carelon
Behavioral Health

Maryland Public Behavioral Health System (PBHS)

Provider Manual

maryland.carelonbh.com

TABLE OF CONTENTS

1. INTRODUCTION

1.01 Welcome

The Maryland Department of Health (MDH), Behavioral Health Administration (BHA), and Maryland Medicaid (MA) are pleased to introduce the Public Behavioral Health System (PBHS) Provider Manual. This manual was prepared through a collaborative effort between BHA, Medicaid Office of Behavioral Health Services, and Carelon Administrative Services Organization (ASO) staff. The manual will serve as an easily referenced and evolving guide for the organizations providing our state's vital behavioral health treatment and support services. As quality of care remains the highest priority, the information contained within aims to empower Maryland's robust network of PBHS providers to deliver optimal care.

1.02 Overview

In accordance with state legislation, the Maryland Department of Health (MDH), Medicaid Office of Behavioral Health Services, and the Behavioral Health Administration (BHA) implemented an integrated Public Behavioral Health System (PBHS) effective January 1, 2015. The Medicaid Office of Behavioral Health Services and BHA oversee and have the authority over the PBHS, which includes policy development, statewide planning, resource allocation, and continuous quality improvement strategies. Carelon Behavioral Health (Carelon) is the Administrative Service Organization (ASO) contracted with MDH to assist with the management of the PBHS. The goal of integration is to build on the existing strengths of the state's public behavioral health program and the Medicaid program to:

- Improve services for participants with co-occurring conditions
- Create a system of care that ensures a "no wrong door" experience
- Expand access to appropriate and quality behavioral health services
- Enhance cooperation and engagement
- Capture and analyze outcome and other relevant measures for determining behavioral health providers and program effectiveness
- Expand public health initiatives
- Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services

MDH oversees Maryland's PBHS, which includes services paid by Medicaid, as well as grant-based programs for the uninsured, and services not included in the Medicaid benefit package (referred to as "state only" services). Within MDH, the Behavioral Health Administration (BHA) and the office of Health Care Financing (Medicaid) jointly manage the PBHS. The Department contracts with an ASO to manage the PBHS in collaboration with Medicaid, BHA, and the local systems managers. In addition to the important role of the local systems managers, it is the coordination between the ASO and the Medicaid managed care organizations (MCO's) that is key to ensuring that the certain essential behavioral health services and supports are available to all people across Maryland, regardless of insurance coverage type or status.

This manual describes the requirements for providers to participate in the PBHS including eligibility, service requirements, and authorization procedures to serve as a resource and answer general questions providers may have. It is by no means all-inclusive. We encourage you to share with us suggestions and updates regarding its content. Providers can send communications regarding the manual to Provider.Relations.MD@carelon.com.

Maryland Medicaid, the BHA, and Carelon share a commitment to continuous quality improvement that involves an ongoing review of our regulations, processes, and procedures. As revisions are made to this manual based on updated information and changes in guidance from the Department, the manual will be updated on the Carelon website. Once again, we welcome you as a provider in the Maryland PBHS and look forward to a successful collaboration.

1.03 Introduction to the Public Behavioral Health System (PBHS) under an ASO Model

Maryland Medicaid, the BHA, and Carelon welcome you to the network of providers for the Maryland PBHS. As a provider participating in the PBHS, you will be working with us to provide quality behavioral health services that are efficient, impactful, and economical to individuals who qualify under the Maryland PBHS. We are excited about the opportunity to work with you in achieving treatment, rehabilitation, and recovery goals for the participants of the PBHS. Maryland's PBHS uses an Administrative Services Organization (ASO) model to administer services for participants in the PBHS.

How is an ASO different from a Managed Care Organization (MCO)?

The key difference between Managed Care and the use of an ASO, is that the service rules, regulations, payment processes and authorizations are determined by the state. While there are several MCOs, each with different benefit packages, from which participants can choose, the ASO is a single source for providers and is a mechanism that supports braided funding for Maryland's unique structure. This structure supports both Medicaid and state/grant funded services through the same ASO resource.

Through a competitive bid process, an ASO is selected for management of the PBHS. Effective January 1, 2025, Carelon Behavioral Health (Carelon) is the ASO contracted with Maryland to implement this critical role in serving Maryland's behavioral health population. The current contract period is January 1, 2025, through December 31, 2029.

The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO, including inpatient, outpatient, residential treatment (for children and adolescents), and partial hospitalization. Specifically, the ASO manages authorizations, service utilization, claims processing, provider education, training, and performance improvement as well as audits. The ASO also manages participant education regarding how to access care in the system.

Services provided and reimbursed through the ASO include a range of recovery and support services, such as mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment and respite care services. The ASO also reimburses for residential crisis services. Substance Use Disorder (SUD) coverage includes comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and all levels of care for residential SUD treatment services.

The following paragraphs summarize the roles of the respective parties in administering the PBHS:

Medicaid

The Office of Health Care Financing within the Department oversees Medicaid-financed behavioral health services in Maryland and manages the behavioral health ASO contract. Over 85 percent of Maryland Medicaid participants are enrolled in HealthChoice, a mandatory Medicaid managed care program that operates under authority of a Section 1115 waiver. Under this waiver, the Medicaid MCOs are responsible for providing a wide array of services to Medicaid participants. Specialty behavioral health services, those that are not performed as part of a primary care practitioner's (PCP's) office visit, are carved out of the MCO benefit package and are administered on a fee-for- service (FFS) basis by the behavioral health ASO. COMAR 10.67.08.02 lists the specific behavioral health services and diagnoses for which the MCO is not responsible and that the ASO, Carelon, administers.

COMAR 10.67.04.14 outlines the MCO's behavioral health referral responsibilities. The MCO is responsible for paying for behavioral health services delivered by the participant's PCP. If the MCO or the participant's PCP determines that primary behavioral health services are not sufficient to meet the enrollee's needs, then the MCO or PCP should refer the participant to the behavioral health ASO, Carelon. MCO participants may also self-refer to Carelon for specialty behavioral health services.

These regulations also require the MCO to cooperate with the behavioral health ASO, Carelon, in establishing referral procedures and protocols.

The MCO is also responsible for care coordination activities as outlined in their annual contracts with the Department. The 2025 contracts require the MCOs to perform the following coordination of care activities for participants with behavioral health conditions:

- Participate in monthly collective MCO medical directors' meetings and one-on-one meetings with the ASO for care coordination
- Cooperate with the Department's high utilizer program
- Assist with the development and coordination of appropriate treatment plans for enrollees
- Conduct provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process
- Conduct provider education about the release of information (ROI) process under 42 CFR Part 2
- Conduct provider education for enrollee identification and referrals to Carelon or core service agencies for behavioral health services

Grant-Based and State-Only Services

BHA oversees grant-based programs for public behavioral health services not included in the Medicaid benefit package, as well as services delivered to uninsured populations where the underlying service is similar to a Medicaid service. BHA determines payment policies for these programs, determines whether they should be administered at the state or local level, ensures that clinical criteria are consistently applied, develops payment rates and methods, and manages the budgets for these programs. Examples of these grants-based services include housing services, respite care, residential crisis services, gambling treatment services, and recovery/supported housing.

Local Systems Managers

Core Service Agency (CSA), Local Behavioral Health Authority (LBHA), or Local Addiction Authority (LAA), the local systems managers are a core component of Maryland's PBHS, tasked with providing behavioral health expertise to and in partnership with many stakeholders and multiple systems at the local level, to ensure that Marylanders have timely access to high quality behavioral health interventions, treatment, services, and supports. They are responsible for planning, managing, and monitoring mental health and substance use disorder services in Maryland's 24 jurisdictions. BHA is currently leading a process to document the roles and responsibilities of the local systems management.

Administrative Services Organization (ASO)

The ASO provides administrative support services to operate the PBHS, documented in the introduction section of this report.

1.04 Responsibilities

Everyone plays a role in the successful management and implementation of a system as vast and complex as Maryland's public behavioral health system.

To this end, MDH, Carelon, and providers have unique responsibilities, which are described in the following detail.

MDH'S RESPONSIBILITIES

MDH, specifically Maryland Medicaid and the BHA, is responsible for:

- Developing and evaluating policies, drafting regulations, and overall administration of behavioral health services to participants in Maryland
- Establishing provider rates and setting the benefit design standards including the amount, duration, and scope requirements
- Setting medical necessity standards
- Establishing utilization review and prior authorization criteria
- Ensuring a process for clinical reviews and participant appeals
- Setting provider participation, compliance, integrity, and audit standards and methods
- Developing claims and encounter data submission standards
- Establishing and managing other data and reporting standards
- Monitoring the Carelon contract and performance in Maryland

CARELON'S RESPONSIBILITIES

Carelon Behavioral Health is responsible for:

- Managing behavioral health services for Medicaid participants, eligible uninsured individuals, and some grant-funded services
- Maintaining online authorization applications and pre-authorizing non-emergency care
- Maintaining 24-hour access for clinically related calls
- Referring individuals to qualified service providers
- Conducting utilization reviews of services
- Processing claims and remitting payments
- Assisting with the evaluation of the PBHS via provider and participation satisfaction surveys
- Auditing providers for quality of documentation and correct billing processes
- Training providers, participants, and advocates via webinar and regional forums on topics of interest to the behavioral health community such as services available for individuals who are deaf or hard of hearing, evidence-based practices, and other programs available to assist participants in their recovery efforts
- Conducting provider and participant forums (such as the Quality Steering Committee) to obtain feedback regarding the performance of the PBHS
- Defining and evaluating performance, outcomes, effectiveness, efficiency, and cost effectiveness of mental health and substance use disorder-related services and systems
- Collecting and analyzing behavioral health and other health-related information

PROVIDERS' RESPONSIBILITIES

Providers are responsible for:

- Engaging in responsible management of behavioral health care by adhering to ethical and professional standards
- Working with participants to provide quality services that meet the participants' goals and needs
- Cooperating and collaborating with Carelon concerning appropriate clinical care for participants
- Obtaining pre-authorization/authorization/registration for appropriate services
- Maintaining a high standard of medically necessary, efficient, and cost-effective care that addresses each participant's individual needs
- Working with Carelon Care Managers and participants to achieve participant satisfaction with service regulations, policies, and procedures
- Involving participants in treatment/service planning
- Delivering the principles of recovery and resiliency in treating participants
- Coordinating treatment with other involved health care providers
- Promoting innovation and best practices in services and systems
- Helping participants obtain appropriate benefits
- Honoring each participant's right to dignity and confidentiality
- Complying with local, state, and federal laws and regulations
- Complying with federal, state, Medicaid, and Medicare rules, as well as with PBHS

1.05 Key Contact Information

Carelon Behavioral Health of Maryland Website: maryland.carelonbh.com

Important email, phone and fax numbers:

Department	Contact Information
Medicaid Provider Enrollment	844-463-7768
Medicaid Recipient Enrollment	855-642-8572
EVS – Eligibility Verification	866-710-1447
Carelon (toll-free; follow prompts)	800-888-1965
Carelon Provider Relations	Provider.relations.MD@carelon.com
Confidential Clinical Fax	877-502-1044
Confidential Support Fax	877-502-1037
BHA Licensing Questions	bha.licensingcompliance@maryland.gov
BHA Licensing Applications	bha.licensing@maryland.gov

Addresses:

Carelon Behavioral Health Maryland Office
7550 Teague Road, Suite 500
Hanover, Maryland 21076

Non-claims Related:
Carelon Behavioral Health
P.O. Box 166
Linthicum, MD 21090

Claims Submission:
Carelon Behavioral Health
ATTN: Maryland
P.O. Box 1850
Hicksville, NY 11802-1850

Claims Appeals:
Carelon Behavioral Health
ATTN: Provider Claims Appeals
P.O. Box 1856
Hicksville, NY 11802

Provider Complaints:
Carelon Behavioral Health
ATTN: Provider Complaints
P.O. Box 1850
Hicksville, NY 11802

2. PROVIDER QUALIFICATIONS AND ENROLLMENT: GUIDANCE ON PARTICIPATION IN PBHS

2.01 Overview

This section provides information about your responsibilities as a provider in the Maryland Public Behavioral Health System (PBHS).

Maryland Public Behavioral Health providers are required to meet the criteria of one of the approved provider types found in section 2.6.

You may access general information about participation in the PBHS as a Medicaid provider by visiting the Medicaid Provider Information page.

You may access provider enrollment and re-enrollment materials on the Medicaid Provider Enrollment page.

You are responsible for keeping up to date with all of the information impacting on the delivery and payment of PBHS services. Therefore, you should regularly review information from Carelon Behavioral Health, MDH, and the Behavioral Health Administration (BHA) websites. Click below to be directed to the following websites:

- Carelon Behavioral Health of Maryland
- Maryland Department of Health (MDH)
- The Behavioral Health Administration (BHA)
- You should contact your local systems manager (formerly referred to as CSA, LBHA and/ or LAA) for concerns about local services and support. For a list of local systems managers by county, please visit the Maryland Association of Behavioral Health Authorities' (MABHA) website.

Providers are required to comply with all federal and state regulations governing service delivery.

2.02 Medicaid and National Provider Identifier Number Requirements

Medicaid providers are required to have an active Medicaid (MA) number. In addition, a separate National Provider Identifier (NPI) and MA number is required for each approved or licensed service at the same location or for the same service provided at multiple locations. Examples:

- A provider with an Outpatient Mental Health Clinic (OMHC), Psychiatric Rehabilitation Program (PRP), and Opioid Treatment Program (OTP) at one location is required to obtain separate NPI/MA numbers for each program
- A provider with three separately licensed OMHCs in three different locations will need three separate NPI/MA numbers

You may contact the Medicaid Provider Enrollment Department at 1-844-463-7768 with questions or to determine if you have an active MA number. You may also check your MA enrollment status using the Provider Verification System.

2.03 Provider Enrollment

Providers need to enroll in Maryland Medicaid in order to deliver Medicaid reimbursable services. As noted above, providers delivering more than one type of approved or licensed service are required to obtain separate Medicaid (MA) and NPI numbers for each Medicaid service and service location.

All Behavioral Health programs need to be accredited and licensed to qualify as a Medicaid provider. Information regarding provider accreditation and licensing for behavioral health providers is available at: BHA – Accreditation and Licensing Information for Behavioral Health Providers.

All individual practitioners are required to be licensed to practice in accordance with their licensing Board and in compliance with COMAR regulations. A list of provider types with their respective regulations is available below in section 2.6.

Once a provider is licensed, either by their licensing Board or by the BHA, an NPI number is also required to enroll with Medicaid. To apply, view, or update your NPI, visit the National Plan and Provider Enumeration System (NPPES) website. Each provider type and location require a separate NPI.

Maryland Medicaid assigns MA numbers when your enrollment application is approved and processed.

Please ensure that you follow all MDH instructions and that all the required documentation is attached to the application. The certifications and licenses identified in the application need to be obtained prior to submission.

Approval

Maryland Medicaid sends letters to providers to notify them of their enrollment status. The letters contain the providers' Medicaid Numbers and effective dates. Maryland Medicaid does not backdate applications. The effective date of the account is the date the completed application was processed.

Providers are at financial risk for services delivered before their MA number is active and for services that have not been authorized by the ASO, Carelon.

2.04 ePREP for Provider Medicaid Enrollment and Registration with Carelon

The state of Maryland has implemented the electronic Provider Revalidation and Enrollment Portal (ePREP). This resource enables online provider enrollment, re-enrollment, revalidation, information updates, and demographic changes.

For resources to assist you with ePREP, visit the Maryland Department of Health Provider Enrollment ePREP Instructions and Training page.

To create a user profile or to log into an existing account for Maryland Medicaid's ePREP portal.

Registering with Carelon

Upon registering with ePREP, providers can then create accounts for the applications within Carelon's Provider Digital Front Door. The Carelon Provider Digital Front Door allows providers to take advantage of our array of online services, making routine tasks such as processing claims, obtaining claims information, submitting authorizations, and verifying eligibility status, both easy and convenient. See section 3.01 for more information on the Carelon Provider Digital Front Door.

2.05 Exclusions of Individuals and Entities from Federally Funded Healthcare Programs

All PBHS providers are responsible for checking the Department of Health and Human Services – Office of Inspector General's (DHHS-OIG) website to assure that they are not wrongfully contracting or employing an excluded individual. Providers should also check the MDH Sanctioned Providers List.

It is every individual's and agency's responsibility to assure that all staff working in programs, either through direct service or administrative support, are eligible to participate in programs receiving federal reimbursement. Failure to screen employees and contractors or to retain documentation that such screening has been performed can result in disciplinary action.

2.06 Provider Types

In addition to reviewing information in this manual, and before you begin the application process, take time to review relevant state regulations to determine the appropriate provider type to select. The table below includes links to some helpful sections from COMAR Title 10 Subtitles 9 (Medical Care Programs) and 63 (Community-based Behavioral Health Programs and Services).

Note: This list is not comprehensive. If your provider type is not covered below, you can search here.

10.09.16	Behavioral Health Crisis Services
10.09.33	Health Homes
10.09.34	Therapeutic Behavioral Services
10.09.36	General Medical Assistance Provider Participation Criteria
10.09.59	Specialty Mental Health Services
10.67.08	Maryland Medicaid Managed Care Program: Non-Capitated Covered Services
10.09.80	Community-based Substance Use Disorder Services
10.63	Community-based Behavioral Health Programs and Services
10.09.06	Adult Residential Substance Use Disorder Services
10.09.95	Hospitals / Special Psychiatric Hospitals
10.09.26	Residential Treatment Centers
10.09.89	1915(i) Intensive Behavioral Health Services for Children, Youth, and Families
10.09.45	Mental Health Case Management: Care Coordination for Adults
10.09.90	Mental Health Case Management: Care Coordination for Children and Youth

Note that COMAR 10.63 requires maintenance of key staff to operate, including:

- OMHC – Medical Director
- OTP – Medical Director
- PRP (Adult and Minor) – Rehabilitation Specialist

In the event your agency loses a key employee, you are required to immediately file for a variance to avoid being out of compliance and at risk of paid claims being retracted. You may reference the COMAR 10.63 Licensed Agencies: Loss of Required Staff and Site Address Changes Provider Alert for more information including how to file for variance.

The following provider types may provide behavioral health services and are required to submit Maryland Medicaid applications:

Provider Type	Description	Classification
01	Acute Hospitals	Facility
06	Special Other Acute Hospitals	Facility
07	Special Other Chronic Hospitals	Facility
10	Laboratory	Facility
15	Psychologist	Individual
20	Physician (includes psychiatrist)	Individual or Group
23	Nurse Practitioner; Certified Registered Nurse Practitioner (CRNP)	Individual or Group
24	Nurse Psychotherapist (Advanced Practice Registered Nurse-Psychiatric Mental Health [APRN-PMH]	Individual
27	Mental Health Group Therapy Provider	Group
32	Clinic, Drug	Facility
34	Federally Qualified Health Center (FQHC) (found under Clinic, FQHC)	Facility
50	Substance Use Disorder Program (Behavioral Health Administration (BHA) Certified/ Approved SUD Program)	Facility
54	IMD Residential SUD for Adults (providers treat adult recipients 18 years and older)	Facility
55	Intermediate Care Facility (IFC) – Addiction (providers treat recipients <21 years of age)	Facility
80	Physician Assistant	Individual
88	Residential Treatment Center (RTC)	Facility
89	1915(i) Intensive Behavioral Services for Children, Youth and Families (Refer to Provider Type "HG" for individual or group provider)	Facility or Program
94	Social Worker (LCSW-C license required)	Individual
CC	Certified Professional Counselor (includes LCPC, LCMFT, and LCADC)	Individual
CF	Behavioral Health Crisis Stabilization Centers	Facility
CM	Mental Health Case Management Provider	Facility
HG	1915(i) Intensive Behavioral Services for Children, Youth and Families (Refer to Provider Type "89" for facility/program provider)	Individual or Group
MC	Outpatient Mental Health Clinic (OMHC)	Facility
MH	Community Based Partial Hospitalization Program	Facility
MS	Mobile Crisis Team	Facility
MT	Mobile Treatment Program	Facility
PR	Psychiatric Rehabilitation Services Facility	Facility
SE	Supported Employment	Facility

Please visit the Maryland Department of Health Provider Enrollment page for more information on Medicaid enrolled provider types. You can also access the Provider specific application addenda.

Individual Providers:

Providers may enroll in Maryland Medicaid as sole practitioners, and they may also affiliate with a group or FQHC.

The following are requirements for individual behavioral health providers who participate in the Maryland Medicaid program:

- Have an active board license or certification
    - Providers who are not independently licensed (LGPC, LMSW, LMFT, LGADC, LCSW) cannot enroll individually in Maryland Medicaid nor be paid for services provided in an individual or group practice.
- Obtain an individual NPI number
    - Only one NPI number is necessary for individual providers regardless of the number of practice locations. The primary practice location will be listed in the Medicaid system.
- Obtain a Medicaid number
    - Register with Carelon's Provider Digital Front Door in order to obtain authorization prior to service delivery and for reimbursement.

Group Providers:

A group provider is an administrative entity that manages a cohort of individual practitioners.

The following are requirements for group behavioral health providers:

- Have a group of at least two individually licensed providers who are separately enrolled in Medicaid, provided that.
    - such providers cannot include practitioners who are not independently licensed (i.e., LGPC, LGSW, LGMFT, LGADC, LCSW), and
    - supervisors may not receive reimbursement for services rendered by supervisees who are not independently licensed.
- Obtain an organizational NPI number. Group providers may obtain an organizational NPI for each service location or select one service location to list in the Medicaid system but practice at multiple locations.
- Obtain a Medicaid number
    - Register with Carelon's Provider Digital Front Door in order to obtain authorization prior to service delivery and for reimbursement.

Facility/Program Providers:

Facilities/organizations are licensed/certified/approved by MDH (BHA) and by accreditation agencies, Core Service Agencies, Local Addictions Authorities, Local Behavioral Health Authorities, accrediting bodies, and Medicaid staff prior to enrollment. Facilities may receive reimbursement for services delivered by individuals under the direct supervision of appropriately licensed staff but are not independently licensed themselves.

The following are requirements for facilities providing behavioral health services:

- Maintain an active provider license and accreditation status
- Obtain an organizational NPI number for each provider type and service location
- Obtain a Medicaid number for each provider type and service location for Medicaid provider types
- Register with Carelon's Provider Digital Front Door in order to obtain authorization prior to service delivery and for reimbursement

The following provider types cannot enroll with Medicaid and are supported only through state funding:

Provider Type	Description	Classification
CR	Crisis Residential	Facility
GA	Gambling Provider	Individual or Group
MR	Maryland Recovery Network (MDRN)	N/A
RE	Respite	Facility

See: BHA – Accreditation and Licensing Information for Behavioral Health Providers

2.07 Provider Terminations

Notifications
According to the Medicaid Provider Agreement, providers are required to notify the MDH Provider Enrollment Department at 1-844-463-7768 within five working days of any of the following:

- Revocation, suspension, restriction, termination, or relinquishment of any provider licenses, authorizations, program approvals, or accreditations, whether voluntary or involuntary
- Any indictment, arrest, or conviction for felony charges or a criminal charge other than traffic offenses
- Revocation, suspension, restriction, termination, or relinquishment of medical staff participantship or clinical privileges at any healthcare facility

Voluntary Termination

Providers are required to submit a disenrollment application in ePREP to terminate their Medicaid provider agreement. Providers may contact the MDH Behavioral Health Division by sending an email to MDH.bhenrollment@maryland.gov or call the Provider Enrollment Department at 1-844-463-7768 for assistance with terminating their Medicaid enrollment.

2.08 Participant Referral

Medicaid and non-Medicaid participants, who are referred to or contact Carelon for behavioral health services, will be referred to provider(s) according to the policies outlined below:

- **Open Referral Process:** Referrals may be initiated by the participant, the participant's primary care provider, a family participant, or legal guardian.
- **Participant Choice:** MDH values participant choice. The wishes and needs of the participant drive the referral process. As such, participants will always be given a choice of providers.
- **Participant Preferences:** Participant preferences can be identified in the following areas:
  - Provider location
  - Transportation to provider office
  - Provider office hours
  - Gender of provider
  - Culture and communication
- **Participant Needs:** Participant preferences can be identified in the following areas:
  - Clinical
  - Child or adolescent
  - Geriatric
  - Deaf or hard of hearing
  - Language
  - Veterans

3. PROVIDER RESOURCES

3.01 Provider Digital Front Door

Providers will have a singular point of entry through Carelon's Provider Digital Front Door – a homebase for provider resources using the power of Availity Essentials and ProviderConnect. The Carelon Provider Digital Front Door allows you to access participant information, including eligibility and benefit details, and perform important administrative tasks, such as submitting authorization requests, checking claim status, and submitting appeal requests. The Provider Digital Front Door supplies you with the information, tools, and resources you need to support the day-to-day needs of the participants you serve and your business functions. See below for details regarding the specific functionalities offered within each resource.

Availity Essentials

Availity Essentials ("Availity") is a secure, one-stop, self-service, multi-payer space and our *preferred choice* for direct data entry claim submissions, EDI claims, checking eligibility and benefits, and more. Using Availity allows providers to streamline workflows with multi-payer access. With this new update, providers will be able to:

- View participant eligibility and benefits information
- Search and review claims details
- Access ProviderConnect through Availity's single sign on (SSO) credentials
- Navigate to ProviderConnect to submit new authorizations and review previously submitted authorizations

ProviderConnect

ProviderConnect is a secure, password-protected portal where providers can conduct certain online activities with Carelon directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Online activities include, but are not limited to:

- Authorization or certification requests for all levels of care
- Concurrent review requests and discharge reporting
- Claim status review for both paper and electronic claims submitted to Carelon
- Verification of eligibility status
- Submission of inquiries to Carelon's provider customer service
- Updates to practice profiles/records
- Electronic access to authorization/certification letters from Carelon
- Provider summary vouchers (PSVs)

Single Sign On (SSO) Credentials

Before you get started, link your ProviderConnect account with a single sign on in Availity.

- Register for a ProviderConnect user account.
- Register for an Availity user account.
- In the Availity payer space, select organization administration to link your Availity account to your Carelon ProviderConnect account. This only needs to occur one time, enabling you to access features within ProviderConnect through Availity.

3.02 Provider Training

Carelon Behavioral Health provides live and pre-recorded training on the use of the Carelon's Provider Digital Front Door for claims submission and authorization/service request for providers and their staff. Training sessions for specialty provider types such as Applied Behavior Analysis (ABA), Psychiatric Rehabilitation Services (PRP), and Maryland Recovery Net (MDRN) are frequently included.

Upcoming provider trainings are posted each month to the Carelon Behavioral Health of Maryland website. Here, you can access this calendar to view and register for upcoming training. We provide a full range of trainings year-round to educate, inform, and share industry-wide best practices and policies.

Trainings cover a variety of topics ranging from claim submission guidelines and Carelon's Provider Digital Front Door support to behavioral health in youth and motivational interviewing.

Provider Orientation Webinar for Providers

Carelon conducts Provider Orientation for Maryland Providers on a regular basis thereafter. These webinars are available to new and existing providers. Webinars are recorded and available on the Carelon website. Topics covered in the provider orientation webinars include, but are not limited to:

- Provider registration and enrollment
- Covered services delivery based on Provider Type (PT)
- Authorization/Medical Necessity review, and combination of service limitations.
- Claims submission process and billing the PBHS for both professional and institutional billing.
- How the provider can assist individuals in accessing the system and how to make referrals for care
- Maryland Recovery Net requests and claim submissions
- Using Carelon's Provider Digital Front Door
- Linking Availity and ProviderConnect

3.03 Provider Communications

Provider Alerts and Bulletins

Carelon emails Provider Alerts to announce important information, such as changes within the PBHS, Maryland Department of Health (MDH) announcements, and important regulatory guidance. Providers can register for Provider Alerts via the form on the Carelon website. Provider Bulletins will also be sent periodically and include a roundup of the most recent Provider Alerts and non-urgent information.

Provider Newsletter

Carelon publishes a quarterly newsletter with information useful to both providers and participants. This newsletter highlights new clinical innovations, upcoming events within the state, news for participants, as well as innovations happening within our provider community. If you have any ideas for the newsletter, please email your comments to Provider.Relations.MD@carelon.com.

3.04 Carelon Behavioral Health of Maryland Website

Carelon's website includes both public information and access to secure transactions. For providers, publicly accessible information located under the Behavioral Health Providers menu includes:

- Provider Resources and Support
- Behavioral Health Services information
- Provider Communications
- Provider Training & Education
- Quality Management
- Crisis Resources
- Specialty Programs
- Provider Alerts
- Provider Manual
- Provider Forms
- Maryland Data Initiative
- Care Coordination
- Screening Tools

4. BENEFITS FOR THE UNINSURED AND UNDERINSURED

4.01 Overview

As the ASO, Carelon manages all Medicaid and state-only funds for the Public Behavioral Health System (PBHS). Services are fully integrated into one common data system.

4.02 Uninsured Eligible

Uninsured eligible participants are individuals for whom the cost of medically necessary and appropriate community-based behavioral health services may be subsidized by the Behavioral Health Administration (BHA) because of the severity of illness and financial need. Depending on the availability of state funding, services may be provided to participants who meet specific eligibility guidelines.

Providers can verify a participant's eligibility or initiate a request for uninsured eligibility through Carelon's Provider Digital Front Door or by calling the Carelon customer service team at 1-800-888-1965.

For non-insured participants for whom Medicaid eligibility is anticipated, Carelon encourages the provider to request a courtesy review. When medical necessity criteria are met and a courtesy review is on file, the provider will only need to submit a claim, if and when, the participant obtains Medicaid. If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days.

When an uninsured eligible participant presents with a major illness that requires hospital level of care, the institution providing that care is expected to assist the family with an application for Medicaid.

4.03 Uninsured Eligibility for Behavioral Health Services

An open and active uninsured eligibility span is necessary for Carelon to pay for some medically necessary, behavioral health services. Approval is dependent upon state funding availability. Carelon may make payment for behavioral health services provided to an uninsured eligible participant if all of the following are met:

- The participant meets all the requirements for uninsured eligibility
- The provider has maintained documentation that the uninsured eligibility criteria have been met
- The behavioral health services have been authorized as medically necessary, prior to services beginning (except for urgent services)
- The behavioral health services requested are one of the following:
    - Mental health case management
    - Outpatient Mental Health Clinic Services (OMHCs)
        - Excluding OMHCs in HSCRC regulated space
        - Excluding intensive outpatient services
    - Outpatient mental health office services (non-OMHCs)
    - Respite services
    - Enhanced support services
    - Psychiatric Rehabilitation Program (PRP) services, on and off-site*
    - Mental health residential crisis services**
    - Mobile Crisis

- Mobile treatment services**
- Supported employment services***
- Residential Rehabilitation Program (RRP) services****
- SUD Outpatient Level 1
- SUD Methadone Maintenance (Opioid Treatment Program services)
- SUD Intensive Outpatient
- SUD Residential ASAM Level 3.1
- SUD Residential ASAM Level 3.3
- SUD Residential ASAM Level 3.5
- SUD Residential ASAM Level 3.7
- SUD Residential ASAM Level 3.7WM
- Problem Gambling Program

Note: Uninsured requests will be denied with no exception when the participant; does not have a primary behavioral health diagnosis or is not a Maryland resident.

*Participant is required to meet additional criteria to quality for these services

**No copays apply to PBHS funded services

***The participant's income from supported employment will not be included in the income verification

****Participants are required to contribute to the cost of care for RRP

4.04 Registering a New Participant

After logging into Carelon's Provider Digital Front Door, you can search for a participant to learn whether the individual is already receiving services from the PBHS. When the participant is new to the PBHS, they need to be added to the system in order for Carelon to assign them a Carelon medical record number.

4.05 Application for Eligibility

When applying for uninsured eligibility in the Carelon Provider Digital Front Door, the provider will receive an immediate eligibility response of a participant's uninsured eligibility status.

There are six criteria for uninsured eligibility and all six are required to be met for the individual to be eligible. The provider is to verify and document the participant meets the following six uninsured eligibility criteria:

1. The participant requires treatment for one or more behavioral health diagnoses covered by the PBHS.
2. The participant meets the financial criteria (under 250% of federal poverty level) and is not covered by Medicaid or other insurance.
    - The service provider is responsible for collecting and maintaining documentation from the participant that validates the participant's financial need. This may include documentation of application and outcome for benefits, pay stubs, other income, etc. to document that the participant meets the financial criteria.
3. The participant has a verifiable social security number.

4. The participant is a Maryland resident.
5. The participant has applied for Medicaid, the Health Care Exchange (Maryland Health Connection), Social Security Income (SSI), or Social Security Disability Insurance (SSDI), if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for 12 months or more).

    - If the participant is not eligible for Medicaid, SSI, or SSDI, documentation from Medicaid or Social Security stating the reason for ineligibility needs to be provided and maintained in the participant's medical record.

    OR

    - The participant is currently a Medicare beneficiary but is NOT Qualified Medicare Beneficiary (QMB) eligible or Specified Low Income Medicare Beneficiary (SLMB) eligible AND the service request is for a service that is not fully Medicare reimbursable.

6. The participant meets U.S. citizenship requirements

    OR is a qualified, non-citizen immigrant who meets one or more of the following criteria:

    - Has permanent U.S. resident status.
    - Was granted parole for at least one year under §212(d)(5) of the Immigration and Naturalization Act (INA).
    - Has been battered or treated with extreme cruelty by his or her spouse who is a U.S. citizen or legal permanent resident or by the spouse's family living with the individual and his or her spouse

    AND has lived continuously in the U.S for at least five years since becoming a legal permanent resident, UNLESS the participant meets one or more of the following:

    A. Is an honorably discharged Veteran of the U.S. Armed Forces
    B. Is on active duty in the U.S. Armed Forces.
    C. Is the lawfully admitted spouse of a U.S. citizen, including a surviving spouse who has not yet remarried.
    D. Was lawfully admitted to the U.S. as an Amerasian immigrant with permanent legal status under §584 of the Foreign Operations, Export Financing and Related Programs Act of 1988.
    E. Was admitted to the U.S. as a refugee under §207 of the INA.
    F. Was granted asylum under §208 of the INA.
    G. Is having deportation withheld under §243(h) of the INA as in effect prior to April 1, 1997; or§241(b)(3) of the INA, as amended.
    H. Is a Cuban or Haitian entrant to the U.S., as defined by §501(e) of the Refugee Education Assistance Act of 1980.
    I. Was granted conditional entry to the U.S. under §203(a)(7) of the INA in effect before April 1, 1980
    J. Is a child receiving federal payments for foster care or adoption assistance under Part B or E of Title IV of the Social Security Act if the child's foster or adoptive parent is considered a U.S. citizen or qualified alien.

K. Is a victim of a severe form of trafficking in accordance with §103(b)(1) of the Trafficking Victims Protection Act of 2000, who has been subjected to:

   i. sex trafficking, if the act is induced by force, fraud, or coercion, or the individual who was induced to perform the act was younger than 18 years old on the date that the visa application was filed; or

   ii. involuntary servitude

Coordination of benefits applies. Please reference Section 13.08 for more information.

BHA requires providers to maintain documentation in the medical record to validate the individual's uninsured eligibility. Carelon and BHA will be monitoring requests for uninsured eligibility spans and providers without documentation may be audited. Failure to maintain all supporting documentation may result in a retraction of funds.

Exceptions to the documentation requirement may be made by BHA under extenuating circumstances. The exceptions are related to the type of crisis and type of service. If a participant is in immediate need for services (such as acutely suicidal) or the participant's symptoms prevent that person from being able to provide information and they are being seen by an assertive community treatment team, mobile crisis team, residential crisis program, or other outpatient setting, documentation criteria may be waived.

If an individual is in immediate need of services, the participant will be given an uninsured span of 90 days. If at the end of the 90-day period the participant still is in crisis and documentation is still not available, the provider may request another 90 days by completing the registration for the uninsured span again. If at the end of the second 90-day period, the provider again requests an uninsured eligibility span without the documentation, the request will be denied and the provider is required to submit a written request to the local systems manager (formerly referred to as the Core Service Agency (CSA), Local Behavioral Health Authority (LBHA), or Local Addiction Authority (LAA)) to demonstrate the need for continued services despite the missing documentation.

If Carelon denies the request for an uninsured eligibility span due to the individual not meeting the minimum criteria, the provider may request a review by the local systems manager for an exception to the criteria due to an urgent care or special exception need. Allowable certification periods for uninsured spans that can be granted by the local systems manager are outlined in section 4.06. Once these allowable certification periods are exhausted, the provider may request a review by BHA for an exception criteria due to an urgent care or special exception need as outlined in section 4.06.

The provider can request an exception by completing the registration process and attaching the additional information for the exception request as a PDF. The document will be routed to the local systems manager for review and coordination with BHA. The local systems manager will review the request to deter. mine if an urgent care need is met and an exception will be granted. Rationale for the exceptions is to include discharge/release or diversion from a state hospital or other inpatient setting or detention center. If the local systems manager denies the request, the local systems manager notifies the provider.

If the local systems manager approves the exception, the local systems manager forwards the "State of Maryland - Request for Reimbursement for Non-Medicaid Outpatient Services" form (if participant number, Medicaid ID is available) to Carelon.

The "Maryland: Provider Request to the local systems manager for Urgent Care for Uninsured" form will not be sent to Carelon but retained by the local systems manager. Upon receipt, Carelon will enter the participant information into our system typically within 24 hours but no later than two business days. Carelon will update the form with the participant ID and email it back to the local systems manager with a copy to the provider. The form requires the provider's email address to be included.

If the local systems manager approves, then an uninsured eligibility span is established. If at any point during this process, the provider updates the uninsured participant's eligibility record with the missing documentation, the uninsured eligibility span is established for three months from the initial begin date of the uninsured span.

Additionally, there are other exceptions to documentation if the participant meets these criteria:

If the individual meets all of the above documentation criteria except item two and one of the following special conditions:

1. Is under age 19
2. Has been released from prison, jail, or Department of Corrections facility within the last three months
3. Is pregnant
4. Is an injection drug user (an individual who habitually injects by means of a hypodermic needle, hypodermic syringe, or equivalent implement an illicit substance, usually, but not necessarily limited to, heroin, into the individual's own vein or who is in treatment for intravenous substance use)
5. Is receiving medication to treat an opioid use disorder
6. Has HIV/AIDS
7. Was discharged from a Maryland-based psychiatric hospital within the last three months
8. Was discharged from a Maryland-based medically monitored residential treatment facility within the last 30 days (American Society of Addiction Medicine Level 3.7)
9. Is requesting services required by HG 8-507 order or referred by drug or probate court
10. Is receiving services as required by an order of conditional release
11. Requested service is one of the following:
    - Supported employment
    - Residential crisis
    - MDRN
    - Respite
12. Is currently receiving SSDI for mental health reasons (disregard #2, #5 in Section 4.05)
13. Is homeless within the state of Maryland (disregard #2, #4 in Section 4.05)
14. Is a veteran (disregard #2, #3, #5 in Section 4.05)
15. Has received a special exception from BHA

4.06 Uninsured Certification Periods

When a request meets the state's uninsured Eligibility Criteria (Section 4.05), the initial uninsured eligibility span is for 90 days granted through the ASO, Carelon. A second 90-day span will be granted upon request if the individual continues to meet uninsured Eligibility Criteria. To continue to be eligible for any further spans after the second 90-day span within a year, the participant is required to also meet at least one Special Conditions criterion outlined in Section 4.05. As long as the individual meets all of the uninsured Eligibility Criteria (except #2) and at least one Special Condition criterion, the individual will continue to qualify for uninsured eligibility granted through the ASO, Carelon.

Individuals who do not meet uninsured eligibility may file an uninsured exception request as outlined in Section 4.05. The request will be assigned to the local systems manager for the jurisdiction in which the consumer resides, which will have the ability to grant a maximum number of two 30-day eligibility spans. Further exceptions require specific written approval from the BHA medical director or designee.

Recertification Process

Changes during the 90-day period that may impact eligibility need to be reported to Carelon by the participant or provider. The PBHS requires every provider to request that each participant/applicant apply for any Medicaid benefits or EID for which he/she may be eligible.

Requests for uninsured eligibility will not be backdated unless the participant has an open authorization with an end-date beyond the end-date of the participant's current uninsured eligibility span. Backdating of uninsured eligibility spans will be allowed in the following scenarios:

- If the participant was discharged from a hospital, Carelon will backdate to the date of hospital discharge
- If the provider or participant is notified of pending termination from Medicaid and the date of Medicaid termination is no longer than 30 days before the start date of the requested uninsured span
- If the participant is receiving care in a designated hospital diversion program

Please refer to Section 6 for more information on recertification process for specialty programs.

5. AUTHORIZATION PROCESS

5.01 Authorization Process

Authorizations can be requested electronically through the Carelon Provider Digital Front Door, which can be accessed 24/7, including weekends and holidays through the Carelon website. All requests for inpatient treatment that are made while the participant is in the ER, can be submitted electronically through the Provider Digital Front Door. If the level of care is medically necessary, services will be authorized.

Providers are expected to submit complete authorization requests, including clinical information supporting medical necessity criteria and any required attachments. Additional information or forms may be required based on the level of care being requested. Please see the program description (section 5.3) for additional information.

Providers obtain additional authorizations through the electronic submission of a concurrent review request via the Carelon Provider Digital Front Door. Concurrent requests should also be submitted with supporting clinical information.

Services provided to participants in any higher level of psychiatric or substance abuse treatment are reviewed at the time of the initial request and on each concurrent review by Care Managers. These reviews provide information regarding the participant's status, treatment provided to date, and the need for continued care. Carelon reserves the right to require a direct conversation with the attending psychiatrist or other treating provider before authorizing benefits for admission or continued stay.

If the Carelon Clinical Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Carelon Medical Director for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non-authorized case will be communicated both via the Carelon Provider Digital Front Door and telephonically to the provider (refer to Section 8, Complaints, Appeals and Grievances for further information).

Medical Necessity Criteria Is available on Carelon's website and is also available upon request. To order a copy of the ASAM criteria, visit the ASAM website. In addition, Carelon disseminates criteria sets via the websites, provider handbook, provider forums, newsletters, and individual training sessions. Training, reference materials, and decision trees are provided to ensure clinical staff chooses the correct criteria. To determine the proper medical necessity criteria, the following can be used as a guide based on plan type and type of service being requested. If a provider requests a copy of the medical necessity criteria for Carelon, a copy will be provided.

Carelon reviews all requests based on standard industry turnaround time guidelines set by the National Committee for Quality Assurance (NCQA). Clinicians are required to follow determination timeframes, unless more stringent by contract or regulation. In deciding what timeframe applies, the clinician needs to consider the type of review (prospective or concurrent), the urgency of the review (routine or urgent), and the timing of the review (prior to treatment, greater or less than 24 hours before the end of the current authorization or after services have been rendered).

5.02 Discharge Planning

Providers are expected to initiate aftercare/discharge planning at the beginning of service delivery or at the time of admission. Providers are also required to submit the aftercare/ discharge plan as part of the authorization request. Providers are expected to work collaboratively with the participants, parents, legal guardians and/or identified proxies of participants to develop a discharge plan that will provide stability and adequate behavioral health treatment services.

When planning discharge from residential levels of care, providers should work with state Care Coordinators funded by the local systems managers in the participant's county of residence to coordinate transition from residential to community services. Providers should be working towards linking participants to outpatient level services and all needed social determinants (such as housing, community support and employment) in the community throughout the residential stay.

Providers should notify Carelon that discharge has occurred by completing an end date/discharge form in the Provider Digital Front Door. Providers are allowed to discharge their authorizations prior to an authorization's expiration date for specified reasons. The following information may be requested and is required to be documented: Discharge date, aftercare date (i.e., date of first appointment, with whom and where), other treatment resources to be utilized, medications, support systems, EAP linkage if indicated, medical aftercare if indicated, and family/work community preparation.

Providers may need to submit the required DLA-20 and supplemental questions at discharge. Collect any department-required data elements through the use of data capture forms/outcome questionnaires to support federal reporting requirements by the Substance Abuse and Mental Health Services Administration (SAMHSA) and report on outcomes.

5.03 Physical Health Services While in a Psychiatric Hospital

The Managed Care Organization (MCO) is responsible for all non-psychiatric physician or nurse practitioner consultations which are not related to the psychiatric diagnosis.

5.04 Emergency Medical Treatment and Active Labor Act (EMTALA)

When a non-insured participant who needs inpatient care presents at an emergency department of a psychiatric unit, the hospital is required to admit the participant to a bed on the hospital's psychiatric unit if available or arrange for disposition to another inpatient setting as required under the Emergency Medical Treatment and Active Labor Act (EMTALA). (Additional information is available on the Centers for Medicare and Medicaid Services (CMS) website.

The expectation is that participants will be admitted to these facilities without regard to ability to pay. If a person in need of psychiatric inpatient care is in an emergency department without a psychiatric unit, the emergency department will find the bed and coordinate admission to the other facility.

A hospital that has specialized capabilities, or facilities such as psychiatric hospitals, CANNOT refuse to accept an appropriate transfer of an individual (from a hospital in the United States) who requires such specialized capabilities or facilities IF the hospital has the capacity to treat the individual, 42 CFR §489.24(f). This provision applies to any hospital (those that accept Medicare and thus Medicaid) regardless of whether the hospital has a dedicated ED, §489.24(f)(i). The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician and other treatment providers (e.g., substance use disorder treatment) when clinically indicated, with appropriate release of information.

6. MEDICAL NECESSITY CRITERIA AND PROGRAM DESCRIPTION REQUIREMENTS

6.01 Medical Necessity

The state of Maryland's Administrative Services Organization (ASO), Carelon Behavioral Health (Carelon), will make clinical decisions about each participant based on the clinical features of the participant case, the medical necessity criteria, and the resources available.

Under the auspices of the Maryland Department of Health (MDH), Carelon bases its decisions on medical necessity. Medical necessity is met when a participant has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that is able to safely meet the participant's behavioral health and medical needs.

The State of Maryland designated Medical Necessity Criteria can be found in section 6.03 of this manual. Please reference the American Society of Addiction Medicine (ASAM) Criteria (3rd edition) for substance use disorders (SUD).

