Maryland Medicaid HealthChoice and PAC Substance Abuse Form Instructions

Form Instructions for the following Community-Based Substance Abuse Services:

Individual Outpatient Therapy,
Group Outpatient Therapy,
Intensive Outpatient
and Methadone Maintenance

May 1, 2012

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INTRODUCTION

This manual was designed by the Maryland Alcohol and Drug Abuse Administration (ADAA), in partnership with Maryland Medicaid, to assist community-based substance abuse (SA) providers complete the updated forms that are required for HealthChoice and PAC MCO SA treatment notification: the Notification Form, the Ambulatory Concurrent Review Form, and the Discharge Summary Form. Providers should use these forms for recipients in: Individual Outpatient Therapy, Group Outpatient Therapy, Intensive Outpatient Therapy, and/or Methadone Maintenance. Regulatory requirements for these services can be found in COMAR 10.09.80, COMAR 10.09.08.04, COMAR 10.09.67.28, and COMAR 10.09.7.10. To further assist providers, there are examples of completed forms in Attachments 1-3.

To ensure payment, all SA providers must follow the Substance Abuse Improvement Initiative (SAII) protocol for MCO notification procedures (see Attachment 4 for more information). The SA Protocol includes information about the services listed above, as well as other SA services not included in these billing instructions, such as Ambulatory Detoxification and Partial Hospitalization (for non-PAC recipients). Familiarity with the entire Self-Referral protocol is crucial. Providers not following these procedures could be denied authorization and/or payment.

Before using the enclosed forms, providers should be familiar with the Maryland Medicaid CMS 1500 Billing Instructions, which detail the billing procedures for the following community-based substance abuse services: Comprehensive Substance Abuse Assessment, Individual Outpatient Therapy, Group Outpatient Therapy, Intensive Outpatient and Methadone Maintenance. Providers can find these billing instructions and updated fillable PDF forms on the Medicaid website: http://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Substance%20Abuse%20Improvement%20Initiative.aspx or on the Alcohol and Drug Abuse Administration website: http://adaa.dhmh.maryland.gov/SitePages/Medical%20Assistance%20PAC.aspx.

Please find a listing of MCO notification, billing, and service coordination contacts in Attachment 5.

Instructions for Completing the HealthChoice and PAC Substance Abuse Notification Form

As stated above, all SA providers must follow the SAII notification procedures to ensure payment. For Outpatient Level I Services, providers must notify the MCO/BHO by fax or email and provide initial treatment plan within three (3) business days of admission to Level I therapy services. Providers should use the Notification Form whenever there is a change in the Level of Care. For a complete explanation of notification requirements and HealthChoice and PAC approval criteria, please see Attachment 4.

The following table provides information on how to complete each field on the HealthChoice and PAC Substance Abuse Notification Form. Please note that all fields are required. Attach more pages if needed. For help completing the HealthChoice and PAC Substance Abuse Notification Form, please see mock-Notification form in Attachment 1.

FIELD	INSTRUCTIONS
Field 1	**LEVEL OF CARE** – Select Level(s) of Care for this Notification Form
Field 2	**MCO NAME AND DATE SUBMITTED TO MCO** – Enter the name of the recipient's MCO and the date and time you submitted the Notification Form to the MCO.
Field 3	**CLIENT'S NAME** – Enter the recipient's first and last name as it appears on the Medical Assistance card.
Field 4	**CLIENT'S DATE OF BIRTH** – Enter the recipient's date of birth.
Field 5	**CLIENT'S GENDER** – Check off the recipient's gender.
Field 6	**CLIENT'S MA NUMBER** – Enter the recipient's 11-digit Maryland Medical Assistance (MA) number as it appears on the Medical Assistance card. The MA number must appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by web or phone EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447 or online at http://www.emdhealthchoice.org
Field 7	**CLIENT'S MCO NUMBER (if different)** – Enter the recipient's unique MCO number. Please note that not all MCOs have unique MCO numbers for their clients. Currently, the following MCOs have unique numbers: MedStar Family Choice, UnitedHealthcare, and Priority Partners. If you do not have the recipient's unique number, call the MCO and get that number before submitting the Notification Form. If there is no unique MCO number, enter "N/A" in this box.
Field 8	**OTHER INSURANCE GROUP NUMBER** – Please remember that Maryland Medicaid and HealthChoice/PAC MCOs are the payers of last resort. You MUST bill other insurance (including Medicare and/or private insurance) before billing Medicaid. For information regarding recipient's coverage, contact the Maryland Medicaid Third Party Liability Unit at 410-767-1771.
Field 9	**CLIENT'S COMPLETE ADDRESS** – Enter the recipient's complete mailing address with zip code. If the recipient is homeless, please write "Homeless" in this field.
Field 10	**CLIENT'S PHONE NUMBER** – Enter the recipient's phone number. Enter "No Phone" if the client does not have a phone.
Field 11	**TREATMENT FACILITY NAME** – Enter the facility name, address, phone and fax numbers where the recipient is receiving SA treatment.

