons who received services reimbursed entirely by private insurance, Medicare or self-pay.

MHIS replaces Program Outcome Status Reporting (POSR) as of July 1, 2012. You must submit your POSR data, if you have not already done so. Technical assistance for MHIS and POSR can be found at either dhs.amhis@state.mn.us or 651-431-2239.

Q. Where do I go to report for MHIS?

A. MHIS is an application found in the secure MN-ITS portal (https://mn-its.dhs.state.mn.us). All enrolled MHCP providers and billing agencies have secure access to MN-ITS. For questions on how to register for a MN-ITS account, please contact the MHCP Provider Help Desk at 651-431-2700 or 1-800-366-5411.

Q. I don't see MHIS after I login to MN-ITS, what should I do?

A. User access to MHIS is determined by your organization's MN-ITS Administrator. Please see the MN-ITS User Manual for MN-ITS Administration help, or contact the MCHP Provider Help Desk at 651-431-2700 or 1-800-366-5411 for assistance with adding an application.

Provision of Services (return to top of the page)

Q. Who can facilitate a DBT group?

A. DBT programs must provide group skills training by qualified members of the certified team for the recommended duration of two to two and half hours per week. Group skills training is provided by a combination of the following qualified team members:

- Two mental health professionals, or
- One mental health professional with one mental health clinical trainee or
- One mental health professional co-facilitating with one mental health practitioner

Q. Who can provide individual therapy?

A. DBT programs must provide individual DBT therapy by a qualified member of the certified team for the recommended duration of one hour per week. Individual dialectical behavior therapy is provided by one of the following qualified team members

- mental health professionals
- mental health clinical trainee or

- mental health practitioner

Q. What is the difference between a Team Lead and a Treatment Supervisor and what are the requirements for each?

A. The team leader is responsible for ensuring that the DBT-certified team maintains structural fidelity to the original DBT model and is capable of achieving outcomes. The team lead also bears some responsibility for adherence to the program's DBT treatment manual, that new clinicians are oriented to the team and that core competencies are achieved within the designated time frame, and that any treatment barriers are identified and addressed so that program fidelity is ensured.

The qualified team leader:

- Must be a mental health professional and be an active member of the DHS-certified DBT team by employment, contract or affiliation.
- Must have appropriate competencies and working knowledge of DBT principles and practices;
- Must have knowledge of and the ability to apply the principles and DBT practices that are consistent with evidence based practices

Q. Do team leads have to carry a caseload?

A. Best practices recommend that a team leader provide some direct services to clients through individual therapy, skills training or both.

Q. Can a team have more than one team lead?

A. The recommended consultation team size is 6-8 persons so that each therapist can receive the care, and in depth consultation that they need. Adding a second team lead may be one way that teams can address to the issue of growing teams within their organization.

Q. What are some other responsibilities of the team lead?

A. Consultation meetings are the primary place for team members to get the care and support that they need to maintain motivation and prevent burnout. This is also a task of the team lead. While they do not have to run every meeting as these roles generally rotate. The team lead still bears a certain responsibility for the team as a whole.

Must have knowledge and ability to apply the principles and DBT practices that are consistent with evidence based practices (EBP)

Q. What is a Treatment Supervisor?

A. A treatment supervisor ensures oversight of staff who are not yet mental health professionals and are providing treatment services to clients. The treatment supervisor and supervisee must create a plan that focuses on each client's treatment needs and the ability of the staff person under treatment supervision to provide services.

All work of the practitioner (and clinical trainee) must be billed under someone who is enrolled as a treatment supervisor. The treatment supervisor does not have to be the Team Leader, but does need to be a member of the DBT certified team (with DBT competencies) who supervises the practitioners delivering any component of DBT.

Qualified Clinical Supervisor is a designated term used by licensing boards to indicate which professionals have done additional work and are qualified to supervise practitioners and clinical trainees. DHS does not monitor or regulate these requirements or standards. With the new USS Standards, the term "clinical supervision" will no longer be used. Treatment supervision will be used throughout allowing all enrolled mental health professionals qualified to supervise in alignment with the new law. This change will allow clinical trains to be paid. **Please note, it will be up to individual professionals to determine when and in what circumstances they are willing to perform treatment supervision.**

Q. If we have low group numbers (less than 6), can just one person lead it?

A. One person cannot facilitate a DBT skills group. **MN Statute 256B.0671 subpart 6,** DBT certification standards, require two facilitators for each skills group. One of the skills group trainers must be a mental health professional qualified under section 245I.04 subdivision 2, the other trainer can be a mental health practitioner qualified under section 245I.04 subdivision 4 or clinical trainee qualified under section 245I.04 subdivision 2. You may consider putting a master's level intern who meets the definition of a clinical trainee or practitioner to work as a co-facilitator.

Q. Can Team Consultation ever be done less often than weekly?

A. The purpose of team consultation holds three components: consultation to the therapist, mindfulness, and didactic activities. There is no allowance for meeting less than 90 minutes per week for Team Consultation.

For teams that meet by telephone or video/online, those teams must structure a plan for meeting in person no less than one time per month.

Q. What is the recommended size for consultation groups?

A. The recommended size for a consultation group is 6-8 members.

Q. What are the standards around telephone coaching calls?

A. The intent of phone coaching is to reduce suicidal crisis behaviors and increase the generalization and use of functional skill learned through DBT skills training. These coaching calls are intended to reduce these crisis behaviors and support the individual in the moment thus preventing the use of higher level services such as crisis response, emergency room visits, and hospitalization.

The one acceptable modification to phone coaching at this time allows for other trained members of the team to deliver the phone coaching component; however, access to the individual therapist may be determined to be necessary by the on-call skills coach. A route for reaching the therapist must be established ahead of time. In addition, pages 492-495 in Cognitive Behavioral Treatment of Borderline Personality Disorder by Marsha Linenan provide clear guidance as to the protocol that should be used when collateral therapists are involved.

Certification Process (return to top of the page)

Q. Is certification as a 245I.20 Mental Health Clinic required for DBT certification?

A. Rule 245I.20 certification is not required; however, it is required that you are an enrolled MHCP provider.

Q. Can we bill for Adaptations to DBT (using DBT with specialties such as SUD, ED, Anxiety Disorders, etc.) and get reimbursed the enhanced rate?

A. DBT IOP was established as Medicaid benefit in 2011. Only the standard, comprehensive model was approved for certification and thus eligible for reimbursement at the enhanced rate. Clients meeting the criteria outlined for treatment under MN Statue 256.0671 subd. 6 will be approved for reimbursement under this Medicaid program. Medicaid reimbursement and treatment fidelity relies on treatment being consistent with the original DBT model and treatment being done with the population it has been most validated on.