Annually, Carelon reviews the utilization management (UM) criteria and procedures for applying them and updates the criteria when appropriate. Carelon also involves appropriate providers in developing, adopting, and reviewing criteria.

Permission to treat a minor is required from the legal guardian. Adolescents ages 12 and over may consent to treatment for themselves.

6.02 Affirmative Incentive Statement

Utilization management decision-making is based only on the appropriateness of care as defined by The State of Maryland Medical Necessity Criteria for mental health services and the ASAM, 3rd Edition Criteria for substance use disorder services. Please see section 6.03 of this manual and refer to the Maryland Program Description information for additional guidance and requirements.

All levels of care and coverage determination guidelines are intended to standardize interpretation and application of available benefits, including benefit exclusions or limitations,

Carelon expects all treatment provided to be outcome-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Carelon does not reward its staff, practitioners, or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

6.03 Program Description Requirements

Carelon Behavioral Health Maryland maintains Maryland PBHS Level of Care for both Mental Health and Substance Use Disorder Services that includes the following information, as applicable, by level of care:

- Who is eligible to receive the service
- Who is eligible to provide the service
- Eligibility reminders
- Authorization Reminders
- Service Reminders
- Billing Reminders

Program Description Table of Contents

Please refer to the below Maryland PBHS Program Description information for additional guidance and requirements related to level of care service and authorization requirements. Click on the program description to learn more.

Emergency Department Services	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Services rendered in the emergency department (ED) do not require pre-authorization. ED service providers are expected to collect behavioral health and medical history, exchange information, and coordinate care with the participant's Primary Care Provider (PCP) and other treatment providers (e.g., substance use disorder treatment, mental health treatment, and other health care providers) when clinically appropriate. If the participant in emergency circumstances is thought or known to be eligible for Maryland Developmental Disability Administration (DDA) services, the appropriate regional office in the DDA should be contacted to arrange rapid evaluation (where available), and to delineate service options. This is a service reimbursable only for participants with Medicaid. • The Maryland Public Behavioral Health System (PBHS) does not cover services for participants presenting at an ED whose primary diagnosis is not a PBHS-covered diagnosis. A list of PBHS covered diagnoses is available on the Carelon website.
Provider Eligibility (Who is Eligible to Provide this Service?)	• EDs regulated by the state of Maryland are eligible providers. Out-of-state EDs are required to enroll with Medicaid.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participants • Dual participants (Medicare/Medicaid) • Uninsured eligible participants • Emergency Petition
Claims Submission (What is Required to Submit a Claim for this Service?)	• Claims are required to be submitted on a CMS 1500 form or UB-04 form with appropriate billing codes and with a specified ICD-10 code for reimbursement. Once the service has been delivered, claims should be sent to Carelon Behavioral Health. Reimbursement for ED services pertaining to medical diagnoses for participants enrolled in HealthChoice is the responsibility of the Managed Care Organization (MCO) in which the participant is enrolled. • Mental health and poisoning diagnosis for the professional and facility charges: for SUD, Carelon Behavioral Health is only responsible for the facility charge. The professional fee remains the responsibility of the MCO or Fee for Service (FFS) if not enrolled in an MCO.

Emergency Crisis Services

Behavioral Health Crisis Stabilization Center (BHCSC)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	A BHCSC is a facility-based outpatient service offering de-escalation, stabilization, assessment, intervention, and referral for up to 24 hours for individuals experiencing a behavioral health crisis. The service manages the full array of behavioral health emergencies including alcohol and substance abuse, symptoms of mental illness, and emotional distress. Individuals receive immediate walk-in services regardless of the ability to pay. This service is intended to provide the least restrictive environment for individuals at risk for emergency department visits, hospitalization, and incarceration.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.21 • COMAR 10.09.16
Provider Eligibility (Who is Eligible to Provide this Service?)	• Eligible providers are required to meet the licensing requirements of COMAR 10.63.21 and Medicaid COMAR 10.09.16 to qualify to operate this service.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP as Provider Type (PT) CF
Participant Eligibility (Who is Eligible to Receive this Service?)	• Participants are eligible for behavioral health crisis stabilization center services if they experience a behavioral health crisis. Individuals receive services regardless of insurance status (Medicaid, Medicare, commercial insurance, uninsured) or ability to pay.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• BHCSC services do not require prior authorization. However, in order to bill for services, providers need to gather appropriate claims processing information and will need to register participants in the PBHS. • Services are limited to a single admission episode of less than 24 hours. The second day would be a second admission.
Claims Submission (What is Required to Submit a Claim for this Service?)	• Claims are submitted electronically through Carelon (837), or through submission of a HCFA 1500. Medicare claims should be submitted directly to Medicaid with crossover to Medicaid, not the ASO, for individuals who are dually eligible. • Claims for services to participants qualifying for state Uninsured coverage is submitted to the ASO, Carelon • Billable services include medically necessary services for an episode of less than 24 hours. Providers may bill one S9485 code and one E&M code with the UC (crisis) modifier per participant admission. • For an E&M rendered via telehealth, providers need to utilize either the GT (audio-visual) or UB (audio-only) modifier.

Behavioral Health Crisis Stabilization Center (BHCSC)	
Service Name	**Notes**

Claims Submission *continued*	Third Party Liability/Coordination of Benefits
	• For participants who are Medicaid eligible and have commercial coverage, the provider should bill Medicaid for the S9485 code and commercial for the E&M code.
	  ○ Commercial insurance does not currently cover the S9485 service equivalent but does cover E&M codes
	• For participants who are dual Medicaid and Medicare eligible, providers should bill Medicaid for the S9485 code and Medicare for the E&M code.
	  ○ Medicare does not cover the S9485 service equivalent but does cover E&M codes
	• For participants who are Medicare eligible only, providers should bill through state uninsured fund for the S9485 code and Medicare for the E&M code.
	• For participants who have commercial insurance only, providers should bill through state uninsured fund for the S9485 code and commercial insurance for the E&M code.
	• For participants without any insurance coverage, providers should bill both S9485 code and E&M code through the state uninsured fund.

Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• BHCSC is designed to provide less than 24 hours of service, with further referral to outpatient, crisis residential and inpatient services, as necessary.

Emergency Crisis Services

Mobile Crisis Team (MCT)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	MCT is a community-based service offering de-escalation, stabilization, assessment, intervention, referral and follow up to individuals experiencing urgent symptoms or behaviors that are interrupting their behavioral health functioning. The service is available 24 hours per day, 365 days a year to individuals of all ages. This service consists of an in-person response by a team of at least two participants and requires a licensed mental health professional (LMHP) to render services as one of the 2 in-person team participants or by telehealth as a third team participant.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.20 • COMAR 10.09.16
Provider Eligibility (Who is Eligible to Provide this Service?)	• Eligible providers are required to meet the licensing requirements of COMAR 10.63 and Medicaid COMAR 10.09.16 to qualify to operate this service. • This service is limited to providers selected at the local jurisdiction level by the relevant Local Behavioral Health Authority (LBHA) or CSA. • Accreditation from a Maryland-approved accreditation organization authorized to approve this service. Currently, these accreditation organizations are The Joint Commission and CARF. • Providers obtain an Agreement to Cooperate with the local jurisdiction in which they are operating the service.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP as Provider Type (PT) MS
Participant Eligibility (Who is Eligible to Receive this Service?)	• Participants are eligible for mobile crisis services if currently experiencing a behavioral health crisis. Individuals receive services regardless of insurance status (Medicaid, Medicare, commercial, uninsured) or ability to pay. Services may be dispatched at the request of concerned family or community participants.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** Initial (H2011) Mobile Crisis services do not require prior authorization. However, in order to bill for services, providers need to gather appropriate claims processing information and will need to register participants in the PBHS. All follow-up outreach services (H2015) requested are auto authorized for up to 16 hours (64 units) for 14 days. Only one authorization for this service is allowable per each mobile crisis service (H2011) episode.

Mobile Crisis Team (MCT)	
Service Name	**Notes**
Claims Submission (What is Required to Submit a Claim for this Service?)	• Claims are submitted electronically through Carelon (837), or through submission of a HCFA 1500. Medicare claims should be submitted directly to Medicaid with crossover to Medicaid for individuals who are dually eligible. Services to participants qualifying for state Uninsured coverage are submitted to the ASO, Carelon. • Allowable POS - For initial visit = POS 15. For follow up = 15, 11, 12 • Medicare should be billed before the PBHS is billed. Medicare claims crossover to Medicaid and are not handled by Carelon. • Claims may only be submitted for services that were actually delivered. If no contact is made with the participant this service is not eligible for reimbursement. **Criteria** Billable services include: • H2011 Mobile crisis team services per 15-minute increment Max 32 units per day • H2015 Mobile crisis follow-up outreach per 15-minute increment Max 32 units per day Visit the Carelon website for Behavioral Health Crisis Services Fee Schedule for reimbursement rate information Third Party Liability/Coordination of Benefits • For participants who are Medicaid eligible and have commercial insurance coverage, the provider should bill Medicaid for the H2011 and H2015 codes. ○ Commercial insurance does not currently cover mobile crisis services • For participants who are dual Medicaid and Medicare eligible, providers should follow Medicare COB process for cross over billing. • For participants who are Medicare eligible only, providers should bill Medicare directly. • For participants who have commercial insurance only, providers should bill through state uninsured fund. • For participants without any insurance coverage, providers should bill through the state uninsured fund.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• MCT is required to refer participants as appropriate to follow up non-crisis services including outpatient, Behavioral Health Crisis Stabilization Center, crisis residential, and inpatient services, as necessary.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. Daily evaluations by a psychiatrist, 24-hour skilled psychiatric nursing care, medical evaluation, and structured milieu are required. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition. Typically, the individual is in imminent danger to self or others; is grossly impaired; and/or behavioral or medical care needs are unmanageable at any available lower level of care. Active family involvement is important unless clinically contraindicated. The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each participant, including comorbidities, safety and supportiveness of the participant's environment, and the unique needs and vulnerabilities of children and adolescents.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.92 (Acute Hospitals)
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include: • Hospitals licensed as an acute hospital and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP
Participant Eligibility (Who is Eligible to Receive this Service?)	An individual is eligible for MH Inpatient AC services if the individual is a Medicaid Participant. Providers treating uninsured individuals are encouraged to request courtesy reviews. When participants have a mental health crisis that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs. Acute inpatient psychiatric treatment is defined as a 24-hour inpatient level of care that provides highly skilled psychiatric services to adults with severe mental disorders. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Admission Criteria	**Inpatient - General Adult and Child/Adolescent** The following criteria is necessary for admission. A-C below must be met: A. The participant must have a diagnosed or suspected mental health crisis that can be expected to improve significantly through medically necessary treatment. B. The evaluation and assignment of the mental disorder diagnosis must take place in a face-to-face evaluation of the participant performed by an attending physician prior to, or within 24 hours, following the admission. C. Presence of the disorder(s) must be documented through the assignment of a DSM-5 code for the primary diagnosis, except for the diagnoses included in Appendix A (appended). **Severity of Need and Intensity of Service at the Acute Level of Care** Criterion A must be met. In addition, B, C, D, or E must be met: A. PBHS specialty mental health DSM-5 diagnosis. B. The participant makes dire threats or there is a clear and reasonable inference of serious harm to him or herself, where suicidal precautions or observations on a 24-hour basis are required. C. The participant demonstrates violent, unpredictable, or uncontrolled behavior which represents potential serious harm to him or herself or others or there is reasonable inference of harm to self or others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24-hour basis. D. The participant demonstrates severe psychiatric symptoms which cannot be safely treated in an outpatient setting or which are not able to be successfully treated in a lower level of care due to their severity. This care must require an individual plan of active psychiatric treatment which includes 24-hour need for, and access to, the full spectrum of psychiatric staffing and services. E. Where diagnostic assessment or treatment are not available or are unsafe on an outpatient basis (e.g., participant needs somatic treatment, such as electroconvulsive therapy or medication management that can only be safely accomplished in a hospital setting with 24-hour psychiatric and nursing care). **Continuing Stay Criteria** The individualized treatment plan should include documentation of diagnosis (DSM-5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Admission Criteria Continued	In addition to continuing to meet the criteria given above for admission, and continued evidence of active treatment, one of the criteria A-C, and D must be met for continued stay: a) Clinical evidence indicates that the persistence of the problems that caused the admission to the degree which would necessitate continued hospitalization, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree which would necessitate continued hospitalization. b) There is clinical evidence that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. c) There is clinical evidence that disposition planning, progressive increases in hospital privileges, and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. d) There is clinical evidence of symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered. **Inpatient - Acute Neurobehavioral Unit** Admission Criteria All of the following criteria are necessary for admission: • The participant must have a diagnosed or suspected mental disorder/ serious emotional disturbance, with maladaptive behaviors or symptoms relating to that disorder. • The participant's symptoms and/or behaviors can be expected to improve significantly through medically necessary treatment. Symptoms and/or behaviors that are not improving or likely to improve are considered habilitative and do not meet admission criteria. • The evaluation and assignment of the mental disorder/serious emotional disturbance must take place by a face-to-face evaluation of the participant and performed by an attending physician prior to, or within 24 hours following an admission • Presence of a mental disorder/serious emotional disturbance must be documented through the assignment of DSM 5 codes **Continuing Stay Criteria** The individual treatment plan should include documentation of diagnosis (DSM 5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Admission Criteria Continued	All of criteria a, b and c must be met. met. Evidence must also exist for meeting at least one of criteria d-f a. The participant continues to meet admission criteria despite treatment efforts. b. There is clinical evidence of symptom improvement or behavior reduction using the service. If there has been no improvement, the treatment plan has been reviewed and/or a second opinion of the treatment plan has been obtained. Lack of evidence of improvement or behavior reduction is grounds for reconsideration of admission and reassessment of habilitative nature of symptomatology. c. There is documented evidence that disposition planning, including plans to train after-care providers (home, school etc.) on behavioral strategies and interventions, is begun from the time of admission and continues throughout the hospitalization. d. The targeted outcome of 75 percent reduction in seriously unsafe behaviors has not yet been reached. e. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. f. The emergence of additional problems or behaviors which are consistent with the admission criteria and to the degree that would necessitate continued hospitalization. **Discharge Criteria** Any of the following criteria are sufficient for discharge from this level of care: ● Reduction of targeted behaviors (those which led to hospitalization) by 75 percent. ● Extended lack of evidence of improvement or behavior reduction despite multiple re-evaluations of treatment plan and second opinions. Per admission criterion, needs to be re-assessed to determine if symptomatology is habilitative in nature. ● Identification of a safe, continuing care program which can be arranged and deployed at a lower level of care. Follow-up aftercare should continue to further develop and implement behavioral treatment plans developed on the neurobehavioral unit. Development of such a treatment plan and basic training of primary caretakers is sufficient for discharge. ● The participant no longer meets admission criteria or meets criteria for a less intensive level of care.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** Delivery of MH Inpatient Hospital Psychiatric Services requires prior authorization to ensure medical necessity for services being rendered and includes the following required clinical information: the participant's current need for treatment, precipitating event(s), treatment history, medications, substance use history, medical history, and risk assessment. **Criteria** • Providers are expected to submit the authorization request with supporting clinical information the day of admission, but no later than 24 hours, or one calendar day from date of admission. • Crisis services, hospital diversion programs, or CSA or LBHA crisis response systems will be explored prior to admission, when applicable, and available in the area. • Concurrent authorization requests should be submitted via Provider Connect with supporting clinical information on the first uncovered day. For example, after an initial authorization span of March 1st to March 4th, if needed, the continued stay request should be submitted on March 4th. • For voluntary admissions, both the clinician and Participant must sign the application. • For involuntary admissions, the doctor treating the Participant and a second doctor must sign the application. • A courtesy review can be requested for uninsured participants.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • During an Inpatient stay, the Maryland PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant. • Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland PBHS for one history and physical per admission; authorization is not required. **Criteria** • Providers shall comply with the ASO Billing Manual for the submission and payment of claims **Restrictions** • Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric IP day is covered. An additional authorization for professional fees is not needed. Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric IP unit and requires discharge to a nursing home or residential treatment center; however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized IP day.

Mental Health Inpatient Hospital Psychiatric Services – PT01 Acute Hospitals	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Providers are expected to initiate discharge planning at the beginning of service delivery. A preliminary discharge plan should be included with the authorization request, and subsequent discharge plans with each concurrent review (if applicable). • Providers are responsible for entering a finalized and collaboratively agreed upon (by the participant and treating provider) discharge plan when the participant completes treatment. The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1st at 11:45 p.m., March 1st is a covered day. If the participant is discharged on March 4th at 4:00 p.m., March 4th is not a reimbursable day. March 3rd would be considered the last day covered.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. Daily evaluations by a psychiatrist, 24-hour skilled psychiatric nursing care, medical evaluation, and structured milieu are required. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition. Typically, the individual is in imminent danger to self or others; is grossly impaired; and/or behavioral or medical care needs are unmanageable at any available lower level of care. Active family involvement is important unless clinically contraindicated. The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each participant, including comorbidities, safety and supportiveness of the participant's environment, and the unique needs and vulnerabilities of children and adolescents.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.95 (Special Psychiatric Hospitals)
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include: • Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP
Participant Eligibility (Who is Eligible to Receive this Service?)	An individual is eligible for MH Inpatient AC services if the individual is a Medicaid Participant. Providers treating uninsured individuals are encouraged to request courtesy reviews. When participants have a mental health crisis that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs. Acute inpatient psychiatric treatment is defined as a 24-hour inpatient level of care that provides highly skilled psychiatric services to adults with severe mental disorders. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Participant Eligibility continued	Admission and or under 30 days for adolescents up to 21 years of age and/or 65 years and older upon admission. Please refer to PT07 for stay over 30 days for adolescents and ages 65+.
Admission Criteria	**Inpatient - General Adult and Child/Adolescent** The following criteria is necessary for admission. A-C below must be met: A. The participant must have a diagnosed or suspected mental health crisis that can be expected to improve significantly through medically necessary treatment. B. The evaluation and assignment of the mental disorder diagnosis must take place in a face-to-face evaluation of the participant performed by an attending physician prior to, or within 24 hours, following the admission. C. Presence of the disorder(s) must be documented through the assignment of a DSM-5 code for the primary diagnosis, except for the diagnoses included in Appendix A (appended). **Severity of Need and Intensity of Service at the Acute Level of Care** Criterion A must be met. In addition, B, C, D, or E must be met: A. PBHS specialty mental health DSM-5 diagnosis. B. The participant makes dire threats or there is a clear and reasonable inference of serious harm to him or herself, where suicidal precautions or observations on a 24-hour basis are required. C. The participant demonstrates violent, unpredictable, or uncontrolled behavior which represents potential serious harm to him or herself or others or there is reasonable inference of harm to self or others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24-hour basis. D. The participant demonstrates severe psychiatric symptoms which cannot be safely treated in an outpatient setting or which are not able to be successfully treated in a lower level of care due to their severity. This care must require an individual plan of active psychiatric treatment which includes 24-hour need for, and access to, the full spectrum of psychiatric staffing and services. E. Where diagnostic assessment or treatment are not available or are unsafe on an outpatient basis (e.g., participant needs somatic treatment, such as electroconvulsive therapy or medication management that can only be safely accomplished in a hospital setting with 24-hour psychiatric and nursing care). **Continuing Stay Criteria** The individualized treatment plan should include documentation of diagnosis (DSM-5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Admission Criteria Continued	In addition to continuing to meet the criteria given above for admission, and continued evidence of active treatment, one of the criteria A-C, and D must be met for continued stay: A. Clinical evidence indicates that the persistence of the problems that caused the admission to the degree which would necessitate continued hospitalization, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree which would necessitate continued hospitalization. B. There is clinical evidence that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. C. There is clinical evidence that disposition planning, progressive increases in hospital privileges, and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. D. There is clinical evidence of symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered. **Inpatient - Acute Neurobehavioral Unit** Admission Criteria All of the following criteria are necessary for admission: • The participant must have a diagnosed or suspected mental disorder/ serious emotional disturbance, with maladaptive behaviors or symptoms relating to that disorder. • The participant's symptoms and/or behaviors can be expected to improve significantly through medically necessary treatment. Symptoms and/or behaviors that are not improving or likely to improve are considered habilitative and do not meet admission criteria. • The evaluation and assignment of the mental disorder/serious emotional disturbance must take place by a face-to-face evaluation of the participant and performed by an attending physician prior to, or within 24 hours following an admission • Presence of a mental disorder/serious emotional disturbance must be documented through the assignment of DSM 5 codes **Continuing Stay Criteria** The individual treatment plan should include documentation of diagnosis (DSM 5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Admission Criteria Continued	All of criteria a, b and c must be met. met. Evidence must also exist for meeting at least one of criteria d-f a. The participant continues to meet admission criteria despite treatment efforts. b. There is clinical evidence of symptom improvement or behavior reduction using the service. If there has been no improvement, the treatment plan has been reviewed and/or a second opinion of the treatment plan has been obtained. Lack of evidence of improvement or behavior reduction is grounds for reconsideration of admission and reassessment of habilitative nature of symptomatology. c. There is documented evidence that disposition planning, including plans to train after-care providers (home, school etc.) on behavioral strategies and interventions, begins from the time of admission and continues throughout the hospitalization. d. The targeted outcome of 75 percent reduction in seriously unsafe behaviors has not yet been reached. e. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. f. The emergence of additional problems or behaviors which are consistent with the admission criteria and to the degree that would necessitate continued hospitalization. **Discharge Criteria** Any of the following criteria are sufficient for discharge from this level of care: • Reduction of targeted behaviors (those which led to hospitalization) by 75 percent. • Extended lack of evidence of improvement or behavior reduction despite multiple re-evaluations of treatment plan and second opinions. Per admission criterion, needs to be re-assessed to determine if symptomatology is habilitative in nature. • Identification of a safe, continuing care program which can be arranged and deployed at a lower level of care. Follow-up aftercare should continue to further develop and implement behavioral treatment plans developed on the neurobehavioral unit. Development of such a treatment plan and basic training of primary caretakers is sufficient for discharge. • The participant no longer meets admission criteria or meets criteria for a less intensive level of care.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** Delivery of MH Inpatient Hospital Psychiatric Services requires prior authorization to ensure medical necessity for services being rendered and includes the following required clinical information: the participant's current need for treatment, precipitating event(s), treatment history, medications, substance use history, medical history, and risk assessment.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Authorization Process Continued	**Criteria** • Providers are expected to submit the authorization request with supporting clinical information the day of admission, but no later than 24 hours, or one calendar day from date of admission. • Crisis services, hospital diversion programs, or CSA or LBHA crisis response systems will be explored prior to admission, when applicable, and available in the area. • Concurrent authorization requests should be submitted via Provider Connect with supporting clinical information on the first uncovered day. For example, after an initial authorization span of March 1st to March 4th, if needed, the continued stay request should be submitted on March 4th. • For voluntary admissions, both the clinician and Participant must sign the application. • For involuntary admissions, the doctor treating the Participant and a second doctor must sign the application. • A courtesy review can be requested for uninsured participants.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • During an Inpatient stay, the Maryland PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant. • Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland PBHS for one history and physical per admission; authorization is not required. **Criteria** • Providers shall comply with the ASO Billing Manual for the submission and payment of claims **Restrictions** • Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric IP day is covered. An additional authorization for professional fees is not needed. Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric IP unit and requires discharge to a nursing home or residential treatment center; however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized IP day.

Mental Health Inpatient Hospital Psychiatric Services – PT06 Psychiatric Hospital (IMD)	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	Providers are expected to initiate discharge planning at the beginning of service delivery. A preliminary discharge plan should be included with the authorization request, and subsequent discharge plans with each concurrent review (if applicable). Providers are responsible for entering a finalized and collaboratively agreed upon (by the participant and treating provider) discharge plan when the participant completes treatment. The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1 at 11:45 p.m., March 1 is a covered day. If the participant is discharged on March 4 at 4 p.m., March 4 is not a reimbursable day. March 3 would be considered the last day covered.

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. Daily evaluations by a psychiatrist, 24-hour skilled psychiatric nursing care, medical evaluation, and structured milieu are required. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition. Typically, the individual is in imminent danger to self or others; is grossly impaired; and/or behavioral or medical care needs are unmanageable at any available lower level of care. Active family involvement is important unless clinically contraindicated. The following criteria are intended as a guide for establishing medical necessity for the requested level of care. They are not a substitute for clinical judgment and should be applied by appropriately trained clinicians giving consideration to the unique circumstances of each participant, including comorbidities, safety and supportiveness of the participant's environment, and the unique needs and vulnerabilities of children and adolescents.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.95 (Special Psychiatric Hospitals)
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include: • Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP
Participant Eligibility (Who is Eligible to Receive this Service?)	An individual is eligible for MH Inpatient AC services if the individual is a Medicaid Participant. Providers treating uninsured individuals are encouraged to request courtesy reviews. Up to 21 years of age and/or 65 years and older upon admission. When participants have a mental health crisis that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs. Acute inpatient psychiatric treatment is defined as a 24-hour inpatient level of care that provides highly skilled psychiatric services to adults with severe mental disorders. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Admission Criteria	**Inpatient - General Adult and Child/Adolescent** The following criteria is necessary for admission. A-C below must be met: A. The participant must have a diagnosed or suspected mental health crisis that can be expected to improve significantly through medically necessary treatment. B. The evaluation and assignment of the mental disorder diagnosis must take place in a face-to-face evaluation of the participant performed by an attending physician prior to, or within 24 hours, following the admission. C. Presence of the disorder(s) must be documented through the assignment of a DSM-5 code for the primary diagnosis, except for the diagnoses included in Appendix A (appended). **Severity of Need and Intensity of Service at the Acute Level of Care** Criterion A must be met. In addition, B, C, D, or E must be met: A. PBHS specialty mental health DSM-5 diagnosis. B. The participant makes dire threats or there is a clear and reasonable inference of serious harm to him or herself, where suicidal precautions or observations on a 24-hour basis are required. C. The participant demonstrates violent, unpredictable, or uncontrolled behavior which represents potential serious harm to him or herself or others or there is reasonable inference of harm to self or others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24-hour basis. D. The participant demonstrates severe psychiatric symptoms which cannot be safely treated in an outpatient setting or which are not able to be successfully treated in a lower level of care due to their severity. This care must require an individual plan of active psychiatric treatment which includes 24-hour need for, and access to, the full spectrum of psychiatric staffing and services. E. Where diagnostic assessment or treatment are not available or are unsafe on an outpatient basis (e.g., participant needs somatic treatment, such as electroconvulsive therapy or medication management that can only be safely accomplished in a hospital setting with 24-hour psychiatric and nursing care). **Continuing Stay Criteria** The individualized treatment plan should include documentation of diagnosis (DSM-5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment. In addition to continuing to meet the criteria given above for admission, and continued evidence of active treatment, one of the criteria A-C, and D must be met for continued stay:

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Admission Criteria Continued	A. Clinical evidence indicates that the persistence of the problems that caused the admission to the degree which would necessitate continued hospitalization, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree which would necessitate continued hospitalization. B. There is clinical evidence that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. C. There is clinical evidence that disposition planning, progressive increases in hospital privileges, and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization. D. There is clinical evidence of symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered. **Inpatient - Acute Neurobehavioral Unit** Admission Criteria All of the following criteria are necessary for admission: • The participant must have a diagnosed or suspected mental disorder/ serious emotional disturbance, with maladaptive behaviors or symptoms relating to that disorder. • The participant's symptoms and/or behaviors can be expected to improve significantly through medically necessary treatment. Symptoms and/or behaviors that are not improving or likely to improve are considered habilitative and do not meet admission criteria. • The evaluation and assignment of the mental disorder/serious emotional disturbance must take place by a face-to-face evaluation of the participant and performed by an attending physician prior to, or within 24 hours following an admission • Presence of a mental disorder/serious emotional disturbance must be documented through the assignment of DSM 5 codes **Continuing Stay Criteria** The individual treatment plan should include documentation of diagnosis (DSM 5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There should be daily progress notes documenting the provider's treatment and the participant's response to treatment. All of criteria a, b and c must be met. met. Evidence must also exist for meeting at least one of criteria d-f a. The participant continues to meet admission criteria despite treatment efforts.

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Admission Criteria Continued	b. There is clinical evidence of symptom improvement or behavior reduction using the service. If there has been no improvement, the treatment plan has been reviewed and/or a second opinion of the treatment plan has been obtained. Lack of evidence of improvement or behavior reduction is grounds for reconsideration of admission and reassessment of habilitative nature of symptomatology. c. There is documented evidence that disposition planning, including plans to train after-care providers (home, school etc.) on behavioral strategies and interventions, is begun from the time of admission and continues throughout the hospitalization. d. The targeted outcome of 75 percent reduction in seriously unsafe behaviors has not yet been reached. e. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. f. The emergence of additional problems or behaviors which are consistent with the admission criteria and to the degree that would necessitate continued hospitalization. **Discharge Criteria** Any of the following criteria are sufficient for discharge from this level of care: • Reduction of targeted behaviors (those which led to hospitalization) by 75 percent. • Extended lack of evidence of improvement or behavior reduction despite multiple re-evaluations of treatment plan and second opinions. Per admission criterion, needs to be re-assessed to determine if symptomatology is habilitative in nature. • Identification of a safe, continuing care program which can be arranged and deployed at a lower level of care. Follow-up aftercare should continue to further develop and implement behavioral treatment plans developed on the neurobehavioral unit. Development of such a treatment plan and basic training of primary caretakers is sufficient for discharge. • The participant no longer meets admission criteria or meets criteria for a less intensive level of care.

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** Delivery of MH Inpatient Hospital Psychiatric Services requires prior authorization to ensure medical necessity for services being rendered and includes the following required clinical information: the participant's current need for treatment, precipitating event(s), treatment history, medications, substance use history, medical history, and risk assessment. **Criteria** • Providers are expected to submit the authorization request with supporting clinical information the day of admission, but no later than 24 hours, or one calendar day from date of admission. • Crisis services, hospital diversion programs, or CSA or LBHA crisis response systems will be explored prior to admission, when applicable, and available in the area. • Concurrent authorization requests should be submitted via Provider Connect with supporting clinical information on the first uncovered day. For example, after an initial authorization span of March 1st to March 4th, if needed, the continued stay request should be submitted on March 4th. • For voluntary admissions, both the clinician and Participant must sign the application. • For involuntary admissions, the doctor treating the Participant and a second doctor must sign the application. • A courtesy review can be requested for uninsured participants.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • During an Inpatient stay, the Maryland PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant. • Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland PBHS for one history and physical per admission; authorization is not required. **Criteria** • Providers shall comply with the ASO Billing Manual for the submission and payment of claims **Restrictions** • Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric IP day is covered. An additional authorization for professional fees is not needed. Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric IP unit and requires discharge to a nursing home or residential treatment center; however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized IP day.

Mental Health Inpatient Hospital Psychiatric Services – PT07 Psychiatric Long-Term Hospital for Adolescents	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	Providers are expected to initiate discharge planning at the beginning of service delivery. A preliminary discharge plan should be included with the authorization request, and subsequent discharge plans with each concurrent review (if applicable). Providers are responsible for entering a finalized and collaboratively agreed upon (by the participant and treating provider) discharge plan when the participant completes treatment. The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1 at 11:45 p.m., March 1 is a covered day. If the participant is discharged on March 4 at 4 p.m., March 4 is not a reimbursable day. March 3 would be considered the last day covered.
Additional Information	• Prior to payment, the state of Maryland requires Carelon Behavioral Health to review all claims for inpatient services at Psychiatric (IMD) and RTCs to determine if a long-term care span has been properly established. A long-term care span is required when the participant meets the state's definition of an institutionalized participant. In general, a participant becomes institutionalized when he/she is admitted to a facility for more than one calendar month. The span is specific to the facility, participant, and the time period of the admission. The long-term care span allows the state to establish Long Term Eligibility. Most participants will become a "family of one" when the definition of institutionalization is met. The state may determine that renewable assets exist and that a "share amount" should be deducted from each monthly payment. It is the Facility's responsibility to collect the Monthly Share Amount from the source. To establish a long-term care span, the Psychiatric (IMD) or RTC is required to complete the Long-Term Care Application and OES 1000 and send to the MDH Waiver unit and a copy of the OES to the MDH Health Choice Unit.

Electroconvulsive Therapy (ECT)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Principles for Medical Necessity Criteria** Electroconvulsive therapy (ECT) is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The participant receiving treatment is placed under general anesthesia and muscle relaxants are given to prevent body spasms. The ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). The number of sessions undertaken during a course of ECT usually ranges from six to 12. ECT is most commonly performed at a schedule of three times per week. Continuation and maintenance ECT are most commonly administered at one- to four-week intervals. The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific participant. This analysis considers the diagnosis of the participant and the severity of the presenting illness, the participant's treatment history, the necessary speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT. ECT can be safely administered at multiple levels of care including the outpatient setting. The least restrictive setting possible should be utilized. The medical necessity criteria for the requested setting should be utilized to determine level of care for delivery of the ECT. The medical necessity determination for ECT should be independent of the determination for the level of care. A medical necessity review should be done for the appropriateness of ECT. A separate medical necessity review should be done for the appropriateness of level of care based on the applicable criteria (e.g., inpatient, outpatient, etc.). ECT should not be given at a higher level of care solely for convenience, due to dispositional factors, transportation issues, or due to provider protocols unless medical necessity is independently established for that level of care. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Electroconvulsive Therapy (ECT)	
Service Name	**Notes**
Admission Criteria	The following criterion is necessary for admission: • The participant has been evaluated by a licensed psychiatrist and demonstrates severe symptomatology consistent with a DSM 5 primary diagnosis of major depression, bipolar disorder, mania, schizophrenia, or related psychotic disorder, which requires, and can reasonably be expected to, respond to ECT. • In addition, one of the following (1-3) are required to be present: 1. The participant has the immediate need for a rapid or high probability of response due to the existence of severe unstable medical illness or significant risk to him or herself or other and other somatic treatments would potentially put the participant at significant risk due to the slower onset of action. 2. The participant has failed to respond to at least two adequate trials of pharmacotherapy. 3. The participant is at significant risk of relapse or reoccurrence of a major mental illness that was successfully treated with ECT in the past. **Exclusion Criteria** One of the following criteria (1-2) is sufficient for exclusion from this level of care: 1. The participant can be safely maintained and effectively treated with a less intrusive therapy 2. Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific participant from this level of care. Such conditions include but are not limited to: a. Unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease b. Aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure c. Increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions d. Recent cerebral infarction e. Pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia f. Anesthetic risk rated as American Society of Anesthesiologists level 4 or 5 **Continued Stay Criteria** Continued Stay Criteria All of the following criteria (1-10) are necessary for continuing treatment:

Electroconvulsive Therapy (ECT)	
Service Name	**Notes**
Admission Criteria Continued	1. Treatment planning is individualized and appropriate to the participant's changing condition with realistic and specific goals and objectives stated. This process should actively involve family, guardian, and/or other natural support systems unless contraindicated. 2. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice. 3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved; or adjustments in the treatment plan to address lack of progress evident. 4. Care is rendered in a clinically appropriate manner and focused on the participant's behavioral and functional outcomes as described in the discharge plan. The provider documents that there is careful monitoring of mood, psychosis, cognitive factors, and physical symptoms between treatments. 5. The total number of treatments administered should be a function of both the degree and rate of clinical improvement and the severity of adverse side effects. The typical course of treatment is between six to 12 sessions. In the absence of significant clinical improvement after six to10 sessions, the indication for continued ECT should be reassessed. Partial response needs to be evident to extend authorization beyond 10 sessions. 6. The participant is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition. 7. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as the treatment plan requires or there are active efforts being made and documented to involve them. 8. A thorough evaluation of the use of any psychopharmacological agents has been completed. This could include the concurrent use of medications or the requirement for discontinuation. 9. There is documented active discharge planning from the beginning of treatment. 10. There is documented active coordination of care with other behavioral health providers, the PCP, and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue. **Discharge Criteria** Any of the following criteria (1-5) is sufficient for discharge from this level of care: 1. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed.

Electroconvulsive Therapy (ECT)	
Service Name	**Notes**
Admission Criteria Continued	2. The participant, family, and/or legal guardian is competent but not engaged in treatment or in following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues. 3. Consent for treatment is withdrawn and, it has been determined that involuntary ECT treatment is not a valid legal option. 4. The participant is not making progress toward treatment goals, and there is no reasonable expectation of progress, nor is ECT required to maintain the current level of functioning. 5. The participant's physical or psychiatric condition necessitates discontinuation of ECT.

Residential Treatment Center (RTC)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Introduction** • A RTC is defined as a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting. RTCs offer 24-hour care focused on maximizing a participant's development of appropriate living skills. This is a very intense level of care and can only be provided when therapeutic services available in the community are insufficient or have failed to address the participant's behavioral health needs. **Services Provided** • Patient supervision, assessment, screening, evaluation including psychiatric evaluation, psychological testing, and individual treatment plan; ward activities; individual, group and family treatment; patient and family education; medication management; treatment planning; case management; placement and aftercare/discharge planning. • Services are provided by a coordinated multi-interdisciplinary treatment team that addresses daily living skills within a group setting; family involvement in treatment to the greatest extent possible, restoration of family functioning; and any other specialized areas that the individualized diagnostic and treatment process reveals is necessary for the patient and family. • RTC also provides a comprehensive educational program that includes general, special education, pre-career, and technology instruction consistent with COMAR 13A.05.01-Provision of a Free Appropriate Public Education and COMAR 13A.09.09 Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities. **CPT/Revenue Codes** 100, 101
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.07.04 • COMAR 10.09.29 • COMAR 10.24.07 • COMAR 13A.05.01 • COMAR 13A.09.09
Provider Eligibility (Who is Eligible to Provide this Service?)	• All RTCs must have a Maryland or other state license to provide residential treatment center services. • The RTC must also have an active Maryland Medicaid provider number.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via Maryland ePREP as Provider Type (PT) 88

Residential Treatment Center (RTC)	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participants under the age of 21 • Some participants with a private insurance carrier may find it necessary to seek Medicaid when fiscal or time period limitations on their private policies have been exhausted. These participants will be reviewed at the time of the application for Medicaid. • Prior to admission to an RTC, the participant should be referred to their CSA for possible diversion services. The result of this review should determine if community services can meet the required level of treatment or if the participant should be referred for the RTC level of care.
Admission Criteria	Medical necessity for admission to an RTC level of care must be documented by the presence of all the criteria given below in Severity of Need and Intensity of Service. The child or adolescent must have a mental health disorder amenable to active clinical treatment. The evaluation and assignment of a DSM 5 diagnosis must result from a face-to-face psychiatric evaluation. **Continuing Stay Criteria** In addition to meeting all of the admission criteria on a continuing basis, and continued evidence of active treatment, criteria below must be met to satisfy the criteria for continued medical necessity for RTC: • There must be evidence of the need for continued support 24 hours per day, seven days a week due to the degree of functional and/or behavioral health impairment. • There is clinical evidence that the child or adolescent can continue to make measurable progress in the program, as demonstrated by a further reduction in psychiatric symptoms, or acquire requisite strengths in order to be transitioned from the program or moved to a less restrictive level of care. • There must be a reasonable expectation by the family and treating clinician that if treatment services as currently provided in the plan of care were withdrawn, the child or adolescent's condition would deteriorate, relapse further, or require a move to a more restrictive level of care. • For youth served in an RTC short-term, therapeutic visits home with the purpose of testing treatment efficacy and supporting the goal of eventual family reunification are not, in and of themselves, to be considered grounds for a denial of continued stay. However, therapeutic passes to home are to be considered an indicator of upcoming discharge to home.

Residential Treatment Center (RTC)	
Service Name	**Notes**
Admission Criteria continued	**Service Delivery** • The child or adolescent has a PBHS specialty mental health DSM 5 diagnosis. • There must be clinical evidence the child or adolescent has: o A serious emotional disturbance (for children under 18) o A serious mental illness (for youth over age 18 but not yet 22) • Due to the serious emotional disturbance or serious mental illness, the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to him or herself or others, across settings, including the home, school, and community. The serious harm does not necessarily have to be of an imminent nature. The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment. • The child or adolescent requires services and supports to be available 24 hours a day, seven days a week to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational and therapeutic services; and to develop the adaptive and functional behaviors that will allow him or her to remain successfully in the home and community and regularly attend and participate in work, school, or training. In particular, the child or adolescent requires the availability of crisis and/or mental health services 24 hours a day, seven days a week, with flexible scheduling and availability of other services and supports. • Due to the serious emotional disturbance or serious mental illness, the child or adolescent also requires that there be a parent, guardian, individual, or organization that is responsible for the 24-hour care and supervision of that child or adolescent. **Intensity of Service** • RTC placement or community-based RTC level of care is considered medically necessary when all less intensive levels of treatment have been determined to be unsafe, unsuccessful, or unavailable. • The child or adolescent requires a 24-hour a day, seven day a week structured and supportive living environment. • The child or adolescent requires the provision of individualized, strengths-based services and supports that: • Are identified in partnership with the child or adolescent, if developmentally appropriate, and the family and support system to the extent possible • Are based on both clinical and functional assessments • Are clinically monitored and coordinated with 24-hour availability

Residential Treatment Center (RTC)	
Service Name	**Notes**

Admission Criteria continued	• Are implemented with oversight from a licensed mental health professional
	• Includes:
	  • Assisting with the development of skills for daily living
	  • Care coordination to plan and arrange access to a range of educational and therapeutic services
	  • Services that support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in the home and community and regularly attend and participate in work, school, or training
	  • When appropriate and relevant, psychotropic medications to be used with specific target symptoms identification, with medical monitoring by a psychiatrist and 24-hour psychiatric availability as needed by the client
	  • Screening and assessment for current medical problems and concomitant substance use disorder issues
	  • Coordination with the child or adolescent's community resources with the goal of transitioning the youth out of the program as soon as possible and appropriate

Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• Authorizations for initial and continued stay RTC services are requested electronically through Carelon. Electronic authorizations are completed by the provider through submission of a request in ProviderConnect which can be accessed 24/7, including weekends and holidays through the Carelon website.
	• A federally mandated Certificate of Need (CON) for services is required. The CON is time-sensitive in that all elements need to be dated within 30 days from when the participant enters the RTC. There is no standardized CON form; each provider uses his or her own format and all formats will be accepted if they each recommend an RTC placement. They also need to include the following:
	  • A psychiatric evaluation, completed by a board-certified psychiatrist with a summary of the participant's presenting problem, current psychiatric symptoms and behaviors, treatment, medication, family, and educational history; all applicable diagnoses and a clear recommendation that the participant be placed in an RTC.
	  • A psychosocial evaluation, completed by a licensed mental health professional; an evaluation completed by a licensed graduate social worker (LGSW) or licensed graduate professional counselor (LGPC) that is co-signed by a licensed mental health professional. The psychosocial evaluation may include the components delineated in the psychiatric evaluation but will provide further detail regarding: the presenting problem, family involvement, religious, social, educational, and legal history, and a clear recommendation that the participant be placed in an RTC.

Residential Treatment Center (RTC)	
Service Name	**Notes**
Authorization Process continued	• A history and physical examination signed by a physician or certified registered nurse practitioner (CRNP) that attests that the participant is medically appropriate and cleared for RTC placement. • The CON is required to be sent to both the LBHA/CSA and Carelon. • Concurrent authorization requests should be submitted via ProviderConnect with supporting clinical information on the first uncovered day.
Claims Submission (What is Required to Submit a Claim for this Service?)	• RTC Providers submit claims monthly to Carelon for services to participants who are enrolled in care. • LTC Span - Initial auth for 120 days and a concurrent auth for 60 days
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Participant to be discharged when primary care team and ASO determine medical necessity criteria (MNC) no longer met. • Prior to discharge, a transitional discharge plan needs to be developed in collaboration with parents/guardians. • D/C Expectation: Information regarding participants' plans and progress toward discharge goals is to be shared with the placing agency and/or Child's parent/guardian, and Adolescent Coordinator at the LBHA/CSA for that participant's county of residence or other responsible state agencies. Should issues arise which interfere with activating the discharge plan, the LBHA/CSA Child and Adolescent Coordinator is to be contacted for assistance. A LBHA/CSA directory is available at: https://mabha.org/getting-help. • Specifics things to be called out in the discharge plan: o Housing arrangements. o Documentation of post-discharge medications (with prescriptions, if needed). o Continued treatment options and initial appointments; services can include Outpatient (OP), Psychological Rehabilitation Program (PRP), Targeted Case Management (TCM), 1915(i), etc. o Crisis contingency plan.
Additional Information	• Treatment at this level of care requires family involvement. This needs to be documented in the participant's medical record. • Enhanced support services are not available in an RTC. All services provided by the RTC are required to be included in the RTC rate. • Psychological testing performed while a participant is being treated in an RTC is included in the RTC daily rate. • Participants with another primary insurer (i.e., a commercial plan, TRICARE, etc.) should seek treatment in RTC facilities that are credentialed by (in-network with) that insurer.

Residential Treatment Center (RTC)	
Service Name	**Notes**

Additional Information Continued	• Admission to a non-participating facility, for any payer, does not make Medicaid the primary payer.
	• Information regarding participants' plans and progress toward discharge goals is to be shared with the Child and Adolescent Coordinator at the LBHA/CSA for that participant's county of residence. Should issues arise which interfere with activating the discharge plan, all efforts should be made to engage. parents/guardians, caregivers, and all other vested agencies (ex. LBHAs/CSAs, DHS, DDA, etc.) for assistance. A LBHA/CSA directory is available at: https://mabha.org/getting-help.
	• The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician (PCP) and other treatment providers when clinically appropriate.
	• RTCs will be reimbursed for an overnight therapeutic leave of absence (TLOA) of less than 72 hours. A TLOA that lasts longer than 72 hours requires pre-authorization by Carelon. Any TLOAs of 72 hours for more will not be paid for. TLOAs may be allowed when the provider identifies specific goals for this type of service planning and while the participant continues to meet medical necessity criteria for a continued RTC stay. TLOAs include, but are not limited to the following:
	  ○ An admission to an inpatient psychiatric bed
	  ○ An admission to an inpatient medical bed
	  ○ Home or transitional visits to practice symptom management techniques developed in the residence.
	• There are no reimbursable administrative days for care in an RTC beyond the point in time where the participant no longer meets the medical necessity criteria for residential treatment services. Initial span is 60 days - concurrent span of 30.
	• Prior to payment, the state of Maryland requires Carelon Behavioral Health to review all claims for inpatient services at Psychiatric (IMD) & RTCs to determine if a long-term care span has been properly established. A long-term care span is required when the participant meets the state's definition of an institutionalized participant. In general, a participant becomes institutionalized when he/she is admitted to a facility for more than one calendar month. The span is specific to the facility, participant, and the time period of the admission. The long-term care span allows the state to establish Long Term Eligibility. Most participants will become a "family of one" when the definition of institutionalization is met. The state may determine that renewable assets exist and that a "share amount" should be deducted from each monthly payment. It is the Facility's responsibility to collect the Monthly Share Amount from the source. To establish a long-term care span, the Psychiatric (IMD) or RTC is required to complete the Long-Term Care Application and OES 1000 and send to the MDH Waiver unit and a copy of the OES to the MDH Health Choice Unit.

