SUBSTANCE ABUSE INITIATIVE

Since 1999, HealthChoice enrollees have been able to self-refer for a comprehensive substance abuse assessment by an ADAA-certified provider if the enrollee is not already in treatment and has not already had a self-referred assessment that calendar year. See Substance Abuse Provider Transmittal NO. 1 (June 25, 1999). In 2001 the Substance Abuse Improvement Initiative (SAII) gave HealthChoice MCOs the flexibility to allow their enrollees to select their own provider for substance abuse treatment as well. The purpose of the Initiative was to increase access to substance abuse treatment and to minimize billing disputes between treatment providers and Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs). Key features of self-referral under the SAII are:

1. A HealthChoice enrollee can self-refer for a substance abuse assessment to any appropriate, willing substance abuse treatment provider.
   - The enrollee cannot already be in substance abuse treatment;
   - The enrollee cannot have already self-referred for an assessment during the calendar year;
   - The provider does not need to be part of the enrollee's MCO/BHO network; and
   - A provider is not required to accept the enrollee as a patient or a client, but does have a professional obligation to refer the individual to another provider.

2. Agreed-upon reimbursement.
   - The out-of-network provider must agree to accept Medicaid fee-for-services rates.
   - Out-of-network Local Health Departments have special rates. These rates only apply to HealthChoice services delivered under the SAII.

3. The Self-Referral Treatment Protocol
   - The protocol includes preauthorized units of service, the notification process for each treatment modality, and other important information. When a HealthChoice enrollee presents, the provider should identify the ASAM level of care and follow the provisions for the appropriate treatment modality. This protocol is on page 2.
   - Familiarity with the entire protocol is crucial. Providers not following these procedures could be denied authorization and/or payment.

Standardized forms. Providers, MCO/BHO, and DHMH staff developed five forms to streamline communications between providers and all MCO/BHOs. These forms satisfy the requirement for a treatment plan for the Office of Health Care Quality. These forms are in this manual. They are:

1	Initial Treatment Plan for Ambulatory Detox, Intensive Outpatient Treatment, Methadone Maintenance, Traditional Outpatient Treatment
2	Standard Information Required for Progress Report and Assessment of Continued Stay for Partial Hospitalization
3	Standard Information Required for Telephonic Authorization for Intermediate Care Facility Treatment, Acute Inpatient Treatment
4	Outpatient Concurrent Review Authorization of Care
5	Discharge Summary

These materials, and others, are available on the HealthChoice web site. http://dhmh.state.md.us/mma/healthchoice/

HealthChoice Substance Abuse Treatment Self-Referral Protocols – in ASAM Order
Substance Abuse Improvement Initiative (SAII)
April 2009

Billing Codes: Sub Abuse TX & Procedure Codes	ASAM Level	If patient presents for:	Minimum number of days or visits automatically approved	Provider Communication responsibility (phone, fax)	MCO/BHO Communication and Feedback responsibility	Notes or Comments	Medicaid/ HealthChoice Coverage
0919 or H0014	**I–Outpatient Services**	**Ambulatory detox** By an ICF-A	Minimum of five days will be paid	Within 72 hours of admission to detox program or service, provider submits a verbal or written treatment plan to the MCO or BHO.	MCO or BHO liaison will respond to provider within 48 hours. Confirmation number will be provided.	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of five (5) days will be automatically approved. If the MCO does not respond to the call, up to five days will be paid without contention.	Medicaid covers for as long as medically necessary.
90801, 90804-90809, 90847, 90853, 90857. H0005-H0006, H0022, H2035 Out of network Local Health Departments (LHDs) use 90899 for individual and 90899.HQ for group services.	**I–Outpatient Services**	**Individual, family and group therapy, and all other traditional outpatient services**	30 sessions within six months per episode of care (see comments - end of row)	Within 72 hours, notify MCO or BHO by either faxing in the first page of the Initial Treatment Plan or telephoning in the information. Treatment plan will be submitted within 24 hours after the fourth session.	MCO or BHO liaison will respond to provider within 48 hours. Confirmation number will be provided.	An episode of care lasts for six months. If there is a break in services for more than 30 days, treatment is considered terminated, or ended. The next visit after the 30-day break would be considered a new episode of care, and requires a re-notification and authorization process.	Medicaid pays for individual and group counseling for as long as medically necessary. The service is delivered to the enrollee, who must be present for an appropriate length of time but not need be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the enrollee.
0906 and H0015 preferred, but 0919, 0944, and 0945 accepted. Out of network LHDs use 90899.HQ .	**II-Intensive Outpatient**	**IOP – intensive outpatient**	30 Calendar Days without pre-certification	Within 72 hours of admission, the provider submits a verbal or written Treatment Plan to the MCO or BHO. At the end of week three, the provider notifies the MCO of the discharge plan or the need for additional, continued treatment.	MCO or BHO liaison will respond to provider within 48 hours with confirmation number.	While this service is only covered (by Medicaid) for pregnant women and children under 21; some MCOs cover this service for all members, regardless of age. Medicaid does not compensate the MCOs for rendering services to those members.	Covered only for children and adolescents under age 21 and pregnant and postpartum women for as long as medically necessary and the enrollee is eligible for the service. Postpartum means within eight weeks of delivering a child. Adolescents under 18 receive a maximum of 9 (nine) hours per week, decreasing to a minimum of 6 hours per week. Pregnant and postpartum women receive a maximum of 20 hours per week, decreasing to a minimum of 6 hours per week. This is not a Medicaid covered service for individuals older than 21 or who are not pregnant or postpartum. However, an MCO or BHO, at its discretion, might choose to cover it.
911, 912	**II-Partial**	**Partial hospitalization**	2 day minimum guaranteed	By morning of second day of admission, provider will	MCO or BHO liaison will respond	Providers will aim for the least restrictive level of care. If the	Medicaid reimburses this service only when it occurs in a hospital.