Field 12	**FACILITY MA #** – Enter the 9-digit Maryland Medicaid provider number for the facility named in Field 11.
Field 13	**FACILITY TAX ID #** – Enter the Federal Tax I.D. number for the Billing Provider.
Field 14	**PRIMARY CARE PHYSICIAN** – Enter the PCP name if known. If unknown, write "N/A"
Field 15	**TREATMENT START DATE** – Enter the date the recipient began treatment in reported Level of Care. This date may be prior to the date of MCO Notification if the facility provided treatment prior to MA eligibility. Please note that the MCO will not pay for dates of service before eligibility and/or appropriate notification timelines. For example, this should be the date that the recipient began the Level of Care that you selected in Field 1, without a break in treatment of 60 days or more.
Field 16	**REQUESTED START DATE FOR MCO COVERAGE** – Enter the date the MCO will start paying for treatment. Please note that the MCO will not pay for dates of service before eligibility and/or appropriate notification timelines.
Field 17	**CLIENT PREGNANT** – Enter "Yes" if the client is pregnant, and "No" if the client is not pregnant. If "Yes", indicate due date if known.
Field 18	**SUBSTANCE ABUSE** – Name the substance(s) that the recipient is abusing and complete the Severity, Frequency and Method fields using SMART language. If you are not familiar with SMART language, you can use the guide below. Additionally, complete the Date of Last Use field. **Severity:** **0**-Not a problem **1**-Mild Problem **2**-Moderate problem **3**-Severe problem **Frequency:** **0**=No use past month **1**=1-3 times past month **2**=1-2 times past week **3**=3-6 times per week **4**=Once Daily **5**=2-3 times daily **6**=More than 3 times daily **7**=Unknown **Route:** **1**=Oral **2**=Smoking **3**=Inhalation **4**=Injection **5**=Other **Date of Last use:** Provide the date the recipient last used the primary, secondary and tertiary substances.
Field 19	**PRIOR SUBSTANCE ABUSE TREATMENT HISTORY** – If known, enter the prior three years of Substance Abuse Treatment history, including the name of the treatment facility, the type of treatment received, the dates of service, and self-reported treatment status. If this is the first time the recipient is in treatment, enter "None". If the recipient does not remember detailed information, enter "N/A".
Field 20	**LIST ALL REPORTED CURRENT MEDICATIONS** – List all reported current medications, including medical, psychiatric and substance abuse medications such as suboxone and methadone. For each reported and/or known medication, enter the name of the medication, the dosage, the frequency, and adherence. For "Adherence", write "Yes", "No", or Unknown.
Field 21	**DIAGNOSIS/DSM IV-TR** – Complete all five axes of the DSM IV-TR. Use appropriate DSM IV-TR codes.
Field 22	**ASAM PPC** – Circle the Level of Risk (0, 1, 2, 3 or 4) for all six Dimensions of the ASAM criteria. (Note: On the Level of Risk scale, 0=No Risk and 4=Most Risk)
Field 23	**TREATMENT** – Enter the treatment being requested on this notification form. The treatment selection should correspond with the Level of Care selected in Field 1.

Field 24	**ANTICIPATED DISCHARGE DATE FROM THIS LEVEL OF CARE (IF KNOWN) –** Enter the anticipated discharge date (if known) from the Level of Care selected in Field 1.
Field 25	**COMMENTS –** If applicable, include notes on adherence to prescribed medication that may be critical to coordination of care. Also, include notes on unmet somatic and/or mental health needs, the name of the recipient's mental health care provider if known, as well as barriers to treatment (e.g., transportation, housing).
Field 26	**TREATMENT CLINICIAN'S NAME** – The Notification Form will not be considered complete without the Treatment Clinician's Name (printed and signed). Enter the Treatment Clinician's credentials, date, email and phone number.

Instructions for Completing the HealthChoice and PAC Substance Abuse Ambulatory Concurrent Review Form

Providers must complete the Ambulatory Concurrent Review Form when the client needs continuing care beyond the approved units of service in the Notification Form. The Concurrent Review Form allows MCOs to authorize ongoing treatment beyond what is available through the initial notification process.

The following table provides information on how to complete each field on the HealthChoice and PAC Substance Abuse Ambulatory Concurrent Review Form. Please note that all fields are required. Attach more pages if needed. For help completing the HealthChoice and PAC Substance Abuse Concurrent Review Form, please see mock-Concurrent Review form in Attachment 2.

FIELD	INSTRUCTIONS
Field 1	**LEVEL OF CARE** – Select Level(s) of Care for the Concurrent Review Form
Field 2	**MCO NAME AND DATE SUBMITTED TO MCO** – Enter the name of the recipient's MCO and the date and time you submitted the Concurrent Review Form to the MCO.
Field 3	**CLIENT'S NAME** – Enter the recipient's first and last name as it appears on the Medical Assistance card.
Field 4	**CLIENT'S DATE OF BIRTH** – Enter the recipient's date of birth.
Field 5	**CLIENT'S GENDER** – Check off the recipient's gender.
Field 6	**CLIENT'S MA #** – Enter the recipient's 11-digit Maryland Medical Assistance (MA) number as it appears on the Medical Assistance card. The MA number must appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by web or phone EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447 or online at http://www.emdhealthchoice.org
Field 7	**CLIENT'S MCO # (if different)** – Enter the recipient's unique MCO number. Please note that not all MCOs have unique MCO numbers for their clients. Currently, the following MCOs have unique numbers: MedStar Family Choice, UnitedHealthcare, and Priority Partners. If you do not have the recipient's unique number, call the MCO and get that number before submitting the Notification Form. If there is no unique MCO number, enter "N/A" in this box.
Field 8	**OTHER INSURANCE GROUP NUMBER** – Please remember that Maryland Medicaid and HealthChoice/PAC MCOs are the payers of last resort. You MUST bill other insurance (including Medicare and/or private insurance) before billing Medicaid. For information regarding recipient's coverage, contact the Maryland Medicaid Third Party Liability Unit at 410-767-1771.
Field 9	**CLIENT'S COMPLETE ADDRESS** – Enter the recipient's complete mailing address with zip code. Confirm whether there has been an address change. If homeless, please write "Homeless" in this field.
Field 10	**CLIENT'S PHONE #** – Enter the recipient's phone number. Enter "No Phone" if the client does not have a phone.
Field 11	**TREATMENT FACILITY NAME** – Enter the facility name, address, phone and fax numbers where the recipient is receiving SA treatment.
Field 12	**FACILITY MA #** – Enter the 9-digit Maryland Medicaid provider number for the facility named in Field 11.