Residential Crisis Services (RCS)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**RCS** Residential Crisis Services offers intensive mental health and support services that are provided to an adult with mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the client's ability to function in the community and is designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments. • RCS is intended to be used on a short-term basis to treat mental health conditions and not to be used solely to meet an individual's housing needs. • A participant may need additional clinical services (e.g., a partial hospitalization program or an onsite psychiatric rehabilitation program) while in RCS. These additional services are authorized separately, and the participant needs to meet medical necessity criteria. Enhanced support services are authorized only in rare circumstances when extreme clinical need exists. **Criteria** • Prior authorization is required. • A face-to-face assessment should be completed prior to requesting services. • Providers can request additional authorizations by submitting a concurrent authorization request through ProviderConnect. Concurrent authorization requests will be routed to the CSA or LBHA, in the area which the participant resides, for review. Providers are required to must submit the concurrent request prior to the expiration of the previous authorization span. **Restrictions** • A participant is not eligible if the individual requires immediate involuntary inpatient psychiatric admission; has a sole diagnosis of substance use disorder, intellectual disability, or neurocognitive disorder; or is not medically stable. **CPT Codes** • H0018 • T2048
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.04.04
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include programs: • Approved residential crisis programs, according to COMAR 10.63.04.04.

Residential Crisis Services (RCS)	
Service Name	**Notes**
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers are required to complete and submit the Application for Licensure Under COMAR 10.63 Community-Based Behavioral Health Programs and Services, for each location in which a participant will be housed while receiving crisis services Providers will coordinate through Carelon Provider Relations for Maryland Medicaid to have their provider files created. Carelon Behavioral Health of Maryland: • Phone: 1-800-888-1965 • Email: provider.relations.MD@carelon.com
Participant Eligibility (Who is Eligible to Receive this Service?)	An individual is eligible for RCS services if the individual is a: • Medicaid participant • Dual participant (Medicare/Medicaid) • Uninsured Eligible

Admission Criteria	All the following criteria are necessary for admission:
	• The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention.
	• The participant is at-risk for hospitalization or continued hospitalization.
	• There is a need for immediate intervention because the participant:
	  ○ Is at-risk for harm of him or herself or others, or
	  ○ Is experiencing rapid deterioration of functioning as a result of psychiatric symptoms
	• All less-intensive levels of treatment have been determined to be unsafe or unsuccessful.
	
	Continuing Stay Criteria
	All the following criteria are necessary for continuing treatment at this level of care:
	• The participant continues to meet admission criteria.
	• Diversion from inpatient hospitalization continues to appear possible.
	• The participant's current available living environment is not suitable for stabilizing the participant during the crisis.
	• Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident.
	
	Service Delivery
	
	• Medical necessity for admission to residential crisis services is required to be documented by the presence of all of the criteria. Length of service varies based on medical necessity but is designed to be short-term. Active involvement of the participant, family, caregiver, or others involved in the individual's treatment should be sought.

Residential Crisis Services (RCS)	
Service Name	**Notes**

Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description**
	
	The RCS authorization process initiates when the referring agency determines the participants need to receive RCS services and refers the participant to the RCS Provider. The RCS provider conducts a screening to determine if the Participant's meets the eligibility to receive RCS services.
	
	• If the participant does not meet the screening criteria, the RCS provider notifies the Referring Agency of the screening denial.
	• If the participant meets the screening criteria, the RCS Provider conducts and documents the clinical assessment of the Participant.
	  ○ The RCS Provider prepares and submit the initial authorization request which includes the initial authorization request form, Medical Necessity Checklist (MNC), Physician Evaluation (only hospital documentation), and the Provider clinical Assessment.
	  ○ Carelon receives the authorization request and conducts a clinical review of authorization request, which includes an administrative review of the submitted documentation. Carelon reviews the authorization request to determine whether the Participant meets the medical necessity criteria
	  ▪ If Carelon finds that the participant meets medical necessity criteria, then Carelon sets the 10-day authorization span.

Claims Submission (What is Required to Submit a Claim for this Service?)	In general, the only mental health professionals who may bill separately are psychiatrists. Services by other professionals are included in the RCS rate and will not be authorized or reimbursed separately. **Restrictions** • If the participant has insurance other than Medicaid, the provider is expected to bill the primary carrier for RCS and go through all appeals processes with the primary carrier prior to submission to Carelon. The PBHS will not pay for RCS for individuals with private insurance. The provider is to contact the private insurer directly to seek reimbursement.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**RRP** • Provides residential and supportive services to single participants. The goal of the RRP is to provide services that will support a participant to transition to independent housing of their choice. • RRP provides staff support around areas of personal needs such as medication monitoring, independent living skills, symptom management, stress management, entitlements management and case management relapse prevention planning with linkages to employment, education and/or vocational services, crisis prevention and other services that will help with the participant's recovery. **Criteria** • The participant must need, and be willing to participate in, off-site PRP services provided in the RRP residence. • Attendance at an onsite PRP program is not a requirement for the participant to receive RRP services and may not be mandated. • Participants may attend an onsite PRP with a provider which is different than where the participant receives the off-site residential services. • Enhanced support services are available in certain situations and are authorized by the CSA or LBHA via electronic submission through Carelon's Provider Digital Front Door. • For supported employment (SE) participants in RRP, income derived from SE may be reviewed to determine if the individual has sufficient earned income to contribute to RRP cost of care without jeopardizing the individual's motivation for employment. Providers are expected to negotiate with the individual regarding contributing to the cost of care so as to preserve the financial incentive for employment. **Restrictions** • Participants in RRP will not be authorized for case management services as a separate authorization. • Participants in RRPs are not eligible for simultaneous mobile treatment services. Some clinical exceptions may apply.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.09 • COMAR 10.63.02.03 • COMAR 10.63.02.04 • COMAR 10.63.04.05
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include programs: • Service providers are RRPs approved by the MDH under COMAR 10.63.04.05.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	RRP is not a direct enrollment with Maryland Medicaid, but a subsidiary of PRP. RRP providers enroll their PRP via Maryland ePREP as a PT PR.
Participant Eligibility (Who is Eligible to Receive this Service?)	An individual is eligible for RRP services if the individual is a: • Medicaid participant • Dual participant (Medicare/Medicaid) • Uninsured eligible Requests for RRP services requires completion of the Residential Rehabilitation Program Application Form.
Admission Criteria	All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis, included in the priority population, which is the cause of significant functional and psychological impairment, and the participant's condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation, and support. • The participant requires active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment, and manage the effects of his/her illness. As a result of the participant's clinical condition (impaired judgment, behavior control, or role functioning) there is significant current risk of one of the following: o Hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of the illness. o Harm to him or herself or their self, others as a result of the mental illness and as evidenced by the current behavior or past history. o Deterioration in functioning in the absence of a supported community-based residence that would lead to the other items. • The participant's own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced for example, by one of the following: o The participant has no residence and no social support. o The participant has a current residential placement, but the existing placement does not provide sufficiently adequate supervision to ensure safety and ability to participate in treatment. o The participant has a current residential placement, but the participant is unable to use the existing residence to ensure safety and ability to participate in treatment, or the relationships are dysfunctional and undermine the stability of treatment. • The participant is judged to be able to reliably cooperate with the rules and supervision provided and to contract reliably for safety in the supervised residence. • All fewer intensive levels of treatment have been determined to be unsafe or unsuccessful.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Admission Criteria Continued	The specific diagnostic criteria may be waived for the following two conditions: • A participant committed as not criminally responsible who is conditionally released from a BHA facility OR • A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for Developmental Disabilities Administration's residential services. **Continuing Stay Criteria** All the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria. • There is continued risk of deterioration in functioning that may lead to inpatient admission or harm to him or herself and/or others. • There is evidence that the resources and social support system, which are available to the participant outside the supervised residence, continue to be inadequate to provide the level of residential support and supervision currently needed for safety, self-care or effective treatment despite current treatment, rehabilitation, and discharge planning. • Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. • There is documented active planning for transition to a less intensive level of care. **Service Delivery** • Medical necessity for admission to residential crisis services is required to be documented by the presence of all of the criteria. Length of service varies based on medical necessity but is designed to be short-term. Active involvement of the participant, family, caregiver, or others involved in the individual's treatment should be sought.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** The RRP authorization process initiates with a pre-assessment conducted by the Hospital/Community Source, who then follows the assessment with the preparation and submission of the RRP referral application to LBHA. The RRP referral application needs to include the pre-assessment conducted by the hospital/community source as part of hospital discharge plan. • All referrals for RRP services need to be completed using the statewide RRP application, which are required to be sent with supporting documentation to the CSA or LBHA of the applicant's jurisdiction of origin.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Authorization Process Continued	• The CSA or LBHA screens referrals for RRP and also determines if other services are needed to support the Participant. When other services are needed, the CSA or LBHA directs the referral source or the applicant to Carelon. Carelon may also refer and authorize an array of support services. These services may negate the need for RRP or may sustain the applicant until RRP services are available. • The CSA or LBHA reviews the application within two working days, and if appropriate, refers the applicant to an RRP that has an available bed. • The CSA or LBHA authorizes an assessment for the RRP, the RRP has ten working days to evaluate and render a disposition; indicate decision to admit or not to admit. The RRP notifies the CSA or LBHA of the disposition and, if the participant is to be admitted to the RRP, the CSA or LBHA signs a Certificate of Determination (COD) to document their approval of the placement and the requested level of care. • After the RRP has evaluated and admitted the participant, the RRP electronically submits prior authorization request via Carelon's Provider Digital Front Door for the required general or intensive PRP services and RRP bed days for review by Carelon, to include the RRP application and the Certificate of Determination signed by the CSA/LBHA. Carelon reviews the prior-authorization request and approves the RRP services if medically necessary. An authorization request will not be approved in the absence of an RRP application signed by the Participant a COD signed by the LBHA or CSA. • For participants in need of RRP who are unable to access the service due to lack of beds, the CSA or LBHA maintains a waiting list. • The CSA or LBHA reviews and updates the waiting list monthly, checking to see if the participant has been linked to other PBHS services to support the participant, and if RRP is still needed. • At all times, the CSA or LBHA decision is based on the need of the participant. Each CSA or LBHA has a written policy, approved by BHA that addresses waiting lists, including prioritizing for state hospital referrals, community referrals, and other services.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Authorization Process Continued	**Criteria** • Concurrent authorization requests should be submitted via Carelon's Provider Digital Front Door prior to the expiration of the previous authorization time span. • Changes in level of care need to be requested via Carelon's Provider Digital Front Door for medical necessity review. • Changes in place of service (i.e., change from blended service to off-site only) do not require a medical necessity review. This type of request can be submitted via Carelon's Provider Digital Front Door or called into Carelon for a change to the authorization's place of service. • For participants in need of RRP who are unable to access the service due to lack of beds, the CSA or LBHA maintains a waiting list. • The CSA or LBHA reviews and updates the waiting list monthly, checking to see if the participant has been linked to other PBHS services to support the participant, and if RRP is still needed. • At all times, the CSA or LBHA decision is based on the need of the participant. Each CSA or LBHA has a written policy, approved by BHA that addresses waiting lists, including prioritizing for state hospital referrals, community referrals, and other services.

Discharge/Aftercare Planning
(Explain any rules/conditions to end these services, and what should be done for aftercare?)
	• Providers are required to develop discharge plans for participants.
	• Discharge of participants from RRPs, who are dropped off at emergency rooms while hospitalized is not acceptable. Providers need to instead complete the following procedures:
	  ○ The Program Director will collaborate with Carelon to arrange for discharge from the program when services are no longer authorized by Carelon or to discontinue residential services to a participant whose clinical needs exceed the RRP's ability to secure the safety and welfare of the participant or others.
	  ○ The Program Director will maintain clearly written policies and procedures for the following processes:
	  ▪ Discharge from the program
	  ▪ Temporary suspension from a residence
	  ▪ Discontinuing residential services when a participant's clinical needs exceed the RRP's ability to secure the safety and welfare of the participant or others, including criteria for discontinuation, and the progressive steps and interventions that the program will enact prior to discontinuing services
	• Please contact the CSA or LBHA in advance of any discharge plans for those participants with complex clinical, medical, and rehabilitation needs who are at-risk of being discharged from the RRP. CSAs or LBHAs will assist community programs to access consultation in order to develop and implement a managed intervention plan (MIP) to further support the participant in the placement and to mitigate the risk of an unplanned discharge.

Residential Rehabilitation Program (RRP)	
Service Name	**Notes**
Additional Information	Out of County RRP • The CSA or LBHA may refer the participant to an out-of-county RRP only for the following reasons: 1. Participant Preference a. The participant requests to live in a particular jurisdiction. b. The participant's family has relocated to another county and the participant wishes to be near their family. 2. Provider Capacity a. The current RRP agencies in the CSA or LBHA jurisdiction are at capacity and are not in a position to expand services. 3. Provider Capability a. The current RRP agencies in the CSA or LBHA jurisdiction lack special programming to meet the needs of particular participants referred (e.g., individuals who are deaf or hard of hearing, individuals who have a mental illness or developmental disabilities). • When the participant meets out-of-county criteria, the originating CSA or LBHA will forward the RRP application and supporting documentation to the CSA or LBHA of the jurisdiction in which the participant prefers to reside. The receiving jurisdiction acts on the request within two days of receipt. • To obtain authorization for transitional visits, also known as trial visits, the provider needs to submit a prior authorization request through ProviderConnect. The CSA or LBHA will review and authorize as appropriate.

Mental Health Partial Hospitalization Program (PHP)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**MH PHP Program** Partial hospitalization programs (PHPs), also known as Psychiatric Day Treatment services (PDTP), are required to be rendered by a provider approved under COMAR 10.63. This is an outpatient, short-term, intensive, psychiatric treatment service that parallels the intensity of services provided in a hospital, including medical and nursing supervision and interventions. PHPs are an alternative to inpatient care when the participant can safely reside in the community while engaged in treatment. This level of service is a benefit for children, adolescents, and adults. Those providers who choose to provide a full day of PHP services need to provide at least six and a half (6.5) hours of treatment. Freestanding PHPs may provide a full-day or a half-day (minimum of four consecutive hours) of treatment.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.02.02 • COMAR 10.63.03.08 • COMAR 10.09.36 • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	These services may be provided by hospitals, or community-based programs in compliance with COMAR 10.63.03.08 and have applicable reimbursement rates depending on their site. A multidisciplinary team, including a psychiatrist, a nurse, and other professionals, should be available to provide this service.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via ePREP. Community-based PHP programs enroll as a PT MH.
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant • Dual participant (Medicare/Medicaid)
Admission Criteria	All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis, and the participant's condition can be expected to be stabilized at this level of care. • There is clinical evidence that the participant would be at-risk to him or herself or others if the participant was not in a partial hospitalization program. • There is clinical evidence that the participant will be safe in a structured environment under clinical supervision for part of the day, and has a suitable environment for the rest of the time, and that a partial hospitalization program can safely substitute for or shorten a hospital stay to prevent deterioration that would lead to a re-hospitalization. • All fewer intensive levels of treatment have been determined and documented to be unsafe or participant has been unsuccessful in engagement.

Mental Health Partial Hospitalization Program (PHP)	
Service Name	**Notes**
Admission Criteria Continued	**Severity of Need and Intensity of Service** • Medical necessity for admission to a PHP is required to be documented by the presence of all of the criteria. The length of the program varies based on the participant's needs and medical necessity. • Evidence of a stable and safe living environment and participant safety during non-treatment hours is imperative to meet criteria and distinguish it from inpatient services. Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment should be sought. **Criteria for Continued Stay** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the participant's response to treatment.) • Clinical attempts at therapeutic re-entry into a less restrictive level of care have, or would, result in exacerbation of the mental disorder to the degree that would warrant the continued need for partial hospitalization services. • There is evidence that the participant, family, caretaker, or significant other is involved in treatment in the frequency and manner indicated by the treatment plan. • There is documented active planning for transition to a less intensive level of care
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • Authorizations can be requested telephonically, or electronically through Carelon. Telephonic authorizations are initiated by calling Carelon customer service line and providing clinical information to a licensed Clinical Care Manager in the Clinical Department. Electronic authorizations are completed by the provider through submission of a request in the Provider Digital Front Door. The Provider Digital Front Door can be accessed 24/7, including weekends and holidays; if the level of care is medically necessary, services will be authorized. • Providers obtain additional authorizations through the electronic submission of a continued stay request in the provider portal. To request initial authorizations, providers are expected to submit the authorization request, with supporting clinical information, on the day of admission. Concurrent authorization requests are submitted with supporting clinical information on the first uncovered day.

Mental Health Partial Hospitalization Program (PHP)	
Service Name	**Notes**
Authorization Process Continued	• If an ASO Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to an ASO Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non- authorized case will be communicated both via the provider portal and telephonically to the provider. Providers are to refer to the Provider or Billing Manual for guidance on Grievances and Appeals. **Criteria** Service Rules • Psychological testing for participants enrolled in a PHP requires a separate authorization and are required to be administered outside of the hours billed for PHP. A physician's service may be billed for a Medicaid recipient, in addition to the PHP stay, when provided in a hospital setting. One psychiatric visit per day is allowed without a separate authorization. • Non-hospital-based PHPs do not have a provision for this additional physician payment as it is already included in the PHP rate. • Occupational therapy performed in a PHP setting, by the PHP staff, does not require an authorization. Private occupational therapists or occupational therapy groups require authorization. • The mental health service provider is expected to exchange information and coordinate care with the participant's PCP and other treatment providers (i.e., substance use disorder treatment) when clinically appropriate.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Provider Type MH Programs should submit claims electronically using the 837P format or on a CMS 1500 form. Claims need to specify an ICD-10 code for reimbursement. • Hospital-based programs should submit claims electronically using the 837I format or on a UB04 form. **Criteria** • In order to receive reimbursements through PBHS, all providers under COMAR 10.63 are required to also be Medicare providers or compliant with Medicare rules if in a freestanding PHP. **Billing Codes** • For non-hospital staff physicians to be reimbursed for physical examinations, providers need to complete a CMS 1500 form. The CPT codes accepted for this service are 99241-99245. • Claims are required to specify an ICD-10 code (not DSM-5 code) for reimbursement. • Claims for unauthorized PHP days will be denied.

Mental Health Partial Hospitalization Program (PHP)	
Service Name	**Notes**
Claims Submission continued	**Restrictions** • Claims for unauthorized partial hospitalization days will be denied.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Discharge and aftercare planning is expected to begin at the same time as service delivery. All discharge and aftercare plans need to be submitted in the authorization request.

Outpatient Mental Health (OPM) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	The Outpatient Mental Health (MH) Treatment Program refers to behavioral health services that do not require an inpatient hospital stay. Outpatient care offers the benefits of mental health treatment while also allowing patients to return home at night and continue elements of daily living. Services under this program are designed to help diagnose and treat people with mental health disorders, like depression and anxiety. These services include assessment and evaluation and individual, group, and family therapies. Services can be delivered by these types of health professionals: • Psychiatrists or physicians who demonstrate the competency to provide specialty mental health services • Clinical professional counselors (LCPC, LCPAT, LCMFT and LCADC) • Clinical psychologists • Clinical social workers (LCSW-C) • Pediatric Nurse Practitioner with a PMHS • Psychiatric Nurse practitioners (CRNP-PMH) • Nurse psychotherapists (APRN-PMH) Restrictions • For the individual practitioner, a limit of only one individual or group therapy per day per participant, regardless of the provider. Individual and family therapy may be rendered on the same day if performed as a separate and distinct service during a different time interval.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.02 • COMAR 10.63.03.05 • COMAR 10.09.36 • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	Approved OPM provider types: • Outpatient Mental Health Clinics (OMHCs) regulated under COMAR 10.63.03.05. • Individual mental health professionals authorized and/or licensed by the appropriate practice boards. • All providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with the MDH.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via Maryland ePREP: • PT MC - OMHC • PT 15- Psychologist • PT 20 - Physician, Psychiatrist • PT 23 - Nurse Practitioner (CRNP-PMH) • PT 24 - Nurse psychotherapists (APRN-PMH) • PT 94 - Clinical Social Worker (LSWC-C) • PT CC - Clinical professional counselors (LCPC, LCPAT, LCMFT and LCADC) • PT 27 - Mental Health Group
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participants • Dual participants (Medicare/Medicaid) • Uninsured eligible participants

Outpatient Mental Health (OPM) Program	
Service Name	**Notes**

Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• Prior to admission, an authorization request needs to be made via ProviderConnect.
	• Outpatient services require registration via ProviderConnect.
	• The authorization request (Auth Request) is required to include:
	  o Completed Auth Request form
	  o Optional Federal data collection form
	• Authorization Span Specifications: Initial and concurrent: authorization span length determined by provider, but cannot exceed 10 days per episode and no more than 30 total days in a year
	• Outpatient services will only be authorized for registered PBHS participants who have a mental health diagnosis covered by the PBHS. For a list of diagnosis, visit the Carelon website.

Admission Criteria	Both of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM-5 diagnosis with at least mild symptomatic distress and/or impairment in functioning due to the psychiatric symptoms and an appropriate description of the symptoms consistent with the diagnosis. • The participant's behaviors or symptoms can be safely and effectively treated while living independently in the community. **Continuing Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria. • The target outcomes have not yet been reached. • Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. **Service Delivery** Medical necessity for admission to outpatient mental health services is required to be documented by the presence of all of the criteria. Length and frequency of service varies based on the participant's needs and medical necessity. Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment should be sought.
Claims Submission (What is Required to Submit a Claim for this Service?)	• OPM Providers submit claims via Carelon's Provider Digital Front Door for services to clients who are enrolled in care. • The Maryland PBHS will not reimburse as the primary payer for services covered by Medicare for Medicare recipients served by Outpatient Mental Health Centers (OMHCs) or individual practitioners.

Outpatient Mental Health (OPM) Program	
Service Name	**Notes**
Additional Information	• Family psychoeducation (FPE) is a reimbursable service under the PBHS only if the agency/provider is an approved OMHC and meets the eligibility requirements outlined by the Maryland Behavioral Health Administration (BHA). FPE is not age-restricted and is available to both Medicaid participants and uninsured eligible participants. The groups meet bi-weekly and may extend for up to two years. Prior authorization is required. • OMHCs, individual practitioners, and those in private group practice may provide services in any location except a hospital medical unit, an adult medical daycare center, and emergency departments (if included in the hospital rate). However, the fee remains the same as on-site service rates. • Private practitioners of any discipline are not allowed to bill for services provided by non-licensed/certified mental health professionals (e.g., students or interns). Only OMHCs, federally qualified health centers, and hospitals with formal training programs and supervision may receive reimbursement for other types of licensed/certified mental health professionals and professional students who are in a formal training program. • Only providers rendering services in an OMHC or Health Services Cost Review Commission (HSCRC) regulated outpatient service may be reimbursed for extended sessions (CPT 90839).

Repetitive Transcranial Magnetic Stimulation (rTMS)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Repetitive Transcranial Magnetic Stimulation (rTMS) is a noninvasive method of brain stimulation. In rTMS, an electromagnetic coil is positioned against the individual's scalp near his or her forehead. A Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. rTMS does not induce seizures or involve complete sedation with anesthesia in contrast to the Electroconvulsive Therapy (ECT). The Food and Drug Administration (FDA) approval for this treatment modality was sought for patients with treatment resistant depression. Additionally, the population for which efficacy has been shown in the literature is that with treatment resistant depression. Generally speaking, in accordance with the literature, individuals would be considered to have treatment resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration and with treatment adherence. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. rTMS is not considered proven for maintenance treatment. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific participant. This analysis considers the diagnosis of the participant and the severity of the presenting illness, the participant's treatment history, any potential risks, anticipated adverse side effects and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.
Admission Criteria	The following admission criteria is required: • The participant is at least 18 years of age. • The participant demonstrates behavioral symptoms consistent with unipolar Major Depression Disorder (MDD), severe degree without psychotic features, either single episode, or recurrent, as described in the most current version of the DSM, or corresponding ICD, and has this diagnosis. • Depression is severe as defined and documented by a validated, self-administered, evidence-based monitoring tool (i.e., Inventory of Depressive Symptomatology Self-Report, Quick Inventory of Depressive Symptomology (QID), Patient Health Questionnaire (PHQ-9), Hamilton Depression Rating Scale (HAM-D) or Beck Depression Scale (BDI), etc.). • The diagnosis of MDD cannot be made in the context of current or past history of manic, mixed or hypomanic episode. • The participant has no active (within the past year) substance use or eating disorders.

Repetitive Transcranial Magnetic Stimulation (rTMS)	
Service Name	**Notes**

Admission Criteria Continued	• The participant exhibits treatment-resistant depression in the current treatment episode with all of the following:
	  ○ Lack of clinically significant response (less than 50% of depressive symptoms)
	  ○ Documented symptoms on a valid, evidence-based monitoring tool
	  ○ Medication adherence
	  ○ Lack of response to at least two psychopharmacologic trials in the current episode of treatment at the minimum dose and from two different medication classes.
	• rTMS is administered by a US Food and Drug Administration (FDA) cleared device for the treatment of MDD in a safe and effective manner according to the manufacturer's user manual and specified stimulation parameters.
	• The order for treatment is written by a physician who has examined the participant and reviewed the record, has experience in administering rTMS therapy and directly supervises the procedure (on site and immediately available).
	The following criteria may apply:
	• History of response to TMS in a previous depressive episode as evidenced by a greater than 50% response in standard rating scale for depression (e.g., Geriatric Depression Scale (GDS), Personal Health Questionnaire Depression Scale (PHQ-9), Beck Depression Scale (BDI), Hamilton Rating Scale for Depression (HAM-D), Montgomery-Asberg Depression Rating Scale (MADRS), Quick Inventory of Depressive Symptomatology (QIDS), or the Inventory for Depressive Symptomatology Systems Review (IDS-SR)
	Continuing Stay Criteria
	The following are requirements for continuing stay:
	• The participant continues to meet admission criteria
	• An alternative treatment would not be more appropriate to address the participants ongoing symptoms
	• The participant is in agreement to continue rTMS treatment and has been adherent with treatment plan
	• Treatment is still necessary to reduce symptoms and improve functioning
	• There is evidence of objective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress

Repetitive Transcranial Magnetic Stimulation (rTMS)	
Service Name	**Notes**
Admission Criteria Continued	• Treatment is to continue within the authorization period only when continued significant clinical benefit is achieved (evidenced by scales referenced throughout this document) and treatment outweighs any adverse effects • There is documented coordination with family and community supports as appropriate • Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out **Discharge Criteria** Any one of the following criteria: • The participant has achieved adequate stabilization of the depressive symptoms • Participant withdraws consent for treatment • The participant no longer meets authorization criteria and/or meets criteria for another level of care, either more or less intensive • The participant is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement (e.g., validated rating scale and behavioral description) and there is no reasonable expectation of progress • The participant experiences a worsening of depressive symptoms such as increased suicidal thoughts/behaviors or unusual behaviors **Exclusion Criteria** The participant cannot meet any of the exclusionary criteria below. Any of the following criteria are sufficient for exclusion from this level of care: • The participant has medical conditions or impairments that would prevent beneficial utilization of services • The participant requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting • The safety and effectiveness of rTMS has not been established in the following participant populations or clinical conditions through a controlled clinical trial, therefore the following are exclusion criteria • Participants who have a suicide plan or have recently attempted suicide. • Participants who do not meet current DSM criteria for major depressive disorder • Participants younger than 18 years of age or older than 70 years of age

Repetitive Transcranial Magnetic Stimulation (rTMS)	
Service Name	**Notes**
Admission Criteria Continued	• Participants with recent history of active of substance abuse, obsessive compulsive disorder or post-traumatic stress disorder • Participants with a psychotic disorder, including schizoaffective disorder, bipolar disease, or major depression with psychotic features • Participants with neurological conditions that include epilepsy, cerebrovascular disease, dementia, Parkinson's disease, multiple sclerosis, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the CNS • The presence of vagus nerve stimulator leads in the carotid sheath • The presence of metal or conductive device in their head or body that is contraindicated with rTMS. For example, metals that are within 30cm of the magnetic coil and include, but are not limited to, cochlear implant, metal aneurysm coil or clips, bullet fragments, pacemakers, ocular implants, facial tattoos with metallic ink, implanted cardioverter defibrillator, metal plates, vagus nerve stimulator, deep brain stimulation devices and stents • Participants with vagus nerve stimulators or implants controlled by physiologic signals, including pacemakers, and implantable cardioverter defibrillators • rTMS is not indicated for maintenance treatment There is insufficient evidence to support the efficacy of maintenance therapy with rTMS • rTMS for maintenance treatment of major depressive disorder is experimental / investigational due to the lack of demonstrated efficacy in the published peer reviewed literature

Mental Health (MH) Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**MH Intensive Outpatient Program (IOP)** Intensive outpatient programs (IOPs) offer intensive, outpatient mental health services to individuals who require less than 24-hour care, but who need more comprehensive evaluation and treatment than can be provided in a traditional outpatient setting. IOPs are treatment programs used to address a mental health DSM-5 diagnosis, and the participant's condition can be expected to be stabilized at this level of care. They enable individuals to continue with their normal, day-to-day lives in a way that residential treatment programs do not. Whereas residential treatment requires that clients reside on site, clients in intensive outpatient programs live at home while engaged in treatment. **Criteria** • IOP is an acute, short-term intervention for participants experiencing an exacerbation of psychiatric symptoms. The mental health service provider is expected to exchange information and coordinate care with the participant's PCP and other treatment (i.e., substance use disorder treatment) providers when clinically indicated and with appropriate releases of information. • When an outpatient mental health center (OMHC) provides IOP treatment, physician services are included in the rate. When delivered by a hospital-based program, physician services may be billed separately. It is considered duplicative to bill two IOP units for the same participant/same day (i.e., substance use IOP and mental health IOP). Services for participants with co-occurring needs should be integrated and individualized to meet the needs of the participant.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.05 • COMAR 10.63.03.08 • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include: • Partial hospitalization programs (PHP) (Psychiatric Day Treatment Programs (PDTP) approved under COMAR 10.63.03.08 and OMHCs approved under COMAR 10.63.03.05
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are to enroll through Maryland ePREP o Community-based PHP programs enroll as PT MH o OMHCs enroll as PT MC
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid)
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** Initial MH-IOP Requests Authorization requests for initial and continued stay IOP services can be requested telephonically, or electronically through ProviderConnect. Telephonic authorizations are initiated by calling Carelon and providing

Mental Health (MH) Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Authorization Process Continued	clinical information to a licensed Clinical Care Manager in the Clinical Department. Electronic authorizations are completed by the provider through submission of a request in ProviderConnect, which can be accessed 24/7, including weekends and holidays through the Carelon website. If the level of care is medically necessary, services will be authorized. Providers obtain additional authorizations through the electronic submission of a continued stay request in the Carelon website. Concurrent authorization needs to be submitted with supporting clinical information on the first uncovered day. If a Carelon Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non-authorized case will be communicated both via the Carelon website and telephonically to the provider, and an alternate level of care will be recommended. Concurrent MH-IOP Requests All concurrent requests are required to use the authorization plan "MH IOP Concurrent." Concurrent reviews will continue to be clinically reviewed for medical necessity, prior to approval being rendered. The available units for concurrent authorizations will remain as up to 35 units over a duration of 60 days with providers able to enter the specific units being requested. **Criteria** • Participants with Medicaid and participants who are dually eligible Medicare/Medicaid recipients are eligible for IOP • ASO Care Manager may ask a Carelon physician to review the Auth Request in the event the request does not meet MNC. • Concurrent Auth Request Application needs to include clinical justification/ Medical Needs Criteria Checklist. **Restrictions** • The PBHS does not reimburse IOP services rendered to uninsured eligible participants
Admission Criteria	Both of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM-5 diagnosis and the participant's impairment(s) can be expected to be stabilized at this level of care. • The participant is experiencing acute symptoms of a mental health diagnosis which requires more specialized, intensive therapy than could be provided by only individual, group, or family therapy on an outpatient basis. • The participant does not require a more intensive level of care.

Mental Health (MH) Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Admission Criteria Continued	**Continuing Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria • Clinical evidence indicates that the therapeutic re-entry into a less intensive level of care would result in exacerbation of the symptoms of the participant's mental health disorder. • Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the participant's response to treatment.) • There is evidence that the participant, family, caregiver, or significant other is involved in treatment in the frequency and manner indicated by the treatment plan. • There is documented active planning for transition to a less intensive level of care. **Service Delivery** Medical necessity admission to an IOP is required to be documented by the presence of all of the criteria. The length of the program varies based on the participant's needs and medical necessity. IOP is less intensive than partial hospitalization services but is intended for participants whose condition is not likely to respond to traditional outpatient services and requires an integrated program of coordinated and structured multidisciplinary services at least three hours a day. Active involvement of the participant, family, caregivers, or significant others involved in the participant's treatment should be sought.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** When IOP is provided by: • an OMHC, physician services are included in the rate • a hospital-based program, physician services may be billed separately. It is considered duplicative to bill two IOP units for the same participant/same day (i.e., substance use IOP and mental health IOP). **Criteria** • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. • Claims need to specify ICD 10 codes, not DSM-5 codes.

Mental Health (MH) Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Claims Submission Continued	**Restrictions** • One day equals one unit; date spans will not be accepted. • Claims for unauthorized services will be denied. • The Maryland PBHS does not reimburse for non-mental health services such as 12-step programs. • IOP codes cannot be billed for the same service date across MH. • MH Inpatient community-based services cannot be billed for the same service date except for date of admission • MH community-based services cannot be billed for the same service date except for date of admission
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	Providers are expected to initiate discharge planning at the beginning of service delivery.

Psychological and Neuropsychological Testing	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Psychological and neuropsychological testing involves the administration of reliable and valid psychological and neuropsychological tests for the purpose of answering specific questions about the participant's diagnosis and the development of clinically appropriate treatment recommendations. Psychological and neuropsychological testing should not be considered as a routine or normal procedure in a participant's treatment. Specific testing procedures selected by the psychologist should clearly relate to the questions listed on the request for psychological and neuropsychological testing. When participants have a mental disorder that requires professional evaluation and treatment, they should be treated in the least intensive setting able to meet their medical needs. Satisfaction of all admission and continued care criteria is required be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.
Who is eligible to provide these services	Licensed Psychologists and Psychology Associates under the supervision of Licensed Psychologist
Admission Criteria	Specific Medical Necessity Criteria for Psychological and Neuropsychological Testing: • Testing request cannot be solely for the purpose of vocational or educational assessments. • Testing request should be considered when other interventions are not successful in providing sufficient information with which to establish a diagnosis or to develop an appropriate plan of treatment or prior treatment has not been clinically effective. o Participants should have already had a thorough diagnostic evaluation by a licensed mental health professional. • Testing for a medical condition (e.g., stroke, brain tumor, epilepsy, anoxia, head injury, etc.) is the responsibility of the Managed Care Organization (MCO) and should be referred to the MCO for authorization when the primary reason for the request is due to a medical diagnosis.

Therapeutic Behavioral Services (TBS) – Child and Adolescent	
Service Name	**Notes**
Service Description (An Explanation of the Service)	TBS is a rehabilitative referred service for children and adolescents under 21 years of age. It is designed to provide rehabilitative treatment interventions to reduce or ameliorate the target maladaptive behavior(s) appropriately through restoration of a participant to his/her best possible functional level. When participants have a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs. Satisfaction of all admission and continued care criteria is required to be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	COMAR 10.09.34
Who is eligible to provide these services	A Developmental Disabilities Administration provider in compliance with COMAR 10.22.02, An Outpatient Mental Health Clinic in compliance with COMAR 10.63.03.05, A Mobile Treatment Service Provider in compliance with COMAR 10.63.03.04, or a Psychiatric Rehabilitation Program Provider in compliance with COMAR 10.63.03.09 or .10.
Provider Enrollment	Providers enroll via ePREP as a PT 51
Admission Criteria	All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis with maladaptive behaviors or symptoms relating to that diagnosis. • There is clinical evidence that the behaviors or symptoms place the participant's current living arrangement at risk and create a risk for a more restrictive placement or prevent transition to a less restrictive placement. • The services required are rehabilitative, not habilitative, custodial or activities of daily living. • The participant's behaviors or symptoms can be safely and effectively treated in the community. • The participant requires on-site one-to-one behavioral assistance and intervention in order to accomplish outcomes specified in the behavioral plan. **Continuing Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems

Therapeutic Behavioral Services (TBS) – Child and Adolescent	
Service Name	**Notes**
Admission Criteria continued	consistent with the admission criteria. • The target outcomes have not yet been reached. • The services have been decreased proportionally when indicated by the participant's progress. • There is clinical evidence of symptom improvement using the service. If there is no improvement: o The participant was reassessed for new target symptoms, and o The treatment plan has been reviewed and/or a second opinion of the treatment plan. **Discharge Criteria** Any of the following criteria are necessary and sufficient for planned discharge from TBS services: • The consumer turns 21 years old. • The current behaviors no longer put the consumer at risk of out of home placement. • The consumer (consumer's family) has reached maximum benefit from TBS services as evidenced by the current care being more habilitative (rather than rehabilitative), custodial, or more focused on activities of daily living. • The parent, guardian or the individual who customarily provides care is no longer a pivotal part of the behavioral plan, or when the care giver fails to participate as outlined in the behavioral plan. • The parent, guardian or the individual who customarily provides care has learned to implement the behavioral plan and can continue to independently do so with consultation as needed from an outpatient therapist. • TBS has proven inadequate in addressing the consumer's needs. Therefore, additional or more intensive services are clinically indicated. • TBS services are no longer medically necessary.

Therapeutic Behavioral Services (TBS) – Child and Adolescent	
Service Name	**Notes**
Admission Criteria continued	**Service Delivery** Medical necessity for admission to TBS care is required to be documented by the presence of all of the criteria. Length and frequency of service varies based on the participant's needs and medical necessity. Although TBS will be decreased proportionally when indicated by the participant's progress, TBS will continue to be authorized when it is medically necessary. A parent, guardian or the participant who customarily provides care needs to be present during the provision of services to participate in the behavioral plan unless there are clinical goals specifically addressed in the behavior plan that require that the parent, guardian, or participant who customarily provides care not be present.

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program** • MTS-ACT is a community-based, intensive, outpatient service rendered by providers approved under Maryland Law (COMAR 10.21.19). MTS-ACT assertive outreach, treatment, and support is offered to individuals with serious mental illness who may be experiencing homelessness, or for whom more traditional forms of outpatient treatment have been ineffective. • MTS-ACT services include psychiatric evaluation and treatment, clinical assessment, medication management/monitoring, interactive therapies, support with daily living skills, assistance with locating housing and obtaining entitlements and case management. • MTS-ACT services are mobile, provided by a multidisciplinary team, in the individual's natural environment (e.g., home, street, shelters…). Mobile Treatment Services also are available for children, adolescents and their families who require more intensive intervention to clinically stabilize the child's or adolescent's psychiatric condition, to promote family preservation and/or to return functioning and quality of life to previously established levels as soon as possible. • The duration, frequency and intensity of services provided are determined by an individual's treatment plan.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.03.04 • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include: • MTS providers approved under COMAR 10.63.03.04 • ACT providers are required to meet COMAR 10.63.03.04 requirements and be accredited by BHA as an Evidence-Based Practice (EBP) To be licensed as an MTS/ACT services provider, the provider's program is required to: A. Provide intensive, assertive outpatient mental health treatment and support services by a multidisciplinary team to an individual who is homeless or is otherwise unable or unwilling to access traditional outpatient treatment services as follows: 1. Flexibly in a community setting considered appropriate to the individual; and 2. On an on-call basis, 24 hours per day, 7 days a week. B. Be designed to enable the individual to remain in the community, thus reducing admissions to emergency rooms, inpatient facilities, or detention facilities; and C. Provide discharge services, including developing a transition plan and arranging to initiate authorized services before the planned discharge, in collaboration with the individual, the treatment team, family participants, and significant others who are designated by the individual, the CSA, LBHA, ASO and the designated transition service providers. To be licensed as an ACT services provider, the provider's program needs to be approved by BHA as an Evidence-Based Practice (EBP)

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via ePREP as a PT MT
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant • Dual participant (Medicare/Medicaid) • Uninsured eligible participant

Authorization Process
(How does a provider seek Authorization for the Service, and what forms are needed?)
	Description
	• Delivery of MTS-ACT services requires prior authorization to ensure medical necessity and appropriateness of care prior to services being rendered. The process also includes a determination of whether the service being requested is a covered benefit under the participant's behavioral health benefit plan.
	
	Criteria
	• Service authorization is determined by the ASO, Carelon; requests are required to be reviewed by Carelon within a determined number of hours after receipt of the request.
	• The MTS-ACT will first conduct an intake assessment to determine if the participant is eligible for MTS-ACT services. If eligible, the MTS-ACT provider needs to submit the authorization request for MTS-ACT services via Carelon's Provider Digital Front Door.
	• If the participant is 18 years old, or older, the authorization the request needs to include a completed Daily Living Activities (DLA-20) form.
	• All authorization requests are required to include a completed Medical Necessity Checklist.
	• Carelon will review the authorization request, and approve or deny it, based on the submitted information.
	• Some authorization requests may require a Carelon Physician Advisor review prior to determination.
	• For initial authorization requests:
	  o For participants 18 years old or older, Carelon will establish (up to) a 60-day authorization span.
	  o For participants under 16 years old, Carelon will establish a six-month authorization span.
	• Concurrent authorization requests can be submitted 60 days prior to expiration of the current authorization span; for these Carelon will establish a six-month authorization span regardless of age.
	• If the authorization request is disapproved, the MTS-ACT provider will be notified and can take action to correct deficiencies in the request and resubmit it.
	
	Restrictions
	• Participants 18 years or older require a completed DLA-20 form.
	• Authorization requests with a 21 or U9 modifier require the ACT provider to be approved as a Maryland Evidence-Based Practice (EBP) provider.
	• For participants 18 years or older, all concurrent authorization requests require an updated DLA-20 form; Medical Necessity Checklist; an updated is only required for the 2nd and subsequent concurrent authorization requests.

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Authorization Process Continued	• For participants younger than 18 years old, an updated Medical Necessity Checklist is required for the 1st and subsequent concurrent authorization requests.
Admission Criteria	**Admission Criteria (Adult)** All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis included in the priority population, which is the cause of significant psychological, personal care, and social impairment. • The impairments result in at least one of the following: o A clear, current threat to the participant's ability to live in his/her customary setting, or the participant is homeless and would meet the criteria for a higher level of care if mobile treatment services were not provided; or is in a state institution or inpatient psychiatric facility and with the introduction of mobile treatment level of care would be able to return to living in his/her customary setting. o An emerging risk to self, property, or others, or the participant would experience heightened risk in these areas if mobile treatment services were not provided. o Inability to engage in, participate in, and benefit from traditional outpatient treatment. • Inability to form a therapeutic relationship on an ongoing basis as evidenced by one or more of the following: o Frequent use of emergency rooms/crisis services for psychiatric reasons; o A pattern of repeated psychiatric inpatient facility admissions or long-standing psychiatric hospitalizations; or o Arrest for reasons associated with the participants mental illness. • The specific diagnostic criteria may be waived for the following two conditions: o A participant committed as not criminally responsible who is conditionally released from a BHA facility; **OR** o A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for Developmental Disabilities Administration's residential services. **Continuing Stay Criteria** One of the following is necessary for continuing treatment at the level of care: • The participant continues to meet the admission criteria despite documented efforts to engage and support the participant in treatment and rehabilitation, or there is an emergence of additional problems consistent with admission criteria. • There is clinical evidence of symptom or functional improvement; however, o The participant continues to be at-risk for a higher level of care based on the participant's response to attempts to reduce the frequency or intensity of services in a planned way, **OR**

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Admission Criteria Continued	○ There is documented evidence that the participant is at risk due to the tenuous nature of clinical or functional gains. • There is documented evidence that the participant has either: ○ Had limited or no progress toward goals and there are changes to the treatment plan and interventions, **OR** ○ Had progress toward goals and there are changes to the treatment plan to support the participant's transition to traditional outpatient services (i.e., scheduling and assisting participant with appointments, assisting participant with using public transportation independently, supporting participant's efforts to actively participate in treatment, etc.). **Discharge Criteria** I or (II, III and IV) are necessary and sufficient for planned transition from MTS/ACT services: **I:** A period of transition (as evidenced by overlapping authorizations between MTS/ACT and a less intensive service) has demonstrated the participant's ability to engage, participate in, and benefit from less intensive services **II:** There is little to no threat of hospitalization or incarceration as evidenced by both: No significant psychological, personal care, or social impairment No significant threat to self, property, or others **AND** **III:** There has been no emergency department utilization and no mental health crisis services (as evidenced by services provided by the MTS/ACT during evening or weekend hours) in the last six months **AND** **IV:** The participant no longer requires an intensive, assertive, multidisciplinary treatment team to develop/restore specific independent living skills **Service Delivery/Severity of Need and Intensity of Service** The participant's condition requires intensive, comprehensive, integrated assertive mental health treatment, somatic treatment, and psychiatric rehabilitative services provided by a multidisciplinary team providing a minimum of weekly face to face contact to develop and restore independent living skills to support a participant's recovery. **Admission Criteria (Child and Adolescent)** All of the following criteria are necessary for admission: • The participant has a primary DSM 5 diagnosis that is the cause of significant psychological impairment. • The participant is at-risk for out-of-home placement and either: ○ The participant has not maintained, on a continuous basis, community mental health services that are prescribed; or

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Admission Criteria Continued	○ The participant is exhibiting behavior that is a risk of harm or self-harm • The primary caretaker: ○ Has the goal of maintaining the child or adolescent safely in the home; and ○ Agrees to participate in MTS **Continuing Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria despite treatment efforts or there is emergence of additional problems consistent with the admission criteria. • Documentation exists of failed attempts to integrate the participant into traditional outpatient treatment. • There is clinical evidence of symptom improvement using the service. If there is no improvement, there is documentation of treatment plan changes and/or a second opinion of the treatment plan. • The primary caretaker continues to support in-home placement and the MTS. **Discharge Criteria** I or (II, III and IV) are necessary and sufficient for planned transition from MTS/ACT services: **I:** A period of transition (as evidenced by overlapping authorizations between MTS/ACT and a less intensive service) has demonstrated the participant's ability to engage, participate in, and benefit from less intensive services **OR** **II:** There is little to no threat of hospitalization or incarceration as evidenced by both: ○ No significant psychological, personal care, or social impairment ○ No significant threat to self, property, or others **AND** **III:** There has been no emergency department utilization and no mental health crisis services (as evidenced by services provided by the MTS/ACT during evening or weekend hours) in the last six months. **AND** **IV:** The participant no longer requires an intensive, assertive, multidisciplinary treatment team to develop/restore specific independent living skills. **Service Delivery/Severity of Need and Intensity of Service** The participant's condition requires intensive, assertive mental health treatment and supportive services delivered by a multidisciplinary team, providing a minimum of weekly face-to-face contact.