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	Hospital-ization	**(adults and children)**		review client's Treatment Plan with MCO/BHO by telephone. Provider will submit progress report ***and*** assessment for justification of continued stay beyond day five. Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.	to providers within 2 hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	client does not qualify for partial hospitalization, the BHO will work with the provider to determine the appropriate level of care. If ASAM is met, and MCO/BHO has provided confirmation or authorization, an additional three days will be automatically approved. If the MCO does not respond to the call, three additional days will be paid without contention.	
0123, 0124, 0126, 0136, 0138, 1002 Out of network LHDs use 90899.	**III-Residential and Inpatient**	**ICF-A (under 21)** **Pre-authorization required.**	Requires ASAM assessment	Within 2 hours, provider calls MCO or BHO for authorization, using a beeper or special phone number.	MCO/BHO liaison will respond to provider within 2 hours with a final authorization or disposition. RN or MD can be empowered to make the decision. MCO/BHO must have 24/7 availability.	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of three days will be automatically approved. If the MCO does not respond to the urgent call, up to three days will be paid without contention. If the client does not qualify for ICF-A, the BHO will work with the provider to determine the appropriate level of care.	Covered only for children and adolescents under age 21 for as long as medically necessary and the enrollee is eligible for the service. (This service is available to parents over 21, but MCOs are not responsible for the cost.) Medicaid does not pay for these services if they are not medically necessary, even if a Court has ordered them.
H0020 Out of network LHDs use 90899.HG.	**Opioid Maintenance Treatment**	**Methadone**	13 weeks initially, then an additional 13 weeks following submission of treatment plan (total is 26 weeks to start)	Within 72 hours of admission, provider notifies MCO or BHO by either faxing in the first page of the Initial Treatment Plan or telephoning in the information. Next approvals will be at six-month intervals.	MCO or BHO will respond to provider within 48 hours. Confirmation number will be provided. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	The provider will submit treatment plan to the MCO by the 12th week of service.	Medicaid coverage determined by medical necessity. Unit of service is one week.
0126, 0128, 0136 0138, H0008, H0009, DRGs 433-437	**IV–Medically Managed Patient** **Or** **III.7.D-**	**Inpatient detox in an inpatient setting** **Or** **Inpatient detox**	Requires ASAM assessment	Within 2 hours, provider calls MCO or BHO for authorization, using a beeper or special phone number.	MCO or BHO will respond to provider within 2 hours with a final authorization or disposition. RN	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of three days will be automatically approved.	

Billing Codes: Sub Abuse TX & Procedure Codes	ASAM Level	If patient presents for:	Minimum number of days or visits automatically approved	Provider Communication responsibility (phone, fax)	MCO/BHO Communication and Feedback responsibility	Notes or Comments	Medicaid/ HealthChoice Coverage
H0010, H0011	**Inpatient Detox in other settings**	**in a rehabilitation or ICF-A facility** **Pre-authorization required.**			or MD can be empowered to make the decision. MCO/BHO must have 24/7 availability.	If the MCO does not respond to the urgent call, up to three days will be paid without contention. If the client does not qualify for inpatient detox, the BHO will work with the provider to determine the appropriate level of care.	