Field 13	**FACILITY TAX ID #** – Enter the Federal Tax I.D. number for the Billing Provider.
Field 14	**PRIMARY CARE PHYSICIAN** – Enter the PCP name if known. If unknown, write "N/A"
Field 15	**TREATMENT START DATE** – Enter the date the recipient began treatment in reported Level of Care. This date may be prior to the date of MCO Notification if the facility provided treatment prior to MA eligibility. Please not that the MCO will not pay for dates of service before eligibility and/or appropriate notification timelines. For example, this should be the date that the recipient began the Level of Care that you selected in Field 1, without a break in treatment of 60 days or more.
Field 16	**REQUESTED START DATE FOR MCO AUTHORIZATION** – Enter the date the MCO will start paying for treatment. Please note that the MCO will not pay for dates of service before eligibility and/or appropriate notification timelines.
Field 17	**CLIENT PREGNANT** – Enter "Yes" if the recipient is pregnant, and "No" if the recipient is not pregnant. If "Yes", indicate due date if known. Enter "Yes" or "No" regarding whether the recipient is scheduled to receive prenatal care.
Field 18	**UPDATED DIAGNOSIS/DSM IV-TR** – Enter updated diagnosis information for all five axes. Enter the DSM IV codes even if there are no changes.
Field 19	**LIST ALL REPORTED CURRENT MEDICATIONS** – List all reported current medications, including medical, psychiatric and substance abuse medications such as suboxone and methadone. For each reported and/or known medication, enter the name of the medication, the dosage, the frequency, and adherence. For "Adherence", write "Yes", "No", or Unknown.
Field 20	**RESPONSE TO TREATMENT** – You must ATTACH a copy of the COMAR required treatment plan when you submit this Ambulatory Concurrent Review Form to the recipient's MCO (10.47.01.04.C). This treatment plan should list specific gains made since initial treatment plan and all remaining symptoms with frequency and severity. The updated treatment plan should also provide justification for continuation of treatment.
Field 21	**ALCOHOL/DRUG SCREENS** – Enter information on the last 6 drug screens and/or breathalyzer results. Include positive screen for medications not prescribed by the treatment program. Indicate the type of screen performed, the date of the specimen, and whether the screen was negative or positive. If positive, indicate which substances were positive as well as the level present if known. **Please note:** Since clients may have more frequent breathalyzer tests, six most relevant clinical tests (i.e., generally, a urinalysis should always be included at least once here). If the last 6 screens were breathalyzer tests, please note that this section must include the results from at least one urinalysis test (the one performed most recently).
Field 22	**IS THE CLIENT CURRENTLY ABUSING SUBSTANCES?** – Indicate whether the recipient is currently using – "Yes" or "No". If yes, list interventions in place to address continued usage. For example, indicate if the recipient needs administrative detox or a change in the level of care.
Field 23	**TREATMENT** – Enter the treatment being requested on this notification form. The treatment selection should correspond with the Level of Care selected in Field 1.
Field 24	**ANTICIPATED DISCHARGE DATE FROM THIS LEVEL OF CARE** – Enter the anticipated discharge date from the Level of Care selected in Field 1.
Field 25	**AFTER CARE PLAN** – Enter information regarding the recipient's after care plan.

Field 26	**COMMENTS –** Enter any information not addressed in the treatment plan but that supports your request for continued level of care. Continued Stay Criteria should identify specific deficits in areas affecting the request for ongoing treatment. For example, employment, family, housing, health status, socialization and/or support system information.
Field 27	**TREATMENT CLINICIAN'S NAME –** The Concurrent Review will not be considered complete without the Treatment Clinician's Name (printed and signed). Enter the Treatment Clinician's credentials, date, email and phone number.

Instructions for Completing the HealthChoice and PAC Substance Abuse Discharge Summary Form

In accordance with COMAR 10.47.01.04.G, providers must complete a Discharge Summary within 30 days of discharge from the SA program. In the event of a patient's transfer from the program to another program, the discharging program shall complete a written transfer summary at the time of the patient's discharge to the other program.

The following table provides information on how to complete each field on the HealthChoice and PAC Substance Abuse Discharge Summary Form. Please note that all fields are required. Attach more pages if needed. For help completing the HealthChoice and PAC Substance Abuse Discharge Summary Form, please see mock-Notification form in Attachment 3.