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**

Claims Submission (What is Required to Submit a Claim for this Service?)	**Description**
	• MTS-ACT services are paid through a monthly rate that is reimbursed through Medicaid or with state general funds.
	• The expectation is that participants will be seen, at a minimum, for four face-to-face contacts in a month. The four visits are a minimum requirement; additional contacts will be provided as needed.
	• Since MTS targets individuals who previously have not engaged in mental health treatment, services are expected to be delivered in community settings. Office visits may be counted under certain circumstances, such as co-occurring groups, etc.
	• MTS-ACT is authorized in monthly blocks. Regardless of when in the month a request for MTS-ACT services is authorized, the first day of the month is used as the beginning date of authorized service. For example, if the service begins mid-month, the provider will receive payment for the full month.
	
	Criteria
	• Claims should be submitted via Carelon's Provider Digital Front Door; in the format of a CMS-1500 form.
	• Only one monthly fee is reimbursable. Providers should bill with the first date of service the participant was seen using a CMS 1500 form.
	• Claims may not be submitted for the monthly fee until the calendar month has ended.
	• Claims need to specify an approved ICD-9 code for reimbursement.
	• In rare circumstances, MTS-ACT services may be authorized for individuals with complex and unique needs who may also be receiving PRP and/or Case Management Services.
	• Claims for unauthorized services will be denied.
	• Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted.
	• Claims need to specify specific ICD 10 codes, not DSM 5 codes.
	• For billing codes and rates regarding this reimbursement, please see the MTS-ACT fee schedules posted to Carelon's website.
	• Problems and solutions
	  ○ If the services requested do not meet Medical Necessity Criteria and care is non- authorized, please refer to Carelon for help.
	  ○ Authorizations can expire because the authorized time frame for services has ended. To ensure reimbursement for services, if additional services are needed beyond the time frame originally authorized, the provider needs to submit a concurrent authorization request for services.
	  ○ The concurrent authorization request is required to be submitted prior to the end of the current authorization time span.
	  ○ More information about initial and concurrent authorization requests is available on Carelon's Provider Digital Front Door.

Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• It is necessary to notify Carelon if it is anticipated that a participant will be discharged prior to the end of the authorized time span. • More information and directions for discharging participants from MTS-ACT services can be found on Carelon's Provider Digital Front Door. • A participant must be discharged from MTS-ACT services when the participant:

Mobile Treatment Services-Assertive Community Treatment (MTS-ACT) Program	
Service Name	**Notes**
Discharge/Aftercare Planning Continued	○ Has accomplished goals and objectives which were identified in the treatment plan, and subsequent treatment plan updates. ○ Refuses further treatment. ○ Has been referred to other appropriate treatment, which cannot be provided in conjunction with the outpatient service. ○ Relocates outside of Maryland. ○ Health prohibits his/her attendance in treatment.
Additional Information	• A Mobile Treatment Service is eligible to receive evidence-based practice rates of reimbursement after meeting the requirements outlined in the MHA Memorandum entitled Assertive Community Treatment (ACT) Evidenced-Based Practice (EBP) Project Treatment Programs and updated in the BHA Memorandum entitled Fidelity Reviews of Assertive Community dated July 29th 2024, including meeting the required scores to be considered an EBP ACT program All providers are required to have an active Maryland MA provider number and a signed provider agreement with MDH.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Supported Employment (SE) services are individualized and provided to assist eligible individuals to choose, obtain, maintain, or advance within competitive employment, in a community-integrated work environment, consistent with their interests, preferences, and skills. The SE service, funded under the Public Behavioral Health System (PBHS), consists of the following reimbursable service phases: 1. **Pre-Placement Phase (H2023):** a. Authorized as one unit per authorization span. b. includes, at a minimum, Mental Health Vocational Program (MHVP) assessment, referral to Division of Rehabilitation Services (DORS), entitlements counseling, and discussion of the risks and benefits of disability disclosure and informed choice. c. A request for re-authorization of the pre-placement service phase may be approved at the Core Service Agencies (CSA's) or local behavioral health authority's (LBHA's) discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of re-authorization requests is not guaranteed. d. The authorization span begins on the actual date of the initial interview with the individual and extends for twelve months, inclusive of the month of the service request, ending on the last date of the 12th month. e. Approval of re- authorization requests for supported employment pre-placement services may be granted in cases in which the individual has not been placed within a competitive employment position within the initial twelve-month authorization span, based on a change in individual circumstances or the emergence of a new service need. Approval of reauthorization requests is not guaranteed. 2. **Placement in a Competitive Job Phase (H2024)** (does not include agency-sponsored employment): a. Authorized as one unit per authorization span. b. The authorization span begins on the date of job initiation (the first date of employment) and extends for forty-five (45) calendar days, ending on the 45th calendar day. c. The provider needs to secure a competitive placement prior to seeking authorization from the CSA or LBHA for the placement phase. d. This includes assisting the participant in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of employment, to include any reasonable accommodations and adaptations requested by the individual.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description Continued	e. The provider is required to attach a copy of the completed Individual Vocational Plan (IVP) when making the authorization request the Provider Digital Front Door. f. A request for re-authorization for the placement service phase may be approved at the CSA's or LBHA's discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of re-authorization requests is not guaranteed, and the request is required to reflect the need for a separate and independent job development activity. g. For all job placement re-authorization requests, the Employment Record Form needs to be updated in the Provider Digital Front Doorto reflect the end date of the prior employment position (if applicable) and include accurate and complete information on the new employment placement. 3. **Intensive Job Coaching Phase (H2024-21)** (reimbursed by DORS; special intensive exceptions may be made for PBHS reimbursement): a. One unit=15 minutes of service b. This includes the use of systematic intervention techniques designed to assist the supported employee to learn to perform job tasks to the employer's specifications, develop the interpersonal skills necessary to assume the employee role and to be employed as a full-status employee at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention to assist the individual in preserving the job placement, resolving employment crises and in stabilizing the employment situation for continuing employment. Job coaching also includes related job analysis, environmental assessment, vocational counseling, employer education and advocacy, mobility skills training and other support services as needed. c. The SE provider may submit a request for pre-authorization of intensive job coaching services to the relevant CSA or LBHA jurisdiction and specify the estimated number of units of service required, based on the individual's specific job duties and a corresponding assessment of the expected frequency, intensity, and duration of his or her support needs.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description Continued	d. The CSA or LBHA may grant authorizations up to 400 units of service per participant, with one unit of service equal to 15 minutes of service. All DORS service rules apply. The authorization is in lieu of a DORS authorization, when an official denial of service has been received, and is not intended to supplement the DORS authorization of intensive job coaching hours. The SE provider will furnish documentation of the official denial of service from DORS when requesting the authorization. 4. **Ongoing Support Services Phase (non-evidenced based-H2026 or evidence based- H2026-21):** a. One unit per month of authorized service. i. Non-Evidence Based Providers (non-EBP): One unit= two visits at a minimum of 15 minutes each ii. Evidence Based Providers (EBP): One unit= three visits at a minimum of 15 minutes each. (EBP SE Providers are eligible for a rate differential). b. The authorization begins on the 46th calendar date of employment and ends on the last day of the twelfth month. c. At least one service needs to be performed on the job unless the individual has chosen not to disclose the presence of a disability to the employer. When this occurs, the service may be performed in a mutually agreed upon community-based location, as indicated in the rehabilitation or disclosure plan. d. This includes proactive employment advocacy, supportive counseling, and ancillary support services at or away from the job site, to assist the individual in maintaining continuous, uninterrupted, competitive employment and to develop an employment related support system. This includes encouraging the use of natural supports to the maximum extent possible. e. This service is not time limited and continues until the individual no longer needs or desires the service. 5. **Psychiatric Rehabilitation Program Services to Individuals in Supported Employment (PRP-SE) (S9445):** a. One unit per month of authorized service; minimum of two visits for non-evidenced based providers. b. The authorization span is twelve months, ending on the last date of the 12th month.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description Continued	c. Includes psychiatric rehabilitation service interventions needed to assist the individual to restore and improve coping skills, assertiveness skills, interpersonal skills and social skills necessary to function adaptively in the work environment or to develop compensatory strategies to minimize the impact of the individual's mental illness on his or her behavior while on the job. d. If the individual is employed, the service needs to be provided on the job, unless the individual has chosen not to disclose his or her disability to the employer. At the individual's request, the service may be performed at a mutually agreed upon community-based location, as indicated in the individual vocational plan (IVP) or disclosure plan. i. Non-EBP Providers: PRP-SE services may be requested in conjunction with the initial or concurrent request for authorization for supported employment extended support services (H2026). The participant is required to be competitively employed to receive this service. ii. EBP Providers: PRP-SE services may be requested in conjunction with the initial or concurrent request for authorization for any supported employment service (including clinical coordination) or may be requested as a standalone service e. This service is delivered and documented separately from other services provided. PRP-SE services are specifically designed and intended to support an individual's recovery-oriented employment goals. 6. **Clinical Coordination Services to Individuals in Supported Employment (S9445-52, for EBP Providers Only):** a. One unit per month of authorized service. b. The authorization span is twelve months, ending on the last date of the 12th month. c. May be requested in conjunction with the initial or concurrent request for authorization for any supported employment service (including (PRP-SE) or may be requested as a standalone service.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description Continued	d. Clinical coordination encounters need to be substantive in nature and constitute more than incidental contact, to include the exchange of relevant clinical and employment-related information necessary and sufficient for the individual to attain, to maintain, and to advance within competitive employment, as it relates to the individual's rehabilitation or treatment goals. If no substantive contact has occurred for a given month, then the service cannot be billed. Additionally, in those instances wherein the individual's consent for clinical coordination has not been secured, the service cannot be billed. e. If the individual is unwilling to engage in or receive psychiatric treatment services (i.e., outpatient therapy or medication management services), the service should not be billed for the sixth or twelfth month in which the contact with the treating clinician would have occurred had the individual been actively receiving treatment services. **Criteria** • The SE provider is required to have an active and fully executed cooperative agreement with DORS to be eligible for SE authorization and reimbursement. o The provider is required to have capacity to provide all SE service phases and may not selectively limit the provision of SE services to certain SE service phases. • All SE service recipients within the PBHS need to apply for eligibility for DORS- funded job development and job coaching services, within the context of SE program services. o In rare instances, when the individual refuses to be referred for DORS services and multiple failed attempts to engage the individual in DORS services have been documented and all other avenues to resolution of issues precluding the individual from accessing DORS services have been exhausted, a waiver of the referral requirement may be granted with CSA or LBHA approval and supporting documentation. • Services are available for adults in the PBHS with a diagnosis of serious mental illness and transition age youth with a primary mental health diagnosis who: o Express an interest in competitive employment and desire to work in the community; and o Demonstrate a work history which has been non-existent, interrupted, or intermittent due to a significant psychiatric impairment and requires SE services to choose, obtain, maintain, or advance within competitive employment.

Supported Employment (SE) Program	
Service Name	**Notes**
Service Description Continued	• The PBHS may authorize payment for intensive job coaching services if funds are available, with CSA or LBHA approval, when written documentation from the DORS field counselor on DORS letterhead of the DORS denial of service is submitted and sufficient justification exists to support the request. • SE service recipients who acquire third party health insurance as a result of employment, obtained by virtue of receipt of SE services through an approved MHVP, may retain eligibility for SE. o PRP-SE services need to meet all applicable requirements for PRP services, as delineated in COMAR 10. 63.03.09. o Claims for PRP services to participants in SE need to be substantiated by the submission of visit data, which reflects the provision of a minimum of two discrete service visits per month, separate and apart from the visit data submitted to validate other PRP levels of care. • The SE program must provide one employer contact per month, with proper consent and only if the individual has disclosed the existence of a disability to the employer. **CPT/Revenue Codes** • H2023 • H2024 • H2024-21 • H2026 • H2026-21 • S9445 • S9445-52 **Service Restrictions** N/A
Legislative/Regulatory References (COMAR, other laws affecting this service?)	COMAR 10.63.03.09 COMAR 10.63.03.16
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** • SE programs are required to be licensed under COMAR 10.63.03.16. • PRP-SE services may only be performed by a program jointly approved as a MHVP and a PRP and is regulated according to the provisions of COMAR 10.63.03.09. • Licensed SE programs may choose to obtain a designation as an Evidence-Based Practice (EBP) program. Maryland's EBP SE programs follow principles which have been rigorously studied and have demonstrated empirically better outcomes than the traditional SE service model. EBP SE providers in Maryland undergo regular and thorough assessment to ensure that the services rendered adhere to the principles of the EBP service model. As such, programs that are found to be faithful to the EBP service model are eligible for a reimbursement rate differential on some SE services. Additionally, EBP SE providers are able to provide additional services that are not reimbursable for providers without an EBP designation.

Supported Employment (SE) Program	
Service Name	**Notes**
Provider Enrollment	• Providers enroll via ePREP as PT SE • Authorized Provider Types: SE
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant • Dual participant (Medicare/Medicaid) • Uninsured eligible participant • Participants who are recovering from serious mental illness or are transitioning from PRP services retain access to and eligibility for SE services as their symptoms abate and functioning improves as a means to further support, sustain, or extend their recovery from serious mental illness. • With participant consent, upon CSA or LBHA review and approval, the designated DORS counselor is granted access to the Carelon system. The DORS counselor's documented review of medical and psychological information found in the Carelon system is sufficient for purposes of eligibility determination and disability priority assignment.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Criteria** • SE providers need to submit the authorization request for SE through ProviderConnect. • Requests are reviewed by the CSA or LBHA within 48 hours of the request. • Service authorization is determined by the CSA or LBHA. • The DORS referral and application are coincidentally completed with the request for authorization of the Pre- placement Phase, and the uploading of a signed copy of the approved Request for Maryland Division of Rehabilitation Services (DORS) and Authorization to Disclose Health Information form. - Prior to submitting the initial authorization request for CSA or LBHA approval, the SE provider needs to ensure that all fields required for authorization of the SE service have been completed so that the DORS application may be populated. • SE providers may submit a request for pre-authorization of intensive job coaching services to the relevant CSA or LBHA jurisdiction and specify the estimated number of units of service required, based on the individual's specific job duties and a corresponding assessment of the expected frequency, intensity, and duration of his or her support needs. • The CSA or LBHA may grant authorizations up to 400 units of service per participant, with one unit of service equal to 15 minutes of service. All DORS service rules apply. - The authorization is in lieu of a DORS authorization, when an official denial of service has been received, and is not intended to supplement the DORS authorization of intensive job coaching hours. • SE providers need to secure a competitive placement prior to seeking authorization from the CSA or LBHA for the placement phase. - The CSA or LBHA will review the placement information to screen out requests for authorization for agency-sponsored employment.

Supported Employment (SE) Program	
Service Name	**Notes**
Authorization Process continued	**Restrictions** • Any SE placement or related SE services, occurring in a facility, entity, subsidiary, affiliate, or contract site that is owned, operated, or managed by its own approved supported employment program or its umbrella organization, will be considered to be agency sponsored employment, and will not be eligible for supported employment authorization and reimbursement within the PBHS.
Admission Criteria	**Admission Criteria for Adult (ages 26 and above)** The following criteria are necessary for admission: 1. The participant has one of the following specialty mental health diagnoses in the modified priority population: o Schizophrenia o Schizophreniform Disorder o Schizoaffective Disorder, Bipolar Type o Schizoaffective Disorder, Depressive Type o Other Specified Schizophrenia Spectrum and Other Psychotic Disorder o Unspecified Schizophrenia Spectrum and Other Psychotic Disorder o Delusional Disorder o Major Depressive Disorder o Unspecified Depressive Disorder o Bipolar I Disorder, Current or Most Recent Episode Manic o Bipolar I Disorder, Current or Most Recent Episode Depressed o Bipolar I Disorder, Current or Most Recent Episode Hypomanic o Bipolar I Disorder, Current or Most Recent Episode Unspecified o Other Specified Bipolar and Related Disorder o Unspecified Bipolar and Related Disorder o Bipolar II Disorder o Schizotypal Personality Disorder o Borderline Personality Disorder WHICH: a. May include other specifiers WITH THE EXCEPTION OF “single episode,” “in partial remission,” or “in full remission;” and b. May co-occur with an intellectual disability or neurodevelopmental disorder (i.e., communication disorder, autism spectrum disorder, attention deficit/hyperactivity disorder, motor disorder, or other neurodevelopmental disorder), provided that the co-occurring diagnosis does not meet eligibility criteria for Developmental Disability Administration services and the most prominent symptoms, behavior, or functional impairments are primarily attributable to a diagnosed serious mental illness and NOT primarily attributable to an intellectual disability or neurodevelopmental disorder; AND

Supported Employment (SE) Program	
Service Name	**Notes**
Admission Criteria Continued	2. Have demonstrated impaired role functioning, on a continuing or intermittent basis, for at least two years, comprising three serious functional impairments including: a. Marked inability to maintain independent employment, characterized by an established pattern of unemployment, underemployment, or sporadic employment, which requires intervention by the behavioral health system beyond what is typically available in mainstream workforce development or social service organizations, and which is primarily attributable to symptoms, behavior or other functional limitations primarily associated with a diagnosed serious mental illness and NOT primarily associated with an intellectual disability or neurodevelopmental disorder; and b. Two or more of the following functional limitations: o Social behavior that results in interventions by the behavioral health system. o Inability, due to cognitive disorganization, to procure financial assistance to support living in the community; o Severe inability to establish or maintain a personal support system; or o Need for assistance with basic living skills. AND 3. Express the desire to work in competitive, integrated employment. **Admission criteria for Transition Age youth or Young Adult (ages 16 to 25):** The following criteria are necessary for admission: 1. Have one of the following DSM-V diagnoses: o Schizophrenia o Schizophreniform Disorder o Schizoaffective Disorder, Bipolar Type o Schizoaffective Disorder, Depressive Type o Other Specified Schizophrenia Spectrum and Other Psychotic Disorder o Unspecified Schizophrenia Spectrum and Other Psychotic Disorder o Delusional Disorder o Disruptive Mood Dysregulation Disorder o Major Depressive Disorder o Unspecified Depressive Disorder o Bipolar I Disorder, Current or Most Recent Episode Manic o Bipolar I Disorder, Current or Most Recent Episode Depressed o Bipolar I Disorder, Current or Most Recent Episode Hypomanic o Bipolar I Disorder, Current or Most Recent Episode Unspecified o Other Specified Bipolar and Related Disorder o Unspecified Bipolar and Related Disorder o Bipolar II Disorder o Schizotypal Personality Disorder o Borderline Personality Disorder

Supported Employment (SE) Program	
Service Name	**Notes**
Admission Criteria Continued	○ Social Anxiety Disorder ○ Panic Disorder ○ Agoraphobia ○ Generalized Anxiety Disorder ○ Obsessive Compulsive Disorder ○ Posttraumatic stress disorder WHICH: a. May include other specifiers; and b. May co-occur with an intellectual disability or neurodevelopmental disorder (i.e., communication disorder, autism spectrum disorder, attention deficit/hyperactivity disorder, motor disorder, or other neurodevelopmental disorder), provided that the co-occurring diagnosis does not meet eligibility criteria for Developmental Disability Administration services and the most prominent symptoms, behavior, or functional impairments are primarily attributable to the priority population diagnosis and NOT primarily attributable to an intellectual disability or neurodevelopmental disorder. AND 1. Have demonstrated impaired role functioning, on a continuing or intermittent basis, for at least two years, comprising three serious functional impairments including: a. Marked inability to maintain independent employment, characterized by an established pattern of unemployment, underemployment, or sporadic employment, which requires intervention by the behavioral health system beyond what is typically available in mainstream workforce development or social service organizations, and which is primarily attributable to symptoms, behavior or other functional limitations primarily associated with a diagnosed serious mental illness and NOT primarily associated with an intellectual disability or neurodevelopmental disorder; and b. Marked inability to function in a work or school setting due to delayed or impaired psychological, emotional, social, or cognitive skill development which is primarily attributable to symptoms, behavior or other functional limitations primarily associated with a diagnosed mental illness and NOT primarily associated with an intellectual disability or neurodevelopmental disorder; and c. One or more of the following functional impairments: ○ Need for frequent assistance with performing developmentally appropriate self-care tasks or maintaining one's personal environment; ○ Marked impairment in impulse control, emotional regulation, or judgment; ○ Persistent inability to effectively manage the symptoms of one's illness;

Supported Employment (SE) Program	
Service Name	**Notes**
Admission Criteria Continued	○ Persistent inability to modulate one's behavior, not otherwise manifested by criminal behavior, in response to social cues and societal or cultural norms; ○ Marked or persistent inability to independently initiate and complete tasks or to sustain effort and perseverance; or ○ Marked impairments in reality testing or social behavior associated with psychosis, AND 2. Express the desire to work in competitive, integrated employment. The specific diagnostic criteria may be waived if the individual is not otherwise eligible for Developmental Disability Administration (DDA) services and: a. Is transitioning from a Residential Treatment Center (RTC); or b. Has a history of two or more inpatient psychiatric hospitalizations; or c. Is receiving Home and Community-Based Services: Intensive Behavioral Health Services for Children, d. Youth, and Families – 1915(i); or e. Is receiving specialty behavioral health services from a BHA-designated Transition-Age Youth program. **Continuing Stay Criteria - Adult and Transition-Age Youth and Young Adult** The following criteria are necessary for continuing treatment at this level of care: • The participant expresses the desire to receive supported employment services; **AND** • The participant continues to meet admission criteria and requires supported employment interventions to choose, obtain, maintain, or advance within competitive employment, within a community-integrated work environment; **OR** • The individual requires supported employment interventions to change jobs, increase hours of employment or advance within his or her career.

Supported Employment (SE) Program	
Service Name	**Notes**
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • One unit is billed for each phase, except for the Intensive Job Coaching Phase o The number of units billed for Intensive Job Coaching services is based on the actual number of units authorized with one unit equal to 15 minutes of service • Claims submitted with date spans will be denied • Visit data needs to be submitted to establish the actual number of Psychiatric Rehabilitation Program (PRP) services delivered for Psychiatric Rehabilitation Program- Supported Employment (PRP-SE) • S9445 is the code for billing the PRP-SE monthly rate • Only one unit of S9445 per participant/per provider may be billed each month • The date of service for the monthly claim may be any date within the month, (i.e., the January monthly claim may have any date of service of January) • The monthly claim may be billed, at the earliest, the first day of the month following the month of service being billed, (i.e., the January monthly claim may be billed no earlier than February 1) or the date the two visits for the month is achieved • Visit claims should be submitted at the time the service is rendered or on the claim with the monthly rate • If submitted with the monthly rate, the monthly rate should be billed on claim line item 1 and the visits reported on an individual claim line with one unit per date of service • Visit claims may not be submitted prior to the date of service of the visit • Visit claims may only have one line per visit with one date of service and one unit • Visit claims should be billed as H2016 U1 with a billed at amount of $1 and will be reimbursed at $0 • A minimum of two visits counts per month is required to be submitted in order to be reimbursed for the monthly rate.
Additional Information	• For SE service recipients, income derived from SE may be reviewed to determine if the individual has sufficient earned income to contribute to RRP cost of care without jeopardizing the individual's motivation for employment. o Providers are expected to negotiate with the individual regarding contributing to the cost of care, to preserve the financial incentive for employment. • Participants who are recovering from serious mental illness or are transitioning from PRP services retain access to and eligibility for SE services as their symptoms abate and functioning improves as a means to further support, sustain, or extend their recovery from serious mental illness • A Supported Service is eligible to receive evidence-based practice rates of reimbursement after meeting the requirements outlined in the MHA and BHA Policy and Policy Clarification Memorandum. All providers are required to have an active Maryland MA provider number and a signed provider agreement with MDH.

Respite Care (RC) Program Description	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Introduction** • Respite Care (RC) is provided when the caregiver, family participant, or participant requires another environment on a short-term basis to support the participant in order to prevent escalation to more intensive levels of care. • In addition to the home environment, respite is an option when participants who live in a congregate setting need a hiatus from the interactions with roommates in order to maintain their living environment. • When an individual has a mental disorder that requires professional evaluation and treatment, he/she should be treated in the least intensive setting able to meet the individual's medical needs. Satisfaction of all admission and continued care criteria needs to be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized. • Respite care services for children provide temporary relief to parents and caregivers who are taking care of children with emotional and/or behavioral health needs. These services can vary depending on the specific needs of the child and their family, but some common examples of respite care services for children include: o In-home respite care: A caregiver comes to the family's home to provide care for the child while the primary caregiver takes a break. o Facility-based respite care: The child attends a respite care center where they can participate in activities and receive care from trained staff. o Overnight respite care: The child stays overnight at a respite care facility or with a trained caregiver to give the primary caregiver a break. **CPT/Revenue Codes** • T1005 (In-home) -both adult & C&A • H0045 (Facility based/ out of home)- Adult • H0045-UA (facility based/out of home)- C&A
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.02 • COMAR 10.63.03.15
Provider Eligibility (Who is Eligible to Provide this Service?)	• Approved respite service providers according to COMAR 10.63.03.15 • Respite Provider Type: RS • There are five (5) Respite Care facilities in Maryland for C&A. o Children's Choice o Community Behavioral Health o Crossroads Community o Maple Shade Youth and Family Services, Inc. o Villa Maria, Associated Catholic Charities

Respite Care (RC) Program Description	
Service Name	**Notes**
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	The following are requirements for respite providers: • Be licensed per COMAR and approved as a respite care services program in compliance with COMAR 10.63.03.15 Providers will coordinate through Carelon Provider Relations for Maryland Medicaid to have their provider files created. Carelon Behavioral Health of Maryland: • Phone: 1-800-888-1965 • Email: Provider.relations.MD@carelon.com
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant • Dual participant (Medicare/Medicaid) • Uninsured eligible participant

Authorization Process
(How does a provider seek Authorization for the Service, and what forms are needed?)
	• Prior to admission, an authorization request needs to be made via Carelon's Provider Digital Front Door.
	• The authorization request (Auth Request) is required to include:
	  ○ Completed Auth Request form
	  ○ Statement of DSM 5 diagnosis
	  ○ Treatment history
	  ○ Medications
	  ○ Substance use history
	  ○ Risk assessment
	• Concurrent authorization requests should be submitted via Carelon's Provider Digital Front Door with clinical information that shows the participant continues to meet all eligibility (admission) requirements.

Admission Criteria	**Admission Criteria (Adult)** All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis and has emotional and/or behavioral problems which stress the ability of the caregiver to provide for the individual in the home. • The family or caregiver's ability to participate in normal activities of daily life in the community, including employment, training opportunities, other family obligations, and social connection is compromised as a result of caring for the individual. • The additional stress on the caregiver of caring for the participant puts the participant at-risk of out-of-home placement, homelessness, or a higher level of care. **Service Delivery/Severity of Need and Intensity of Service** Medical necessity for the use of respite care is required to be documented by the presence of all of the criteria. Respite care can be used in a variety of

Respite Care (RC) Program Description	
Service Name	**Notes**
Admission Criteria Continued	settings to de-escalate situations that put the individual at risk of losing his/her placement or needing higher levels of care. **Admission Criteria (Child & Adolescent)** All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis and has emotional and/or behavioral problems which stress the ability of the caregiver to provide for the individual in the home. • The family or caregiver's ability to participate in normal activities of daily life in the community, including employment, training opportunities, other family obligations, and social connection is compromised as a result of caring for the individual. • The additional stress on the caregiver of caring for the participant puts the participant at-risk of out-of-home placement. **Continuing Stay Criteria (Adult + Child / Adolescent)** The following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet all admission criteria. **Service Delivery/Severity of Need and Intensity of Service (Child & Adolescent)** Medical necessity for the use of respite care is required to be documented by the presence of all of the criteria. When an Individual has a mental disorder that requires professional evaluation and treatment, caring for this Individual can create a burden on caregivers. As a result, the level of burden on the family caregivers is as important a dimension in determining medical necessity as the clinical status of the individual.
Claims Submission (What is Required to Submit a Claim for this Service?)	• Respite providers submit claims monthly to Carelon for services to clients who are enrolled in care. • Facility – H0045 per diem • In-Home Respite – T1005 (billed in 15 min increments)

Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Planned Conclusion: At the agreed upon time of conclusion of a respite care episode, the program director should confirm a documented summary of the episode in the individual's record.
	• Individual's Discontinuation of Services: If an individual elects to discontinue services before the planned conclusion of a respite episode, as described in §A of this regulation, the program director needs to:
	  o Promptly notify the individual's caregiver or designated emergency contact
	  o If the individual is a child, discharge the child only to an adult who is legally responsible for the child
	  o Notify the CSA/LBHA and the Administration's ASO of the action
	  o Assure that staff document a summary of the episode in the individual's record

Respite Care (RC) Program Description	
Service Name	**Notes**
Discharge/Aftercare Planning Continued	• Program's Recommendation to Discontinue Services: If the program director recommends discharging an individual who does not comply with the program's rules or for whom the program's services are not appropriate, the program director should follow the provisions outlined above.
Additional Information	• Adult, child, and adolescent respite services are authorized as follows: o Facility Based Respite: ▪ Facility based respite providers can include licensed foster homes, group homes, or other facilities approved as a respite services provider. ▪ Authorized in full-day increments, 12-hour minimum o In-home Respite: ▪ In-home respite services may be provided in the community at a variety of locations through prearrangement with the caregiver and the participant. ▪ Authorized in hourly increments, 10 hours a day, maximum • Service Reminders o Respite services differ from the following services: ▪ PRP services, which target active rehabilitation and training in social skills and instrumental activities of daily living. ▪ Residential crisis services, which target acute psychiatric symptoms in a therapeutic milieu ▪ Shelter care, provided through the Maryland Department of Social Services (DSS) o Enhanced support services will not be authorized in conjunction with respite services for adults, children, or adolescents.

Enhanced Support Services (ESS) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Introduction** • Enhanced Support Services (ESS) are short-term, in-home, one-to-one services to provide supervision and assistance to a participant experiencing an increase or instability of psychiatric symptoms, or participants transitioning from an inpatient level of care. This service is only provided by a provider of psychiatric rehabilitation program (PRP), residential rehabilitation program (RRP), or mobile treatment services (MTS). **CPT/Revenue Codes** • S5150
Legislative/Regulatory References (COMAR, other laws affecting this service?)	COMAR 10.63
Provider Eligibility (Who is Eligible to Provide this Service?)	• Approved ESS provider types: PRP and MT • Enhanced support services can only be provided by approved Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRP), and Mobile Treatment Services (MTS)
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	The following are requirements for ESS providers: o Be licensed per COMAR o Have an active Maryland Medicaid provider o Enroll via ePREP as a PT PR (PRP) or PT MT (MTS)
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant • Dual participant (Medicaid/Medicaid) • Uninsured eligible participant
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• Prior to admission, an authorization request needs to be made via Carelon's Provider Digital Front Door. • To assist with the submission of the authorization request, provider should have all pertinent clinical information justifying the need for the service. At minimum, this includes the requested start and end date and number of hours per day the service is requested. • Upon submission of the request, the Core Service Agency (CSA) or Local Behavioral Health Authority (LBHA) reviews the requests and makes determinations • If a CSA or LBHA Care Manager is unable to authorize the service as medically necessary, the request for services will be referred to a CSA or LBHA Physician Advisor for review • Determinations will be communicated via Carelon's Provider Digital Front Door • Authorization Span Specifications: Initial and concurrent: authorization span length determined by provider, but cannot exceed 10 days per episode and no more than 30 total days in a year • All of the following criteria are necessary for continuing treatment at this level of care:

Enhanced Support Services (ESS) Program	
Service Name	**Notes**
Authorization Process Continued	○ The participant continues to meet admission criteria but has not reached the maximum episodic or annual limitations. ○ Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident. • There is documented active planning for transition to a less intensive level of care.
Admission Criteria	**Admission Criteria (Adult)** All of the following criteria are necessary for admission: • The participant either has Medicaid, is PBHS-eligible Medicare, or is uninsured eligible for uninsured coverage. The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention. • The participant's functioning is seriously disrupted and threatens the safety of the participant, family, community, or in-home placement. • The participant/family has the capacity and is willing to actively participate in this intervention. • There are multiple systemic problems that may require in- home intervention up to several hours per week. **Continuing Stay Criteria** The following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria but has not reached the maximum episodic or annual limitations. • Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident. • There is documented active planning for transition to a less intensive level of care. **Service Delivery** Enhanced support services will be reimbursed for a maximum of ten days per episode/30 days per calendar year. Enhanced support services cannot be authorized in conjunction with respite services.
Claims Submission (What is Required to Submit a Claim for this Service?)	• ESS Providers submit claims via Carelon's Provider Digital Front Door for services to clients who are enrolled in care. • A unit of enhanced support Services is one hour of services

Enhanced Support Services (ESS) Program	
Service Name	**Notes**
Claims Submission Continued	• The number of units is required to equal the number of hours of enhanced support services that were provided (e.g., one unit = one hour, six hours = six units) • Each day of service needs to be on a separate claim form line, with claims specifying an ICD-10 code, not DSM 5 code. ICD-10 is for claims. • Enhanced support services will be reimbursed for a maximum of ten days per episode/30 days per calendar year. • Enhanced support services cannot be authorized in conjunction with respite services.
Additional Information	• Enhanced support services: o Will be provided in the participant's place of residence o Are not available for participants in inpatient facilities, residential treatment center (RTC) settings, or partial hospitalization programs (PHPs) o Are considered short-term and will be reimbursed for a maximum of 10 days per episode/30 days per calendar year o Cannot be authorized in conjunction with respite services o Do not cover the provision of personal care services, which may be reimbursable by Medicaid under a separate funding authority o Are not available for individuals who meet criteria for a Medicaid Home and Community Based Waiver (e.g., DDA Community Pathways Waiver, TBI Waiver, Community Options Waiver - Community First Choice

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** • An accreditation-based licensed program that provides community-based psychiatric rehabilitation services to facilitate recovery by supporting the individual to develop the skills and to access the resources necessary to participate fully in the community, including promoting the ability to make decisions about one's life and the opportunity to exercise informed choice. The following are the levels of care offered via the PRP: **1. Community PRP (authorized as PR1, billed as U2) –** Services provided to: a. Participants aged 18-25 (transition age youth [TAY] if services are provided by a BHA- designated TAY program). b. Adults under legal guardianship. Services are provided to participants at a minimum of two encounters per month. **2. Supported/Independent Living PRP (authorized as PR2, billed as U3) –** a. Services provided to adults who are their own legal guardian. b. Services are provided to participants at a minimum of three encounters per month. **Criteria** • One unit of PRP is equivalent to one month of PRP services. • Each level of PRP service stipulates a minimum number of face-to-face visits to be provided. • Encounter data for face-to-face visits need to be submitted. • At least two days of encounters are required for participants receiving the community level (PR1/U2 and PR2/U3). • Encounters that occur at a nursing home, hospital, or other institution cannot be submitted to support the monthly PRP claim. **CPT/Revenue Codes** • H2018 (requires the applicable U code modifier) • H0002 (assessment code, does not require authorization, reimbursable once per year) **Service Restrictions** • PRP services are not to be utilized for individual/family therapy. • Transportation is not a PRP service and cannot be counted as a visit. • BHA will not authorize or pay for PRP for a child residing in a therapeutic group home, or therapeutic foster care setting if similar support services are part of the per diem rate of that youth in placement. o There may be limited reimbursement for a child residing in a regular group home. ▪ These residential settings are responsible for promoting the skills required for daily living and may at times need to provide intensive support or supervision to youth in their care.

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**

Service Description Continued	• BHA will not authorize or reimburse a provider for on-site only PRP services for a participant who is receiving Medicaid-covered adult medical day care services during the same month. However, the provider may submit the blended rate PRP services provided to a participant also receiving medical day care as long as the minimum service requirements are met by providing only off-site services.
	  o The off-site PRP services may not be delivered at the medical day care program.
	• Requests for targeted case management or mobile treatment for participants enrolled in PRPs will not be approved.
	  o Participants receiving PRP services are expected to receive basic case management functions, such as assistance in securing and maintaining entitlements, facilitation of transportation to appointments, coordination of services, and liaison with external services (somatic, substance use, and mental health) within the provision of PRP services.
	• On-site services provided by two different PRPs, as well as off-site services provided by two different PRPs, is a duplication of services and is not allowed.
	• No more than one transitional PRP service per day, for a minimum requirement of four PRP services, while a participant is in a state psychiatric hospital may be authorized, as medically necessary.
	  o These visits need to be pre-authorized by the LBHA/CSA and are paid out of state general funds.
	• All adult PRP services need to be referred by the licensed mental health provider who is treating the participant.
	  o There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional every six months.

Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.01.05: Licensed Community-based Behavioral Health Programs • COMAR 10.63.02: Accreditation-based Licensed Behavioral Health Programs • COMAR 10.63.03.09: Psychiatric Rehabilitation Program for Adults (PRP-A) • COMAR 10.63.06: Application and Licensure Process • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** • PRP-A providers need to be approved according to COMAR 10.63.03.09 and COMAR 10.09.59.04B(1), for PRP-A providers. • PRP-M providers need to be approved according to COMAR 10.63.03.10 and COMAR 10.09.69.04B(2), for PRP-M providers. • Providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with BHA.
Provider Enrollment	• Providers enroll via ePREP as PT PR. • Authorized Provider Types: PR

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** • Participants are required to have federally funded or state-funded Medicaid (Qualified Medicare Beneficiary [QMB] or Specified Low-Income Medicare Beneficiary [SLMB]) OR • Participants need to be fully eligible for both Medicare/Medicaid OR • Participants need to have been receiving PRP services when they lost their federally funded insurance OR • Participants need to meet uninsured eligibility criteria
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** The PRP authorization process ranges from initial participant referral to determination of participant need for additional services. The PRP provider decides whether to admit the participant, completes the required documentation, sets the appropriate modifier, enters any applicable data, and submits the initial service request to the Administrative Services Organization (ASO). If Carelon denies the authorization/registration request the PRP provider has the option to appeal or accept the decision. If appealing the decision, the PRP provider is required to share additional information about the participant with a Carelon psychiatrist. If Carelon approves the authorization/registration request the PRP provider can render services to the participant. **Criteria** • All adult PRP services are required to be referred by the licensed mental health provider who is treating the participant. • When submitting the PRP authorization to Carelon, the signed referral form needs to accompany the request for all initial authorizations. There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional for each continued stay request. **Restrictions** PRP providers are required to complete an individualized rehabilitation plan (IRP) according to the requirements of COMAR 10.63.03.09 and COMAR 10.63.03.10.
Admission Criteria	**Admission Criteria (Adult)** All of the following criteria are necessary for admission: • The individual meets DSM-5 diagnostic criteria for a Public Behavioral Health System (PBHS) specialty mental health diagnosis in the Priority Population (either Category A or Category B). **A. Category A Diagnoses **** • Paranoid Schizophrenia • Disorganized Schizophrenia • Catatonic Schizophrenia • Undifferentiated Schizophrenia • Residual Schizophrenia • Schizophreniform disorder • Other schizophrenia • Schizophrenia, unspecified • Schizoaffective disorder, bipolar type • Schizoaffective disorder, depressive type • Other schizoaffective disorders

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Admission Criteria Continued	• Schizoaffective disorder, unspecified • Delusional disorders • Other psychotic disorder • Unspecified psychosis • Bipolar I disorder, manic, severe with psychotic features • Bipolar I disorder, depressed, severe with psychotic features • Bipolar I disorder, mixed, severe w/ psychotic features • Major Depressive Disorder, recurrent, severe with psychotic features ***The specific diagnostic criteria may be waived for one of the following two conditions: 1. An individual found not competent to stand trial or not criminally responsible due to a mental disorder pursuant to Criminal Procedure, § 3-101 et. seq, Annotated Code of Maryland, and receiving services recommended by a Behavioral Health Administration/Maryland Department of Health evaluator or facility or court order. 2. An individual in a Maryland state psychiatric facility with a length of stay of more than three months who requires Residential Rehabilitation Program (RRP) services upon discharge. This excludes individuals eligible for Developmental Disabilities Administration Services. OR **B. Category B Diagnoses** • Bipolar I disorder, hypomanic • Bipolar I disorder, manic, severe • Bipolar I disorder, depressed, severe • Bipolar I disorder, mixed, severe without psychotic features • Bipolar II disorder • Bipolar disorder, unspecified • Major Depressive Disorder, recurrent, severe, without psychotic features • Borderline personality disorder Category A diagnoses are necessary to meet either C or D. Category B diagnoses are required to meet criteria in D. C. The individual is currently enrolled in SSI or SSDI D. The individual demonstrates impaired role functioning for at least two years. To be considered evidence of impaired role functioning at least three of the following need to have been present on a continuing or intermittent basis: • Marked inability to establish or maintain independent competitive employment, characterized by an established pattern of unemployment, underemployment, or sporadic employment that is primarily attributable to a diagnosed serious mental illness, which requires intervention by the behavioral health system beyond what is available to the individual from by mainstream workforce development, educational, faith-based, community or social service organizations. This does not include limitations due to factors such as geographic location, poverty, lack of education, availability of transportation, or loss of driver's license due to legal problems.

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Admission Criteria Continued	• Marked inability to perform instrumental activities of daily living (shopping, meal preparation, laundry, basic housekeeping, medication management, transportation, and money management) that is primarily attributable to a diagnosed serious mental illness, which requires intervention by the behavioral health system beyond what is available to the individual from by mainstream workforce development, educational, faith-based, community or social service organizations. This does not include limitations due to factors such as geographic location, poverty, lack of education, availability of transportation, or loss of driver's license due to legal problems. • Marked inability to establish or maintain a personal support system, characterized by social withdrawal or isolation, interpersonal conflict, or social behavior (other than criminal behavior) that is not easily tolerated in the community and primarily attributable to a diagnosed serious mental illness, and which requires intervention by the behavioral health system beyond what is available to the individual from by mainstream workforce development, educational, faith-based, community or social service organizations. This does not include limitations due to factors such as geographic location, poverty, lack of education, availability of transportation, or loss of driver's license due to legal problems. • Marked or frequent deficiencies of concentration, persistence or pace that is primarily attributable to a serious mental illness resulting in a failure to complete in a timely manner tasks commonly found in work, school, or home settings, which requires intervention by the behavioral health system beyond what is available to the individual from by mainstream workforce development, educational, faith-based, community or social service organizations • Marked inability to perform or maintain self-care (hygiene, grooming, nutrition, medical care, personal safety) that is primarily attributable to a serious mental illness, and which requires intervention by the behavioral health system beyond what can be reasonably provided by mainstream workforce development, educational, faith-based, community or social service organizations. • Marked deficiencies in self-direction, characterized by an inability to independently plan, initiate, organize, and carry out goal-directed activities that is primarily attributable to a serious mental illness, and which requires intervention by the behavioral health system beyond what can be reasonably provided by mainstream workforce development, educational, faith-based, community or social service organizations. • Marked inability to procure financial assistance to support community living, which inability is primarily attributable to a serious mental illness, and which requires intervention by the behavioral health system beyond what can be reasonably provided by mainstream workforce development, educational, faith-based, community or social service organizations. This does not include limitations due to factors such as geographic location, poverty, lack of education, availability of transportation, or loss of driver's license due to legal problems. AND • The nature of the participant's functional impairments and/or skill deficits can be effectively remediated through specific, focused skills-training activities designed to develop and restore (and maintain) independent living skills to support the individual's recovery. • The participant needs to be concurrently engaged in outpatient mental health treatment.