Footnotes

1. Days or Hours used in descriptions of the communication and response timeframes are intended to mean Business Days and Business Hours. The exception to this is that MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute.
2. MCOs/BHOs will honor substance abuse authorizations for all services made by an enrollee's previous MCO provided the ASAM level of care is met and there is no break in service. The provider must submit written verification of this authorization to the new MCO within 72 hours of receiving it from the previous MCO.
3. MCOs pay the full FQHC per visit rate for services rendered on and after January 1, 2009, except Three Lower Counties will receive $83.31 from the MCOs and a supplemental payment from the DHMH.
4. An MCO may not require a peer-to-peer review for a pre-certification in cases where the patient is new and has not been seen by the provider's physician.
5. An MCO may not require written approval from a commercial insurer before deciding on a pre-certification in cases where the patient has dual insurance.
6. A comprehensive substance abuse assessment is considered part of treatment and is not generally reimbursed separately. However, separate reimbursement is permitted in the following circumstances:

- *Provider determines that enrollee does not need substance abuse treatment.* Bill using CPT Code 90801 (except for Local Health Departments using 90899), with diagnostic code 799.9 to indicate "no diagnosis/diagnosis" referral.")
- *Provider does not offer level of care that the enrollee requires.* Bill using CPT Code 90801 (except for Local Health Departments using 90899). Notify the enrollee's MCO/BHO with information on the appropriate level of care and appropriately document the referral on the UB 92 or HCFA 1500 form.
- *Provider conducts assessment but enrollee does not return for treatment*. Bill using CPT Code 90801 (except for Local Health Departments using 90899),
  ☞**Note**: *MCOs are not required to pay for more than one self-referred assessment for an enrollee per year.*
  ☞**Note:** HealthChoice regulations require the use of the Problem Oriented Screening Instrument for Teenagers (POSIT) for enrollees under age 20 and the Addiction Severity Index (ASI) for enrollees age 20 and older, as well as a placement appraisal to determine the appropriate level and intensity of care for the enrollee-based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration.

5. Proof of notification is the faxed confirmation sheet and/or a documented phone conversation (date, time and person spoken to).
6. The postpartum period is 8 weeks from the date of delivery.
7. "One session" means a face-to-face meeting with a provider.

Department of Health and Mental Hygiene website: http://www.dhmh.state.md.us/
DHMH Provider Hotline: 1-800-766-8692
Or call the Complaint Resolution Unit's supervisor, Ellen Mulcahy-Lehnert, or Division Chief, Ann Price, at
1-888-767-0013 or 1-410-767-6859 from 8:30 AM to 4:30 PM Monday - Friday

Summary:

1. All communication between providers and MCOs or BHOs will be via phone, fax or email. Additional information is needed regarding confidentiality protections for the patient if email is used (i.e. use of passwords or identification via Medicaid ID number rather than member name).

2. MCOs shall provide written confirmation of the level of care and dates of service authorized within 48 hours.

3. ASAM criteria will be used to assess need for all levels of service.

4. If the enrollee presents to a non-network provider, the provider is not required to provide treatment. However, the provider will notify the enrollee's MCO/BHO that its enrollee is seeking substance abuse treatment.

5. Within 10 days of discharge or release from treatment, the substance abuse treatment provider will:
   a. send a discharge summary to the MCO or BHO.
   b. having obtained the patient's consent will send a discharge summary to the PCP.
   ☞**Note:** MCOs/BHOs stress the importance of speedy notification when their enrollees complete treatment or leave treatment prematurely. Providers should contact the MCO/BHO immediately rather than wait until they complete discharge summaries.

5. The following guidelines should be used when an enrollee fails to keep appointments:
   a. A provider should report to the appropriate MCO within two business days any Medicaid enrollee who fails to appear for an intake or assessment appointment.
   b. A provider should report to the appropriate MCO within two business days any enrollee who misses two consecutive counseling appointments.
   c. A provider should report to the appropriate MCO any enrollee who in the provider's judgment shows a pattern of inconsistent attendance even though the enrollee has not missed consecutive appointments.

6. Out-of-network providers will be reimbursed at the Medicaid fee-for-service rate for the service and provider type.

7. All providers, MCOs and BHOs will use the same forms (See attachments 3a-e).

8. Please refer to the attached document for the procedures that must be adhered to for Continued Stay with ICF-As.

9. If all of the communication and response timeframes have been met, there will be no retrospective denials of care for the minimum number of days or services. Furthermore, the providers and managed care organizations agree to the following "IF-THEN" Scenarios for notification and payment responsibilities

Notification and Response Scenarios…	**Result**	**And**
If the provider does not meet the agreed upon notification timeline…….	**Then** the MCO or BHO is not responsible for the cost of treatment on those days	The provider may bear the cost for those unauthorized days or services (rendered before they contacted the MCO or BHO
If the MCO does not meet the agreed upon response timelines……..	**Then** the MCO will reimburse the provider for those services or days of care in accordance with the policy guidelines.	
If the provider contacts the MCO after the agreed upon time lines…….	**Then** the MCO is financially responsible for services approved for the remaining period of time or number of units.	The MCO or BHO has the option of paying for the first unauthorized days or units of services on a case by case basis