FIELD	INSTRUCTIONS
Field 1	**LEVEL OF CARE** – Select the client's Level(s) of Care at the time of discharge.
Field 2	**MCO NAME AND DATE SUBMITTED TO MCO** – Enter the name of the recipient's MCO and the date and time you submitted the Discharge Form to the MCO.
Field 3	**CLIENT'S NAME** – Enter the recipient's first and last name as it appears on the Medical Assistance card.
Field 4	**CLIENT'S DATE OF BIRTH** – Enter the recipient's date of birth.
Field 5	**CLIENT'S GENDER** – Check off the recipient's gender.
Field 6	**CLIENT'S MA #** – Enter the recipient's 11-digit Maryland Medical Assistance (MA) number as it appears on the Medical Assistance card. The MA number must appear in this Block regardless of whether or not a recipient has other insurance. Medical Assistance eligibility should be verified on each date of service by web or phone EVS. EVS is operational 24 hours a day, 365 days a year at the following number: 1-866-710-1447 or online at http://www.emdhealthchoice.org
Field 7	**CLIENT'S MCO # (if different)** – Enter the recipient's unique MCO number. Please note that not all MCOs have unique MCO numbers for their clients. Currently, the following MCOs have unique numbers: MedStar Family Choice, UnitedHealthcare, and Priority Partners. If you do not have the recipient's unique number, call the MCO and get that number before submitting the Notification Form. If there is no unique MCO number, enter "N/A" in this box.
Field 8	**OTHER INSURANCE GROUP NUMBER** – Please remember that Maryland Medicaid and HealthChoice/PAC MCOs are the payers of last resort. You MUST bill other insurance (including Medicare and/or private insurance) before billing Medicaid. For information regarding recipient's coverage, contact the Maryland Medicaid Third Party Liability Unit at 410-767-1771.
Field 9	**CLIENT'S COMPLETE ADDRESS** – Enter the recipient's complete mailing address with zip code. Confirm whether there has been an address change. If the recipient is homeless, please write "Homeless" in this field.
Field 10	**CLIENT'S PHONE #** – Enter the recipient's phone number. Enter "No Phone" if the client does not have a phone.
Field 11	**TREATMENT FACILITY NAME** – Enter the facility name, address, phone and fax numbers where the recipient is receiving SA treatment.
Field 12	**FACILITY MA #** – Enter the 9-digit Maryland Medicaid provider number for the facility named in Field 11.
Field 13	**FACILITY TAX ID #** – Enter the Federal Tax I.D. number for the Billing Provider.

Field 14	**PRIMARY CARE PHYSICIAN** – Enter the PCP name if known. If unknown, write "N/A"
Field 15	**DISCHARGE DATE FROM THIS FACILITY** – Enter the recipient's discharge date.
Field 16	**CLIENT PREGNANT** – Enter "Yes" if the recipient is pregnant, and "No" if the recipient is not pregnant. If "Yes", indicate due date if known. Enter "Yes" or "No" regarding whether the recipient is scheduled to receive prenatal care.
Field 17	**UPDATED DIAGNOSIS/DSM IV-TR** – Enter updated diagnosis information for all five axes of the DSM IV-R criteria. Enter the DSM IV-TR codes even if there are no changes.
Field 18	**LIST ALL REPORTED CURRENT MEDICATIONS** – List all reported current medications, including medical, psychiatric and substance abuse medications such as suboxone and methadone. For each reported and/or known medication, enter the name of the medication, the dosage, the frequency, and adherence. For "Adherence", write "Yes", "No", or Unknown.
Field 19	**ALCOHOL/DRUG SCREENS** – Enter information on the last 6 drug screens and/or breathalyzer results. Include positive screen for medications not prescribed by the treatment program. Indicate the type of screen performed, the date of the specimen, and whether the screen was negative or positive. If positive, indicate which substance were positive as well as the level present.
Field 20	**REASON FOR DISCHARGE** – Select at least one reason for discharge.
Field 21	**AFTER CARE PLAN** – Check all After Care Services that apply. For each service selected, enter the Program Name, as well as a contact name and telephone number.
Field 22	**NOTIFICATION TO PRIMARY CARE PHYSICIAN** – Indicate whether your SA treatment facility notified the PCP regarding the recipient's discharge from this level of care. If "Yes", enter the date you contacted the PCP.
Field 23	**SUMMARY OF TREATMENT** – This is the only optional field on the Discharge Summary Form.
Field 24	**TREATMENT CLINICIAN'S NAME** – The Notification Form will not be considered complete without the Treatment Clinician's Name (printed and signed). Enter the Treatment Clinician's credentials and date.

Attachment 1 – Mock Notification Form

PLEASE PRINT

Page 1 of 2

HealthChoice and PAC Substance Abuse Notification Form

ALL FIELDS ARE REQUIRED

Attach more pages if more space is needed

Please complete all sections. The information has been disclosed to you from records protected by Federal Confidentiality rules (CFR 42, Part 2). The Federal Ruled prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42, Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] **Level I: Traditional Outpatient** [ ] **Level II.1: Intensive Outpatient** [X] **OMT: Methadone Maintenance**

2. MCO Name: Maryland Physicians Care **Date Submitted to MCO:** 03/23/2011 **Time:** 2:30PM am/pm

3. Client's Name: (Last) George **, (First)** Lisa

4. Client's Date of Birth:	**5. Client's Gender:**	**6. Client's MA Number:**	**7.Client's MCO Number** (if different) **:**
02/03/1990	M____ F_X_	99123294900	

8. Other Insurer Group # (if applicable) **:**	**9. Client's Complete Address:**	**10. Client's Phone Number:**
N/A	2345 Broadway Street, Baltimore MD 12345	(410) 983-1234