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Admission Criteria Continued	• All participants residing in an RRP are required to have PRP services available. • The participant does not require a more intensive level of care. • All less intensive levels of treatment have been determined to be unsafe or unsuccessful • Peer or natural support alternatives have been considered or attempted, and/or are insufficient to meet the need for specific, focused skills training to function effectively. E. Individuals meeting the criteria in Category D who do not yet have two years of impaired functioning may be considered for PRP if they have new onset category A diagnosis and PRP services would be considered the most effective means to diminish the risk: F. Severity of Need and Intensity of Service Medical necessity for admission to Psychiatric Rehabilitation Program services are required to be documented by the presence of all of the criteria. The length and frequency of the services varies based on the individual's needs and medical necessity. Professional and/or social support needs to be identified and available to the participant outside of program hours, and the participant is required to be capable of seeking them as needed. Active involvement of the participant, family, caretakers, or significant others involved in the individual's psychiatric rehabilitation cannot sought. **Exclusionary Criteria:** 1. Individual's level of cognitive impairment, current mental status, or developmental level cannot be reasonably accommodated within the psychiatric rehabilitation service such that the severity of impairment precludes the individual from benefiting from psychiatric rehabilitation services. 2. The individual meets eligibility for full funding for Developmental Disability Administration services. 3. The primary etiology of the individual's dysfunction is related to an organic process or syndrome, intellectual disability, neurodevelopmental disorder, or neurocognitive disorder. 4. The individual meets criteria for a higher level of care and cannot be safely or effectively served in psychiatric rehabilitation services 5. The individual can be effectively served with less intensive formal services, or with natural supports, such as peers and family. 6. As of July 1, 2020, PRP may not be provided in conjunction with a. Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT) -Adult b. Adult Targeted Case Management (TCM) c. Inpatient d. MH-Residential Treatment Center (RTC) e. Residential SUD Treatment Level 3.3 and higher f. SUD IOP/2.1 g. MH IOP/PHP h. Residential Crisis

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Admission Criteria Continued	**Continued Stay Criteria** All of the following criteria are necessary for continuing service at this level of care: A. The individual continues to meet admission criteria. B. Clinical evidence indicates that the therapeutic re-entry into a less intensive level of care would result in exacerbation of the symptoms of the individual's mental disorder. C. There is an individualized rehabilitation plan justifying ongoing services that details the services and interventions to be provided. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but rehabilitation goals have not been achieved or adjustments in the rehabilitation plan to address the lack of progress are evident and/or a second opinion on the rehabilitation plan has been considered. (There should be daily progress notes that document psychiatric rehabilitation interventions and the individual's response to the interventions.) D. There is evidence that the participant, family, caretaker, or significant other is involved in psychiatric rehabilitation in the frequency and manner indicated by the rehabilitation plan. E. There is documented active planning for the transition to a less intensive level of care F. The participant is required to be engaged in mental health treatment with an outpatient clinician that does not work in or receive remuneration in any form from the PRP Intermittent periods of disengagement secondary to the psychiatric disability may occur and cannot be construed to exclude the individual from services, if evidence exists that assertive and motivational strategies are being employed to re-engage the individual in treatment, and there is documented communication between the PRP and clinician. **Discharge Criteria** A. The individual has achieved maximum rehabilitative benefit from the psychiatric rehabilitation service and is assessed to no longer require this level of care to apply skill gains in natural, community settings. B. The individual has achieved self-identified rehabilitation goals and is not at risk of further skill deterioration due to withdrawal of service. C. The individual has not demonstrated significant improvement in functioning and requires a higher level of care or reassessment to identify a more effective service setting or modality. A time-limited authorization may be granted to facilitate this assessment and transition. D. The individual can be effectively served with less intensive formal services, or with natural supports, such as peers and family. Individuals no longer wishing to receive services should be assisted with referrals to other providers whenever possible. **Service Delivery** Medical necessity for admission to PRP services is required to be documented by the presence of all of the criteria. The length and frequency of the services varies based on the participant's needs and medical necessity. Professional and/or social supports need to be identified and available to the participant outside of program hours, and the participant is required to be capable of seeking them as needed. Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment should be sought.

Psychiatric Rehabilitation Program (PRP) Program - Adult

Service Name	Notes
Claims Submission (What is Required to Submit a Claim for this Service?) **Claims Submission Continued**	**Criteria** The monthly billing/payment code for either PRP or RRP therapeutic services (monthly rate) is H2018 along with the appropriate modifier based on the level of service. The modifiers are: **Modifier** / **Description** U2 – Adults ages 18-21 in a TAY-designated PRP, or adults with a legal guardian. Legal guardians are appointed through the legal system. Note: A participant who still lives with his parents at the age of 18 (or older) but there is no legal guardian is an adult (use U3) U3 – PRP for adults with no legal guardians U4 – A RRP client in the general level of care who is either on or off-site U5 – A RRP client in the intensive level of care who is either onsite or off-site U6 – A RRP client in the general level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity U7 – A RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in an onsite or off-site capacity Providers should choose the appropriate modifier when submitting the requests for authorization and use that same modifier on the monthly billing. The visit code for either PRP or RRP therapeutic services is H2016. The visit codes have minimum visits per month and are to be billed at $1.00 and paid at $0. These minimum service visits along with the place of service billed is used to calculate the fee to be paid on the monthly claim. Additional rules for submitting claims are: • H2018 is required to be billed with the appropriate modifier consistent with the authorization • Only one unit of H2018 per participant/per provider may be billed each month • The date of service for the monthly claim may be any date within the month, (i.e., the January monthly claim may list any date of service in January) • The monthly claim may have POS 49 for Blended, POS 52 for Onsite, or POS 15 for Offsite • Monthly claim H2018 may be submitted once the minimum number of authorized encounters is met for the applicable level of billing for the month. (see Provider transmittal PT-14-20) • Encounter data is required to be submitted • If there are additional encounters, the provider needs to void the original claim and submit a new claim with all encounter data for the month

Psychiatric Rehabilitation Program (PRP) Program - Adult	
Service Name	**Notes**
Claims Submission continued	• The monthly claim may be billed, at the earliest: ○ the first day of the month following the month of service being billed, (i.e., the January monthly claim may be billed no earlier than February 1), or the day the minimum visit for the month is achieved • Visit claims should be submitted at the time the service is rendered or on the claim with the monthly rate • If submitted with the monthly rate, the monthly rate should be billed on claim line item 1 and the visits reported on an individual claim line with one unit per date of service • Visit claims may not be submitted prior to the date of service of the visit • Visit claims need to have one line per visit with one date of service and one unit • Visit claims do not have a modifier • The charge submitted for the monthly service should equal the amount shown on the cascade fee schedule for the modifier and place of service, with visit units rounding down to the nearest count • Claims will be reimbursed based on the count of the visit claims received prior to, or with, the monthly claim. If the provider visit data was excluded in its H2016 claim submission, the provider needs to submit a CORRECTED claim to void the original H2018 claim and resubmit an updated H2018 claim that includes the missing H2016 visit data • Providers are required to obtain an authorization for this service. Claims without an authorization will be denied Restrictions • In the event the provider does not meet the service level minimum encounters for the authorized level of service but does meet the minimum encounters for a lower level of service, the provider will bill using the originally authorized modifier but will bill at the lower "allowed charge." • Off-site encounters are required to be a minimum of 15 minutes and on-site encounters need to be a least 60 minutes. Multiple encounters which occur on the same day and are less than the minimum duration can be combined to meet the time requirement. • It is necessary for the provider to ensure the billed amount corresponds to the level of service that has been delivered.
Discharge/Aftercare Planning	Documented active planning for the transition of the participant to a less intensive level of care is required. Once the participant has met all identified IRP goals and can no longer benefit from PRP services, the participant should be stepped down with the appropriate linkage to community-based resources, such as ongoing outpatient treatment, to maintain independence and support continued stay in the community.

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** • An accreditation-based licensed program that provides community-based psychiatric rehabilitation services to facilitate recovery by supporting the individual to develop the skills and to access the resources necessary to participate fully in the community, including promoting the ability to make decisions about one's life and the opportunity to exercise informed choice. The following are the levels of care offered via the PRP: 1. **Community PRP (authorized as PR1, billed as U2) –** Services provided to: a. Children in foster homes in which psychiatric services are not part of the day rate. Services are provided to participants at a minimum of two encounters per month. 2. **Supported/Independent Living PRP (authorized as PR2, billed as U3) –** a. Services are provided to participants at a minimum of three encounters per month. **Criteria** • One unit of PRP is equivalent to one month of PRP services. • Each level of PRP service stipulates a minimum number of face-to-face visits to be provided. • Encounter data for face-to-face visits need to be submitted. • At least two days of encounters are required for participants receiving the community level (PR1/U2 and PR2/U3). • Encounters that occur at a nursing home, hospital, or other institution cannot be submitted to support the monthly PRP claim. **CPT/Revenue Codes** • H2018 (requirements include the applicable U code modifier) • H0002 (assessment code, does not require authorization, reimbursable once per year) **Service Restrictions** • PRP services are not to be utilized for individual/family therapy. • Transportation is not a PRP service and cannot be counted as a visit. • Children and adolescents placed in a crisis bed program may attend a PHP or PRP during the day, depending upon the clinical needs of the participant. o Services are requested, reviewed, and authorized separately based on the participant's needs and respective medical necessity criteria. • BHA will not authorize or pay for PRP for a child residing in a therapeutic group home, or therapeutic foster care setting if similar support services are part of the per diem rate of that youth in placement. o There may be limited reimbursement for a child residing in a regular group home. ▪ These residential settings are responsible for promoting the skills required for daily living and may at times need to provide intensive support or supervision to youth in their care.

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**

Service Description Continued	• BHA will not authorize or reimburse a provider for on-site only PRP services for a participant who is receiving Medicaid-covered adult medical day care services during the same month. However, the provider may submit the blended rate PRP services provided to a participant also receiving medical day care as long as the minimum service requirements are met by providing only off-site services.
	  o The off-site PRP services may not be delivered at the medical day care program.
	• Requests for targeted case management or mobile treatment for participants enrolled in PRPs will not be approved.
	  o Participants receiving PRP services are expected to receive basic case management functions, such as assistance in securing entitlements, facilitation of transportation to appointments, coordination of services, and liaison with external services (somatic, substance use, and mental health) within the provision of PRP services.
	• On-site services provided by two different PRPs, as well as off-site services provided by two different PRPs, is a duplication of services and is not allowed.
	• No more than one transitional PRP service per day, for a minimum requirement of four PRP services, while a participant is in a state psychiatric hospital may be authorized, as medically necessary.
	  o These visits are required to be pre-authorized by the LBHA/CSA and are paid out of state general funds.
	• All child/adolescent PRP services need to be referred by the licensed mental health provider who is treating the participant.
	  o There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional every six months.

Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63.01.05: Licensed Community-based Behavioral Health Programs • COMAR 10.63.02: Accreditation-based Licensed Behavioral Health Programs • COMAR 10.63.03.09: Psychiatric Rehabilitation Program for Adults (PRP-A) • COMAR 10.63.03.10: Psychiatric Rehabilitation Program for Minors (PRP-M) • COMAR 10.63.06: Application and Licensure Process • COMAR 10.09.59
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** • PRP-A providers are required to be approved according to COMAR 10.63.03.09 and COMAR 10.09.59.04B(1), for PRP-A Providers. • PRP-M providers are required to be approved according to COMAR 10.63.03.10 and COMAR 10.09.69.04B(2), for PRP-M Providers. • Providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with BHA. **Authorized Provider Types** PR

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** • Participants need have federally funded or state-funded Medicaid (Qualified Medicare Beneficiary [QMB] or Specified Low-Income Medicare Beneficiary [SLMB]) OR • Participants need to be fully eligible for both Medicare/Medicaid OR • Participants need to have been receiving PRP services when they lost their federally funded insurance OR • Participants need to meet uninsured eligibility criteria
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** The PRP authorization process ranges from initial participant referral to determination of participant need for additional services. The PRP provider decides whether to accept the participant, completes the required documentation, sets the appropriate modifier, enters any applicable data, and submits the initial service request to Carelon. If Carelon denies the authorization/registration request, the PRP provider has the option to appeal or accept the decision. If appealing the decision, the PRP provider is required to share additional information about the participant with the ASO psychiatrist. If Carelon approves the authorization/registration request, the PRP provider can render services to the participant. **Criteria** • All child/adolescent PRP services are required to be referred by the licensed mental health provider who is treating the participant. • When submitting the PRP authorization to Carelon, the signed referral form needs to accompany the request for all initial authorizations. There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional for each continued stay request. **Restrictions** PRP providers are required to complete an individualized rehabilitation plan (IRP) according to the requirements of COMAR 10.63.03.09 and COMAR 10.63.03.10.
Admission Criteria	**Admission Criteria (Child and Adolescent)** All of the following criteria are necessary for admission: A. The youth has a Public Behavioral Health System (PBHS) specialty mental health DSM-5 diagnosis and the youth's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services. B. The youth's emotional disturbance is the cause of serious dysfunction in multiple life domains (home, school, community) C. The impairment as a result of the youth's emotional disturbance results in: a. A clear, current threat to the youth's ability to be maintained in his/her customary setting, or b. An emerging/impending risk to the safety of the youth and others, or

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	c. Other evidence of significant psychological or social impairments such as inappropriate social behavior causing serious problems with peer relationships and/or family participants. D. The youth, due to the dysfunction, is at-risk for requiring a higher level of care, or is returning from a higher level of care. E. The youth's condition requires an integrated program of rehabilitation services to return to age-appropriate development and to progress accordingly towards independent functioning and independent living skills, F. The youth does not require a more intensive level of care and is deemed to be able to be safely maintained in the rehabilitation program and to benefit from the rehabilitation provided. G. A documented crisis response plan, including both family/guardian and the primary treating provider, is in progress or completed. H. All PRP services are rendered by trained staff supervised by a licensed mental health professional. I. And either a. There is clinical evidence that the current intensity of outpatient treatment is not sufficient to reduce the youth's symptoms and functional behavioral impairment resulting from the mental illness and restore him/her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the youth or others; Or alternatively a. Youth transitioning from an inpatient, day hospital or residential treatment setting to a community setting and there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support a successful transition back to the community or avert the need to initiate or continue a more intensive level of care. J. There is evidence that the use of pharmacotherapy, if deemed appropriate, has been considered by the primary treating clinician. **Severity of Need and Intensity of Service** Medical necessity for admission to Psychiatric Rehabilitation Program services are required to be documented by the presence of all of the criteria. The length and frequency of the services vary based on the needs of the youth and medical necessity. Professional and/or social supports need to be identified and available to the youth outside of program hours and the youth or the youth's parent/caretaker are required to be capable of seeking them as needed. Active engagement of the youth, family, caretakers, or significant others involved in the youth's treatment should be sought.

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	**Continued Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: A. The youth continues to meet the admission criteria. B. Clinical evidence indicates that the therapeutic transition into a less intensive level of care would result in exacerbation of the C. symptoms of the youth's mental disorder. D. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress is evident. The PRP provider is responsible for ensuring encounter notes clearly document services provided and the youth's response to said services. E. A Plan of Treatment/Rehabilitation is reviewed with the parent/guardian and the primary treating (i.e., the referring clinician) clinician with each concurrent review. F. There is evidence that the youth, family, caretaker, or significant other is involved in treatment in the frequency and manner indicated by the treatment plan. G. There is verifiable evidence of ongoing and active participation in routine outpatient treatment including pharmacotherapy if deemed appropriate by primary clinician. H. There is documented active planning for the transition to a less intensive level of care. **Exclusionary Criteria** 1. Youth's level of cognitive impairment, current mental status, or developmental level cannot be reasonably accommodated within the psychiatric rehabilitation service such that the severity of impairment precludes the individual from benefiting from psychiatric rehabilitation services. 2. The youth meets eligibility for full funding for Developmental Disability Administration services, is actively receiving services funded by the autism waiver, or is in active Applied Behavioral Analysis treatment. 3. The primary etiology of the individual's dysfunction is related to an organic process or syndrome, intellectual disability, neurodevelopmental disorder, or neurocognitive disorder. 4. The youth meets criteria for a higher level of care and cannot be safely or effectively served through psychiatric rehabilitation services 5. The youth can be effectively served with less intensive formal services, or with natural supports, such as peers and family. 6. Admission and continued stay requests are required to meet the Combination of Services rules. 7. As of April 2021, PRP-M services may not routinely be provided in conjunction with: a. Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT) b. Targeted Case Management-Level II & Level III c. Inpatient Psychiatric Services d. Crisis Residential Services e. Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	f. Mental Health- Intensive Outpatient Program (IOP) g. Mental Health- Partial Hospitalization Program (PHP) h. Respite i. Therapeutic Behavioral Services (TBS) j. Residential Substance Use Disorder Treatment Level 3.3 or higher k. Substance Use Disorder-Intensive Outpatient Program (IOP) l. Substance Use Disorder- Partial Hospitalization Program (PHP) Requests for PRP in conjunction with the abovementioned services will require clinical justification and documentation of care coordination between the service providers. Be advised requests for TCM Level I and PRP will be denied due to conflict of services. **Service Delivery** Medical necessity for admission to PRP services are required to be documented by the presence of all of the criteria. The length and frequency of the services varies based on the participant's needs and medical necessity. Professional and/or social supports need to be identified and available to the participant outside of program hours and the participant or the participant's parent/caretaker are required to be capable of seeking them as needed. Active involvement of the participant, family, caretakers, or significant others involved in the participant's treatment should be sought.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Criteria** The monthly billing/payment code for either PRP or RRP therapeutic services (monthly rate) is H2018 along with the appropriate modifier based on the level of service. The modifiers are:

Modifier	Description
U2	PRP for all children (up to the age of 18). Legal guardians are appointed through the legal system. Note: A participant who still lives with his parents at the age of 18 (or older) but there is no legal guardian is an adult (use U3)
U4	A RRP client in the general level of care who is either on or off-site
U5	A RRP client in the intensive level of care who is either onsite or off-site
U6	A RRP client in the general level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity
U7	A RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in an onsite or off-site capacity

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Claims Submission Continued	Providers should choose the appropriate modifier when submitting the requests for authorization and use that same modifier on the monthly billing. The visit code for either PRP or RRP therapeutic services is H2016. The visit codes have minimum visits per month and are to be billed at $1.00 and paid at $0. These minimum service visits along with the place of service billed is used to calculate the fee to be paid on the monthly claim. Additional rules for submitting claims are: • H2018 is required to be billed with the appropriate modifier consistent with the authorization • Only one unit of H2018 per participant/per provider may be billed each month • The date of service for the monthly claim may be any date within the month, (i.e., the January monthly claim may list any date of service in January) • The monthly claim may have POS 49 for Blended, POS 52 for Onsite, or POS 15 for Offsite • Monthly claim H2018 may be submitted once the minimum number of authorized encounters is met for the applicable level of billing for the month. (see Provider transmittal PT-14-20) • Encounter data needs to be submitted • If there are additional encounters, the provider needs to void the original claim and submit a new claim with all encounter data for the month • The monthly claim may be billed, at the earliest: o the first day of the month following the month of service being billed, (i.e., the January monthly claim may be billed no earlier than February 1), or the day the minimum visit for the month is achieved • Visit claims should be submitted at the time the service is rendered or on the claim with the monthly rate • If submitted with the monthly rate, the monthly rate should be billed on claim line item 1 and the visits reported on an individual claim line with one unit per date of service • Visit claims may not be submitted prior to the date of service of the visit • Visit claims need to have one line per visit with one date of service and one unit • Visit claims do not have a modifier • The charge submitted for the monthly service should equal the amount shown on the cascade fee schedule for the modifier and place of service, with visit units rounding down to the nearest count • Claims will be reimbursed based on the count of the visit claims received prior to, or with, the monthly claim. If the provider visit data was excluded in its H2016 claim submission, the provider is required to submit a CORRECTED claim to void the original H2018 claim and resubmit an updated H2018 claim that includes the missing H2016 visit data • Providers are required to obtain an authorization for this service. Claims without an authorization will be denied

Psychiatric Rehabilitation Program (PRP) Program – Child and Adolescent	
Service Name	**Notes**
Claims Submission Continued	**Restrictions** • In the event the provider does not meet the service level minimum encounters for the authorized level of service but does meet the minimum encounters for a lower level of service, the provider will bill using the originally authorized modifier but will bill at the lower "allowed charge." • Off-site encounters are required to be a minimum of 15 minutes and on-site encounters need to be at least 60 minutes. Multiple encounters, which occur on the same day and are less than the minimum duration, can be combined to meet the time requirement. • It is necessary for the provider to ensure the billed amount corresponds to the level of service that has been delivered.
Discharge/Aftercare Planning	Documented active planning for the transition of the participant to a less intensive level of care is required. Once a participant has met all identified IRP goals and can no longer benefit from PRP services, the participant should be assisted to transition to a lower level of care with the appropriate linkage to community-based resources, such as ongoing outpatient treatment, to maintain independence and support continued stay in the community.

Targeted Case Management (TCM) Program - Adult	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Targeted case management (TCM) programs are available to assist participants with gaining access to the full range of available mental health services, as well as any needed medical, social, financial, counseling, educational, housing, and other supporting services needed in order to maintain stability in the community. TCM works to enhance participants' mental wellness and community integration by providing access to needed resources that move them forward in their recovery and help them achieve their individual goals. Adult TCM offers two levels of service intensity based on the severity of the participant's mental illness. **Adult TCM Services:** • General Level I – includes a minimum of 1 and a maximum of 2 days of service per month. Does not include the assessment. • Moderate Level II – includes a minimum of 2 and a maximum of 5 days of service per month. • One unit of Adult TCM = any service provided on any given date of service where the contact is a minimum of one hour of either face-to-face contact with the participant or contacts with stakeholders and service providers on behalf of the participant. • The assessment uses one unit of service and is billed separately. Each participant is required to be reassessed after the initial assessment at a minimum of once every six months. A home visit is required at least once every 90 days.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.36.03 • COMAR 10.09.45
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include programs: • Competitively procured and selected by the LBHA or CSA and • Approved under COMAR 10.09.36.03, 10.09.45
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as PT CM
Participant Eligibility (Who is Eligible to Receive this Service?)	To be eligible for services covered under this chapter, a participant or applicant is required to: • Be Medicaid eligible • Meet participant eligibility requirements set forth in COMAR 10.09.45.03 for Adult TCM services

Targeted Case Management (TCM) Program - Adult	
Service Name	**Notes**
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	The TCM provider prepares the participant's TCM Plan of Care and authorization request and submits both to Carelon. Upon receipt of the documentation, Carelon Care Manager determines whether the participant meets the medical necessity criteria. • If the participant does not meet the medical necessity criteria, then the authorization request is sent to Carelon Psychiatrist for review. o If Carelon Psychiatrist also finds that the Participant does not meet medical necessity criteria, then Carelon Care Manager notifies the TCM Provider of the denial. The TCM Provider decides whether to appeal the decision. ▪ MDH Appeal Not Pursued—The TCM Provider decides not to appeal the authorization request denial determination, and the authorization process ends. ▪ MDH Appeal Pursued—The TCM Provider decides to appeal the authorization request denial determination, and the authorization process ends. o If Carelon Psychiatrist finds that the Participant meets medical necessity criteria, then Carelon sets a six-month TCM service span. • If the participant meets the medical necessity criteria, Carelon sets a six-month TCM service span.
Admission Criteria	**Admission Criteria (Adult)** All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention. • And either: o The participant is at-risk of or needs continued community treatment to prevent inpatient psychiatric treatment; **OR** o The participant is at-risk of or needs community treatment to prevent being homeless; **OR** o The participant is at-risk of incarceration or will be released from a detention center or prison The specific diagnostic criteria may be waived for the following two conditions: • A participant committed as not criminally responsible who is conditionally released from a BHA facility; **OR** • A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for Developmental Disabilities Administration's residential services. **Continuing Stay Criteria** The following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria; AND • The participant is reassessed every six months after the initial assessment;

Targeted Case Management (TCM) Program - Adult	
Service Name	**Notes**
Admission Criteria Continued	AND EITHER • The participant's current/available living environment continues to present barriers to stabilizing them; Or • Progress toward initial mental health, medical, social, and educational goals has not facilitated transition to another mental health service and the care plan reflects the necessary changes to address the lack of progress; Service delivery: • Medical necessity for admission to targeted case management services is required to be documented by the presence of all of the criteria. Active involvement of the participant, family, caretaker, or others involved in the participant's treatment should be sought. Levels of service include: o Level I – General: Is based on the severity of the participant's mental illness and if the participant meets at least one of the following conditions: ▪ Not linked to mental health and medical services ▪ Lacks basic supports for shelter, food, and income ▪ Transitioning from one level of care to another ▪ Needs to maintain community-based treatment and services o Level 2 – Intensive: Is based on the severity of the participant's mental illness, and if the participant urgently meets more than one of the following conditions: ▪ Not linked to mental health and medical services ▪ Lacks basic supports for shelter, food, and income ▪ Transitioning from one level of care to another ▪ Needs to maintain community-based treatment and services
Claims Submission (What is Required to Submit a Claim for this Service?)	**Criteria** • Providers should not submit claims unless the service has been authorized by Carelon • Claims should be submitted on a CMS 1500 form. • Case management assessment (CPT Code H0031) does not require pre-authorization for adults. • Adult TCM is billed as a per day rate (CPT code T1016) • Claims are required to specify ICD-10 codes, not DSM 5 codes. • Claims for unauthorized services will be denied.

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Targeted case management (TCM) programs are available to assist participants with gaining access to the full range of available mental health services, as well as any needed medical, social, financial, counseling, educational, housing, and other supporting services needed in order to maintain stability in the community. TCM works to enhance participants' mental wellness and community integration by providing access to needed resources that move them forward in their recovery and help them achieve their individual goals. Child and Adolescent TCM offers three levels of service intensity based on the severity of the participant's mental illness. **Child or Adolescent TCM Services (also known as Care Coordination Services):** • General Level I – includes 12 units/month, 72 units max, plus 4 units for assessment. Minimum of two units of face-to-face contacts with the participant are required. • Moderate Level II – includes 30 units/month, 180 units max, plus 4 units for assessment. Minimum of four units of face-to-face contact with the participant. • Intense Level III – includes 60 units/month, 360 units max, no additional units for assessment. Minimum of six units of face-to-face contact with the participant are required. • One unit of service for a child or adolescent TCM is any service provided on any given date of service where the contact is a minimum of 15 minutes of face-to-face contact with the participant, the minor's parent/guardian, or contacts with stakeholders and service providers on behalf of the participant. • For child and adolescent Level I and Level II TCM services, four additional units of service above and beyond the monthly maximum may be billed during the first month of service to the participant and every six months thereafter to allow for comprehensive assessment and reassessment of the participant.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.36.03 • COMAR 10.09.90
Provider Eligibility (Who is Eligible to Provide this Service?)	Eligible providers include programs: • Competitively procured and selected by the LBHA or CSA and Approved under COMAR 10.09.36.03, 10.09.90
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as PT CM

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	To be eligible for services covered under this chapter, a participant or applicant is required to: • Be Medicaid eligible • Meet participant eligibility requirements set forth in COMAR 10.09.90.03, 10.09.90.04, 10.09.90.05, 10.09.90.06, and 10.09.90.07 for Children and Youth TCM services
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** The TCM Provider prepares the Participant's TCM Plan of Care and authorization request and submits both to Carelon. Upon receipt of the documentation, Carelon Care Manager determines whether the Participant meets the medical necessity criteria. • If the Participant does not meet the medical necessity criteria, then the authorization request is sent to Carelon Psychiatrist for review. o If Carelon Psychiatrist also finds that the Participant does not meet medical necessity criteria, then Carelon Care Manager notifies the TCM Provider of the denial. The TCM Provider decides whether to appeal the decision. ▪ MDH Appeal Not Pursued—The TCM Provider decides not to appeal the authorization request denial determination, and the authorization process ends. ▪ MDH Appeal Pursued—The TCM Provider decides to appeal the authorization request denial determination, and the authorization process ends. o If Carelon Psychiatrist finds that the Participant meets medical necessity criteria, then Carelon sets a six-month TCM service span. • If the Participant meets the medical necessity criteria, Carelon sets a six-month TCM service span.
Admission Criteria	**Admission Criteria (Child and Adolescent)** All of the following criteria are necessary for admission: • The participant has a PBHS specialty mental health DSM 5 diagnosis amenable to active clinical treatment, resulting from a face-to-face psychosocial assessment by a licensed mental health professional ; and, • The participant is at-risk of, or needs continued community treatment to prevent inpatient psychiatric treatment, or • The participant is at-risk of, or needs continued community treatment to prevent treatment in a residential treatment center (RTC), or • The participant is at-risk of and out of home placement due to multiple behavioral health stressors; and, • The participant requires community treatment and support in order to prevent or address emergency room utilization due to multiple behavioral health stressors; or

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	• The participant requires community treatment and support in order to prevent or address homelessness or housing instability, or otherwise lacking in permanent, safe housing; or • The participant requires community treatment and support in order to prevent or address arrest or incarceration due to multiple behavioral health stressors. **Continued Stay Criteria** All of the following criteria are necessary for continuing treatment at this level of care: • The participant continues to meet admission criteria. • The participant is reassessed every six months after the initial assessment. • The participant's current available living environment is not suitable for stabilizing the participant during the crisis. • Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the care plan to address the lack of progress are evident. • There is documented active planning for transition to a less intensive level of care. **Service Delivery/Severity of Need and Intensity of Service** • Medical necessity for admission to care coordination services are required to be documented by the presence of all of the criteria. Active involvement of the participant, family, caretaker, or others involved in the participant's treatment should be sought. Levels of service include: o Level I - General: Based on the severity of the participant's mental illness, and the participant meets at least two of the following conditions: ▪ Not linked to behavioral health, health insurance, or medical services. ▪ Lacks basic supports for education, income, shelter, or food. ▪ Transitioning from one level of intensity to another level of intensity of services. ▪ Needs care coordination services to obtain and maintain community-based treatment and services. ▪ The participant is currently enrolled in Level II or III care coordination services and has stabilized to the point that Level I is most appropriate.

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	○ Level II - Moderate: Based on the severity of the participant's mental illness, and the participant urgently meets three or more of the following conditions: ▪ Not linked to behavioral health services, health insurance or medical services ▪ Lacks basic supports for education, income, food, or transportation ▪ Homeless or at-risk for homelessness ▪ Transitioning from one level of level of intensity to another level of intensity including out of inpatient psychiatric or substance use services; RTC; or intensive behavioral health services ▪ Multiple behavioral health stressors within past 12 months, such as history of psychiatric hospitalizations, repeated visits or admissions to emergency room psychiatric units, crisis beds, or inpatient psychiatric units ▪ Needs care coordination services to maintain community-based treatment and services ▪ The participant is currently enrolled in Level III care coordination services and has stabilized to the point that Level II is most appropriate ▪ The participant is currently enrolled in Level I care coordination and has experienced one of the following adverse childhood experiences during the preceding six months: • Emotional, physical, or sexual abuse • Emotional or physical neglect • Significant family disruption or stressors ○ Level III – Intensive: Based on the severity of the participant's mental illness the participant urgently meets at least one of the following conditions: ▪ Has been enrolled in the 1915(i) for six months or less ▪ The participant is currently enrolled in Level I or Level II targeted case management and has experienced one of the following adverse childhood experiences during the preceding six months: • Emotional, physical, or sexual abuse • Emotional or physical neglect • Significant family disruption or stressors ▪ Meets the following conditions: • Has a behavioral health disorder amenable to active clinical treatment diagnosed through a face–to-face psychosocial assessment by a licensed mental health professional. • Has a serious emotional disturbance and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	• Has been assessed by a licensed mental health professional that finds a significant impairment in functioning representing potential serious harm to him or herself or others, across settings • Scores 3 on the ECSII (Early Childhood Services Intensity Instrument); or 3 or higher on the CASII (Child and Adolescent Service Intensity Instrument) ▪ Youth with a score of 3, 4, or 5 on the CASII are required to also meet one of the following criteria: • Transitioning from an RTC • Living in the community • Be age 6-12 years old and have: o Any combination of two or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months; OR o Have been in an RTC within the past 90 calendar days ▪ Youth who are younger than six years of age who have a score of 3 or 4 on the ECSII are required to: • Be referred directly from one of the following: o Inpatient hospital unit; o Day hospital or partial hospitalization program; o Primary care provider (PCP); o Outpatient psychiatric facility; o Early Childhood Mental Health (ECMH) Consultation program in daycare; o Early Head Start, Head Start or Therapeutic Nursery Programs; o Judy Hoyer Center; or o Home visiting program: or If living in the community, have one or more of the following criteria in the past 12 months: o Psychiatric inpatient or day hospitalizations; o ER visits; o Exhibit severe aggression;

Targeted Case Management (TCM) Program – Child and Adolescent	
Service Name	**Notes**
Admission Criteria Continued	○ Display dangerous behavior; ○ Been suspended from school or childcare setting; ○ Display emotional or behavioral disturbance prohibiting their care by anyone other than their primary caregiver; ○ Be at risk for out-of-home placement or placement disruption; ○ Have severe temper tantrums that place the child or family participants at risk of harm; ○ Have trauma exposures and other life events; or ○ Be at risk of family-related risk factors, including, safety, parent-child relational conflict, and poor health and developmental outcomes
Claims Submission (What is Required to Submit a Claim for this Service?)	**Criteria** • Providers should not submit claims unless the service has been authorized by ASO • Claims should be submitted on a CMS 1500 form. • Child and adolescent TCM is billed per unit (CPT code T1017). • Transitional TCM services can be billed for up to 4 units 30-days prior to discharge from a Residential Treatment Center (RTC), Inpatient Psychiatric Hospital, or Inpatient Acute Hospital (CPT T1017-HA) • Claims are required to specify ICD-10 codes, not DSM 5 codes. • Claims for unauthorized services will be denied.

Baltimore City Capitation (BCC) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Introduction** • The Baltimore City Capitation (BCC) Project provides intensive, 24 hours a day, seven days a week wrap-around services to individuals with serious mental illness (SPMI), including housing supports. The goal of the BCC Program is to ensure these individuals receive sufficient community-based care either to be discharged from a state hospital or to avoid the need for long-term care in an institutional setting. • The BCC program provides a comprehensive range of coordinated services. Individuals can receive medication management, administration, and monitoring; psychiatric evaluation and treatment; individual, group and family therapy; support with daily living skills; entitlements coordination; supported employment; pre-tenancy and tenancy housing supports and care coordination. **Services Provided** • The Capitation Program is responsible for providing, managing, and paying for certain behavioral health services for enrollees as well as select support services. Covered behavioral health services include: o Initial and ongoing mental health assessment and evaluation o Mental health outpatient treatment, partial hospitalizations, intensive outpatient services o Psychiatric rehabilitation program services o Psychiatric emergency department (ED) and inpatient (IP) treatment o Crisis, residential crisis, and respite services o Medication management o Individual and Group therapy o Family support services o Case management o Harm reduction model o Peer recovery specialist o Community integration o Medication monitoring o Court reporting o Transportation to Court and other appointments o Multidisciplinary team approach o Diabetes support o Supported employment services and skills development o Residential support services to include pre-tenancy and tenancy housing supports • Program providers are required to ensure: o Each enrollee is seen as frequently as needed during the month and no less than four different dates per month o Each enrollee is seen at least once in his/her own home or place of residence per month o Collaboration with the enrollee to document a plan of service that details the individual's goals o High risk enrollees receive extra services and monitoring, as necessary. **CPT/Revenue Codes** • G9010 • G9011, differential rate for Medicare

Baltimore City Capitation (BCC) Program	
Service Name	**Notes**
Legislative/Regulatory References (COMAR paras, CMMS, or other laws and regulations affecting this service?)	• Participant as defined in 10.21.25.01D(2) • Has a diagnosis that is listed in COMAR 10.67.08.02
Provider Eligibility (Who is Eligible to Provide this Service?)	• The BCC program is overseen by the Behavioral Health Systems Baltimore (BHSB). The BHSB contracts with two vendors who are responsible for delivery of services (program providers): o Chesapeake Connections, part of Mosaic Community Services (166 patient slots) o Creative Alternatives, part of Johns Hopkins Bayview Medical Center (188 patient slots) • Program providers are required to comply with certain standards including: o Maintaining proper employee certifications and ensuring psychiatrists treating the enrollees are eligible for certification or certified by the American Board of Psychiatry, o Taking reasonable measures to ensure that any housing provider who receives funding from the Capitation Program meet all applicable local, state, and federal requirements; o Meeting performance requirements for visitation rates and other metrics; and o Ensuring all medications dispensed, administered, monitored, or otherwise handled by Capitation staff are handled in accordance with state and federal regulations.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as PT 40
Participant Eligibility (Who is Eligible to Receive this Service?)	• Eligibility criteria (required to meet all three): - Be a Baltimore City resident or be willing to reside in Baltimore City - Have a primary diagnosis of a mental illness causing significant impairment in psychosocial functioning, with one of the following diagnoses: Schizophrenia (295.9/F20.9), Schizoaffective Disorder (295.7/F25.0-F25.1), Delusional Disorder (297.1/F22), Major Depressive Disorder (296.33-296.34/F33.2-33.3), Bipolar I & II Disorder (296.43-296.89/F31.13-F31.9), Schizotypal Personality Disorder (301.22/F21), Borderline Personality Disorder (301.83/F60.3) AND - One of the following: ▪ Currently inpatient in a state psychiatric hospital for at least six consecutive months, ▪ Admitted to a psychiatric hospital unit at least four times within the past two years, or ▪ Admitted to an emergency department for treatment of psychiatric conditions at least seven times within the past two years.

Baltimore City Capitation (BCC) Program	
Service Name	**Notes**
Participant Eligibility Continued	• Additionally, applicants will be interviewed by the program to determine amenability to the program (i.e., interest in the services offered, ability to engage meaningfully in care, etc.), ability of the program to meet the applicant's needs in the community, and availability of other needed services. • It is important that applicants understand that: - They will receive all of their mental health services through the Capitation Project, including psychiatry. - They will not be able to use their Medical Assistance card to get other mental health services. - They will need to use their own funds to pay for certain things, including housing.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• There is no authorization process for the BCC program. Instead, there is an application process that results in the establishment of an open-ended "Eligibility Span." • Referring hospitals, once they have confirmed a participant's eligibility, are required to prepare and submit a BCC application to the Behavioral Health Systems Baltimore (BHSB) via email or fax: - Email: clinicalservices2@bhsbaltimore.org - Fax: 443-320-4568 • The BHSB Program Coordinator and Referrals Manager for the project will review for completeness and eligibility. • The Referrals Manager will send the referral directly to one of the two programs. • The Capitation provider forwards a disposition form for those they do not plan to enroll or the enrollment form for those they plan to enroll. • The provider is required to notify the BHS Baltimore Program Coordinator for the Capitation Project in writing within one (1) business day of enrollment using the Enrollment Form. • The provider enrolls the participant in the Carelon system. • BHSB will notify the Behavioral Health Administration's (BHA) ASO, Carelon, within two business days upon receiving notification of a new participant enrollment from the provider. • BHSB approves enrollment in Carelon's system. • The participant's insurance eligibility is updated in Carelon's system to reflect they are in Capitation once BHSB processes an enrollment.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Monthly BCC Service Delivery Claims** • BCC Providers submit claims on a monthly basis to Carelon for services to clients who are enrolled in care. If any SUD services are delivered, BCC providers need to submit claims for these services separately from BCC services. • Providers are required to request and maintain uninsured eligibility through Carelon for all uninsured clients in the Capitation Project. A month of enrollment is defined as enrollment before the 16th of the month or disenrollment after the 15th of the month.

Baltimore City Capitation (BCC) Program	
Service Name	**Notes**
Claims Submission Continued	• Providers are to bill G9010/G9011 with a HE modifier if the participant does not have Medicare and G9010/G9011 without a modifier if the participant does have Medicare because the providers are required to submit claims to Medicare for any mental health services that are eligible for reimbursement from Medicare. • No other Mental Health services are reimbursable from Carelon. **Partially Active Participant Claims (Set-Aside Claims)** • Partially Active Participant Status is managed by BHSB. BCC providers are required to submit a request using the Partially Active Participant Status request form to the BHSB Coordinator for this project. The coordinator may approve up to three visits per month for three months for a BCC participant who is in a hospital, rehab center, or detention center for more than 30 days. **Provider Annual Incentive Claims:** • Annually, BHSB computes an incentive (award) payment to each BCC provider, based on the number of participants served and outcomes data collected through the year; these Incentive payments are computed at the end of the fiscal year. (June) and paid in the following December • Once computed, BHSB sends a report of intended incentive payments to BHA for review prior to meeting with each BCC provider to review their incentive payment. • After the meeting, the BCC provider is required to submit an incentive claim via the BHSB CMS system (not Carelon's system).
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Individual to be discharged when: o Death o Individual moves outside of Metro Baltimore area o Transferred to long-term care for longer than 30 days o Incarcerated for longer than 30 days o Psychiatric of somatic hospitalization for longer than 30 days o Any combination of hospitalization or longer-term placement for more than 30 days

Pre-Admission Screening and Resident Review (PASRR) Program	
Service Name	**Notes**

Service Description
(An Explanation of the Service)
	• PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities:
	  o Evaluate all applicants for serious mental illness (SMI), or an intellectual or developmental disability
	  o Offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)
	  o Provide all applicants the services they need in those settings
	• PASRR assessments help ensure that participants with serious mental illness are not unnecessarily institutionalized and can live in the least restrictive environment where their needs may be met. If a nursing facility is the least restrictive environment that can meet their needs, then services will be identified for their optimal functioning.
	• PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.
	• The PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a "Level I screen."
	• Those individuals who test positive at Level I are then evaluated in depth, called "Level II" PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.
	• Both the baseline and the comprehensive care plans required for nursing facility residents need to include any “specialized services” identified in the Level II PASRR certification.
	• Behavioral health services may also be arranged for a nursing facility resident who did not require the Level II evaluation yet may need services of a lesser frequency or intensity. The same process applies: the facility identifies a BH provider who requests a prior authorization for services from Carelon via its Provider Digital Front Door.
	• Carelon may recommend “specialized services” as part of an individualized plan of care to treat the behavioral health conditions of persons admitted to the nursing facility.

Legislative/Regulatory References (Notations of the COMAR, CMMS, or other laws and regulations affecting this service?)	• Regulations governing PASRR are found in the Code of Federal Regulations, primarily at 42 CFR 483.100-138
Participant Eligibility (Who is Eligible to Receive this Service?)	• Those that meet the Level I and Level II screening requirements

Pre-Admission Screening and Resident Review (PASRR) Program	
Service Name	**Notes**
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** The PASRR process is outlined below: • PASRR Level I screen is completed by the discharging hospital or admitting nursing facility. The Level I screen identifies persons who have or may have a PASRR related condition and requires them to receive a further physical and psychosocial evaluation, known as a PASRR Level II assessment. • PASRR Level II assessment is completed by the local Health Department, Adult Evaluation and Review Services (AERS) within 5 business days. The Level II Evaluation will include specific and clear recommendations by the AERS Reviewer for nursing facility services. • The completed PASRR Level II assessment is submitted to Carelon's Provider Digital Front Door and a review of the Level II assessment will be completed by Carelon within three business days of a completed request. - A Carelon PASRR nurse will review all requests and communicate the determination to AERS and the requesting facility. - If approved, the PASRR Nurse will send a determination letter to the AERS office. - If a denial is rendered by a Carelon psychiatrist, then the Carelon is required to notify the applicant in writing of their right to appeal the determination. • Initial and concurrent authorization for behavioral health services identified on the PASRR Level II assessment can be requested via ProviderConnect or telephonically.
Claims Submission (What is Required to Submit a Claim for this Service?)	• Maintenance mental health services for participants in nursing homes are expected to be covered by the nursing homes under the day rate paid by Medicaid. • Certain behavioral health services listed below are not covered by the Medicaid day rate. However, the Maryland PBHS will pay for them if prior authorization is obtained from Carelon and medical necessity criteria are met. • The Division of Long-Term Care Services will conduct post-utilization audits of behavioral health claims to evaluate the provision of these services in the nursing facility setting and appropriate utilization, and also determine compliance with PASRR requirements, by matching recipients of services with documentation of PASRR reviews. • Some services require a denial from Medicare before Carelon can authorize the specific service for a dual eligible (Medicare/Medicaid) participant.

Pre-Admission Screening and Resident Review (PASRR) Program

Service Name	Notes
Claims Submission Continued	**Criteria** • Billable services include:

Services Billable to Nursing Facility Place of Service (POS)

Service Code	Service	NF POS	Provider Type
90791	Psychiatric diagnostic evaluation	31, 32	MD, CRNP, APRN, PhD Psychologist, LCSWC, LCPC, RN Therapist, OMHC
90792	Psychiatric diagnostic evaluation w/ medical services	31, 32	MD, CRNP, APRN, OMHC
90832	Individual psychotherapy (30 min) outpatient	31, 32	MD, CRNP, APRN, OMHC
90833	Psychotherapy add on (30 min)	31, 32	MD, CRNP, APRN, OMHC
90834	Individual Psychotherapy (45 min Outpatient)	31, 32	MD, CRNP, APRN, OMHC
90836	45 min Psychotherapy Add on	31, 32	MD, CRNP, APRN, OMHC
90837	Individual Psychotherapy (60 min)	31, 32	OMHC
90838	60 min Psychotherapy add on	31, 32	OMHC
90839	Psychotherapy for Crisis first 60 min	31, 32	OMHC
90840	Psychotherapy for Crisis first 30 min	31, 32	OMHC
99354	Prolonged Service Requiring Face to Face Patient Contact beyond usual service	31, 32	OMHC

Pre-Admission Screening and Resident Review (PASRR) Program					
Service Name	**Notes**				
Claims Submission Continued		99355	Each additional 30 minutes of a prolonged psych service	31, 32	OMHC
		H2027	Family psychoeducation (evidence-based practice) with consumer present	31, 32	OMHC
		H1011	Family psychoeducation (evidence-based practice) with consumer present	31, 32	OMHC
		99252	Initial Inpatient Consultation-Physician Only (40 min)	31, 32	MD
		99253	Initial Inpatient Consultation-Physician Only (55 min)	31, 32	MD
		99254	Initial Inpatient Consultation-Physician Only (80 min)	31, 32	MD
		99255	Initial Inpatient Consultation-Physician Only (110 min)	31, 32	MD
		H0032	Mental Health Service Plan Development by Non-Physician BCARS	31, 32	OMHC
		H0004	SUD Individual Outpatient Therapy	31, 32	OTP, SUD Program
		H0020HG	Methadone Maintenance – Community Based OTP	31, 32	OTP
		H0047	Buprenorphine Maintenance	31, 32	OTP

Pre-Admission Screening and Resident Review (PASRR) Program	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• This program only qualifies participants for Nursing Home entry; aftercare/discharge planning would be covered under the Nursing Home program.
Additional Information	• There are two primary functions of the ASO, Carelon, as it relates to PASRR: • (1) employ a PASRR staff person to conduct PASRR determinations on behalf of BHA **AND** (2) authorize and pay for certain PBHS services for individuals who are admitted to nursing facilities under PASRR (as well as some individuals who are admitted to NFs who do not have a PASRR determination).

