DATA REPORTING GUIDELINES FOR DISCHARGE OF PATIENTS WITH SUBSTANCE RELATED DISORDER

(See attached for data flow sheet)

Given the movement to treating substance-related disorders as chronic conditions that are most appropriately addressed by longer term treatment as opposed to shorter term treatment episodes, the requirement to discharge an individual from outpatient services based on not seeing him/her in a 30-day window requires some reconsideration and revision. To that end, the following are revised requirements for discharge that are more closely aligned with the Public Behavioral Health System's service authorization and payment processes. These guidelines apply to patients receiving both Medicaid (MA) and grant-funded services. Note that these guidelines refer to data reporting, not claims submission.

A. FOR PATIENTS IN LEVEL 1 TREATMENT (Outpatient or Opioid Treatment Program [OTP]):

1. Short term transfer to Level 2.1 (Intensive Outpatient Services), Level 2.5 (Partial Hospitalization Services), Level 3.7 (Medically Monitored Intensive Inpatient Services-Community-based), Level 3.7 WM (3.7 providers also provide withdrawal management services), and 4.0 WM (Medically Managed Intensive Inpatient Services-Hospital-based). When a client in Level 1 (SUD Outpatient) service with an agency provider or an OTP provider is briefly transferred to one of these higher levels of care from which the client is expected to return in a relatively short time period, the patient ***should not be discharged from the Level 1 or OTP service.*** The Level 1 authorization span is effective for six months from the service start date and may be renewed up to 100 days after the expiration of the authorization span. OTP authorizations are for 26-weeks and must be renewed prior to expiration. Keeping the authorization span active during short-term treatment in a more intensive service level will save time and effort on the part of Level 1 and OTP providers and facilitate the return of the patient to the former level of care. Renewal of authorization for Level 1 requires the updating of patient information and completion of the Outcomes Measurement System (OMS) interview every six months to continue the episode of care. Renewal of authorization for OTP services require updating patient information and an authorization review every 26 weeks. There is no change to these requirements.

2. Transfer to Level 3.1 (Clinically Managed Low-Intensity Residential Services). When a patient in a Level 1 or OTP program enters a Level 3.1 placement with the expectation that outpatient treatment will continue with the Level 1/OTP, the patient ***should not be discharged from the Level 1 or the OTP*** and the Level 1/OTP authorization span will remain open as usual (but will have to be renewed when the span expires).

3. Long term transfers to Level 3.3 (Clinically Managed Population-Specific High Intensity Residential Services), 3.5 (Clinically Managed High-Intensity Residential Services). Because these levels of care have relatively long expected lengths of stay and more intensive supports are available in these settings, patients being transferred from Level 1 services into these levels of care ***should be discharged from the Level 1 service***. When the patient returns for outpatient services, a new authorization will be obtained and a new episode of care with the Level 1 provider will begin. However, if the individual is receiving OTP services, medication services, at a minimum, are expected to continue while the individual is in residential care and the individual ***should not be discharged from the OTP program providing methadone or buprenorphine.***

4. ***Patients leaving against medical advice, failing to return for service in a Level 1, Outpatient or OTP.*** The following is a change from earlier policy. There are always a number of patients who leave service without notifying the provider of their intention to do so. In most cases, after an unusual absence from treatment, the provider will know that a given individual is unlikely to return; that time period will vary from patient to patient. Patient discharge processes should be completed at the point when the provider believes that the patient will not be returning for services. Assuming that the patient has been in service for some period, the status of the patient as it was last known to the provider should be reported on the discharge forms. In the past, there was a requirement to discharge these patients when they had not received a service in a 30-day period. In order to ease provider burden, these cases may be kept open until the patient has not had a service for a maximum 90-days, at which time the patient should be discharged. ***In any case, the date of discharge should be the date of the last face-to-face contact with the patient.***

B. PATIENTS TRANSFERRING BETWEEN LEVELS 2.1, 2.5

Patients authorized for services at the Level 2.1 and Level 2.5 will have relatively short periods of authorization and treatment. Admission and discharge processes must be followed for individuals in these levels of care, even when the same provider is rendering both levels of care. These services require separate authorization that includes the complete reporting of admission and discharge information.

C. PATIENTS IN TREATMENT IN LEVELS 3.1, 3.3, 3.5

Patients authorized for residential services at Level 3.1, Level 3.3, and Level 3.5 are expected to have relatively lengthy episodes of care. Reporting of admission and discharge information is required on all patients in these levels of care; additionally, patient data should be updated every six months if the patient's length of stay exceeds six months.

D. PATIENTS IN TREATMENT IN LEVELS 3.7, 3.7 WM

The usual length of stay in a 3.7 is relatively short. For those receiving withdrawal management services while in Level 3.7, the length of stay can be even shorter. For those receiving withdrawal management with providers who are certified as Level 3.7 WM, there is a nearly universal step down to, and continuation of, Level 3.7 services with the same provider. Therefore, ***there is no current requirement to discharge the patient from a level 3.7 WM bed when the patient is immediately transferred to a Level 3.7 bed with the same provider.*** All admissions to Level 3.7 (regardless of whether the provider is providing withdrawal management services) require all admission data elements be reported. Discharge information is required at the time when the individual leaves the Level 3.7 bed***. Should the patient leave the program directly from the 3.7 WM bed, the discharge from the program must be reported along with all discharge data elements.***

Patients Leaving Against Medical Advice from Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 3.7 WM, and Ambulatory Detox. There is no change in policy regarding patients leaving against medical advice from these levels of care. Those who fail to show up for Level 2.1, Level 2.5 or Ambulatory Detox services or those who leave a Level 3.1, 3.3, 3.5, or 3.7 residential services are generally not likely to return and should be discharged as soon as that is known, but no later than 30-days after the last face-to-face contact. ***The date of discharge should be the date of the last face-to-face contact with the patient.***

ASSESSMENT vs. OUTCOME MEASUREMENT SYSTEM (OMS) INTERVIEW ADMINISTRATION

There has been some concern expressed regarding assessments and their relationship to the Outcomes Measurement System (OMS) interviews and authorization requirements. Assessments are global evaluations to determine the treatment needs of an individual, including the detailed determination of needs in all ASAM dimensions. The OMS interview is intended as a snapshot of how an individual is performing on a variety of life domains at regular intervals during treatment. The OMS was implemented as an essential part of the authorization process for program-based, Level 1 services; this served both as an incentive for providers to participate in the process and a helpful tool in treatment plan reviews.

Reimbursement for an assessment (Code H0001) is limited to once per year, per participant, per provider, unless there is more than a 30-day break in treatment. The OMS interview may be administered during the course of an individual therapy/counseling session (Code H0004). While the OMS was implemented to assess system level outcomes, the interview can provide information to formulate and update treatment plan goals and progress as well as an opportunity to determine and discuss areas of patient concern. Therapists are encouraged to use this periodic interview as a special opportunity to review progress on domains of concern with the patient.