11. Treatment Facility Name:	**12. Facility MA # :**	**13. Facility Tax ID # :**
Address: New Day Drug Treatment Program Phone: (410) 443-9876 Fax: (410) 443-9966	76589700	45-678-90-32

14. Primary Care Physician (if known) **:** Dr. Marilyn Haynes

15. Treatment Episode Start Date:	**16. Requested Start Date for MCO Authorization:**	**17. Client Pregnant?:** N If yes, Due Date (if known) **:** Scheduled to receive prenatal care? Y N
12/23/2010	03/23/2011	

18. Substance Abuse	**Severity**	**Frequency**	**Method**	**Date of Last Use**
Primary: Opioids-heroin	3	4	4	03/21/2011
Secondary:				
Tertiary:				

19. Prior Substance Abuse Treatment History - Last 3 Years (if known)

Name of Treatment Facility	**Treatment Type** (e.g., OP, IOP, OMT)	**Dates of Service**	**Treatment Status**	
			Successful	Unsuccessful
Safe Place	OMT	2010		X

20. List ALL Reported Current Medications (Including Medical, Psychiatric, & Sub. Abuse such as: Suboxone & Methadone) – Attach additional pages if necessary

Name of Medication	**Dosage**	**Frequency**	**Adherence** (e.g., Yes, No, Unknown)
Asthma Inhaler	Unknown	Daily	Unknown
Insulin	Unknown	2x/day	Unknown

21. Diagnosis/ DSM IV-R – Please complete all Axes

Axis I: 304.00

Axis II: Deferred

Axis III: asthma, hypertension, diabetes

Axis IV: Legal problems, occupational problems, social/familial problems, housing problems

Axis V (GAF): 50

22. ASAM PPC (Circle one for each Level of Risk)	**Level of Risk**				
Dimension I: Withdrawal	**[0]**	**1**	**2**	**3**	**4**
Dimension II: Biomedical Conditions and Complications	**0**	**1**	**[2]**	**3**	**4**
Dimension III: Emotional/Behavioral Conditions and Complications	**0**	**1**	**[2]**	**3**	**4**
Dimension IV: Treatment Acceptance	**0**	**[1]**	**2**	**3**	**4**
Dimension V: Relapse/Continued Use Potential	**0**	**1**	**2**	**3**	**[4]**
Dimension VI: Recovery Environment	**0**	**1**	**2**	**[3]**	**4**

23. Treatment

	Code	**# of Sessions (S) or Units (U) per week** (circle one)	**Session/Unit conversion**
[ ] Individual	H0004	[ ] S or U per week	1 Session = 4 Units (15 minutes per unit)
[ ] Group	H0005	[ ] S or U per week	1 Session = 1 Unit (60-90 minutes)
[ ] Intensive Outpatient	H0015	[ ] days/week & [ ] total hrs/week	Weekly total must be ≥ 9 hrs (Min.2 hrs/day – max. 4 days/wk)
[X] Methadone	H0020	Per week	1 Session = 1 Unit (Must include at least one face to face encounter with counselor)

24. Anticipated discharge date from this Level of Care (if known): 12/01/2011

25. Comments – optional (please use additional pages if necessary)

26. Treatment Clinician's Name:

Ellen Thompson	*Ellen Thompson*	**LCSW-C**	**03/23/2011**
Printed	Clinician Signature	Credentials	Date

ethompson@newday.org	(410) 443-9876 ext. 12
Treatment Clinician's Email Address	Treatment Clinician's Phone Number

Attachment 2 – Mock Ambulatory Concurrent Review Form

PLEASE PRINT
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HealthChoice and PAC Substance Abuse Ambulatory Concurrent Review Form

ALL FIELDS ARE REQUIRED
Attach more pages if needed

Please complete all sections. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] **Level I: Traditional Outpatient** [ ] **Level II.1: Intensive Outpatient** [X] **OMT: Methadone Maintenance**

2. MCO Name: Maryland Physicians Care **Date Submitted to MCO:** 06/23/2011 **Time:** 2:30PM am/pm

3. Client's Name: (Last) George **, (First)** Lisa

4. Client's Date of Birth:	**5. Client's Gender:**	**6. Client's MA #:**	**7. Client's MCO #** (if different) **:**
02/03/1990	M: _____ F: _X_	99123294900	

8. Other Insurance Group # (if applicable) **:** N/A	**9. Client's Complete Address:** 2345 Broadway Street, Baltimore MD 12345	**10. Client's Phone Number:** (410) 983-1234

11. Treatment Facility Name: Address: New Day Drug Treatment Program Phone: (410) 443-9876 Fax: (410) 443-9966	**12. Facility MA # :** 76589700	**13. Facility Tax ID # :** 45-678-90-32

14. Primary Care Physician (if known) **:** Dr. Marilyn Haynes

15. Treatment Episode Start Date:	**16. Requested Start Date for MCO Authorization:**	**17. Client Pregnant?:** **N** If yes, Due Date (if known) **:** Scheduled to receive prenatal care? Y N
03/23/2011	**06/23/2011**	

18. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

AXIS I: 304.00

AXIS II: deferred

AXIS III: asthma, hypertension, diabetes

AXIS IV: legal problems, housing problems

AXIS V (GAF): 60

19. List ALL Reported Current Medications AND Current Medications prescribed by Substance Abuse treatment provider (such as Methadone or Suboxone). Attach additional pages if necessary.