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** The home and community-based services (HCBS) benefit for children and youth with serious emotional disturbances and their families is authorized under a 1915(i) Medicaid State Plan Amendment. Intensive behavioral health services are provided by a program approved and operated under the provision of COMAR 10.09.89 and are provided in the participant's home or in an approved community-based setting. Services are designed to support the participant remaining in their homes by providing a wraparound service delivery model. Services covered include: • **Care Coordination Organization (CCO)** – provides case management services to 1915(i) participants and families as described in COMAR 10.09.90 • **Child and Family Team (CFT)** - a team of participants selected by the participant and family to work with them to design and implement a plan of care. • **Intensive In-Home Services (IIHS)** - strengths-based interventions with the youth and their family that include a series of components described in COMAR 10.09.89.12. • **Community-Based and Out-of-Home Respite Care** – services offered to provide stabilization and relief to caregivers from the stress of care giving. These services may be provided in the home or community. In-home services offer additional temporary support, in the home and overnight. Out-of-home respite services provide a temporary overnight living. More information about these services is available in COMAR 10.09.89.10. • **Family Peer Support** - services are offered to ensure that family and participant opinions and perspectives are incorporated into the CFT process and plan of care. Services are provided by a family support organization (FSO) as described in COMAR 10.09.89.09. • **Expressive and Experiential Behavioral Services -** use of art, dance, music, equine, horticulture, or drama to accomplish individualized goals as part of the plan of care. Services may be provided individually or in a group. More information about these services is available in COMAR 10.09.89.11. **Criteria** • A licensed mental health professional is required to complete a comprehensive psychosocial assessment within 30 days of the submission of the application to Carelon. o The psychosocial assessment needs to outline how the youth's functioning presents potential danger to self or others, across settings, including the home, school, and/or community. ▪ The serious harm does not necessarily have to be of an imminent nature. o The psychosocial assessment needs to support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21. ▪ ECSII: • Youth are required to receive a score of 3 (Moderate Service Intensity targeted to multiple and/or complex areas of concern that interfere with child and family functioning), 4 (High Service Intensity) or 5 (Maximal Service Intensity)

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Service Description Continued	• Youth who are younger than six years old who have a score of 3-5 on the ECSII are required to: o Be referred directly from an inpatient hospital unit, primary care physician, outpatient psychiatric facility, ECMH Consultation Program in daycare, Head Start, Early Head Start, Judy Hoyer Centers, or home visiting programs; or o If living in the community, have one or more psychiatric inpatient or day hospitalizations, ER visits, exhibit severe aggression, display dangerous behavior, been suspended or expelled or at risk of expulsion from school or child care setting, display emotional and/or behavioral disturbance prohibiting their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family participants at risk of harm, have trauma exposures and other adverse life events, or at risk of family related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months. ▪ CASII: • Youth are required to receive a score of 3 (Intensive Outpatient Services, 4 (Intensive Integrated Services without 24 Hour Psychiatric Monitoring), 5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24-Hours Medially Managed Services) • Youth with a score of 3-6 on the CASII are also required to meet one of the following criteria to be eligible based on their impaired functioning and service intensity level: o Transitioning from a residential treatment center (RTC) o Living in the community and: ▪ Have two or more inpatient psychiatric hospitalizations or ER visits in the past 12 months, or ▪ Resided in an RTC within the past 90 days. • Enrollment begins when youth are identified by a CCO who provides: o Intake o Ongoing assessment o Coordination and facilitation of the CFT o Management of the plan of care o Facilitation of access to services and supports in the plan of care o Assistance with the development of the crisis plan o Regular face-to-face meetings with the family and/or youth o Follow-up monitoring and coordination of care services CPT/Revenue Codes • W5000 • W5001 • W5010 - W5023 • W5026 - W5063

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Service Description Continued	Service Restrictions • Excluded community programs in which a youth may not reside while receiving the HCBS 1915(i) benefit are: o Group home, o Psychiatric respite care facility located on the grounds on an Institution for Mental Disease (IMD) for the purpose of placement, and o Residential program for adults with serious mental illness licensed under COMAR 10.63.02 • Termination of enrollment, for a variety of conditions, is also described in COMAR 10.09.89.04.
Legislative/Regulatory References (Notations of the COMAR, CMMS, or other laws and regulations affecting this service?)	• COMAR 10.09.89 • COMAR 10.09.90.11 • COMAR 10.09.89.12 • COMAR 10.63.02 • COMAR 10.63.03.10 • COMAR 10.63.03.05 • COMAR 10.63.03.04 • COMAR 10.63.03.15
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** • Services may only be provided by approved 1915(i) service providers whose eligibility has been verified by the Maryland Department of Health (MDH)according to the process outlined in COMAR 10.09.89.08.
Provider Enrollment	Providers enroll via ePREP. IIHS, Respite, and Caregiver Peer Support providers enroll as PT 89; Expressive and experiential providers enroll as PT HG, PT 94 (LCSW-C), or PT CC (LCPC, LCMFT, LCPAT, or LCADC) **Authorized Provider Types** • HG 89. 94 and CC
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** The following are requirements for a participant to be eligible for 1915(i) services: • Youth with Medicaid is under 18 years of age at the time of enrollment and meet additional clinical and financial eligibility criteria according to COMAR 10.09.89.03. • Youth is under 18 years of age at the time of enrollment although they may continue in 1915(i) HCBS benefit up to age 22. o Youth under 16 are required to have consent from the parent or legal guardian to participate; for young adults who are 16 or older and already enrolled, the young adult needs to consent to participate. • Youth over 16 who are in the care and custody of the state, require consent from their legal guardian. • Youth need to reside in a home and community-based setting.

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Participant Eligibility Continued	• Youth need to reside in one of the geographic areas where the 1915(i) HCBS benefit is available. • Youth is required to have a behavioral health disorder amenable to active clinical treatment. o The evaluation and assignment of a DSM diagnosis or Diagnostic Criteria 05 (DC 0-5) must result from a face-to-face psychiatric evaluation that was completed or updated within 30 days of submission of the application to Carelon. • Clinical evidence the child or adolescent has a serious emotional disturbance and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment. o Because of the clinical requirement that the young person have a serious emotional disturbance, it will be required for the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) HCBS benefit services. **Restrictions** • Youth will not be eligible for HCBS services if they meet any of the following criteria. Youth: o is enrolled in an Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 10.63.01 and 10.63.04. o is enrolled in a Health Home. o is hospitalized for longer than 30 days. o moves out-of-state for more than 30 days. o moves out of a geographic area within the state of Maryland where the youth cannot reasonably access services and supports during the initial phase-in of the 1915(i) HCBS benefit. o is admitted to and placed in an RTC for longer than 60 days. o is admitted to and placed in a group home setting licensed under COMAR. o is placed in a psychiatric respite care program, a non-medical group residential facility located on the grounds of an IMD primarily for the purpose of placement. o loses eligibility for Maryland Medicaid for more than 30 days. o turns 22 years old. o is detained, committed to a facility, or incarcerated for longer than 60 days. o has an annual medical review that does not meet medical re-certification criteria. o has no CFT meeting held within 90 days. o is no longer actively engaged in ongoing mental health treatment with a licensed mental health professional.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • Initial and concurrent authorization for services should be requested via ASO system. • Some services are automatically authorized with the initial approval for any participant meeting the 1915(i) State Plan Amendment eligibility criteria. - IIHS, community-based, and in-home respite services are also automatically authorized for 60 days.

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Authorization Process Continued	▪ Thereafter, the services will be authorized in six-month increments. - Family Peer Support services are automatically authorized for one year. ▪ Thereafter, the services will be authorized in six-month increments. - Expressive and experiential behavioral services need to receive prior authorization before they are provided to participants. • Children and youth are authorized on an annual basis as participants in the HCBS 1915(i) benefit. **Criteria** • To obtain authorization for 1915(i) services, the CCO, working with the participant and family, need to request a prior authorization. o The clinical information required consists of the list of applicable DSM 5 diagnoses and the current need for requested service. ▪ The description of the requested services should be identified in the participant's individualized plan of care. ▪ The plan of care should be developed through the CFT process.
Admission Criteria	Medical necessity for admission for 1915(i) services is required to be documented by the presence of all the criteria given below in eligibility, as well as meeting the medical necessity criteria defined for intensive care coordination (defined in COMAR 10.09.90). For a participant to be considered meeting the medical necessity criteria for 1915 (i) services documentation needs to be provided to demonstrate meeting the following conditions: • Has a behavioral health disorder amenable to active clinical treatment resulting from a comprehensive psychosocial assessment • Has a serious emotional disturbance and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment • Has been assessed by a licensed mental health professional that finds a significant impairment in functioning representing potential serious harm to self or others, across settings • Scores 3 to 5 on the ECSII (early childhood services intensity instrument); or 3 to 6 on the CASII (Child and adolescent service intensity instrument) Participants aged 16-21 with a sore of 3 to 5 on the CASII should also meet one of the following criteria to be eligible: • Be living in the community and: o Have two or more inpatient psychiatric hospitalizations or ER visits in the past 12 months; or o Have been in an RTC within the past 90 days Participants who are younger than 6 years of age who have a score of 3 to 4 on the ECSII are required to: 1. Be referred directly from an inpatient or day hospital unit, PCP, outpatient, psychiatric facility, ECMH consultation program in daycare, head state, early head start, Judy Hoyer centers, or home visiting program

Home and Community-Based Services (HCBS) 1915i Program	
Service Name	**Notes**
Admission Criteria Continued	OR 2. If living in the community, have one or more psychiatric inpatient or day hospitalizations, ER visits, exhibit severe aggression (i.e. hurting or threatening actions or words directed at infants, young siblings, killing a family pet, etc.), display dangerous behavior (i.e. impulsivity related to suicidal behavior), been suspended or expelled or at risk of expulsion from school or child care setting, display emotional and/or behavioral disturbance prohibiting their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family participants at risk of harm, have trauma exposures and other adverse life events, or at risk of family related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months.
Claims Submission (What is Required to Submit a Claim for this Service?)	• There are no special requirements for claims submission.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• There are no discharge/aftercare planning requirements in place at this time.

American Society of Addiction Medicine Level of Care (ASAM LOC)

Please reference the American Society of Addiction Medicine (ASAM) Criteria (3rd edition) for substance use disorders (SUD). To order a copy of the ASAM criteria, please go to the following website: www.asam.org/asam-criteria.

SUD Inpatient Acute Care (AC) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**SUD Inpatient AC ASAM Level 4.0 Program** This level of care is appropriate for participants with biomedical, emotional, behavioral, and/or cognitive conditions severe enough to warrant primary medical care and nursing care. Services offered at this level differ from ASAM Level 3.7 services in that individuals receive daily direct care from a licensed physician who is responsible for making shared treatment decisions with the patient (i.e., medically managed care). These services are provided in a hospital-based setting and include medically directed evaluation and treatment. • **Setting**: Services may be provided in an acute care general hospital, an acute psychiatric hospital, or a psychiatric unit within an acute care general hospital, or through a licensed addiction treatment specialty hospital. • **Provider Type**: Interdisciplinary team is made up of appropriately credentialed clinical staff including addiction-credentialed physicians who are available 24 hours daily, nurse practitioners, physicians' assistants, nurses, counselors, psychologists, and social workers. Some staff are cross trained to identify and treat signs of comorbid mental disorders. • **Treatment Goal**: Addiction services including medically directed acute withdrawal management are provided in conjunction with intensive medical and psychiatric services to alleviate individual's acute emotional, behavioral, and cognitive distresses associated with the SUD whose acute medical, emotional, behavioral and cognitive problems are so severe that 12 they require primary medical and 24-hour nursing care. Because the length of stay in an ASAM Level 4.0 program typically is sufficient only to stabilize the individual's acute signs and symptoms, a primary focus of the treatment plan is case management and coordination of care to ensure a smooth transition to continuing treatment at another level of care. **Therapies:** Cognitive, behavioral, motivational, pharmacologic, and other therapies provided on an individual or group basis; physical health interventions; health education services; planned clinical interventions; and services for the individual's family, guardian, or significant others.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.06 • COMAR 10.09.36.02

SUD Inpatient Acute Care (AC) Program	
Service Name	**Notes**
Provider Eligibility (Who is Eligible to Provide this Service?)	Providers that: • Meet the license requirements stated in COMAR 10.09.36.02 and, after April 1, 2018, COMAR 10.63.01.05 • Are accredited by a Maryland-approved accrediting body • Meet the conditions of COMAR 10.09.06.04 for ASAM Level 4.0, and • Are licensed by the Office of Health Care Quality for each level of care. • Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. • Providers are to enroll through Maryland ePREP
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid participant An individual is eligible for SUD Inpatient IMD services if the individual is a Medicaid Participant. If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days. Uninsured Participants Carelon encourages the provider to request a courtesy review. When medical necessity criteria are met and a courtesy review is on file, the provider will only need to submit a claim, if and when the participant obtains Medicaid. When an uninsured eligible participant presents with a major illness that requires hospital level of care, the institution providing that care is expected to assist the family with an application for Medicaid.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• Authorizations for SUD Inpatient ASAM Level 4.0 can be requested telephonically or electronically through Carelon. • Electronic authorizations are completed by the provider through submission of a request in Carelon's Provider Digital Front Door, which can be accessed 24/7, including weekends and holidays. • To request initial authorizations for ASAM Level 4.0 in IMD settings, providers are expected to submit the authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day, from date of admission. • Providers obtain additional authorizations through the electronic submission of a continued stay request in ProviderConnect. Concurrent authorizations are to be submitted with supporting clinical information on the first uncovered day.

SUD Inpatient Acute Care (AC) Program	
Service Name	**Notes**
Authorization Process Continued	• If an ASO Clinical Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to an ASO Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-certified, the determination of the non-certified case will be communicated via the provider portal and telephonically to the provider (refer to provider manual for Grievances and Appeals information). • The Managed Care Organization (MCO) is responsible for all other non-psychiatric physician or nurse practitioner consultations which are not related to the psychiatric diagnosis. Authorization by the MCO may be required. The participant's primary care physician or the MCO Special Needs Coordinator should be contacted as needed.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • During an SUD Inpatient stay, Maryland PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant. • Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland PBHS for one history and physical per admission, and authorization is not required. **Criteria** • Providers are required to comply with Carelon's billing guidelines for the submission and payment of claims **Restrictions** • Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric IP day is covered. An additional authorization for professional fees is not needed. • Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric IP unit and requires discharge to a nursing home or residential treatment center, however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized IP day.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Providers are expected to initiate discharge planning at the beginning of service delivery. A discharge plan should be included with the authorization request. • Providers are responsible for entering a discharge when the participant completes treatment. • The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1st at 11:45 p.m., March 1st is a covered day. If the participant is discharged on March 4th at 4:00 p.m., March 4th is not a reimbursable day. March 3rd would be considered the last day covered.

SUD Inpatient Institutes for Mental Diseases (IMD)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Psychiatric Hospitals for SUD Diagnosis** The SUD Inpatient IMD program provides treatment in a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs). Effective July 1, 2019, coverage of IMD services at ASAM Level 4.0 for Medicaid adults who have a primary SUD diagnosis and a secondary mental health diagnosis will be a covered Medicaid benefit. • MDH will provide reimbursement for IMD ASAM Level 4.0 for up to 15 days stay per month. • The days authorized will be based on medical necessity but will not exceed 15 days per month. • All other services beyond the 15-day stay will be paid out of state funds. • An episode of care is defined as services received without any break in treatment. • Participants receiving Level 4.0 services at an IMD and then subsequently transferred to a hospital or other facility for somatic care and are then readmitted will have the new admission counted as a second episode of care or stay. • The facility is required to be in the state of Maryland. This level of care is appropriate for individuals with biomedical, emotional, behavioral, and/or cognitive conditions severe enough to warrant primary medical care and nursing care. Services offered at this level differ from Level 3.7 services in that individuals receive daily direct care from a licensed physician who is responsible for making shared treatment decisions with the patient (i.e., medically managed care). These services are provided in a hospital-based setting and include medically directed evaluation and treatment.
Provider Eligibility (Who is Eligible to Provide this Service?)	• These two IMD facilities are licensed and regulated by the state of Maryland to operate within the state of Maryland to render and receive reimbursement for ASAM Level 4.0 services: o Brook Lane (provider type 06) o Sheppard Pratt Hospital (provider type 06/07) • Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• SUD IMD providers are required to enroll via ePREP at https://ePREP.health.maryland.gov/sso/login.do?

SUD Inpatient Institutes for Mental Diseases (IMD)	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	**Insured Participants** An individual is eligible for SUD Inpatient IMD services if the individual is a Medicaid Participant If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days. **Uninsured Participants** Carelon encourages the provider to request a courtesy review. When medical necessity criteria is met and a courtesy review is on file, the provider will only need to submit a claim, if and when the participant obtains Medicaid. When an uninsured eligible participant presents with a major illness that requires hospital level of care, the institution providing that care is expected to assist the family with an application for Medicaid. **Referrals** • Participants can either self-refer (are in crisis) to hospital emergency room, or arrives via ambulance as result of a 911 call
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • Authorizations for ASAM Level 4.0 in an IMD setting can be requested telephonically or electronically through Carelon's website. Telephonic authorizations are initiated by calling the customer service line and providing clinical information to a licensed Clinical Care Manager in the Clinical Department. • Providers are expected to submit the initial authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day from date of admission. • Initial and concurrent authorization requests can be submitted via Carelon's Provider Digital Front Door or by calling Carelon. Electronic authorizations are completed by the provider through submission of a request in which can be accessed 24/7, including weekends and holidays. If the level of care is medically necessary, services will be authorized. **Initial and Concurrent Authorization Requests** • To request initial authorizations for ASAM Level 4.0 in IMD settings, providers are expected to submit the authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day, from date of admission. • Providers obtain additional authorizations through the electronic submission of a continued stay request in Carelon's website. Concurrent authorizations are to be submitted with supporting clinical information on the first uncovered day. • If a Carelon Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Carelon Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-certified, the

SUD Inpatient Institutes for Mental Diseases (IMD)	
Service Name	**Notes**
Authorization Process Continued	determination of the non-certified case will be communicated telephonically to the provider. **Managed Care Organization (MCO)** • The MCO is responsible for all other non-psychiatric physician or nurse practitioner consultations which are not related to the psychiatric diagnosis. Authorization by the MCO may be required. The participant's primary care physician or the MCO Special Needs Coordinator should be contacted as needed. **LBHA/LAA Assistance** • If assistance is needed from the LBHA, providers should reach out to the jurisdiction that maintains oversight of the services to be rendered by the IMD. For example, if hospitalized in Baltimore County, but residing in Howard County, they should contact the Howard County LBHA.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Effective July 1, 2019, coverage of IMD services at ASAM Level 4.0 for Medicaid adults who have a primary SUD diagnosis and a secondary mental health diagnosis will be a covered Medicaid benefit. o MDH will provide reimbursement for IMD ASAM Level 4.0 for up to 15 days stay per month. o The days authorized will be based on medical necessity but will not exceed 15 days per month. o All other services beyond the 15-day stay will be paid out of state funds. o An episode of care is defined as services received without any break in treatment. • Participants receiving Level 4.0 services at an IMD and then subsequently transferred to a hospital or other facility for somatic care and are then readmitted will have the new admission counted as a second episode of care or stay. • The facility is required to be in the state of Maryland. **Criteria** • Claims are submitted on a CMS 1500 form or on a UB-04 form with the appropriate billing codes. • Claims are required to specify an ICD-10 code, not DSM 5 code for reimbursement. o The primary diagnosis on the claim needs to be one of the approved lists of substance use disorders for reimbursement. o The mental health diagnosis is listed as the secondary diagnosis. • Claims need to reflect revenue code 0124 (for the bed type) for reimbursement. • If seeking reimbursement for administrative days, then the revenue code is 0169. **Restrictions** • Claims for unauthorized inpatient days will be denied.

SUD Inpatient Institutes for Mental Diseases (IMD)	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Providers are expected to initiate discharge planning at the beginning of service delivery. A discharge plan should be included with the authorization request. • Providers are responsible for entering a discharge when the participant completes treatment. • The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1st at 11:45 p.m., March 1st is a covered day. If the participant is discharged on March 4th at 4:00 p.m., March 4th is not a reimbursable day. March 3rd would be considered the last day covered.
Additional Information	If providers need assistance from the LBHA, providers should reach out to the jurisdiction that maintains oversight of the services to be rendered by the IMD. For example, if hospitalized in Baltimore County, but living in Howard County, they should contact the Howard County LBHA.

Adult Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	ASAM Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour living support setting. **Low Intensity Residential (ASAM 3.1)** Low-Intensity Residential Services provide clinically managed, low intensity, substance-related disorder treatment in large and small halfway houses to individuals who: (1) meet ASAM Criteria for level 3.1; and (2) Are capable of self-care but are not ready to return to family or independent living. Services are provided for a minimum of 5 hours per week. Services are directed towards relapse prevention, applying recovery skills, and reintegrating into the community **Medium Intensity Residential (ASAM 3.3)** Medium Intensity Residential Services provide clinically-managed, medium intensity, substance-related disorder treatment based on a comprehensive assessment to individuals who (a) meet ASAM criteria for level 3.3; (b) Are chronic alcohol- or other drug-dependent; (c) Do not need skilled nursing care; (d) May have a history of multiple admissions to Substance Related Disorder programs described in this chapter; (e) May have physical or mental disabilities resulting from a prolonged substance related disorder; and (f) Have been identified as requiring a controlled environment and supportive therapy for an indefinite period of time. Services are provided from 20-35 hours per week. **High Intensity Residential (ASAM 3.5)** High Intensity Residential services provide clinically managed, high-intensity, substance related disorder treatment services based on a comprehensive assessment, in a highly structured professionally monitored environment, in combination with moderate- to high-intensity treatment and ancillary services to support and promote recovery. Services are provided to individuals who meet ASAM Criteria for level 3.5. Services are provided for a minimum of 36 hours of therapeutic activities per week and are characterized by reliance on the treatment community as a therapeutic agent. **Intensive Residential Services (ASAM 3.7)** Intensive Residential Services provide medically monitored, intensive substance related disorder treatment based on a comprehensive assessment to individuals who meet ASAM criteria for level 3.7. Services are provided for a minimum of 36 hours of therapeutic activities a week; are on a planned regimen of 24-hour evaluation, care, and treatment in a residential setting; and meet the requirements for withdrawal management services. ASAM Level 3 programs may provide the following services if the program's license expressly authorizes the services: • (1) A withdrawal management service (See COMAR 10.63.03.18) • (2) An opioid treatment service (See COMAR 10.63.03.19)

Adult Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Service Description Continued	**Criteria** • Hospital or other outpatient provider, or Care Coordinator need to refer to other party for initial (bio/psychosocial/ASAM) multidimensional assessment and drug screen **CPT/Revenue Codes** • RESRB • W7310 • W7330 • W7350 • W7370 • W7375
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.06 • COMAR 10.09.36 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.03.11 • COMAR 10.63.03.12 • COMAR 10.63.03.13 • COMAR 10.63.03.14 • COMAR 10.63.03.18 • COMAR 10.63.03.19
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** The following criteria is required: • Licensed Adult Residential SUD providers in compliance with COMAR 10.09.06, COMAR 10.09.36 and COMAR 10.63.01.05. • Licensed to provide withdrawal management and opioid treatment services, such as MAT where applicable. • Enrolled as a Medicaid Provider
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are required to enroll via ePREP as PT 54
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** SUD Residential (Non-Specialty) Authorization requests for initial and continued stay SUD Residential are requested through Carelon's Provider Digital Front Door. The provider submits the SUD Residential application with required documentation (i.e.,

Adult Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Authorization Process Continued	ASAM Clinical Assessment and intake forms) in Carelon's Provider Digital Front Door. If the participant qualifies for SUD Residential, services Carelon will approve the authorization request. If the Carelon Clinical Care Manager denies the authorization request, the SUD Residential Provider decides whether to submit an SUD Residential application for another level or care or to conclude the authorization process. Refer to sub-program tables below for specific authorization requirements. Upon conclusion of the initial span, the SUD Residential Provider will determine the Participant's need for additional services and submit a concurrent authorization request as needed. **Criteria** • Prior authorization is required and can be requested via Carelon's Provider Digital Front Door. Initial authorizations can be submitted up to 14 days prior to the day of admission with supporting clinical information, but no later than the day of admission. • Concurrent authorizations with supporting clinical information may be requested up to 14 days prior to the last covered day but no later than the first uncovered day. • Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in Carelon's Provider Digital Front Door in order to obtain an uninsured eligibility exception. • Providers are required to request authorization through the system prior to admission to ambulatory or inpatient detox.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Please note that all residential SUD for adult rates are inclusive of drug screening and testing. • For billing codes and rates regarding this reimbursement, please see the SUD fee schedules posted to Carelon's website. **Criteria** • SUD Residential services require prior authorization—claims submitted by Providers who have not received authorization will be denied. • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Claims need to t specify specific ICD 10 codes, not DSM 5 codes. **Restrictions** • Providers should not submit claims unless the service has been authorized by Carelon. • Residential SUD providers (provider type 54) and laboratories may not bill Medicaid separately for drug testing services. • Claims for unauthorized services will be denied.

Adolescents Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** ASAM Level 3 encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour living support setting. It is important to assess the youth's developmental readiness for treatment, inclusion of family/caregivers in treatment process, academic/educational needs if applicable, as well as skills building to address relapse/ sobriety needs. **Intensive Residential Services (ASAM 3.7)** Intensive Residential Services provide medically monitored, intensive substance related disorder treatment based on a comprehensive assessment to individuals who meet ASAM criteria for level 3.7. Services are provided for a minimum of 36 hours of therapeutic activities a week; are on a planned regimen of 24-hour evaluation, care, and treatment in a residential setting; are in an Intermediate Care Facility; and meet the requirements for withdrawal management services. ASAM Level 3 programs may provide the following services if the program's license expressly authorizes the services: • (1) A withdrawal management service (See COMAR 10.63.03.18) • (2) An opioid treatment service (See COMAR 10.63.03.19) **Criteria** • Hospital or other outpatient provider, or Care Coordinator need to refer to other party for initial (bio/psychosocial/ASAM) multidimensional assessment and drug screen • Medicaid-covered ICF-A (Intermediate Care Facilities for Addiction) services are available for adolescents under the age of 21 that meet ASAM criteria. Medicaid does not pay for services that are not medically necessary, even if court ordered. **CPT/Revenue Codes** • 0100
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.23 • COMAR 10.09.36 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.03.11 • COMAR 10.63.03.12 • COMAR 10.63.03.13 • COMAR 10.63.03.14 • COMAR 10.63.03.18 • COMAR 10.63.03.19

Adolescents Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** The following criteria is required: • Licensed Residential SUD ASAM 3.7 providers in compliance with COMAR 10.09.23, COMAR 10.09.36 and COMAR 10.63.01.05.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers are required to enroll via ePREP as PT 55
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** SUD Residential (Non-Specialty) Authorization requests for initial and continued stay SUD Residential are requested through Carelon's Provider Digital Front Door. The provider submits the SUD Residential application with required documentation (i.e., ASAM Clinical Assessment and intake forms) in Carelon's Provider Digital Front Door. If the participant qualifies for SUD Residential, services Carelon will approve the authorization request. If the Carelon Clinical Care Manager denies the authorization request, the SUD Residential Provider decides whether to submit an SUD Residential application for another level or care or to conclude the authorization process. Refer to sub-program tables below for specific authorization requirements. Upon conclusion of the initial span, the SUD Residential Provider will determine the Participant's need for additional services and submit a concurrent authorization request as needed. **Criteria** • Prior authorization is required and can be requested via Carelon's Provider Digital Front Door. Initial authorizations can be submitted up to 14 days prior to the day of admission with supporting clinical information, but no later than the day of admission. • Concurrent authorizations with supporting clinical information may be requested up to 14 days prior to the last covered day but no later than the first uncovered day. • Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in Carelon's Provider Digital Front Door in order to obtain an uninsured eligibility exception. • Providers are required to request authorization through the system prior to admission to ambulatory or inpatient detox.

Adolescents Residential SUD Treatment Non-Specialty Program	
Service Name	**Notes**
Claims Submission (What is Required to Submit a Claim for this Service?)	• Claims should NOT be submitted for services unless there is an initial authorization or a continuing authorization for the service. Claims should be submitted electronically using the facility-based UB-04 format by a Medicaid Provider Type 55. • The procedure code for ASAM Level 3.7 for youth under age 21 is the all-inclusive daily revenue code: 0100. Claims must specify an ICD-10 diagnosis code. Claims for unauthorized services will be denied.

Adult Residential SUD Treatment Court-Ordered Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	The Court-Ordered Program applies to ASAM LOC Level 3 services (3.1, 3.3, 3.5). Please refer to Adult Residential SUD Treatment Non-Specialty Program for ASAM Level 3 Service Descriptions. **Criteria** • Hospital or other outpatient provider, or Care Coordinator need to refer to other party for initial (bio/psychosocial/ASAM) multidimensional assessment and drug screen Health General Article §8-07 (court ordered) providers • The court orders the initial (bio/psychosocial/ASAM) multidimensional assessment pursuant the HG §8-505. • MDH Justice Services are required to conduct a multidimensional evaluation (bio/psychosocial/ASAM) and provide a report back to the Maryland Court within seven working days. • MDH gets participants from the facility into treatment within 21 days. **CPT/Revenue Codes** • RESRB-CP • W7310-CP • W7330-CP • W7350-CP **Service Restrictions** **Health General Article §8-07 (court ordered)** Participants convicted of crimes of violence are required to be eligible for parole.
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.06 • COMAR 10.09.36 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.03.11 • COMAR 10.63.03.12 • COMAR 10.63.03.1 • Health-General Article, §8-505 • Health-General Article, §8-507
Provider Eligibility (Who is Eligible to Provide this Service?)	The following are requirements for Court-Ordered Program Providers: • Licensed Adult Residential SUD providers in compliance with COMAR 10.09.06, COMAR 10.09.36 and COMAR 10.63.01.05. • Enrolled as a Medicaid Provider Type 54 and attest to meeting the staffing components required for these levels of care. • Approved by Maryland Department of Health (MDH) Justice Services (Health General Article, §8-507)

Adult Residential SUD Treatment Court-Ordered Program	
Service Name	**Notes**
Provider Eligibility Continued	• Have an active accreditation by an approved accrediting organization (Health General Article, §8-507)
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as PT 54
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Criteria** • Prior authorization is required and can be requested via Carelon's Provider Digital Front Door. Initial authorizations can be submitted up to 14 days prior to the day of admission with supporting clinical information, but no later than the day of admission. • Concurrent authorizations with supporting clinical information may be requested up to 14 days prior to the last covered day but no later than the first uncovered day. • Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in Carelon's Provider Digital Front Door in order to obtain an uninsured eligibility exception.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Please note that all residential SUD for adult rates are inclusive of drug screening and testing. • For billing codes and rates regarding this reimbursement, please see the SUD fee schedules posted to Carelon's website. • Please note that all residential SUD for adult rates are inclusive of drug screening and testing. • For billing codes and rates regarding this reimbursement, please see the SUD fee schedules posted to Carelon's website. **Criteria** • SUD Residential services require prior authorization—claims submitted by Providers who have not received authorization will be denied. • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Claims must specify specific ICD 10 codes, not DSM 5 codes. **Restrictions** • Providers should not submit claims unless the service has been authorized by Carelon.

Adult Residential SUD Treatment Court-Ordered Program	
Service Name	**Notes**
Claims Submission Continued	• Residential SUD providers (provider type 54) and laboratories may not bill Medicaid separately for drug testing services. • Claims for unauthorized services will be denied.
Discharge/Aftercare Planning (Explanation of rules/conditions to end these services, and what should be done for aftercare?)	**Health General Article §8-07 (court ordered) providers** • An aftercare plan is presented to the ordering Judge at least 30 days prior to the anticipated discharge date • Upon approval from the ordering Judge, a MDH discharge summary is completed (submitted to the court and justice services) at the time of discharge • Discharge plan is completed via Carelon's Provider Digital Front Door • SR ID is generated to close the case

Adult Residential SUD Treatment Pregnant Women and Women with Children (PWWC) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	The Pregnant Women and Women with Children (PWWC) Program applies to ASAM LOC Level 3 services (3.1, 3.3). Please refer to Adult Residential SUD Treatment Non-Specialty Program for ASAM Level 3 Service Descriptions. Services that are required for PWWC Providers • Provide onsite or through referral, prenatal and postpartum medical services, medication evaluation, medication monitoring, psychiatric evaluation • Provide trauma informed services to residents on-site or through referrals. Provide trauma informed training to all staff. • Provide training in Safe Sleep Practices to staff and residents. Ensure that posters on Safe Sleep are evident throughout the residential treatment program. • Provide transportation services for all individuals to appointments, recreational/educational activities, and any other social service needs the individuals may have including but not limited to court appointments, parole and probation, and somatic care appointments. • The program is required to provide on-site children supportive services (childcare services) with the mother on premises. **Criteria** • Licensed providers are required to refer participants to other parties for initial multidimensional assessment (bio/psychosocial/ASAM) and drug screen • The program is required to meet the needs of Health General Article, §8- 507, of the Annotated Code of Maryland for pregnant women or women with children admitted under a court order. • Referring program needs to complete multidimensional assessment (bio/psychosocial/ASAM). **CPT Codes** • RESRB-WC • W7310-WC • W7330-WC **Service Restrictions** • Participant cannot be an active user; if the participant is an active user, the referring program is required to refer the participant to ASAM level 3.7
Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.06 • COMAR 10.09.36 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.03.11 • COMAR 10.36.03.12

Adult Residential SUD Treatment Pregnant Women and Women with Children (PWWC) Program	
Service Name	**Notes**
Provider Eligibility (Who is Eligible to Provide this Service?)	**Criteria** The following are requirements: • Licensed Adult Residential SUD providers in compliance with COMAR 10.09.06, COMAR 10.09.36 and COMAR 10.63.01.05. • Enrolled as a Medicaid Provider Type 54 and attest to meeting the staffing components required for these levels of care.
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as PT 54
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	Initial authorization requests for the PWWC specialty are initiated by a Referring Program who assesses the potential participant and then contacts BHA for pre-approval. PHPA-GSS reviews the request. If PHPA-GSS provides pre-approval and the selected Provider has a bed available, PHPA-GSS simultaneously informs Provider and the Referring Program of pre-approval. Once PHPA-GSS gives pre-approval, then the Residential Provider who creates and submits the SUD Residential application, authorization paperwork and pre-approval letter (i.e., ASAM Clinical Assessment and ASO system intake forms) in ProviderConnect. If the Participant qualifies for the PWWC specialty, Carelon will approve the authorization request. If Carelon denies the authorization request, Carelon will contact the provider to let them know participant was denied. Carelon will work with PHPA-GSS to review the denial. Upon conclusion of the initial span, the SUD Residential Provider will determine the Participant's need for additional services and submit a concurrent authorization request as needed. If BHA does not provide pre-approval or a bed is not available, the Referring Program decides whether to resubmit the request or to conclude the authorization process. **Criteria** • Prior authorization is required and can be requested via Carelon's Provider Digital Front Door. Initial authorizations can be submitted up to 14 days prior to the day of admission with supporting clinical information, but no later than the day of admission. • Concurrent authorizations with supporting clinical information may be requested up to 14 days prior to the last covered day but no later than the first uncovered day. • Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in Carelon's Provider Digital Front Door in order to obtain an uninsured eligibility exception.

Adult Residential SUD Treatment Pregnant Women and Women with Children (PWWC) Program	
Service Name	**Notes**
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Please note that all residential SUD for adult rates are inclusive of drug screening and testing. • For billing codes and rates regarding this reimbursement, please see the SUD fee schedules posted to Carelon's website. **Criteria** • SUD Residential services require prior authorization—claims submitted by providers who have not received authorization will be denied. • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Claims need to specify specific ICD 10 codes, not DSM 5 codes. **Restrictions** • Providers should not submit claims unless the service has been authorized by Carleon. • Residential SUD providers (provider type 54) and laboratories may not bill Medicaid separately for drug testing services. • Claims for unauthorized services will be denied.

SUD Partial Hospitalization Level 2.5 Program	
Service Name	**Notes**

Service Description
(An Explanation of the Service)
	• A partial hospitalization treatment level 2.5 program provides structured outpatient substance-related disorder treatment based on a comprehensive assessment for:
	  ○ (1) Individuals who meet the ASAM Criteria for level 2.5; and
	  ○ (2) From 20 to 35 hours weekly.
	• A partial-hospitalization treatment-level 2.5 program may provide the following services if the program's license expressly authorizes the services:
	  ○ A withdrawal management service (See COMAR 10.63.03.18)
	  ○ An opioid treatment service (See COMAR 10.63.03.19)

Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.36 • COMAR 10.09.80 • COMAR 10.63.01.05 • COMAR 10.63.02 • COMAR 10.63.03.07
Provider Eligibility (Who is Eligible to Provide this Service?)	Community-based SUD programs that: • Meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80. • Must obtain accreditation from a Maryland Approved Accreditation Organization authorized for the service • Providers shall obtain a signed Agreement to Cooperate with the local jurisdictions here they provider services • A community-based substance use program needs to receive a license from the BHA per COMAR 10.63.03.03, including compliance with ASAM criteria involving staffing and support systems. • Enrolled with Maryland Medicaid. Facility-based SUD programs that: • Meet and comply with all requirements set forth in COMAR 10.09.36 • Facility-based SUD programs are accredited by The Joint Commission and licensed through OHCQ • Enrolled with Maryland Medicaid All providers are required to have an active Maryland Medicaid National Provider Identifier (NPI) number and a signed provider agreement with the Maryland Department of Health (MDH).
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• Providers enroll via ePREP as a PT 50 (community-based) or PT 01 (facility-based)
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants

SUD Partial Hospitalization Level 2.5 Program	
Service Name	**Notes**
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • Initial (up to seven days) and concurrent (up to 14 days) authorization requests should be submitted via Carelon's Provider Digital Front Door. Initial authorization requests are for 35 sessions over 60 days. Concurrent authorization requests require submission of updated clinical information and are subject to MNC review. Providers should specify the requested span of days for authorization. • Separate authorization is required if the participant needs ambulatory withdrawal management. • All authorizations are subject to MNC audit. • Partial Hospitalization programs can request authorization for and bill up to five days of ambulatory withdrawal management using procedure code H0014. • Participants are required to receive an ASAM assessment showing the need for service. • PHP programs have an inter-disciplinary staff, including medical staffing, who are immediately accessible. **Restrictions** • Because ASAM 2.5 requires the inclusion of treatment of concurrent mental health conditions in co-occurring capable or enhanced SUD IOP programs, simultaneous treatment in separate SUD and mental health IOP programs is considered duplicative.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Community providers submit electronically via Form 837 or on paper using an HCFA 1500 form. Hospital-based programs should submit claims electronically using the 837i format or on a UB-04 paper form. **Criteria** • Billable services include: o Community-based SUD 2.5 Programs: o The procedure code for a Provider Type 50 community-based program service is H2036, a daily rate. o Sessions need to be a minimum of two hours per day. o This code cannot be billed concurrently with Level 1 services (H0004, H0005, H0015). o Partial hospitalization providers may also bill H0001 for the initial comprehensive assessment. This code can only be billed once per 12 months per provider unless there is more than a 30-day break in treatment. o Partial hospitalization providers may bill up to five days of ambulatory detoxification using procedure code H0014. Hospital-based programs: o Partial Hospital providers may bill peer support services H0024 (Group - up to 8 units per auth) and H0038 (Individual - Up to 20 units per auth) when rendered by Certified Peer Recovery Specialists (CRPS). These are not considered part of the treatment hours. o Hospital-based programs should use revenue code 0912 or revenue code 0913.

SUD Partial Hospitalization Level 2.5 Program	
Service Name	**Notes**
Service Details	• Services at ASAM level 2.5 are from 20 to 35 hours per week. • A partial hospital program is required to comply with ASAM 3rd edition standards on staffing. (Note: This will likely change to ASAM 4th edition in 2025.) • Only one initial evaluation/diagnostic interview (90791/90792) or H0001 may be rendered per year per episode. • Before providing Level 2.5 services, the provider will develop a written individualized treatment plan, with the participant's participation, based on the comprehensive assessment and placement recommendation. It will be reviewed and approved by a licensed behavioral health practitioner. • The treatment plan should include: o An assessment of the participant's needs o Long-range and short-range treatment plan goals o Specific interventions for meeting the treatment plan goals o Target dates for completion of treatment plan goals o Criteria for successful completion of treatment o Referrals to ancillary services, if needed o Referrals to recovery support services, if needed • Each individual and group counseling session will be documented in the participant's record through written progress notes entered by the staff who conducted the session after each counseling session.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Before discharge, the provider will give the participant a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.

SUD Intensive Outpatient Level 2.1 Program	
Service Name	**Notes**

Service Description
(An Explanation of the Service)
	• Intensive outpatient substance use disorder-related treatment services based on a comprehensive assessment:
	• (1) For individuals who:
	  o (a) Meet the ASAM Criteria for level 2.1;
	  o (b) Have a physical and emotional status that allows the individual to function in the individual's usual environment; and
	• (2) Adults require services for 9 to 20 hours weekly, or individuals younger than 18 years old require services for fewer than 6 to 19 hours weekly. Providers may bill for a maximum of 4 days a week, with a minimum of two hours of service per day.
	• (3) An intensive outpatient treatment level 2.1 program may provide the following services if the program's license specifically authorizes the services:
	  o A withdrawal management service as described in COMAR 10.63.03.18; and
	  o An opioid treatment service as described in COMAR 10.63.03.19.

Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.09.36 • COMAR 10.09.80 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.03.03
Provider Eligibility (Who is Eligible to Provide this Service?)	Community-based SUD programs that: • Meet and comply with all requirements set forth in COMAR • 10.09.36 and COMAR 10.09.80. • Must obtain accreditation from a Maryland Approved Accreditation Organization authorized for the service. • Providers shall obtain a signed Agreement to Cooperate with the local jurisdictions where they provide services. • A community-based substance use program is required to receive a license from the BHA per COMAR 10.63.03.03, including compliance with ASAM criteria involving staffing and support systems. Facility-based SUD Programs are accredited by The Joint Commission and licensed through OHCQ. All providers are required to t have an active Maryland Medicaid National Provider Identifier (NPI) number and a signed provider agreement with the Maryland Department of Health (MDH).
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via ePREP as a PT 50 (community-based) or PT 01, PT06 (facility-based)

SUD Intensive Outpatient Level 2.1 Program	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • Initial and concurrent authorization requests should be submitted via Carelon's Provider Digital Front Door. Initial authorizations are auto processed for 35 units over 60 days, while concurrent are clinically reviewed. Based on provider request and MNC, up to 35 units over 60 days are granted based on clinical review. • Initial authorization requests are for 35 sessions over 60 days. • Separate authorization is required if the participant needs ambulatory withdrawal management. • All authorizations are subject to MNC audit. • Intensive outpatient programs can request authorization for and bill up to five days of ambulatory withdrawal management using procedure code H0014. • Participants are required to receive an ASAM assessment showing the need for service. **Restrictions** • Because ASAM 2.1 requires the inclusion of treatment of concurrent mental health conditions in co-occurring capable or enhanced SUD IOP programs, simultaneous treatment in separate SUD and mental health IOP programs is considered duplicative.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Community providers submit electronically via Form 837 or on paper using an HCFA 1500 form. Revenue Codes are available for facilities. **Criteria** • Billable services include, but are limited by, professional credentials: • H0015 may be billed daily, up to four days per week, for IOP (Monday-Sunday). This code cannot be billed concurrently with Level 1 services (H0004, H0005) or partial hospitalization (H2036). • Intensive outpatient programs may also bill H0001 for the initial comprehensive assessment. H0001 can only be billed once per 12 months per provider unless there is more than a 30-day break in treatment. • Partial Hospital providers may bill peer support services H0024 (Group - up to 150 units per auth) and H0038 (Individual - Up to 180 units per auth) when rendered by Certified Peer Recovery Specialists (CRPS). These are not considered part of the treatment hours. • Intensive outpatient programs licensed for ambulatory detox services can bill up to five days of ambulatory detoxification using procedure code H0014. • Hospital-based providers bill through revenue codes: 906

SUD Intensive Outpatient Level 2.1 Program	
Service Name	**Notes**
Service Details	• Services at ASAM level 2.1 are from 9 to 20 hours per week. Higher levels of care would be referred to Level 2.5 or above and lower to Level 1. • Only one initial evaluation/diagnostic interview H0001 may be rendered per year per episode. • Before providing Level 2.1 services, the provider will develop a written individualized treatment plan, with the participant's participation, based on the comprehensive assessment and placement recommendation. It will be reviewed and approved by a licensed behavioral health practitioner. • The treatment plan should include: o An assessment of the participant's needs o Long-range and short-range treatment plan goals o Specific interventions for meeting the treatment plan goals o Target dates for completion of treatment plan goals o Criteria for successful completion of treatment o Referrals to ancillary services, if needed - Referrals to recovery support services, if needed • Each individual and group counseling session will be documented in the participant's record through written progress notes entered by the staff who conducted the session after each counseling session.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Before discharge, the provider will give the participant a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.

