SUD Residential FAQ's

Compiled and Updated February 2018

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Program Requirements

1. **Can providers balance bill individuals who are enrolled in Medicaid or who receive state-funded services?**

   Providers are never permitted to balance bill Medicaid recipients for covered services. Providers are also not permitted to balance bill individuals who receive state-funded services financed by BHA.

Staffing

2. **What should the patient to counselor ratio be for group counseling provided in a residential SUD treatment for adults program? With larger groups the documentation requirements become burdensome.**

   Therapeutic group activities for adult residential SUD generally consist of no more than 12-14 individuals with one staff member. All clinical services must be documented in each individual record when facilitated by a licensed professional. Residential programs should be diverse in their therapeutic activities.

3. **Can a recovery coach, peer support, or direct care worker conduct a group as part of the weekly hourly service requirement?**

   A clinical group may only be led by individuals outlined in COMAR 10.09.59 (http://www.dsd.state.md.us/comar/comarhtml/10/10.09.59.04.htm). Additional types of groups may include relapse prevention to provide guidance on making choices, educational,

occupational, recreational therapies, art, music, movement therapies, and vocational rehabilitation. Peers are a part of the treatment milieu and can provide groups related to their scope of practice.

4. **ASAM level 3.5 is a more intensive level of care than 3.3, yet the staffing requirements are less, why is that?**

   A typical participant receiving ASAM Level 3.3 services has an addictive disorder that is so severe it has resulted in significant temporary or permanent cognitive impairment. Treating the cognitive impairment and associated medical conditions requires additional medical services that are not necessary for participants receiving ASAM Level 3.5. Clinical services tend to be less beneficial for participants receiving Level 3.3 than for the typical participant receiving Level 3.5 and therefore less clinical staff and more medical therapeutic support would be appropriate at Level 3.3. While there are fewer clinical services at level 3.3 versus level 3.5, there is a medical component that is included in level 3.3. The identical rate for 3.3 and 3.5 is a reflection of the service shift from higher level of clinical need to higher level of medical need.

   For more information about ASAM levels of care please review the ASAM criteria (https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Additionally, providers who require technical assistance may request it from Trina Ja'far at trina.ja'far@maryland.gov .

5. **What are the minimum duties of the physician/CRNP? Of the psychiatrist or CRNP psych? Of the recovery coach?**

   Information on required services and staffing can be found in the regulations here: http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.06.*. Providers requiring additional assistance should request technical assistance from BHA by email to trina.ja'far@maryland.gov.

6. **What are the minimum hour requirements per week for the recovery coach?**

   Please see the regulations here: http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.06.*. The requirement for a recovery coach has been amended to state that aftercare coordination services may be provided by a peer support specialist or licensed clinician. The regulations do not specify weekly hour requirements.

7. **What are the requirements and steps to get recovery specialists certified?**

   Please note the requirements in the regulations have been adjusted to reflect that licensed practitioners or peer support may be utilized for aftercare services. There is no longer a requirement that peer support staff must be certified. However, the Department encourages peer support staff to pursue certification. In order for a peer to be certified as a peer recovery specialist, the following steps must be taken.

Training:

a. The peer recovery specialist must obtain 46 hours of training. The required 46 hours are broken down into 4 domains

Hours Required	Domain
16	Ethical Responsibility
10	Advocacy
10	Mentoring and Education
10	Recovery and Wellness

b. One Core Training is required (CCAR-Recovery Coach Academy, WRAP Facilitator Training, DBSA Peer Specialist Training, Intentional Peer Support)
c. Training must have been obtained in the past 10 years
d. Eligible trainings are offered by numerous agencies in Maryland (visit www.mapcb.wordpress.com/cps for updated agencies list)
e. In-service trainings provided by an agency are also eligible. Maximum in-service hours for the CPRS application is 12 hours of the 46 required
f. 5 hours of online training is eligible

Work/Volunteer Requirements:

a. Must be currently working or volunteering in a peer support role
b. 500 hours in a role of peer recovery support (within the past 2 years)
c. 25 hours of the 500 hours must be supervised and documented by a Registered Peer Supervisor (RPS) (www.mapcb.wordpress.com/cprs for RPS list)
d. Supervision must include 5 hours in each of the 4 training domains. 5 additional supervision hours are required and should include discussions regarding the peer's self-care
e. The 500 work/volunteer hours as well as the 25 supervision hours may be completed at multiple settings and under multiple supervisors but will require documentation from each

Application Process:

a. MABPCB's (Maryland Addictions and Behavioral-health Professional Certification Board) website had the full application to download (www.mapcb.wordpress.com/cprs)
b. There is a $100 application fee to initiate the certification process
c. Request high school/GED or college transcripts to be sent directly to MABCPB
d. Request 3 Recovery References to be sent directly to MABPCB and complete the Recovery Reference form on application
e. Submit signed letter(s) from employer(s) on letterhead verifying 500 work/volunteer hours
f. Complete Education/Training Form along with all copies of training certificates

Application Approval:

a. Once documents are verified, dates for the exam will be emailed out to applicant
b. Applicant must schedule a day and time to sit for the certification exam

c. Applicant will be certified upon passing the examination
d. Certified Peer Recovery Specialist will receive a certificate with certification number via mail

Licensure and Enrollment

8. **How can I enroll in Medicaid and be reimbursed for my services?**

   Providers are required to apply as a Provider Type 54. To access the PT 54 Medicaid application see: https://mmcp.health.maryland.gov/Documents/Adult%20Residential%20SUD%20Treatment/IMD_Residential_SUD_Adult_FACILITY_update_V3.pdf.