Name of Medication	Dosage	Frequency	Adherence (e.g., Yes, No, Unknown)
Methadone (New Day)	**120mg**	**Daily**	**Yes**
Asthma (Dr. Haynes)	**Unknown**	**Unknown**	**Yes - Reported**
Diabetes (Dr. Haynes)	**Unknown**	**2x/daily**	**Yes - Reported**

20. Response to Treatment – Please ATTACH COMAR required treatment plan. This treatment plan should list specific gains made since initial treatment plan and all remaining symptoms with frequency and severity. The updated treatment plan should also provide justification for continuation of treatment.

21. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
1. Urine	03/15/2011		Positive for THC
2. Urine	04/01/2011	X	
3. Urine	04/15/2011	X	
4. Urine	05/01/2011	X	
5. Saliva	05/15/2011		Positive for opiates
6. Urine	06/01/2011		Positive for opiates

22. Is client currently abusing substances? **Y**
If yes, list interventions to address usage (e.g., administrative detox, change in level of care):

Member has an appointment to meet with the medical director to address continued use. The issue has been discussed in individual counseling sessions and member will be referred to a higher level of care if use persists.

23. Treatment

	Code	# of Sessions (S) OR # of Units (U) (circle one)	Session/Unit Conversion
[ ] Individual	H0004	[ ] S or U per week	1 Session = 4 Units (15 minutes per unit)
[ ] Group	H0005	[ ] S or U per week	1 Session = 1 Unit (60 – 90 minutes)
[ ] Intensive Outpatient	H0015	[ ] days/week & [ ] total hrs/week	Weekly total must be ≥ 9 hrs (Min.2 hrs/day – max. 4days/wk)
[X] Methadone Maintenance	H0020	Per Week	1 Session = 1 Unit (Must include at least one face to face encounter with counselor)

24. Anticipated Discharge Date from current level of care (if known): 12/31/2011

25. After Care Plan:

Member will continue with methadone maintenance until detox and discharge are appropriate. Member will then be referred to self-help and community treatment options.

26. Comments (anything not addressed in the treatment plan but supports request for continued level of care, e.g. employment, family, housing, health status, socialization, support system):

Continued use, problems with the legal system, and unstable housing necessitate continued care.

27. Treatment Clinician's Name:

Ellen Thompson	Ellen Thompson	LCSW-C	06/23/2011
Printed	Clinician Signature	Credentials	Date

ethompson@newday.org	(410) 443-9876 ext. 12
Treatment Clinician's Email Address	Treatment Clinician's Phone Number

Attachment 3 – Mock Discharge Summary Form

PLEASE PRINT
Page 1 of 2

HealthChoice Substance Abuse Discharge Summary

ALL FIELDS ARE REQUIRED
Attach more pages if needed

Please complete all sections. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42 – Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] **Level I: Traditional Outpatient** [ ] **Level II.1: Intensive Outpatient** [X] **OMT: Methadone Maintenance**

2. MCO Name: Maryland Physicians Care **Date Submitted to MCO:** 12/31/2011 **Time:** 2:30PM am/pm

3. Client's Name: (Last) George , **(First)** Lisa

4. Client's Date of Birth:	**5. Client's Gender:**	**6. Client's MA #:**	**7. Client's MCO #** (if different) **:**
02/03/1990	M: _____ F: _X_	99123294900	

8. Other Insurer Group # (if applicable) **:**	**9. Client's Complete Address:**	**10. Client's Phone Number:**
N/A	2345 Broadway Street, Baltimore MD 12345	(410) 983-1234

11. Treatment Facility Name:	**12. Facility MA # :**	**13. Facility Tax ID # :**
Address: New Day Drug Treatment Program Phone: (410) 443-9876 Fax: (410) 443-9966	76589700	45-678-90-32

14. Primary Care Physician (if known) **:**	**15. Discharge Date from this Facility:**	**16. Client Pregnant?:** N If yes, Due Date (if known) **:** Scheduled to receive prenatal care? Y N
Dr. Marilyn Haynes	12/23/2011	

17. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

AXIS I: 304.00

AXIS II: deferred

AXIS III: asthma, hypertension, diabetes

AXIS IV: legal problems

AXIS V (GAF):
Admission: 50
Discharge: 70

18. List ALL Medications at time of discharge prescribed by the substance abuse treatment provider (including Methadone/LAAM). Attach additional pages if necessary.

Name of Medication	Dosage	Frequency	Adherence (e.g., Yes, No, Unknown)
Asthma Medication – name unknown (Dr. Haynes)	**Unknown**	**As needed**	**Yes - Reported**
Insulin (Dr. Haynes)	**Unknown**	**2x/day**	**Yes - Reported**

19. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
1. Urine	**10/01/2011**	**X**	
2. Urine	**10/15/2011**	**X**	
3. Urine	**11/01/2011**	**X**	
4. Urine	**11/15/2011**	**X**	
5. Urine	**12/01/2011**	**X**	
6. Urine	**12/15/2011**	**X**	

20. Reason for Discharge

- Completed Treatment, No Substance Problem – No Substance Use___X___
- Completed Treatment, No Substance Problem – Some Substance Use_____
- Completed Treatment Plan Referred_____
- Did Not Complete Treatment Referred_____
- Non-Compliance – Administrative Discharge_____
- Client Left Before Completing_____
- Incarcerated_____
- Death_____
- Change in Service Within Episode_____