SUD Outpatient Level 1 Program	
Service Name	**Notes**

Service Description (An Explanation of the Service)	Outpatient treatment level 1 program is required to provide outpatient substance-related disorder treatment based on a comprehensive assessment:
	• (1) For individuals who:
	  ○ (a) Meet the ASAM Criteria for level 1
	  ○ (b) Have a physical and emotional status that allows the individual to function in the individual's usual environment
	• (2) For adults, require services for fewer than nine hours weekly, or, for individuals younger than 18 years old, require services for fewer than six hours weekly.
	• (3) An outpatient treatment level 1 program may provide the following services if the program's license specifically authorizes the services:
	  ○ (a) A withdrawal management service as described in COMAR 10.63.03.18
	  ○ (b) An opioid treatment service as described in COMAR 10.63.03.19
	• Biopsychosocial assessments and evaluations
	• Referrals for inpatient/residential and detoxification services
	• Outpatient individual and group therapy
	• Peer recovery and support services
	• Family education

Legislative/Regulatory References (COMAR, other laws affecting this service?)	• COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.02 • COMAR 10.63.03.06 • COMAR 10.09.80 • COMAR 10.09.36
Provider Eligibility (Who is Eligible to Provide this Service?)	• Providers must obtain accreditation from a Maryland approved accreditation organization authorized for the service. • Providers shall obtain a signed Agreement to Cooperate with the local authority in which they provide services. • Providers must obtain a COMAR 10.63 license from the BHA (COMAR 10.63.06) • All providers are required to have an active Maryland Medicaid provider National Provider Identifier (NPI) number and a signed provider agreement with the Maryland Department of Health (MDH). • Providers must register with the Administrative Service Organization (ASO), Carelon

SUD Outpatient Level 1 Program	
Service Name	**Notes**
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via ePREP as PT 50
Participant Eligibility (Who is Eligible to Receive this Service?)	• Medicaid Participant • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants

Authorization Process
(How does a provider seek Authorization for the Service, and what forms are needed?)
	Description
	
	Below is an outline of the program process:
	• Prior to admission, an authorization request needs to be made via Carelon's Provider Digital Front Door.
	• Outpatient services require registration with Carelon.
	• The authorization request (Auth Request) needs to include:
	  ○ Completed Auth Request form
	  ○ Optional Federal data collection form
	• Authorization Span Specifications: Unlimited six-month span for 300 units are auto authorized.
	• Providers are required to perform an American Society of Addiction Medicine (ASAM) criteria evaluation to determine appropriateness for level of care.
	Restrictions
	
	• SUD authorizations are restricted to individuals diagnosed with an International Classification of Diseases (ICD) 10 SUD disorder and/or Diagnostic and Statistical Manual of Mental Disorders (DSM) 5-TR by the Public Behavioral Health System (PBHS).
	• Individuals diagnosed with co-occurring Mental Health (MH) and SUD diagnoses will receive treatment reimbursement based on the primary SUD diagnosis.

Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Claims need to be submitted electronically via Form 837 or on paper using a Health Care Financing Administration (HCFA) 1500 form. **Criteria** • Billable services include: CPT/HCPCS Codes, 90889, H0001, H0004, H0005 • CPT/HCPS Codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215 for Medication Assisted Treatment (MAT) may be billed when rendered by practitioners with a current DEA registration that includes Schedule III authority • CPT/HCPS Codes H0024 and H0038 may be billed when rendered by a Certified Peer Recovery Specialist (CRPS)

SUD Outpatient Level 1 Program	
Service Name	**Notes**
Service Details	• Services at ASAM level 1 are up to 9 hours per week. If an individual has been assessed as needing more than 9 hours of service per week, then the individual would be referred to a higher level of care at ASAM level 2.1 or above. • Only one initial evaluation/diagnostic interview H0001 may be rendered per year per episode. • Before providing Level I services, the provider will collaboratively develop with the participant a written Individualized Treatment Plan (ITP) based upon a comprehensive assessment and evaluation, and placement recommendation. This plan is required to be updated every 90 days. It will be reviewed and approved by a licensed and credentialed behavioral health practitioner. • The treatment plan includes, but is not limited to: o An assessment of the participant's needs based upon individual choice and clinical assessment by the clinician o Long- and short-term individualized treatment plan goals and objectives o Specific and measurable interventions for meeting the treatment plan goals and objectives; o Target dates for completion of treatment plan goals and objectives o Referrals to ancillary services, if needed, i.e.., somatic care, psychiatric, etc. o Referrals to recovery support services, if needed • Each individual and group counseling session will be documented in the participant's record through written (electronic or paper process) progress notes after each counseling session.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• Before discharge, the provider will collaborate with the participant to develop a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.

Opioid Treatment Program (OTP)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	Opioid Treatment Program (OTP) provides medication-assisted treatment (MAT) for people diagnosed with an opioid use disorder (OUD). OTPs are required to be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body. These services, which help people recover from opioid use disorder, include: • Medication (like methadone, buprenorphine, naltrexone, and naloxone) • Substance use counseling • Individual and group therapy • Drug testing • Intake activities • Periodic assessments • Opioid antagonist medications (like naloxone) approved for the emergency treatment of known or suspected opioid overdose • Overdose education you get along with opioid antagonist medication
Legislative/Regulatory References (COMAR, other laws affecting this service?)	The program is required to comply with: • 42 CFR Part 8 • COMAR 10.63 • COMAR 10.63.01.05 • COMAR 10.63.02 • COMAR 10.63.03.19 • COMAR 10.09.36 • COMAR 10.09.80.
Provider Eligibility (Who is Eligible to Provide this Service?)	All Opioid Treatment Program providers must: • Must be licensed by the BHA in accordance with COMAR 10.63.03.19 and COMAR 10.63.01 • Maintain approval for the U.S. Drug Enforcement Administration • Maintain approval from the DEA • Registration from OCSA
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Providers enroll via ePREP as a PT 32

Opioid Treatment Program (OTP)	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	• Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in the ProviderConnect system in order to obtain an uninsured eligibility exception. • If a participant does not qualify for an uninsured exception, providers are to contact their LAA or LBHA in order to explore alternative funding spans to support any participant who does not qualify for an approved eligibility category.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• Prior to admission, an authorization request needs to be made via Carelon's Provider Digital Front Door. • The authorization request (Auth Request) needs to include: o Completed Auth Request form o Completed Medical Needs Criteria (MNC) checklist o Narrative statement describing how the participant meets MNC
Claims Submission (What is Required to Submit a Claim for this Service?)	• OTP Providers submit claims via Carelon's Provider Digital Front Door for services to clients who are enrolled in care.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• None

Behavioral Health Homes Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Health Homes for Overall Wellness** • Health Homes assist participants of all ages in improving overall wellness through a whole-person approach to addressing their behavioral, somatic, and social needs. • Health Homes for individuals with chronic conditions augments Maryland's broader efforts to integrate somatic and behavioral health services as well as aims to improve health outcomes and reduce avoidable hospital encounters. • The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, including those with serious persistent mental illness, serious emotional disturbance (SED), and opioid substance use disorders. • Health Homes are designed to enhance person-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. • This is accomplished through connecting participants and caregivers to the myriad of supports and services available to them, offering health promotion activities, monitoring both somatic and behavioral health needs, assisting with transitional care, and providing referrals for community and social supports. **Health Homes for Children and Adolescents** • Like adults with serious mental illness, children and adolescents with serious emotional disturbance face an elevated risk of adverse health consequences. While all Health Homes aim to reduce these negative outcomes, those serving children emphasize coordinated prevention, health promotion, and wellness activities that focus on their health-related choices and behaviors. • Health Homes seek to improve outcomes for children with SED by emphasizing the needs of the whole person while supporting their families and caregivers as 1) central decision makers in the process of accessing and utilizing health care; 2) key players in developing self-management skills in the young person; and 3) crucial in providing role modeling and encouragement for their children in adopting healthy lifestyles.
Provider Eligibility (Who is Eligible to Provide this Service?)	• Eligible providers must be actively enrolled with Maryland Medicaid. • Eligible providers must be actively licensed by the Behavioral Health Administration (BHA) as one of the following provider types: • Psychiatric Rehabilitation Program (PRP) - provider type PR • Opioid Treatment Program (OTP) - provider type 32 • Mobile Treatment Services (MTS) program - provider type MT
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	• If not actively enrolled with Maryland Medicaid as a PRP, OTP, or MTS, providers enroll through via ePREP • Providers interested in establishing a Health Home program must complete the Health Home Provider Application: Maryland Medicaid Health Home Provider Application and e-mail the application to mdh.healthhomes@maryland.gov

Behavioral Health Homes Program	
Service Name	**Notes**
Provider Enrollment continued	• For more information regarding the application and the enrollment process and requirements, please see the following: o Health Home Provider Application Instructions o Health Home Provider Manual
Participant Eligibility (Who is Eligible to Receive this Service?)	• Full Maryland Medical Assistance coverage is required for enrollment. - The Health Home provider must ensure the individual's Medicaid eligibility by using the Electronic Verification System (EVS). - Individuals who have both Medicare and Medicaid are eligible only if they have full Medicaid. ▪ Individuals with "QMB Only" and "SLMB Only" coverage have only partial Medicaid eligibility and are not eligible. • Individuals must currently receive services from a PRP or MTS program for a serious and persistent mental illness or serious emotional disturbance; or • Individuals must currently receive services from an OTP for an opioid substance use disorder and be at risk for additional chronic conditions based on: - Current alcohol use, tobacco use, or other non-opioid use; or - A history of alcohol, tobacco, or other non-opioid substance dependence • Individuals receiving 1915i services or targeted mental health case management (TCM) are not eligible for Health Homes due to the duplicative nature of the services. • The Health Home provider needs to ensure the individual is currently enrolled in the provider's applicable PRP, MTS, or OTP program. • Upon confirming the individual's eligibility for the program, the Health Home provider is required to give the individual a description of the program, including data-sharing elements of the program, and then obtain the individual's consent to participate in the Health Home program.
Service Delivery / Claim Submission	• Upon initiating services the Health Home provider conducts a comprehensive assessment of the individual's physical, behavioral health, and social service needs. • To supplement the assessment, the provider is expected to request records from the individual's primary care physician or other providers, as applicable. • The provider's physician or nurse practitioner must sign off on the assessment.

Behavioral Health Homes Program	
Service Name	**Notes**
Service Delivery / Claim Submission Continued	• A new comprehensive assessment is not required if such an assessment has been performed in the preceding 6 months and the enrolling provider has access to that assessment. • The Health Home provider will enter the required intake and baseline health information into the ASO system. • The individual and provider will collaboratively create and sign an initial care plan. • Health Homes providers render an array of different services that fall into one of the 6 core services: o Comprehensive Care Management o Comprehensive Transitional Care o Care Coordination o Individual and Family Support o Health Promotion o Referral to Community and Social Support • There are no predetermined time limitations for these services, but the services need to include a substantive interaction and effort. For example, the act of handing out a health education pamphlet would not qualify as an eligible service, while engaging in a 15-minute discussion with the participant regarding the health information in the pamphlet would. • Services can be rendered individually or in groups; individual services can be performed by other qualified staff in the OTP, PRP, or MTS, not just the dedicated Health Home staff participants. • Health Home providers are able to claim reimbursement for two specific service types: Health Home Intake (W1760) and Health Home Monthly Services (W1761). • Monthly service reimbursement is contingent on the provider performing at least two health home services during that month; each service needs to be accurately entered into Carelon's system. • Providers may only count one group service toward the two monthly services necessary for reimbursement. • For data tracking purposes, prior to submitting a claim for the monthly service (W1761), providers are required to also enter a non-billable code (W1762) in Carelon's system with the appropriate modifier identifying the core service provided for each corresponding monthly encounter. o Please note: this is not required for the intake service entry and claims process. • Claims are only eligible when providers submit the minimum of two W1762 service codes in Carelon's system within 30 calendar days of the end of the month. o For example, if a W1761 is submitted with a date of service of 08/15/2024, the claim will not be eligible for reimbursement unless at least two W1762 encounters are entered by 9/30/2024 • An active authorization is required for reimbursement of health homes service claims.

Behavioral Health Homes Program	
Service Name	**Notes**
Service Delivery / Claim Submission Continued	○ Providers are required to submit claims for services within 30 days from the end of the month during which services were provided. ▪ Late claim submissions may be subject to a 10% reimbursement reduction by the Department. ▪ All claims need to be submitted within the Medicaid timely filing deadline of 365 days from the date of service.
Authorization & Reporting Process	• To obtain initial authorization for this service, the provider is required to perform an eligibility validation and then fully complete the Intake Form in Carelon's system to enroll a participant in their Health Home program. • The initial authorization will be for a period of six months. • Health Home providers are required to complete the Outcomes Measures Re-assessment in Carelon's system every six months. Carelon's system will prompt the provider to complete this re-assessment form in six month increments to maintain enrollment. • Completion of the outcomes measures reporting is required to obtain a new authorization for an additional 6-month period. ○ If the provider fails to complete the re-assessment form within 30 days, Carelon's BHH liaison will contact the provider to confirm if the participant is still receiving services with that provider.
Discharge/Aftercare Planning (What is Required to Submit a Claim for this Service?)	• Discharge from the Health Home is primarily a result of an individual changing from one OTP, MTS, or PRP to another or losing Medicaid eligibility. ○ Providers should submit a discharge in Carelon system as soon as they become aware that an individual has transitioned to a new Health Home program. ○ For loss of Medicaid eligibility, providers may wish to delay discharge--unless the individual is unlikely to regain eligibility--as the individual may regain retroactive eligibility. • In the event of discharge, the provider is responsible for developing a discharge plan which includes referrals to appropriate services and providers. • An individual who has discharged from their OTP, PRP, or MTS program but not yet enrolled in another program may continue to receive health home services for up to 6 months for the purposes of reengagement or transition to another level of care.
Additional Resources	• MDH Health Home website • Health Home State Plan Amendment • Code of Maryland Regulations (COMAR) Health Homes Chapter: 10.09.33 • Program Evaluation and Outcomes • Centers for Medicare and Medicaid Services Health Homes Page • Health Home Staff Roles

Gambling Outpatient Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** • Gambling outpatient services provide problem with individualized treatment plans, family support/counseling, financial counseling, and aftercare in both individual and group therapy settings and typically offer various types of therapy, including cognitive behavioral therapy and motivational interviewing. They are delivered in a clinic, hospital, or other setting. **CPT/Revenue Codes** • 90832, 90834, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90875, 90876, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, H0004, H0005, H2027 **Service Restrictions** • Gambling Outpatient Program services can only be approved under this authorization plan, if the diagnosis code is F63 and the Provider and Participant are not BOTH Medicaid eligible; if the Provider and Participant are both Medicaid enrolled, the Provider should apply through Outpatient Medicaid services.

Provider Eligibility
(Who is Eligible to Provide this Service?)
	Medicaid Providers
	• Providers already enrolled in Maryland Medicaid and registered with Carelon. Please register with Maryland Center of Excellence on Problem Gambling:
	  ○ Apply through the Maryland Center of Excellence on Problem Gambling's (The Center) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application/.
	  ○ Following a review of the application information by Center clinical staff, a confirmation notice of enrollment will be sent to the provider. The provider may then register with ProviderConnect.
	  ○ Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline.
	
	Non-Medicaid Providers
	• Providers do not need to be enrolled and should not enroll with Medicaid if they are only seeking reimbursement for gambling services and do not wish to provide any other Medicaid reimbursed services.
	• In order to be reimbursed for no-cost services provided to gambling participants, non-Medicaid providers need to apply through the Maryland Center of Excellence on Problem Gambling's (The Center) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application.

Gambling Outpatient Program	
Service Name	**Notes**
Provider Eligibility Continued	**Criteria** • Providers eligible for reimbursement of this service must be either a private practitioner (individual or group) or a community-based provider. • Private practitioners are required to be in good standing with the appropriate professional board(s). • Community-based providers are required to be licensed in accordance with COMAR 10.63 as a substance use, mental health, or integrated behavioral health program at the following levels of care: o Ambulatory SUD programs for Level 1 and Level 2.1. o Residential SUD programs for Level 3.1, 3.3 and 3.5. o Outpatient Mental Health Clinics (OMHC). o Mental Health Intensive Outpatient. • Private practitioners and community-based providers need to ensure staff are trained and competent to provide services to individuals with problem gambling and/or loved ones/ concerned others. • The Maryland Center of Excellence on Problem Gambling is available to provide problem gambling training and clinical consultation at no cost to programs. • Providers may contact the Center of Excellence on Problem Gambling at www.mdproblemgambling.com or phone (667) 214-2120 for further information. • Providers eligible for reimbursement of this service need to be either a private practitioner (individual or group) or a community-based provider. o Private practitioners are required to be in good standing with the appropriate professional board(s). o Community-based providers need to be either be a Federally Qualified Health Center or licensed in accordance with COMAR 10.63 as a substance use, mental health, or integrated behavioral health program at the following levels of care: ▪ Outpatient Mental Health Clinics (OMHC) **Authorized Provider Types** • 15 Psychologist Individual • 20 Physician (includes psychiatrist) Individual or Group • 24 Nurse Psychotherapist (Advanced Practice Registered Nurse Psychiatric Mental Health [APRN-PMH] Individual • 27 Mental Health Group Therapy Provider Group • 32 Clinic, Drug Facility • 50 Substance Use Disorder Program (BHA Certified/ Approved SUD Program Facility) • 54 IMD Residential SUD for Adults Facility • 94 Social Worker (LCSW-C license required) Individual • CC Certified Professional Counselor (includes LCPC, LCMFT, and LCADC) Individual • GA Gambling Provider • MC Outpatient Mental Health Clinic (OMHC)

Gambling Outpatient Program	
Service Name	**Notes**
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** • Services are available to all Maryland residents, regardless of insurance coverage. • Participants may be Medicaid eligible, Medicaid ineligible, uninsured or privately insured in the state of Maryland. • Participants are required to be a state of Maryland resident.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• The Gambling Outpatient authorization process ranges from initial Participant referral to authorization request submission and determination for additional services. While there are multiple provider types eligible to deliver this service only provider types 32, 50, or GA can do so without an F63 diagnosis. • Initial and concurrent authorization requests can be requested via ProviderConnect. • Only the following diagnosis are eligible for gambling services: - F63.0 Pathological Gambling - Z72.6 Gambling and Betting - Problems related to Lifestyle - Z71.9 Counseling unspecified **Provider Type is 32, 50, or GA** • If the Provider type is 32, 50, or GA, the Gambling Outpatient Provider determines if the diagnosis code is F63. • The Gambling Outpatient Provider prepares and submits the authorization request in ASO system, the services are automatically authorized for a six-month span. Then the Provider renders gambling services. After which, the Gambling Outpatient Provider determines the need for additional services. **Provider Type is not 32, 50, or GA** • If the Provider type is not 32, 50, or GA, the Gambling Outpatient Provider determines if F63 is the diagnosis code. **Diagnosis Code F63** • If F63 is the diagnosis code, the Gambling Outpatient Provider determines if both the Provider and Participant are Medicaid-enrolled. **Medicaid-enrolled** • If the provider is Medicaid enrolled and the participant is Medicaid eligible, then they cannot submit for services under the Gambling Outpatient program; instead, the provider needs to seek Medicaid funded gambling mental health services. **Not Medicaid-enrolled** • If the Provider and Participant are not Medicaid-enrolled, then the Gambling Outpatient Provider prepares and submits the authorization request in Carelon's system, the services are automatically authorized for a six-month span. Then the Provider renders gambling services. After which, the Gambling Outpatient Provider determines the need for additional services.

Gambling Outpatient Program	
Service Name	**Notes**
Authorization Process continued	**Diagnosis Code Not F63** • If F63 is not the diagnosis code, the Gambling Outpatient Provider prepares and submits the authorization request in ASO system, the services are automatically authorized for a six-month span. Then the Provider renders gambling services. After which, the Gambling Outpatient Provider determines the need for additional services.
Claims Submission (What is Required to Submit a Claim for this Service?)	• Services will only be authorized for registered participants who have a covered diagnosis. If the participant does not have a covered diagnosis, claims will be denied. • Providers should not submit claims unless the service has been authorized by Carelon. **Criteria** • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Mental Health providers rendering problem gambling services to Medicaid eligible individuals with F63.0 as primary diagnosis will be reimbursed using Medicaid funds. • Mental Health providers rendering problem gambling services to Medicaid eligible individuals with Z71.9 or Z72.6 as primary diagnosis will be reimbursed using problem gambling state funds. • Substance Use Disorder providers rendering problem gambling services to any individual with F63.0 or Z71.9 or Z72.6 as primary diagnosis will be reimbursed using problem gambling state funds. • Claims need to specify specific ICD 10 codes, not DSM 5 codes. • Claims for unauthorized services will be denied. • For billing codes and rates regarding this reimbursement, please see the gambling fee schedules posted to Carelon's website.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• A participant is required to be discharged from outpatient service when the participant: o Has accomplished goals and objectives which were identified in the treatment plan, and subsequent treatment plan updates. o Has made no contact with the counselor within 60 days. o Refuses further treatment. o Has been referred to other appropriate treatment, which cannot be provided in conjunction with the outpatient service. o Is disruptive to the service and/or fails to comply with their treatment plan. o Relocates outside of Maryland. o Health prohibits his/her attendance in treatment. • To be reimbursed for gambling discharge costs, providers need to provide, initial and concurrent auth data and discharge form
Additional Information	• Family participants and concerned others are eligible to receive Gambling Outpatient services with the diagnosis code Z72.6

Gambling Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** • Intensive outpatient gambling services provide integrated treatment for problem gamblers, delivered at least three days per week, and serves as a bridge for patients transitioning from residential treatment to outpatient care and are also applicable for patients who require more clinical care than what is offered by standard outpatient treatment. **CPT/Revenue Codes** • H0015 **Service Restrictions** • Gambling Outpatient Program services cannot be authorized under this authorization plan, if the diagnosis code is F63 and it is a Medicaid provider, and the participant is Medicaid eligible; providers should apply through Medicaid services.
Provider Eligibility (Who is Eligible to Provide this Service?)	**Medicaid Providers** • Providers already enrolled in Maryland Medicaid and registered with Carelon. Please register with Maryland Center of Excellence on Problem Gambling: o Apply through the Maryland Center of Excellence on Problem Gambling's (The Center) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application/. o An acknowledgement of receipt of the application will be provided to the applicant. o Following a review of the application information by Center clinical staff, a confirmation notice of enrollment will be sent to the provider. The provider may then register with ProviderConnect. o Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline. **Non-Medicaid Providers** • Providers do not need to be enrolled and should not enroll with Medicaid if they are only seeking reimbursement for gambling services and do not wish to provide any other Medicaid reimbursed services. • In order to be reimbursed for no-cost services provided to gambling participants, non-Medicaid providers need to apply through the Maryland Center of Excellence on Problem Gambling's (The Center) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application. **Criteria** • Providers eligible for reimbursement of this service are required to be either a private practitioner (individual or group) or a community-based provider. • Private practitioners need to be in good standing with the appropriate professional board(s).

Gambling Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Provider Eligibility Continued	• Community-based providers are required be licensed in accordance with COMAR 10.63 as a substance use, mental health, or integrated behavioral health program at the following levels of care: Mental Health Intensive Outpatient **Authorized Provider Types** • 24 Nurse Psychotherapist (Advanced Practice Registered Nurse Psychiatric Mental Health [APRN-PMH] Individual • 27 Mental Health Group Therapy Provider Group • 32 Clinic, Drug Facility • 50 Substance Use Disorder Program (BHA Certified/ Approved SUD Program Facility) • 54 IMD Residential SUD for Adults Facility • 94 Social Worker (LCSW-C license required) • CC Certified Professional Counselor (includes LCPC, LCMFT, and LCADC) • GA Gambling Provider • MC Outpatient Mental Health Clinic (OMHC)
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** • Services are available to all Maryland residents, regardless of insurance coverage. • Participants may be Medicaid eligible, Medicaid ineligible, uninsured or privately insured in the state of Maryland. • Participants are required to be a state of Maryland resident.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • The Gambling IOP authorization process ranges from initial Participant referral to authorization request submission and determination for additional services. The Gambling IOP provider assesses the participant for services and determines if the provider type is 50 or GA. **Provider Type is 50 or GA** • If the provider type is 50 or GA, the Gambling IOP provider prepares and submits the authorization request in Carelon's system. The Carelon Care Manager reviews gambling request and determines whether to approve it. • If the authorization request is approved, the Carelon Care Manager authorizes the span for gambling services. After which, the Gambling IOP provider renders gambling services and determines the need for additional services. • If the authorization request is denied, the Carelon Care Manager discusses the denial with the Gambling IOP provider. The Gambling IOP provider then decides whether to resubmit the authorization request. • If the Provider type is not 50 or GA, the Gambling IOP provider determines if F63 is the diagnosis code. • Participants who require IOP or residential services ASAM Level 3.1, ASAM Level 3.3, or ASAM Level 3.5 are required to have a primary diagnosis of F63.0 Pathological Gambling.

Gambling Intensive Outpatient Program (IOP)	
Service Name	**Notes**

Authorization Process Continued	• If F63 is the diagnosis code, the Gambling IOP provider determines if both the provider and participant are Medicaid-enrolled. If the provider and participant are Medicaid-enrolled, then gambling services need to be funded via another Medicaid service plan.
	• If the provider and participant are not Medicaid-enrolled, then the Gambling IOP provider prepares and submits the authorization request in Carelon's system. The Carelon Care Manager reviews the authorization request and determines whether to approve it.
	
	Authorization Request Approved
	If the authorization request is approved, the Carelon Care Manager authorizes the span for gambling services. After which, the Gambling IOP provider renders gambling services and determines the need for additional services.
	
	Authorization Request Denied
	If the authorization request is denied, the Carelon Care Manager discusses the denial with the Gambling IOP provider. The Gambling IOP provider then decides whether to resubmit the authorization request.
	
	Diagnosis Code Not F63
	If F63 is not the diagnosis code, the provider cannot offer IOP services.
	• Initial and concurrent authorization requests can be requested via ProviderConnect.
	• Only the following diagnosis are eligible for gambling services:
	  ○ F63.0 Pathological Gambling
	  ○ Z72.6 Gambling and Betting - Problems related to Lifestyle

Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Services will only be authorized for registered participants who have a covered diagnosis. If the participant does not have a covered diagnosis, claims will be denied. • Providers should not submit claims unless the service has been authorized by Carelon. **Criteria** • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Mental Health providers rendering problem gambling services to Medicaid eligible individuals with F63.0 as primary diagnosis will be reimbursed using Medicaid funds. • Mental Health providers rendering problem gambling services to Medicaid eligible individuals with Z71.9 or Z72.6 as primary diagnosis will be reimbursed using problem gambling state funds. • Substance Use Disorder providers rendering problem gambling services to any individual with F63.0 or Z71.9 or Z72.6 as primary diagnosis will be reimbursed using problem gambling state funds. • Claims need to specify specific ICD 10 codes, not DSM 5 codes. • Claims for unauthorized services will be denied. • For billing codes and rates regarding this reimbursement, please see the gambling fee schedules posted to Carelon website.

Gambling Intensive Outpatient Program (IOP)	
Service Name	**Notes**
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• A participant is required to be discharged from outpatient service when the participant: o Has accomplished goals and objectives which were identified in the treatment plan, and subsequent treatment plan updates. o Has made no contact with the counselor within seven days. o Refuses further treatment. o Has been referred to other appropriate treatment, which cannot be provided in conjunction with the outpatient service. o Is disruptive to the service and/or fails to comply with their treatment plan. o Relocates outside of Maryland. o Health prohibits his/her attendance in treatment. • To be reimbursed for gambling discharge costs, providers need to provide, initial and concurrent auth data and discharge form

Gambling SUD Residential Program Description	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** • Gambling SUD Residential treatment programs are designed to provide both general and specialized non-hospital-based services 24 hours a day, 7 days a week, in environments in which the participants reside and receive services from personnel who are trained in the delivery of services for persons with gambling disorders. • Gambling SUD Residential treatment programs may include facilities authorized to provide ASAM level 3.1, 3.3 and 3.5 levels of care. **CPT/Revenue Codes** • RESRB • W7310 • W7330 • W7350 **Service Restrictions** • Gambling SUD Residential Program services cannot be authorized under this authorization plan if the diagnosis code is not F63.
Provider Eligibility (Who is Eligible to Provide this Service?)	**Medicaid Providers** • This service is not available for Medicaid providers. • Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline. **Non-Medicaid Providers** • Providers do not need to be enrolled and should not enroll with Medicaid if they are only seeking reimbursement for gambling services and do not wish to provide any other Medicaid reimbursed services. • In order to be reimbursed for no-cost services provided to gambling participants, non-Medicaid providers need to apply through the Maryland Center of Excellence on Problem Gambling's (The Center) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application • Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline. **Criteria** • Providers eligible for reimbursement of this service are required to be a PT50 Substance Use Disorder Program (Behavioral Health Administration (BHA) Certified/ Approved SUD Program Facility. o Community-based providers are required to be licensed in accordance with COMAR 10.63 as a substance use, mental health, or integrated behavioral health program at ASAM levels 3.1, 3.3 and 3.5.

Gambling SUD Residential Program Description	
Service Name	**Notes**
Provider Eligibility Continued	**Authorized Provider Types** • 54 IMD Residential SUD for Adults Facility
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** • Services are available to all Maryland residents, regardless of insurance coverage. • Participants may be Medicaid eligible, Medicaid ineligible, uninsured or privately insured in the state of Maryland. • Participants are required to be a state of Maryland resident. • Participants need to have the F63 diagnosis code to receive this service.
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	**Description** • The Gambling SUD Residential authorization process ranges from initial Participant referral to authorization request submission and determination for additional services. The Gambling provider assesses the Participant for services and submits the authorization request to Carelon. • If the authorization request is approved, the Carelon Care Manager authorizes the span for gambling services. The Gambling SUD Residential Provider renders gambling services. After which, the Gambling SUD Residential Provider determines the need for additional services. • If the authorization request is denied, the Carelon Care Manager discusses the denial with the Gambling SUD Residential Provider. The Gambling SUD Residential Provider then decides whether to resubmit the authorization request. **Criteria** • Participants who require SUD Residential services ASAM Level 3.1, ASAM Level 3.3, or ASAM Level 3.5 are required to have a primary diagnosis of F63.0 Pathological Gambling. If F63 is not the diagnosis code, the Gambling SUD Residential Provider cannot offer SUD Residential gambling services. • Providers requesting gambling IOP or gambling ASAM Level 3.1, ASAM Level 3.3, or ASAM Level 3.5 services are expected to initiate discharge planning at the beginning of service delivery. These providers are also required to submit the discharge plan with each authorization request. • Initial and concurrent authorization requests can be requested via ProviderConnect.
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • Services will only be authorized for registered participants who have a covered diagnosis. If the participant does not have a covered diagnosis, claims will be denied. • Providers should not submit claims unless the service has been authorized by Carelon. **Criteria** • Claims should be submitted on a CMS 1500 form. • Each date of service needs to be submitted on a separate transaction line. Date spans will not be accepted. • Claims need to specify specific ICD 10 codes, not DSM 5 codes.

Gambling SUD Residential Program Description	
Service Name	**Notes**
Claims Submission Continued	• Claims for unauthorized services will be denied. • For billing codes and rates regarding this reimbursement, please see the gambling fee schedules posted to Carelon's website.
Discharge/Aftercare Planning (Explain any rules/conditions to end these services, and what should be done for aftercare?)	• A participant is required to be discharged from outpatient service when the participant: o Has accomplished goals and objectives which were identified in the treatment plan, and subsequent treatment plan updates. o Has made no contact with the counselor within 60 days. o Refuses further treatment. o Has been referred to other appropriate treatment, which cannot be provided in conjunction with the outpatient service. o Is disruptive to the service and/or fails to comply with their treatment plan. o Relocates outside of Maryland. o Health prohibits his/her attendance in treatment. • Upon discharge, the provider needs to discharge the participant from their service by going to ProviderConnect and entering a discharge. Providers should note that entering discharge information is an important step and is reimbursable. • To be reimbursed for gambling discharge costs, providers must provide, initial and concurrent auth data and discharge form

Maryland RecoveryNet (MDRN) Program	
Service Name	**Notes**
Service Description (An Explanation of the Service)	**Description** Maryland RecoveryNet (MDRN) develops partnerships with state Care Coordination entities and certified recovery residences statewide to provide time-limited access to certified recovery residences for individuals with substance-related or /co-occurring mental health and substance-related disorders, in recovery, for whom no other individual, community, family, private or public resource exists to defray the cost of the recovery residence stay. Maryland RecoveryNet funding supplements, but does not replace or supplant, existing services and funding streams. MDRN eligible individuals may access client support services funding through the Local Behavioral Health Authority or Local Addiction Authority for one-time only or emergency goods and services to alleviate a need that presents a barrier to the individuals' recovery. Certified Recovery Residences provide alcohol-free and illicit-drug free environments to individuals with substance-related disorders. The purpose of a recovery residence is to provide a safe and healthy living environment for individuals with substance-related disorders to initiate and sustain recovery and to gain improvement in their physical, mental, spiritual, and social well-being. All state general funds for certified recovery residences will be administered through the Administrative Service Organization (ASO). The State Care Coordinators in each jurisdiction will make referrals to BHA's MDRN staff in order to access funding for recovery housing. If an individual is found eligible for services, the MDRN approved and certified recovery residence will enter the authorization request into Carelon's system. Upon approval, the individual will be granted an initial authorization for recovery housing for 60 days. A recovery residence will submit a concurrent request for additional days for an individual based on the individual's needs through Carelon's system.
Legislative/Regulatory References (COMAR, CMMS, or other regulations)	• There are no COMAR references for MDRN • Regulations are in process.
Provider Eligibility (Who is Eligible to Provide this Service?)	Recovery Residences that are certified by the Maryland Certification of Recovery Residences (MCORR) may request an application for consideration and approval as a Maryland RecoveryNet Housing Provider by email at mdrn.housinginfo@maryland.gov. A separate application needs to be submitted for each location. After receiving the Maryland RecoveryNet Provider Application Packet, BHA's MDRN staff will review all application documents and submit accepted applications for processing. Potential providers whose applications are not accepted will be contacted and given the opportunity to provide additional documentation. Once an application has been reviewed, accepted and processed, the MDRN team may request a service delivery site visit. Upon successful completion of all administrative and required site reviews, the service provider will complete, sign, and return the Maryland RecoveryNet Provider Agreement to the BHA MDRN Regional Area Coordinator (RAC) in order to be registered as an MDRN provider in Carelon's system.

Maryland RecoveryNet (MDRN) Program	
Service Name	**Notes**
Provider Eligibility Continued	Authorized Provider Types • MR Restrictions • Contact the MDRN team for guidance
Participant Eligibility (Who is Eligible to Receive this Service?)	**Criteria** The following are requirements for participant eligibility: • Be 18 years of age or older • Have a substance use disorder diagnosis • Engaged in SUD-related treatment services for the full duration of the individual's eligibility with MDRN • Be a current resident of Maryland and planning to reside in Maryland for the duration of their work with MDRN • Provide verification of income and have an income at or below 200% of the federal poverty level • Be without insurance or other financial resources to pay for MDRN services • If incarcerated, be scheduled for release within 30 days of discharge from MDRN services Request MDRN services : • Work with a Care Coordinator • Participate in at least two monthly contacts • Provide contact information to be located during participation. No confidential information will be provided to persons on the contact page unless authorized by the client through consent to release information. The participant may revoke consent at any time • If participating in the Department of Public Safety and Correctional Services Residential Substance Abuse Program, release from the facility into the community needs to t be scheduled within 30 days of discharge from the treatment program
Provider Enrollment (How do providers Enroll to be a Provider for this Service?)	Recovery Residences that are certified by the Maryland Certification of Recovery Residences (MCORR) may request an application for consideration and approval as a Maryland RecoveryNet Housing Provider by: • Submitting a request to mdrn.housinginfo@maryland.gov • Attending a MDRN Orientation Meeting Note: prospective providers are required to submit a separate application for each location. After receiving the Maryland RecoveryNet Provider Application packet, MDRN staff will review all application documents and submit accepted applications for processing. Potential providers whose applications are not accepted will be contacted and given the opportunity to provide additional documentation. Provider applications may be approved or denied based, in part, on the number of existing Maryland RecoveryNet service providers in specific service areas. Once an application has been reviewed, accepted and processed, the MDRN team may request a service delivery site visit. Upon successful completion of all administrative and facility reviews, the service provider will complete, sign, and return the Maryland RecoveryNet Provider Agreement to the Regional Area Coordinator (RAC). A separate application needs to be submitted for each service and/or service location.

Maryland RecoveryNet (MDRN) Program	
Service Name	**Notes**
Provider Enrollment Continued	Upon approval as a MDRN service provider, you will also be required to register and gain access to Carelon's Provider Digital Front Door. Carelon will provide access and send you a Welcome Letter that will contain your Carelon user ID and password. **Housing Provider is responsibilities:** • Ensuring that a residential request has been completed by the Care Coordinator and approved by the Regional Area Coordinator prior to acceptance of a participant. • Submitting claims for reimbursement in Carelon's Provider Digital Front Door (NOTE: claims will only be paid for services rendered at the service site location authorized by the RAC) • Maintaining bed tracker monitored by BHA • Obtaining the participant's signature for verification of service delivery (see Forms Supplement: Proof of Service Delivery • Communicating concerns with a participant behavior to the Care Coordinator and or Regional Area Coordinator • Notifying the Care Coordinator when a participant is no longer a resident • Notifying the Care Coordinator and Regional Area Coordinator of reportable incidents as outlined in the Provider Manual (See Incident Reporting) • Maintaining documentation as required by the MDRN Provider Manual • Adhering to the rules and regulations outlined in the MDN Provider Manual
Authorization Process (How does a provider seek Authorization for the Service, and what forms are needed?)	• The authorization process begins when a participant who is receiving SUD services requires a recovery residence. . The State Care Coordinator (SCC) verifies the participant's eligibility for Recovery Residence services and prepares the request application and submits it to the approved MDRN Recovery Residence provider. • Upon receiving the MDRN request application from the State Care Coordinator, the approved MDRN provider creates the initial request in Carelon's system • The BHA RAC reviews the new request in ProviderConnect and verifies that the approved Recovery Residence provider is selected. The BHA RAC verifies that the selected provider has a bed available for the Participant's gender. The BHA RAC decides if the MDRN bed stay request meets approval criteria. • If the housing request is approved, BHA RAC establishes 60-days of approved (initial) span in Carelon's system and notifies the MDRN provider of the bed stay request approval. • If denied, the MDRN provider then decides whether to resubmit the MDRN request. If not resubmitting the request, the process concludes. If resubmitting the request, the MDRN provider needs to resolve issues with the original application and resubmit it to BHA RAC. • The MDRN provider then decides whether to resubmit the MDRN bed

Maryland RecoveryNet (MDRN) Program	
Service Name	**Notes**
Authorization Process Continued	stay request. If not resubmitting the request, the process concludes. If resubmitting the request, the MDRN provider needs to resolve issues with the original application and resubmit it to BHA RAC. • The MDRN provider then renders the bed stay through the approved authorization span period. • Within 30 days of the expiration of the approved span, if the participant requires an additional bed stay, the provider prepares a concurrent bed stay authorization request in Carelon's system. When the RAC receives the concurrent authorization request, it is processed for approval in the same way as the initial authorization request. • If the RAC does not approve the concurrent authorization request, the provider is notified of denial and can decide to resubmit the concurrent authorization request. If they resubmit the request, it is processed for approval in the same way as the initial authorization request. If the participant no longer requires housing services, the process also ends
Claims Submission (What is Required to Submit a Claim for this Service?)	**Description** • All billing and claims requests need to be submitted via Carelon's Provider Digital Front Door l using the Direct Claim Submission process. New Service Providers will be trained in claims submission by ASO staff. Additional information can be obtained by visiting Carelon's website. • Claims are a daily bill, which is usually submitted in batches. • **CPT/Revenue Codes:** MDRN2 • A Maryland RecoveryNet covered service is reimbursable only when there is no other funding source for that service. Generally, Carelon processes and pays claims within 14 days of submission however reimbursement may take as long as 30 days. If a MDRN service is a covered service under any other payor, that service cannot be submitted to Carelon for payment. All payments are made via direct deposit through an EFT after the initial payment by check.
Additional Information	• Maryland Department of Health (MDH) MDRN website • Application for a Recovery Resident Certificate of Compliance

7. SERVICES FOR PARTICIPANTS WHO ARE DEAF OR HARD OF HEARING

7.01 Services for the Deaf and Hard of Hearing

Services under the Maryland Public Behavioral Health System (PBHS) are provided to individuals who are deaf or hard of hearing and who meet the eligibility for public behavioral health services. Carelon can be reached by dialing 711 for Maryland Relay to place a call to Carelon at 1-800-888-1965.

In some instances, there may be a need for an American Sign Language (ASL) or other visual language interpreter in order for services to be rendered. An interpreter may be needed in the following instances:

1. A participant is deaf or hard of hearing. If the behavioral health professional selected by the participant is not proficient in ASL/other visual language interpretation, an interpreter can be secured in order for the participant to access services. The treating professional will be reimbursed for the service at normal rates and the interpreting services will also be reimbursed.
2. A participant is a minor and has a parent(s) who is deaf or hard of hearing. If the mental health professional selected for a minor is not proficient in ASL/other visual language interpretation, and the minor's parents are deaf or hard of hearing, an interpreter may be secured in order for the minor's parent(s) to participate in treatment with their child. The treating professional will be reimbursed for the service at normal rates and the interpreting services will also be reimbursed.
3. A provider is deaf or hard of hearing. If the service provider is deaf or hard of hearing and needs an interpreter in order to communicate with the participant, family participant, or group participants participating in the services, interpreter reimbursement is also allowed.

7.02 Reimbursement

Providers need to contact the local systems manager (formerly referred to as CSA, LBHA and/ or LAA) of the participant's residence of record prior to interpreter service delivery. The local care manager will pay for ASL or other visual language interpreting services. The Behavioral Health Administration (BHA) will adjust the local care manager's contract accordingly if funding is not available under their existing contract.

Deaf Addiction Services at Maryland (DASAM) provides Interpreting services or treatment services for substance use disorder treatment for participants who are deaf or hard of hearing:

- Website: umaryland.edu/dasam
- Phone 1-443-462-3416, (TTY) 1-443-462-3089

Providers should also access the Office of the Deaf and Hard of Hearing (ODHH). (For additional information click here). They work as an advocacy group and are a resource for state and local agencies. The ODHH offers awareness training to increase knowledge about the accessibility of services, as well as technical assistance to government agencies that may have questions regarding communication access and constituent services.

7.03 Telehealth

Maryland Medicaid will reimburse services delivered via telehealth to a patient that is deaf or hard of hearing by any enrolled provider that is fluent in ASL. Unlike telehealth for patients who are not deaf or hard of hearing, the individual may be located in their home. The originating site is required to meet the technological requirements listed in COMAR 10.09.49. If the ASL fluent provider is enrolled in Maryland Medicaid, actively licensed, and permitted within scope of practice to use telehealth, the provider may act as a distant site provider. The provider may bill for services rendered via telehealth to the individual that is deaf or hard of hearing, using the GT modifier. As with all specialty behavioral health services, the distant site provider is required to have authorizations for all services delivered via telehealth.

More information, visit the Maryland Medicaid Telehealth Program webpage. Send questions or comments by email to mdh.telemedicineinfo@maryland.gov.

8. SENTINEL EVENTS

8.01 Sentinel Events

Maryland PBHS licensed providers are required to report sentinel events regarding participants receiving services in any level of care. Providers are required to report Sentinel Events to Carelon within 24 hours via the call center, email, or fax.

- Carelon Call Center: 1-800-888-1965 (TTY 711) weekdays from 8 a.m. to 5 p.m.
- Email: corporatepqoc@carelon.com
- Fax: 855-677-7672

A Sentinel Event, also known as a 'critical incident,' is defined as an unexpected occurrence that represents actual or the risk of serious harm of participants or to others, by a participant who is in treatment. Sentinel Events are defined as any of the following:

a. Death (suicide and unexpected) of a program participant.
b. A homicide that is attributed to a participant who, at the time of the homicide, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days.
c. Any serious or life-threatening injury to a program participant when in a treatment setting resulting in urgent/emergent interventions. Serious injury specifically includes:
    - Loss of limb or function
    - Non-consensual sexual activity, as prohibited in COMAR 10.01.18
    - Any sexual activity between a staff participant and a program participant
    - Unexpected evacuation of a building under circumstances that threaten the life, health, or safety of participants
    - Diversion of medication from the stock of a program providing opioid treatment services
    - Any injury related to an opioid medication dispensed by a program providing opioid treatment services
    - Serious adverse reaction to behavioral health treatment requiring urgent or emergent medical treatment
    - Human rights violations (e.g., neglect, exploitation)
    - A serious physical assault of or by a participant, requiring urgent or emergent medical intervention that occurred on facility premises while the participant was receiving facility-based treatment.

The provider's local systems manager (formerly referred to as CSA, LBHA, and/ or LAA) is required to investigate non-ABA related sentinel events, providing feedback and results to the provider.

Sentinel events that occur at a hospital will be submitted to the Office of Healthcare Quality (OHCQ) for investigation. ABA related sentinel events shall be investigated by Carelon. Carelon will submit recommendations to Medicaid and Maryland Division of Children Services. Following their review, a letter of determination will be sent to the Provider indicating the Quality-of- Care concern(s), if any, that contributed to the occurrence of the sentinel event.

8.02 Participant Safety Program

The Carelon Participant Safety Program ensures alignment with NCQA standards. Carelon has a defined procedure for the identification, reporting, investigation, resolution, and monitoring of Potential Quality of Care (PQOC) concerns. PQOC concerns are those that decrease the likelihood of desired health outcomes and are inconsistent with current professional knowledge. These issues may be identified from various sources, including participant and provider/participating provider complaints, internal reviews, clients, government agencies, and others.

These concerns are resolved and monitored at both the state and national level. Both levels have a designated committee, in which Carelon BH medical directors participate, that oversees the investigation and resolution of these issues through to completion.

Carelon's participant safety program includes the following components: prospective identification and reporting and investigation of potential Serious Reportable Events (internal and external events), trend analysis of participant, provider, and client complaints, annual evaluation and updating of existing participant safety policies, prevention activities and the promotion of evidenced-based practice by our network credentialed providers and Carelon employed clinicians.

Carelon's Participant Safety Program utilizes a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TEs). Carelon adopted the National Quality Forum's (NQF) Serious Reportable Event classification system as a base for its Participant Safety Program. This allows the use of a standard taxonomy across a wide variety of settings and supports standard definitions across our diverse organization. For some contracts the term adverse incident, sentinel event, or major incident may be used interchangeably or may have a specific definition based on state requirements.

