Maryland Medicaid HealthChoice Use Form Instructions

Form Instructions for the following Community-Based Substance Use Disorder Services:

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

February 2014

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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: https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Substance%20Use%20Disorder%20Program.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 the SUD CMS 1500 Billing Instructions.

Instructions for Completing the HealthChoice Use Disorder 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 refer to the SUD CMS 1500 Billing Instructions.

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 HealthChoiceUse Disorder 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 Use Disorder 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

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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: 02/03/1990	**5. Client's Gender:** M: ____ F: _X_	**6. Client's MA #:** 99123294900	**7. Client's MCO #** (if different) **:**
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: **03/23/2011**	**16. Requested Start Date for MCO Authorization:** **06/23/2011**	**17. Client Pregnant?:** **N** If yes, Due Date (if known) **:** Scheduled to receive prenatal care? Y N

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:

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

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

Attachment 3 – Mock Discharge Summary Form

PLEASE PRINT

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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