21. After Care Plan – Check all that apply

√	After Care Services	Name of Program	Contact Name and Telephone #
	No Referral		
	To Methadone		
	To Intensive Outpatient (IOP)		
	To Other Outpatient (OP)		
	To Detox		
	To Intermediate House		
	To Halfway House/Group Home		
	To Long Term Care		
	To Other Residential Substance Abuse Program		
√	**To Self-Help Programs (AA, NA)**	**Bright Futures**	**Sam Jones (410) 567-4321**
	To Community Mental Health		
	To General Hospital		
	To Psychiatric Hospital		
	Suboxone		
	Other Community Services		
	Other:		

22. Notification to Primary Care Physician? No _____ Yes__X___ Date__12/15/2011_____

23. Summary of Treatment (optional) :

24. Treatment Clinician's Name:

Ellen Thompson	Ellen Thompson	LCSW-C	12/31/2011
Printed	Clinician Signature	Credentials	Date

ethompson@newday.org	(410) 443-9876 ext. 12
Treatment Clinician's Email Address	Treatment Clinician's Phone Number

Attachment 4 - SAII PROTOCOL

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
Comprehensive Substance Abuse Assessment (CSAA)				
H0001	NA	NA	(1) A Managed Care Organization (MCO) or the Behavioral Health Organization (BHO) which administers the substance abuse services for certain MCOs will pay for a Comprehensive Substance Abuse Assessment once per enrollee per program per 12-month period, unless there is more than a 30-day break in treatment. If a patient returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.	The same rules for HealthChoice apply for PAC.
ASAM Level: I-Outpatient Services (Ambulatory detox) – In this context, ambulatory detox refers to services provided in the community or in outpatient departments of hospitals or ICF-As. It is only covered under HealthChoice.				
H0014 for community-based providers using CMS 1500 0944 and 0945 revenue codes for facility-based providers using UB-04	Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.	MCO or BHO liaison will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation number if approved.	1) If MCO/BHO **does not** respond to provider's notification, MCO/BHO will pay up to five (5) days. 2) If MCO/BHO responds by approving authorization, a LOS of five (5) days will automatically be approved. Additional days must be preauthorized as meeting medical necessity criteria. 3) If MCO/BHO determines client does **not** meet ASAM LOC, MCO/BHO will pay for care up to the point where they formally communicate their disapproval.	Ambulatory detox is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: I – Outpatient Services (Individual, family, and group therapy) – Self-referred individual, family or group therapy services must be provided in the community (not in hospital rate regulated settings).[1] [2]				
H0004 for individual or family therapy H0005 for group therapy	Provider must notify (by fax or email) MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services	MCO or BHO liaison must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.	MCO/BHO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client. Any other individual or group therapy services within the 12-month period must be preauthorized. Medicaid MCOs/BHOs will pay for additional counseling services as long as deemed medically necessary. In order for a provider to bill for family counseling, the enrollee must be present for an appropriate length of time, but does not need to 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. Family therapy is billed under the individual enrollee's Medicaid number.	PAC only covers Level 1, individual, family, and group therapy in community-based settings. All other approval rules for HealthChoice apply for PAC.

[1] Hospital rate regulated clinics must seek preauthorization to provide such services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists.
[2] Hospital-based services are not covered under PAC.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: II.1 – Intensive Outpatient (IOP – intensive outpatient) - Self-referred intensive outpatient services only apply to care delivered in community-based settings. Hospital rate regulated clinics must seek preauthorization to provide such services[3].				
H0015 for community-based providers using CMS 1500 0906 revenue codes for facility-based providers using UB-04	Provider must notify and provide treatment plan to MCO (by fax or email) within three (3) business days of admission to IOP. If they do not notify, they will not be paid for services rendered.	MCO or BHO liaison will respond to provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.	If the treatment plan is approved, MCO/BHO will pay for 30 calendar days of IOP. At the end of week three (3), for care coordination purposes, the provider must notify the MCO of discharge plan or need for remaining treatment. Additional days must be approved based on medical necessity. If determined that client **does not** meet ASAM LOC, MCO/BHO will pay for all services delivered up until the point that they formally notify the provider of the denial. If the client does not qualify for IOP, the MCO/BHO will work with the provider to determine the appropriate level of care.	The same approval rules for HealthChoice apply for PAC. PAC providers must bill using the CMS 1500 form and the H0015 for PAC recipients.