Serious Reportable Events (SREs) include, but are not limited to:

- Surgical or Invasive Procedures (i.e., wrong site, wrong individual, wrong procedure, foreign object, death of ASA class 1 patient)
- Product or Device Events (i.e., contamination, device malfunction, embolism)
- Patient Protection Events (i.e., discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, self-injurious behaviors)
- Care Management Events (i.e., medication error, fall)
- Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)
- Potential Criminal Events (i.e., impersonation, abduction, physical assault, sexual behavior)
- Carelon Specific (i.e., disaster management, accidents, staff misconduct, standards of care, natural death)

Trending Events (TEs) include, but are not limited to the following categories and subcategories:

- Provider inappropriate/unprofessional behavior
    - Inappropriate boundaries/relationship with participant
    - Practitioner not qualified to perform services
    - Aggressive behavior
    - Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
    - Abandoned participant or inadequate discharge planning
    - Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
    - Delay in treatment
    - Effectiveness of treatment
    - Failure to coordinate care or follow clinical practice guidelines
    - Failure to involve family in treatment when appropriate
    - Medication error or reaction
    - Treatment setting not safe
- Access to care-related issues
    - Failure to provide appropriate appointment access
    - Lack of timely response to telephone calls
    - Prolonged in-office wait time or failure to keep appointment
    - Provider non-compliant with American Disabilities Act (ADA) requirements
    - Services not available or session too short
- Attitude and service-related issues
    - Failure to allow site visit
    - Failure to maintain confidentiality
    - Failure to release medical records
    - Fraud and abuse
    - Lack of caring/concern or poor communication skills
    - Poor or lack of documentation
    - Provider/staff rude or inappropriate attitude
- Other monitored events
    - Adverse reaction to treatment
    - Failure to have or follow communicable disease protocols
    - Human rights violations
    - Ingestion of an unauthorized substance in a treatment setting
    - Non-serious injuries (including falls)
    - Property damage and/or fire setting
    - Sexual behavior

Providers are required to report to Carelon within 24 hours all Potential Quality of Care (PQOCs) concerns involving our participants. Carelon investigates PQOCs and uses the data generated to identify opportunities for improvement in the clinical care and service our participants receive. Carelon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for continuous quality improvement. Based on the circumstances of each incident, or any identified trends, Carelon may undertake an investigation designed to provide for participant safety. As a result, providers may be asked to furnish records and/or engage in corrective actions, to address quality of care concerns and any identified or suspected deviations from a reasonable standard of clinical care. Providers may also be subject to disciplinary action through our National Credentialing Committee (NCC), based on the findings of an investigation or any failure to cooperate with a request for information, pursuant to an adverse incident investigation.

9. COMPLAINTS AND APPEALS

9.01 Overview

Carelon maintains a complaint system to review and resolve concerns raised by Maryland Public Behavioral Health Program (PBHP) recipients, providers, and other stakeholders. Complaints about a non-coverage decision we made are reviewed and resolved through the appeal process. Complaints about any other aspect of our conduct, actions or service are investigated and resolved through the grievance process.

Carelon provides one reconsideration and one internal appeal review (Level 1 Appeal) following an initial medical necessity review that resulted in a non-coverage determination of a service request. For administrative (non-medical necessity) non-coverage determinations, Carelon Behavioral Health provides a Level 1 Appeal only. The Maryland Behavioral Health Administration (BHA) provides a second level grievance review. The BHA is the final authority for participants requesting benefits as or on behalf of an uninsured individual. The final authority for Medicaid recipients is Maryland's Office of Administrative Hearings (OAH). The OAH may conduct an Administrative Hearing regarding a Medicaid service determination at any stage following the initial non-coverage determination.

Carelon never takes punitive action against anyone because they filed or supported a complaint, appeal, grievance, or request for expedited resolution.

9.02 Definition of Terms

TERM	DEFINITION
Administrative Non-Coverage Determination	A decision by Carelon Behavioral Health based on administrative requirements set forth by the Maryland PBHS and BHA that results in a termination, denial, or reduction of coverage for a requested service. Examples include denial due to not obtaining prior authorization when it is required, not requesting continued authorization for existing services before the last authorized day of service, requesting a service that is not covered, and termination of coverage/lack of eligibility. May also be called an adverse action, non-certification, or service denial.
Administrative Hearing	A formal process available to Medicaid recipients through the OAH, in which an Administrative Law Judge or other designated authority reviews a non-coverage decision made by Carelon Behavioral Health. May also be called a State Fair Hearing.
Care Advocate	A licensed clinical professional who works with Participants, healthcare professionals, physicians, and insurers to maximize and administer benefits of individuals served by the Maryland PBHS.
Clinical Non-Coverage Determination	A determination by a Carelon Behavioral Health Medical Director that the requested behavioral health services are not medically necessary based on applicable clinical criteria. May also be called an adverse action, non-certification, or service denial. A determination by a Carelon Behavioral Health Medical Director that the requested behavioral health services are not medically necessary based on applicable clinical criteria. May also be called an adverse action, non-certification, or service denial.
Complaint	An expression of dissatisfaction with some aspect of Carelon Behavioral Health or the Maryland PBHS.
Grievance	A process available to PBHS recipients, providers, and representatives in which Carelon Behavioral Health investigates and resolves a complaint about any aspect of Carelon Behavioral Health or the Maryland PBHS, other than a request to change a non-coverage determination.

TERM	DEFINITION
Level 1 Appeal	A formal process available to all PBHS recipients in which Carelon Behavioral Health re-reviews a non-coverage determination.
Level 2 Appeal	A formal process available to all PBHS recipients in which the BHA reviews a Level 1 Appeal decision made by Carelon Behavioral Health.
Medical Director	A board-certified psychiatrist who reviews authorization requests and renders medical necessity determinations. May also be referred to as a Physician Advisor.
Non-Urgent Request	A request for any service level other than a request for pre-authorization of an acute inpatient admission. A request for continued acute inpatient services is a Non-Urgent Request.
Participant	A Maryland Medicaid recipient, uninsured eligible individual, or a representative acting for that person, who requests behavioral health services through the PBHS. A participant acting on behalf of a PBHS recipient may be a provider, a parent of a minor child, a legal guardian, or a person authorized by law or by the recipient.
Reconsideration	A peer-to-peer review between the provider and a Carelon Behavioral Health Medical Director following an initial clinical non-coverage determination of service made without the benefit of a peer-to-peer review.
Urgent Request	A request for pre-authorization for admission to an acute inpatient or crisis residential facility (ASAM level 4.0, 3.7 or 3.7WM) when, in the opinion of Carelon Behavioral Health or the provider, waiting more than 24 hours for a decision would potentially be harmful to the participant.

9.03 Clinical Non-Coverage Determinations

Initial Determination

When an authorization request is submitted by a participant or a provider on behalf of a participant, an initial review is completed by a Carelon Behavioral Health Care Advocate. A Care Advocate may approve authorization but may not issue a clinical non-coverage determination. However, in appropriate cases the Care Advocate may issue an administrative non-coverage determination.

If the Care Advocate is not able to approve the request based on the information provided, they may ask the provider for additional information. Upon receipt of the additional information, the Care Advocate will either authorize the services requested or suggest an alternative level of care based on the information provided. When the Care Advocate is not able to authorize benefits for services as requested, and the participant or provider does not agree to an alternative level of care, the Care Advocate will refer the case to a Carelon Medical Director. A clinical non-coverage determination of services results when the reviewing Medical Director reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service.

Carelon makes the initial determination on pre-authorization requests within one hour from time of request for post stabilization services; within 24 hours for urgent requests; and within 14 calendar days for non-urgent requests.

Notification of the approval or non-coverage determination is sent to the participant and provider advising them which requested services were approved (if any), and which were non-certified (if any). If all or part of the request was non-certified, the notice includes an explanation of the right to further review of the determination through a Level 1 Appeal and, where applicable, reconsideration and/or Administrative Hearing.

Reconsideration

A participant, provider, or participant advocate (with the participant's consent) may request a reconsideration following a clinical non-coverage determination that is completed without the benefit of a peer-to-peer review. The request needs to be made within three calendar days from the initial determination.

To request a reconsideration, you may call Carelon at 1-800-888-1965, weekdays from 8:00 a.m. to 6:00 p.m. Eastern time. To call via TTY/TDD, you may use 711.

The reconsideration is a peer-to-peer review between the provider and a Carelon Behavioral Health medical director. Direct telephone contact with the provider is a necessary part of the reconsideration process. The participant should ensure that the Care Advocate or scheduler has a direct contact number for the provider. The Medical Director will make reasonable attempts to reach the provider to gather information and discuss the case. Carelon may also request documentation from the treatment record when the telephonic information is unclear or incomplete. When reconsideration is requested, the participate should be sure to provide an accurate telephone number to contact the provider directly.

A reconsideration decision will be made within 24 hours or by close of next business day from when the reconsideration request was received. If the non-coverage decision changed upon reconsideration, a new notification letter will be sent to the participant and provider. If the decision is not changed by the reconsideration, a new notification is not sent.

9.04 Administrative Non-Coverage Determinations

Initial Determination

Carelon issues an administrative non-coverage determination when a request for authorization cannot be approved for reasons unrelated to medical necessity. Common bases for administrative non-coverage determinations include:

- The provider failed to obtain a required pre-authorization;
- Timely filing requirements were not met;
- The recipient's benefits do not include coverage for the rendered or proposed service;
- The rendering or proposed provider is not a participant in applicable provider network; and
- The participant was not eligible for benefits on the date(s) of service.

Carelon makes the initial determination on pre-authorization requests within one hour from time of request for post stabilization services; within 24 hours for urgent requests; and within 14 calendar days for non-urgent requests.

9.05 Level 1 Appeals (Carelon Behavioral Health)

Level 1 Appeal

A participant or provider who disagrees with an initial non-coverage determination may request a Level 1 Appeal. Level 1 appeals of clinical non-coverage determinations are completed and decided by a different Medical Director, who did not take part in the prior determinations and is not the subordinate of someone who did. Level 1 appeals of administrative non-coverage determinations are completed and decided by a qualified reviewer who was not the initial decisionmaker, nor their subordinate.

Level 1 Appeal requests need to be submitted within 20 calendar days of the non-coverage decision to be reviewed, or completion of the reconsideration process. Level 1 Appeal requests may be submitted by phone, TTY/TDD, or in writing. The participant and provider have the opportunity to present medical records and other documentation, and allegations of fact or law, in person or in writing. PBHS will consider all available, germane information, regardless of whether it was considered in prior stages review.

Except in expedited cases (described below), Level 1 Appeal reviews are completed and decided within 30 calendar days from our earliest receipt of the appeal request, whether written or telephonic. Under certain circumstances, such as at the participant's request, this timeframe may be extended an additional 14 calendar days.

Carelon sends notification of the Level 1 Appeal decision to the participant and the provider. The notice states which of the requested services was overturned (approved), if any. If all or part of the non-coverage determination was upheld, the notice states which services remain denied and includes an explanation of the right to further review of the determination. This includes a Level 2 Appeal through the BHA and, for Medicaid recipients, an Administrative Hearing through the OAH.

Expedited Level 1 Appeal

Carelon provides an expedited Level 1 Appeal process. Expedited review is available whenever Carelon finds, or the provider indicates, that taking the time for a standard appeal resolution could seriously jeopardize the PBHS recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Expedited Level 1 Appeals are reviewed and decided as quickly as the recipient's condition requires and within 72 hours from receipt of the Level 1 Appeal request.

How to Request a Level 1 Appeal (Standard and Expedited)

To request a Level 1 Appeal by phone, you may call Carelon at 1-800-888-1965, weekdays from 8:00 a.m. to 6:00 p.m. Eastern time. To call via TTY/TDD, you may use 711.

You may also mail a written request to:

Carelon Behavioral Health
ATTN: Provider Claims Appeals
P.O. Box 1856
Hicksville, NY 11802

9.06 Level 2 Appeals (Behavioral Health Administration)

A participant or provider who continues to disagree with Carelon's decision after a Level 1 Appeal may request a Level 2 Appeal through the BHA. Level 2 Appeal requests need to be submitted in writing within 10 business days from the date of the Level 1 Appeal determination notice.

Level 2 Appeal Requests may be submitted in writing to the BHA as follows.

By email: BHA.Appeals@maryland.gov

By Mail: Behavioral Health Administration
ATTN: Grievances and Appeals
Spring Grove Hospital Center - Vocational Rehabilitation Bldg.
55 Wade Avenue
Catonsville, MD 21228

BHA prefers to receive the request via email. If the request is sent by mail, you should also notify the BHA of the request by sending an email to BHA.Appeals@maryland.gov.

If a participant does not utilize the Level 1 Appeal process before submitting their Level 2 Appeal request, BHA may refer the request to Carelon Behavioral Health for re-review. BHA's review process may include input from the Local Behavioral Health Agency, Community Service Agency or Local Addictions Authority, as needed.

The completion timeframe for a Level 2 Appeals is 10 business days from receipt for urgent requests, or 20 business days from receipt for non-urgent requests. BHA will send the participant and provider written notice of the outcome.

BHA is the final authority for participants who are uninsured eligible. However, Medicaid recipients will be informed by BHA of their rights to appeal to the OAH.

Questions about the Level 2 Appeal process may be emailed to BHA.Appeals@maryland.gov.

9.07 Administrative Hearing (Department of Health)

Medicaid participants may request an Administrative Hearing at any stage after the initial non-coverage determination or denial. Administrative Hearing requests may also be submitted in writing within 120 calendar days after the date of Carelon's Initial Determination notice, Reconsideration process completion, or Level 1 Appeal decision notice.

Administrative Hearing Requests may be submitted in writing to the Maryland Department of Health (MDH) as follows.

By email: mdh.MedicaidAppeals@maryland.gov

By Mail: Maryland Department of Health
Attention: Appeals Coordinator
201 West Preston Street, Room 127
Baltimore, Maryland 21201

By Fax: 410-333-5154

The appeals coordinator will receive the materials and transmit the request to the OAH. The OAH is the final authority for Medicaid recipients.

9.08 Continuation of Benefits

In qualifying cases, Carelon will continue to cover and authorize services for a PBHS recipient during the appeal process. Continuation of Benefits is available when the appeal concerns services that were previously authorized but are now being terminated, suspended, or reduced. The prior authorization cannot have expired, and the services are required to have been ordered by an authorized provider. The participant or provider need to request continuation of benefits and file the appeal within 10 calendar days from the initial non-coverage determination date, or the intended effective date of the decision.

If all the conditions are met, we will continue or reinstate coverage or authorization for the services until the appeal process is complete. This happens when (a) the appeal is withdrawn, (b) the appealed determination is overturned (approved), (c) the BHA upholds the Level 1 Appeal decision, or (d) the Administrative Hearing officer upholds the non-coverage determination.

9.09 Provider Complaints

When Carelon receives a complaint that does not request appeal review of a non-coverage determination or denial, the matter is investigated and resolved through the grievance process. A grievance may be filed by phone or in writing, at any time. With a PBHS recipient's consent, any representative may file a complaint on their behalf.

To file a grievance by phone, you may call PBHS at 1-800-888-1965, weekdays from 8:00 a.m. to 6:00 p.m. Eastern time. To call via TTY/TDD, you may use 711.

You may also mail a written request to:

Carelon Behavioral Health
ATTN: Complaints
P.O. Box 1850
Hicksville, NY 11802

Emergency medically related grievances are investigated and resolved within 24 hours from receipt. Non-emergency medically related grievances are investigated and resolved within five calendar days of receipt. Administrative (non-medically related) grievances are acknowledged in writing within five calendar days and are investigated and resolved within 30 calendar days. Notice of the resolution is sent to the participant, unless the nature of the grievance is such that the details need to remain confidential.

9.10 Additional Assistance

Carelon can assist with filing an appeal or grievance, including through translation services. For information or assistance, you may call us at 1-800-888-1965, weekdays between 8 a.m. and 6 p.m. Eastern time.

10. COMPLIANCE AND PROVIDER AUDITS

10.01 Site Audits

Providers who participate in the Maryland Public Behavioral Health System (PBHS) are subject to announced and unannounced audits by Carelon Behavioral Health. It is expected that all providers will be in compliance with all applicable state and federal regulations, including COMAR 10.09.36 and COMAR 10.09 associated with the service(s) rendered.

Carelon Behavioral Health will perform audits on PBHS programs including:

- Individual and group practitioners
- Inpatient hospitals
- Residential treatment centers
- Substance use disorder programs and providers
- Community mental health program providers
- Other licensed or approved programs, as directed.

Audits may include, but are not limited to, a review of any of the following:

- Physical environment
- Staffing
- Documentation: including consents, uninsured eligibility documentation, assessments, treatment plans, and contact/progress notes
- Evaluation of service delivery
- Billing records

Providers are selected for an audit based on random selection, unusual service patterns, billing outliers, high utilization, need to evaluate overall service delivery, practice patterns that may constitute fraud, waste, or abuse, and at the recommendation of and approval by BHA and/or Medicaid. Carelon Behavioral Health uses audit tools approved by Medicaid and the Behavioral Health Administration (BHA). The audit tools can be found on the Carelon website.

Upon completion of an audit, Carelon Behavioral Health will issue a report to be shared with the provider, BHA, Medicaid, and local designated authority and, as required, Office of the Inspector General (OIG) and/or OIG/Medicaid Fraud Control Unit.

Reports detail audit findings and billing retraction amounts. Providers are required to submit a Program Improvement Plan (PIP)/Corrective Action Plan (CAP) for audit areas with less than eighty-five percent (85%) compliance rate.

If potentially fraudulent or unethical behavior is identified or reported, providers will be referred to the appropriate state enforcement entity. Audits resulting in state disciplinary action and/or a PIP/CAP may require close monitoring by Carelon Behavioral Health or the local designated authority and may be subject to additional audits.

The SIU may conduct announced and unannounced on-site visits to address allegations of FWA, when appropriate and/or as required by contract.

Examples of what the SIU may do include but are not limited to the following:

- Gather medical records, or any other documentation, e.g., sign-in sheets, treatment plans, etc., in support of furnished services that were billed
- Confirm provider and other health professionals' signatures
- Request and document statements from provider employees involved in a participant's care
- Verify the provider enrollment status and review applicable certifications/licensure for all staff involved in a participant's care
- Validate the provider's/supplier's location and legal status
- Review applicable training records for the Provider and staff

10.02 Fraud, Waste and Abuse

Carelon is committed to protecting the integrity of our health care programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person—or any other person—committing it. This includes any act that constitutes fraud under applicable federal or state law.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** behaviors that are inconsistent with sound financial, business, and behavioral health practices and result in unnecessary costs and payments for services that are not clinically necessary or fail to meet professionally recognized standards for health care. This includes any participant actions that result in unnecessary costs.

To help prevent fraud, waste and abuse, providers can assist by educating participants. For example, spending time with participants and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent Participant fraud is as simple as reviewing the participant identification card to ensure that the individual seeking services is the same as the participant listed on the card. It is the first line of defense against possible fraud.

10.03 Reporting Fraud, Waste and Abuse

If someone suspects any participant or provider (a person who receives benefits) has committed fraud, waste, or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

Report concerns by:

- Calling Provider Services at 800-397-1630
- Calling the Carelon Ethics and Compliance hotline at 888-293-3027

You may also report suspected fraud directly to state agencies:

- Maryland Attorney General, Medicaid Fraud & Vulnerable Victims Unit (MFVVU)
  Phone: 888-743-0023
  Email: MedicaidFraud@oag.state.md.us
- Maryland Department of Health – Office of the Inspector General
  Phone: 866-770-7175
  Online complaint form

Any incident of fraud, waste or abuse may be reported to Carelon anonymously; however, Carelon's ability to investigate an anonymously reported matter may be limited if Carelon does not have enough information. Carelon encourages Providers and Facilities to give as much information as possible. Carelon appreciates referrals for suspected fraud but be advised that Carelon does not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of participant Fraud, Waste and Abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the participant's ID (Identification) card
- Relocating to out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a participant include:

- The participant's name
- The participant's date of birth, participant ID or case number if available
- The city where the participant resides
- Specific details describing the fraud, waste, or abuse

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering behavioral health records to misrepresent actual services provided
- Billing for services not provided
- Billing for behavioral health unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (anyone rendering or billing for behavioral health services) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

10.04 Investigation Process

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. Carelon may take corrective action with a Provider or Facility, which may include, but is not limited to:

- Written warning and/or education: Carelon sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment or may advise of further action.
- Audits and behavioral health record review: Carelon reviews behavioral health records to investigate allegations or validate the appropriateness of Claims submissions.
- Prepayment Review Edits: A certified professional coder or investigator evaluates Claims and places payment or system edits in Carelon's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- Recoveries: Carelon recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

10.05 Prepayment Review

One method Carelon uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Carelon's attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to Carelon's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit behavioral health records and any other supporting documentation with each Claim so Carelon can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the behavioral health records and supporting documentation submitted. Failure to submit behavioral health records and supporting documentation to Carelon in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, Carelon may review coding, documentation, and other billing issues. In addition, Carelon may use one or more clinical utilization management guidelines in the review of claims submitted by the provider or facility, even if those guidelines are not used for all providers or facilities delivering services to Plan Participants.

The provider or facility will remain subject to the prepayment review process until Carelon is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider or facility could face corrective measures, up to and including termination from our network.

Finally, providers and facilities are prohibited from billing a participant for services Carelon has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit behavioral health records as set forth above. Providers or facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their provider and facility agreement, proper billing procedures and state law. Providers or facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

10.06 Acting on Investigative Findings

In addition to the previously mentioned actions, Carelon may refer suspected criminal activity committed by a participant, provider, or facility to the appropriate regulatory and/or law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse the provider:

- Will be referred to the Special Investigations Unit
- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from Maryland's plan.

If a participant appears to have committed fraud, waste or abuse or has failed to correct issues, the participant may be involuntarily dis-enrolled from Maryland's health care plan, with state approval.

10.07 Recoupment/Offset/Adjustment for Overpayments

Carelon is entitled to offset and recoup an amount equal to any overpayments or improper payments made by Carelon to providers or facilities ("Overpayment Amount") against any payments due and payable by Carelon or any affiliate to providers or facilities. The provider or facility should voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carelon that an Overpayment Amount is due from a provider or facility, the provider or facility is required to refund the Overpayment Amount to Carelon within 30 calendar days of the date of the overpayment refund notice from Carelon to the Provider or Facility. If the Overpayment Amount is not received by Carelon within the 30 calendar days following the date of such notice letter, Carelon is entitled to offset the unpaid portion of the Overpayment Amount against other claims payments due and payable by Carelon or an affiliate to a provider or facility in accordance with Regulatory Requirements. In such event, the provider or facility agrees that all future claim payments, including affiliate claim payments, applied to satisfy provider's or facility's repayment obligation shall be deemed to have been legally paid to provider or facility in full for all purposes, including affiliates and/or Regulatory Requirements as defined by the provider or facility agreement. Should a provider or facility disagree with any determination by Carelon or a plan that provider or facility has received an overpayment or improper payment, the provider or facility has the right to appeal such determination under Carelon's procedures set forth in the Provider Manual, provided that such appeal does not suspend Carelon's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment. Carelon reserves the right to employ a third-party collection agency in the event of non-payment.

Directions to Providers and Facilities

All providers should routinely review claims and payments to assure that the provider has coded its claims correctly and the provider has not received any overpayments. Carelon will notify providers and providers of overpayments identified by Carelon, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- Duplicate payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations
- Payments made in excess of amounts due in instances of third-party liability and/or coordination of benefits
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

10.08 Relevant Legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least five million dollars (cumulative from all sources), are required to comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies need to provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A). This function is coordinated and tracked by Carelon Behavioral Health's Compliance Department.

- As part of such written policies, include detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse, and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse, and waste.

Compliance with COMAR

Carelon Behavioral Health and all providers serving the state of Maryland are required to and agree to comply with the requirements under COMAR 10.09.36.03 and any amendments or state mandates.

11. LAB SERVICES

11.01 Lab Services: Substance Use Disorder (SUD) Service Providers

Federal regulations require that all Ordering, Referring, and Prescribing practitioners be enrolled with Maryland Medicaid. Laboratory claims that do not include the National Provider Identifier (NPI) for an ordering or referring provider who is actively enrolled in Maryland Medicaid will be denied. Participants can check their ordering or referring provider's enrollment status using the Provider Verification System.

For more information on ORP provider policy and resources for patients please visit https://bit.ly/3TKORP.

NOTE: Refer to section 2.06 Provider Types (PT) in this manual. PT 32, 54, and PT 50 IOP (ASAM Level 2.1) and PHP (ASAM Level 2.5) programs are required to have contracts with independent labs (PT 10) and these services are not payable through the ASO, Carelon. Please note, clinicians need to submit their CLIA, lab permit, and/or letter of exception of a lab permit upon enrolling.

Drug testing should be used as needed within ASAM clinical recommendations to improve outcomes and should be integrated into the process of making treatment decisions.

Clinicians treating individuals who are at risk for or have a previous SUD diagnosis should do random testing, be aware of the most prevalent drugs within the community, and order only those tests which are medically indicated.

- On site CLIA-waived tests, which provide immediate results, should be rapidly integrated into treatment decisions and clinical assessments.
- Ordered tests should match individualized treatment needs. In the clinical setting, this would correlate with more frequent testing during the initial phase of treatment or during relapse, followed by less frequent random tests when medically indicated by the individual's recovery progress.
- When ordering drug toxicology tests, it is important to know exactly how many drugs are being tested. The number and types of tests ordered should match the number and types of tests on the results.

For presumptive drug tests, coverage will include:

- 80305 (already covered for in-office testing) Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
- 80306 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
- 80307 Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (e.g., immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, OHPC, OC mass spectrometry), includes sample validation when performed, per date of service.

For definitive tests, only reimbursable to laboratories, coverage will include:

- 00480: Per day, 1-7 drug class(es), including metabolite(s) if performed; and
- 00481: Per day, 8-14 drug class(es), including metabolite(s) if performed.

Providers should follow the guidelines of ASAM SMART testing.

Maryland Substance Use Laboratory Testing for Drug and Alcohol Use

This clinical criterion relates to laboratory testing used in the initial assessment and ongoing monitoring of individuals at risk of or with substance use disorder who receive behavioral and/or addiction services.

The assessment of continued drug use should be based on treatment interactions, behavioral observations, as well as mental status and history and physical evaluation. Review of findings consistent with drug use in many cases results in self-disclosure of ongoing substance use. However, the validity of an individual's self-reported substance use is not always reliable.

Ambulatory laboratory testing for drugs of abuse is a medically necessary and useful component of substance use disorder treatment. Drug tests results are of importance in treatment programs and in outpatient chemical-dependency treatment. General testing should be ongoing, random, and more intense earlier in treatment. The drug screen result can influence treatment and level-of-care decisions; point-of-care testing (POCT) is encouraged to aid in these decisions. It is important that ordered tests match treatment needs, the documented history, and the most current version of the DSM diagnosis. Ordering providers should document drug-testing rationale indications and test results.

11.02 Lab Services: Mental Health Providers

The Maryland Public Behavioral Health System (PBHS) will reimburse laboratories that are in compliance with COMAR 10.09.09 for medically necessary tests and procedures related to psychiatric treatment rendered to Medicaid recipients by psychiatrists in the PBHS. The laboratory is required to have a valid Maryland license and be Clinical Laboratory Improvement Amendment (CLIA) certified. The referring/ordering provider needs to be included on the claim and be a Maryland Medicaid enrolled provider to order/refer for testing.

12. PHARMACY AND TRANSPORTATION

12.01 Pharmacy Information

Federal regulations require that all Ordering, Referring, and Prescribing practitioners be enrolled with Maryland Medicaid. Pharmacy claims that do not include the National Provider Identifier (NPI) for a prescribing provider who is actively enrolled in Maryland Medicaid will be denied. Participants can check their prescriber's enrollment status using the Provider Verification System.

For more information on ORP provider policy and resources for patients please visit https://bit.ly/3TKORP.

Participants with Medicaid should use the pharmacy network and the pharmacy card they received from their Managed Care Organization (MCO) at the time of enrollment. Participants who do not belong to an MCO should use their Medicaid cards. Participants do not need to carry a separate card or use a different pharmacy network for their SUD or mental health medications.

Participants without Medicaid may contact their local systems manager or contact their Core Service Agency (CSA) or Local Addictions Authority (LAA) to inquire about pharmacy assistance or other help that may be available. Additional information regarding the Medicaid Pharmacy benefit may be accessed at Maryland Department of Health: Medicaid Pharmacy Program.

Medication Coverage

The Maryland Medicaid Pharmacy Program (MMPP) has a Preferred Drug List (PDL). Substance use disorder (SUD) medications are part of this program. The PDL is posted on the MMPP website at Maryland Department of Health: mmcp.health.maryland.gov/pap/Pages/Preferred- Drug-List.aspx

Alternatively, you may search the status of a drug using Epocrates Online (http://online.epocrates.com/rxmain).

Some medications, including some SUD medications, require prior authorization due to quantity limits and/or clinical criteria, which are measures to encourage the safe and appropriate use of a drug. Medications that have quantity limits and/or clinical criteria are available at:

- Quantity Limits: Maryland Medicaid Pharmacy Program Quantity Limits
- Clinical Criteria: Medicaid Pharmacy Program - Clinical Criteria

12.02 Transportation

For Medicaid recipients, transportation to outpatient mental health centers (OMHC) appointments for medically necessary ambulatory treatment services is primarily the responsibility of the local health department. Transportation services for Medicaid recipients will be based on the closest, willing provider.

Transportation is included in the rate of reimbursement under the Maryland Public Behavioral Health System's (PBHS) fee-for-service payment for participants in a psychiatric rehabilitation program (PRPs), residential programs for pregnant women and children, or substance use services that are court ordered under Health General §8-507. Transportation time and the act of transporting the participant is not allowed. Transportation time and the act of transporting individuals to a rehab service are not reimbursed.

If an ambulance is called for a behavioral health emergency involving a Medicaid recipient, the ambulance provider is required to bill Medicaid directly. Ambulance services are not authorized through Carelon, and the claim should not be sent to Carelon.

Emergency Petition Related Transportation for Non-Medicaid:

There are two instances in which Carelon may be billed for transportation where the state will pay:

1) In accordance with Health General Article 10-628 for reimbursement of services provided under the emergency petition process, the Maryland Behavioral Health Administration (BHA) will pay for transportation of an individual by a public safety officer, to an emergency facility for an emergency evaluation if the individual is uninsured or their insurance does not cover this.

2) If, after evaluation by a physician, the individual is verified for an involuntary admission, BHA will reimburse the transportation from the community hospital's emergency department to the receiving hospital that has been identified to accept that person as an involuntary admission.

However, if an individual is subsequently found to have private insurance, the ambulance service bill will be paid by the private insurance carrier. For costs requested for transportation reimbursement under the emergency petition process, Carelon will be provided a bill and documentation of services.

13. CLAIMS PROCEDURES

The following are requirements to facilitate claims processing:

- Be either the uniform bill claim form or electronic claim form in the format required by Carelon
- Be submitted by a Provider for payment by Carelon rendered to a covered participant
- Be considered to be a Complete Claim which means, unless state law otherwise requires, it contains all information necessary to process the Claim and make a benefit determination

Providers in the Carelon network are encouraged to submit all claims electronically whenever possible. Electronic submission will expedite claims processing. Electronic claim submissions are also accepted through clearinghouses. When using the services of a clearinghouse, providers need to reference Carelon's Payer ID, BHOMD, to ensure Carelon receives those claims. Each clearinghouse may have a payer list that provides an alternative value specific to Carelon, the value published on their website can also be used.

13.01 Electronic Claim Submission and Clearinghouses

Carelon has contracted with Availity Essentials ("Availity") as our primary clearinghouse. All providers and facilities that generate HIPAA compliance 837 files will need to register with Availity and submit their files through the Availity SFTP server (also referred to as Carelon's Provider Digital Front Door). Availity also offers direct data entry of claim records using both professional and institutional claim formats.

Providers and facilities that are submitting through a clearinghouse other than Availity (i.e., Change Healthcare, Office Ally) can continue to do so as all existing clearinghouse trading partners will be routing claims through Availity to Carelon.

For information about testing and setup for EDI, review Carelon's 837 companion guide available on Carelon's website. Carelon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 999 and 277CA response.

13.02 Claim Submission Guidelines

Paper Claim Submissions

Carelon will accept paper CMS-1500 forms or Uniform Billing (UB)-04 forms. Claims billed on discontinued forms may be denied. Please use original forms with red ink.

- CMS-1500 forms are for professional/practitioner services
- UB-04 forms are for inpatient and outpatient facility claims

When submitting on paper, providers are required to use current CMS-1500 form, found on the Carelon website.

Claim Mailing Address:

Carelon Behavioral Health
ATTN: Maryland
PO BOX 1850
Hicksville, NY 11802

Electronic Claim Submissions

For electronic claim submission, please use Availity Essentials

- Can be used to submit batch 837 claims file
- Direct Data Entry (DDE) single claim submission

For the Carelon companion guide to 837 submissions please refer to the Carelon website.

Claim Submission Filing Tips

Claims for covered services rendered to participants should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by Carelon included. Tip sheets containing Carelon's required claim fields to make a clean claim for the UB04 and CMS-1500 are located on the Carelon website.

All data elements noted are required to be provided and match what the subscriber's employer has on file. If the participant's ID on the claim is illegible or does not match what the subscriber's employer has provided, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the participant's ID card and validate that it is current at the time of each visit.

There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.

Claims that are not submitted on a CMS 1500 2012-02 or a UB04 often will not contain the information we need to consider the claim clean and will cause the claim to reject or take a longer processing time. Claims submitted on old claim forms may be returned.

Electronically submitted claims need to be in a HIPAA 5010 compliant format and conform to the Carelon companion guide to be considered clean.

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the participating provider will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status.

Claims submission guidance, including required claim fields to make a clean claim, is available on the Carelon website.

For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the participating provider does not follow these guidelines, claims may be returned from the scanning vendor:

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212012)
- Use a fixed width font (Courier, for example)

Providers are required to file or submit claims within 365 calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payer. Claims after the above noted 365-day time period after the date of service may be denied due to lack of timely filing. Claims need to match the authorization or certification or notification applicable to covered services for which the claim applies to avoid potential delays in processing.

Providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern, or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern, or psychological assistant.

Separate claim forms need to be submitted for each participant for whom the participating provider bills along with all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description (e.g., 90832, 90833, 90834, 90836, 90837, 90838, 90839, and appropriate Evaluation and Management codes, the actual time spent needs to clearly be documented within the participant's treatment record. This time should be documented indicating a session's start and stop times (e.g., 9:00-9:50).

Providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Carelon relies on claims edits and investigative analysis processes to identify claims that are not in accordance with national and industry standards and therefore were paid in error. The claims edits and investigative analysis processes include CMS's National Correct Coding Initiative (NCCI), which consists of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claims edits can include but are not limited to the following:

- Invalid procedure and/or diagnosis codes
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- State-specific edits to support Medicaid requirements
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary procedure code
- Charges not supported by documentation based on review of medical records
- Claims from suspected fraudulent activities of providers and participants that warrant additional review and consideration
- Services provided by a sanctioned provider or provider whose license has been revoked or restricted
- Incorrect fee schedule applied
- Duplicate claims paid in error
- No authorization on file for a service that requires prior authorization

13.03 Claims Timely Filing

If the original claim was filed with Carelon within 12 months of the date of service, the provider may resubmit the claim with additional information for consideration to Carelon within that same 12-month period, or if after the 12-month period, within 60 days of the date of the Carelon provider voucher which denied the claim. (COMAR 10.09.36.06 B)

When Commercial Insurance is Primary

The timely filing limit for claims is 60 days from the date of the other carrier's EOB, or 12 months from the first DOS, whichever is later. The provider is required to submit the claims to the primary carrier within the primary carrier's timely filing limit.

Carelon requires the other carrier's remittance advice as proof of timely filing.

When Medicare is Primary

If Medicare part A benefits are exhausted, the provider should submit the A3 occurrence code in FL31a-34a and date Medicare benefits were exhausted in FL31b-Fl34b. If Medicare will deny benefits for another reason, the provider is required to submit claims to Medicare within Medicare's timely filing limits and submit the paper claim and Explanation of Medicare benefits (EOMB) to Carelon within 12 months of DOS or 120 days from EOMB, whichever is later) of Medicare's EOMB date. Authorizations are required for services not covered or exhausted by Medicare. (COMAR 10.09.36.06 B (2) a -b)

If the service is known not to be covered by Medicare, e.g., PRP, or most substance use disorder services, the provider does not need to submit to Medicare. Refer to the "EOP Required" grid on the Carelon website to identify services for which a Medicare EOMB is not required.

For services and providers covered by Medicare, submit claims directly to Medicare following Medicare's timely filing guidelines. Claims covered by Medicare should not be sent to Carelon.

When Medicaid Eligibility is Assigned Retroactively

Claims are to be submitted to Carelon within 12 months from the date of eligibility determination. The Department of Social Services Medical Assistance Eligibility Determination Award Letter I (MA-81 letter of retro-eligibility) or a retro-eligibility timely filing waiver form needs to be submitted with every claim.

The Form can be downloaded by visiting the Carelon website and selecting Behavioral health Providers > Providers Resources > Guides and Forms. Please include the Medical Assistance Eligibility Determination Letter, if available. (COMAR 10.09.36.06 B (6-8))

13.04 Claims Processing

Carelon, or its designee, will process complete and accurate claims submitted by providers for covered services rendered to participants in accordance with normal claims processing policies and procedures, the payment terms included in the provider agreement, and applicable state and/or federal laws, rules and/or regulations with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider/participating provider for covered services or in a request for submission of treatment records.

Participating provider agrees that no payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for covered services provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care will be at the contracted reimbursement rate in effect on the date of admission.

Payment for services rendered to participants is impacted by the participant's eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any preauthorization/certification/notification requirements, participant expenses, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Regardless of any provision to the contrary, providers acknowledge and agree that the payment rates in the provider agreement extend and apply to services rendered to participants of benefit plans administered in whole or in part by Carelon.

13.05 Corrected Claims

All billings by the provider are considered final unless adjustments or a request for review is received by Carelon within 60 calendar days from the date indicated on the Explanation of Benefits (EOB). Payment for services is based upon authorization, certification, or notification (as applicable), coverage under the participant's benefit plan and the participant's eligibility at the time of service.

The individual provider is ultimately responsible for the accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency is required to ensure a legal contract (made available to Carelon upon request) stating the responsibility of said billing service to report claim information as directed by the provider in compliance with all policies stated by Carelon. It is also the provider's responsibility to submit claims timely.

A corrected claim is performed when a paid claim is determined to have been incorrectly processed, either due to an error or when updated information is provided. An adjustment means the paid claim is reversed (and dollars paid are backed-out) and a new claim is processed with the correct information. If the new claim results in a lesser payment than the original paid claim, or is denied, then the provider's account is in a negative balance. Future payments to the provider will be used to offset a negative balance.

Providers can request a corrected claim using one of the following methods:

- Submit an electronic claim with the appropriate frequency indicator and referencing the original claim submission
- Submit a paper claim with the appropriate frequency indicator and referencing the original claim submission

13.06 Authorization

Providers need to determine if such requirements exist prior to the provision of non-emergency services to participants.

Providers may verify participant eligibility, submit, and review authorization requests, and view authorizations through Carelon's Provider Digital Front Door.

13.07 No Balance Billing

Providers may not balance bill participants for any services rendered. This means that the participating provider may not bill, charge, or seek reimbursement or a deposit from the participant for services. Providers are required to comply with provisions of Carelon's code of conduct where applicable, including, without limitation, cooperation with claims and billing procedures and participation in training and education. Balance billing education is provided by Carelon as included in quarterly Fraud, Waste, and Abuse provider training. It is the provider's responsibility to check benefits prior to beginning treatment of the participant, to obtain appropriate authorization to provide services, if applicable, and to follow the procedures set forth in this Handbook.

13.08 Coordination of Benefits

Some participants may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers.

Providers should obtain information from participants as to whether the participant has health benefits coverage from more than one source, and if so, provide this information to Carelon.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the participant's benefit plan and applicable state and/or federal laws, rules, and/or regulations. To the extent not otherwise required by applicable laws or regulations, providers agree that in no event will payment from primary and secondary payers for covered services rendered to participants exceed the rate specified in the provider agreement.

Providers need to submit a copy of the EOB with their claim submission. If submitting the claim electronically, through our direct submission model using Carelon's Provider Digital Front Door, the EOB can be uploaded. When submitting a claim using electronic data interchange or via mail, the EOB is required to be sent via mail and includes the primary payer's determination. The services included in the claim submitted to Carelon should match the services included in the primary payer EOB.

Authorization, certification, or notification requirements under the participant's benefit plan still apply in coordination of benefits situations.

For participants with simultaneous Medicare and/or Commercial coverage, a coordination of benefits (COB) is required of Carelon. Carelon will coordinate benefits with the primary insurer before behavioral health benefits can be paid against the uninsured eligibility span. Carelon may pay for services to a dually insured participant, under an uninsured eligibility span, if the participant is:

- A Medicare beneficiary, and Medicare does not cover this service, and the individual does not have other insurance to cover the service
- Covered by a commercial insurance and the benefit for this service is exhausted, there is no benefit for this service, or the service was deemed not medically necessary by the insurer and the provider has exhausted all appeal options.

COB for both Medicare and commercial insurance is not required for the following services:

- Supported employment services
- Residential Rehabilitation Program (RRP) services
- Respite services
- Enhanced support services
- Psychiatric Rehabilitation Program (PRP) services
- Occupational therapy services*

For individuals ages 18-64 who are uninsured, have SSDI/SSI, are employed, and are requesting authorization for behavioral health services, Carelon will direct the provider to apply for Employed Individuals with Disabilities (EID) benefits on behalf of the individual. EID eligibility information and application instructions are available on the MDH website. Exceptions will be granted only for an urgent behavioral health emergency and for referrals from state hospitals.

For veterans in Maryland, BHA will provide funding for gap services, outpatient treatment, and crisis intervention services until their U.S. Veterans Administration benefits are activated and available.

Financial data is required to be reviewed annually, documented, and maintained in the participant's medical record.

13.09 Provider Summary Vouchers

PSVs or remittance advices are the documents that identify the amount(s) paid and participant expenses due from the participant. Providers should access PSVs through Carelon's Provider Digital Front Door or request copies of PSVs via facsimile through Carelon's automated PSV faxback service at 866-409-5958. Additionally, Provider Summary Vouchers may be obtained through Zelis (formerly known as PaySpan), our vendor responsible for distribution of claim payment. Accessing PSVs electronically is a transaction subject to the e-commerce initiative.

13.10 Zelis (Previously known as PaySpan)

Providers are required to use Zelis for electronic fund transfer. Zelis enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes. Providers can also configure Zelis to communicate with their clearinghouse for 835 ingestions.

13.11 Claim Appeals

A provider who disagrees with Carelon's denial or reimbursement rate for a claim may request a claim appeal. Claim appeal requests may be submitted in writing to the address given in the PSV. A complete appeal request needs to be received within 90 calendar days from date of the payment determination being appealed.

To file an appeal based upon the denial of a payment request, please use the Provider Claim Appeals Request form and mail to:

Carelon Behavioral Health
ATTN: Provider Claims Appeals
P.O. Box 1856 Hicksville, NY 11802

A claim appeal request is not considered complete until all necessary information has been received. At a minimum, it is required to include the individual's name and identifying information, the provider's name and contact information, the billed service and dates of service, and the reason the provider believes Carelon's determination is incorrect. The provider may submit any additional information for Carelon to consider in our decision. If Carelon finds that additional information is necessary to make a decision, Carelon will notify the provider of the information needed and the timeframe to submit the information.

Carelon issues a provider claim decision within 45 calendar days from receipt of a complete appeal request and sends the participating provider a written decision letter. If the appealed determination is upheld, the decision letter will explain the reason it was upheld. If the determination is overturned, the claim will be reprocessed in accordance with the decision within 30 calendar days from the date of the appeal decision.

Providers may file a dispute with the MCO/BHASO (Behavioral Health Administrative Services Organization) Dispute Resolution Committee after exhausting Carelon's internal claim appeal process. The Committee's scope of authority to make determinations is limited to disputes concerning whether treatment is medical or behavioral health.

The MCO/BHASO (Behavioral Health Administrative Services Organization) Dispute Resolution Committee reviews cases deemed complete. The submission is complete if the submission includes the following documents:

(1) BHASO Remittance Report evidencing the completion of the first level of appeal;
(2) Patient's UB04 Form;
(3) Patient's Medical Record from date(s) in question, including: Physician History and Physical Exams from hospital admission and discharge, or ED visit; and
(4) MCO/BHASO Dispute Resolution Review Form filled out sections:
a. Hospital Information
b. Patient Claim Information
c. BHASO Remittance Information

Send complete submissions to:
Maryland Department of Health
ATTN: Maryland MCO/BHASO Dispute Resolution Committee
201 W Preston St, Room 523
Baltimore, MD 21201

Concerns regarding receipt of payment should not be sent to the Committee since ensuring payment is outside the scope of the Committee.

The Committee does not accept and will not review cases:

(1) Where the date of service exceeds one year's time from the date stamp of envelope or email,

(2) If the third-party payor is a commercial payor,

(3) In the appeal process of either BHASO or the patient's MCO, or

(4) Where the dispute concerns medical necessity, other procedural, or administrative requirements necessary for payment.

14. OUTCOMES DATA AND FEDERAL REPORTING

14.01 General Information

The approach to capture and report outcomes measures along with federally required data elements is under revision with the implementation of Carelon as the ASO effective January 2025. Revisions to this guide will be published when the measures and associated reporting capability are established.

15. MANUAL UPDATES AND GOVERNING LAW

15.01 Manual Updates

This handbook may be updated at any time and is subject to change. If there is a material change to this handbook, then Carelon will make reasonable efforts to notify Providers and Facilities in advance of such change through web-posted newsletters, letters, or email communications. In such cases, the most recently published information will supersede all previous information and be considered the current directive. This handbook is not intended to be a complete catalog of all Carelon policies and procedures. Other policies and procedures not included in this handbook may be posted on the Carelon website or published in specially targeted communications, including but not limited to bulletins and newsletters.

Links to the website, other information, and forms referenced throughout this handbook are included for convenience purposes only and such information and/or forms are subject to change without notice. Providers should access and download the most up-to-date information and/or forms from the provider website at the time needed.

15.02 Governing Law and Contract

The Maryland PBHS Provider Manual applies to Medicaid recipients and eligible uninsured individuals served by the PBHS. It is governed by, and construed in accordance with, applicable federal, state, and local laws, and current MDH transmittals or alerts.

maryland.carelonbh.com