[3] Hospital regulated clinics must seek preauthorization to provide services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists. Hospital regulated clinics are not covered under the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: II.5 – Partial Hospitalization (Partial hospitalization (adults and children)) - HealthChoice reimburses this service only when it occurs in a hospital or other facility setting. It is not covered under PAC.				
0912 and 0913 revenue codes for facility-based providers using UB-04	By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider must submit progress report **and** assessment for justification of continued stay beyond day five (5). Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.	MCO or BHO liaison will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	1) Two (2) day minimum guaranteed. If ASAM is met, MCO/BHO will authorize an additional three (3) days. Any additional days must be preauthorized by the MCO based on medical necessity. 2) If the MCO/BHO is **not available or does not respond** to provider within two (2) hours, they will pay the extra three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity. Providers shall provide the least restrictive level of care. If the client does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.	Partial hospitalization is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: III – Residential and Inpatient (ICF-A, under 21) - HealthChoice only covers children and adolescents under age 21 for as long as medically necessary and the enrollee is eligible for the service. HealthChoice does not pay for these services if they are not medically necessary, even if a Court has ordered them. This service is not covered under PAC.				
Providers should speak to MCOs/BHOs about appropriate codes to use within their billing systems	Within two (2) hours, provider calls MCO or BHO for authorization.	MCO/BHO liaison will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability.	1) If MCO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized. 2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized. 3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.	ICF-A is not covered by the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: Opioid Maintenance Treatment (Methadone) - In regards to the self-referral option under HealthChoice, methadone maintenance refers to services provided in the community or in outpatient departments of hospitals. It will not however be covered under PAC.				
H0020	Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan. The provider will submit an updated treatment plan to the MCO/BHO by the 12th week of service to promote the coordination of care. Next approvals will be at six-month intervals.	MCO or BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation/ authorization number if approved. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Continued eligibility for coverage will be determined by medical necessity. Additional approvals beyond the first 26 weeks will be at six-month intervals. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO.	PAC covers methadone treatment only in a community-based setting (not hospital). All other HealthChoice approval rules apply. PAC providers must bill using the CMS 1500 and the H0020 code.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: IV.D -Medically Managed Patient (Inpatient detox in an inpatient hospital setting or ICF-A facility) - This service is provided in a hospital or ICF-A setting and is only covered under HealthChoice.				
0126 and 0136 revenue codes for facility-based providers	Within two (2) hours, provider calls MCO/BHO for authorization.	MCO or BHO will respond to provider within two (2) hours with a final disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.	If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized as medically necessary. If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care. If MCO/BHO does not respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized as medically necessary.	Inpatient detox is not covered by PAC.

Attachment 5 – MCO Contact Information

Managed Care Organization Behavioral Health Organization (BHO)	Authorization/ Notification Both in- & out-of-network	MCO Problem/Concern Contact Call numbers to the left first	Provider Relations	Claims	Special Needs Coordinator
AMERIGROUP Community Care	Providers: 1-800-454-3730 (have AMERIGROUP provider ID number or NPI number to more easily navigate system) Members: 1-800-600-4441 Fax: 1-800-505-1193	Mark Segal 410-859-5800 x44526	Helen Homon Director, Network Management 410-981-4516 Fax: 1-866-920-1873 hhomon@amerigroupcorp.com	Provider Relations Department 1-800-454-3730	Ornita Moore 410-981-4060 Fax: 866-920-1867 omoore1@amerigroupcorp.com
Diamond Plan Coventry Health Care BHO: MHNet	1-800-454-0740 Ambulatory Detox & IOP Fax: 1-407-831-0211 Outpatient and OMT Fax: 512-340-4213	Malaika Vasilidas 800-835-2094	Carol Robinson Network Contracting Director 1-800-727-9951 x 1523 Fax: 1-866-602-1246 crobinson@cvty.com	Joel Coppadge VP. of Service Operations 211 Lake Drive Newark, DE 19702 302-283-6564 Fax: 302-283-6787 jcoppadge@cvty.com	Denise Defoe 1-800-727-9951 x1551
MedStar Family Choice BHO: Value Options	1-800-496-5849	Victoria Gonzalez, Sr.Acct.Exec. 433 River Street Troy, NY 12180 (518) 271-2126	1-800-397-1630	1-800-496-5849	Blaine Willis 410-933-2226
Jai Medical Systems	Jemma Chong Qui 410-327-5100 Fax: 410-327-0542 Jemma@jaimedical.com	Jemma Chong Qui 410-327-5100	Adrienne McPherson 410-433-2200 Fax: 410-433-4615 adrienne@jaimedical.com	Provider Relations Department 410-433-2200	Georgia West 410-433-2200 Fax: 410-433-8500 georgia@jaimedical.com
Maryland Physicians Care	1-800-953-8854 option 7 Fax: 860-907-2649	Linda Dietsch 410-401-9452 Fax: 860-907-2684 linda.dietsch@ marylandphysicianscare.com	Barbara LaPlante 410-401-9508 Fax: 860-907-2694 barbara.laplante@ marylandphysicianscare.com	All Authorizations Fax: 860-907-2649 Claims Inquiry-Research 1-800-953-8854	Shannon Jones 410-401-9443 Fax: 860-970-2710 shannon.jones@ marylandphysicianscare.com
Priority Partners	1-800-261-2429 Option 3 Fax: 410-424-4891	Jamie Miller 1-800-261-2429 or 410-424-4919 Fax: 410-424-4891	Dina Goldberg, Director 410-424-4634 Fax: 410-424-4604 dgoldberg@jhhc.com	Provider Customer Service 410-424-4490 or 1-800-819-1043	Michael Papi 1-800-261-2396 Fax: 410-424-4906 snc@jhhc.com
UnitedHealthcare BHO: United Behavioral Health	1-888-291-2507 Fax: 1-855-250-8159	Alicia McKnight, LCSW Account Director 615-297-1995 Fax: 727-773-8564 alicia.s.mcknight@optum.com	Katie Hinkle Network Manager 215-231-3005 Fax: 215-832-4707 Katie.hinkle@optumhealth.com	1-888-291-2507	Brenda McQuay 410-379-3434 Fax: 410-540-5977 E-Fax: 1-855-273-1594 brenda_e_mcquay@uhc.com