   In order to complete the Medicaid application you will need:

   a. A BHA license for each ASAM level of care you provide.
   b. A copy of your facility's/ organization's NPI printout from the National Plan and Provider Enumeration System (NPPES). One NPI is required for each location. For more information about NPI number or to apply for a number, please visit the NPPES website here: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

9. **What is the process to be licensed or certified as an adult residential SUD provider?**

   The program must obtain licensure for the levels of care they are qualified to provide from the Behavioral Health Administration. For additional information about accreditation and licensure through the Behavioral Health Administration, please see the website here: https://bha.health.maryland.gov/Pages/Accreditation-Information.aspx.

10. **Can a residential treatment program be eligible to deliver more than one ASAM level of care?**

    Yes, a facility may offer multiple ASAM levels of care. Each level of care will need to be licensed by BHA and abide by the regulations set forth in COMAR 10.09.06 and 10.63.

11. **What if I am already enrolled as an ICF-A for children (Provider Type 55)?**

    Provider type 55s (residential services for under 21 year olds) who do **not** provide services to individuals 22 years or older do **not** need to enroll as a provider type 54.

    If you would like to enroll to be reimbursed for services provided to adults, please follow the instructions on the residential SUD treatment for adults webpage (https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx) to enroll as a provider type 54 (Residential SUD for Adults) with a separate MA/NPI from your provider type 55.

12. **Does a facility need a separate MA/NPI number for each ASAM level of care?**

    No, a facility only needs one MA/NPI number. However, each facility needs one MA/ NPI number per service per location. For example, if a program has a Provider Type 50 at the same location, they will need an additional MA/ NPI number for a Provider Type 54.

Audit/ Documentation

13. **What documentation is required for clinical services associated with residential SUD treatment for adults? Do we need to document the times of all the groups, description of the group and an individual note describing the person's performance in the group?**

    Review the documentation requirements outlined in the regulations for residential SUD treatment for adults here: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.06.04.htm. Programs must maintain adequate documentation of each clinical contact with a participant as part of the medical record, which includes at a minimum:

    a) An individualized treatment plan
    b) The date of all clinical encounters with start and end times and a description of services provided
    c) Documentation of all clinical services received by the participant
    d) Progress notes updated on each day services are provided
    e) An individualized discharge plan
    f) An official e-Signature or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate degree or title on all clinical progress notes

14. **Since all clinical treatment happens in our program from Monday-Saturday, there are no clinical notes entered on Sundays. Our clients are still in group, but no clinical notes are entered. Can we bill just the room and board charge or do we need to have a clinical note in conjunction with the room and board?**

    Providers must document for the dates on which the service occurred and can never be backdated. Although the daily rate is billed for therapeutic services and room and board, the service hours are based on a weekly minimum and documentation should reflect a service array that contributes towards that minimum. Service arrays include combinations of counseling led by licensed or certified providers, as well as symptom reduction activities which may be led by certified and/or experience based providers and recovery activities that assist individuals in moving through the continuum of care towards treatment in their community environment. Programs must document in each individual's chart to indicate that the minimum number of service hours per level of care has been met in order to bill for the therapeutic services.

15. **We understand that audits will require demonstration of competence in delivering the EBP attested to during the application process. We understand that we should document CEUs, but we need some guidance on how fidelity measurements of EBP implementation should be demonstrated.**

    Please find the list of approved EBPs in answer to question 16. The program should have in its policies and procedures the types of EBPs utilized for service delivery. The progress notes and treatment plan should provide evidence that the EBPs are being applied in clinical services. For example, if a provider is facilitating CBT, then it would be expected that in the chart there would be specific references to problematic thinking patterns, behaviors related to those thinking

patterns, how this relates to the individuals' recovery process and ways to challenge these thinking patterns and behaviors. For a provider that is utilizing motivational interviewing, it would be expected that the charts will include discussions on the individuals' stage of change, motivators, and specific enhancement techniques that are being utilized to move the individual within the stages of change. Additionally, the personnel files of staff must contain evidence of Continuing Education training.

Evidence Based Practices

16. **What is the list of approved Evidence Based Practices (EBPs)? Can you provide more information on what each EBP consists of?**

    All Residential SUD Treatment Providers are required to attest to providing a minimum of three of the EBPs listed and defined below as part of the Maryland Medicaid provider enrollment process. Subsequent provider site visits and audits will require demonstration of competence in the provider's ability to deliver the EBPs attested to. This may include evidence of staff with continuing education units demonstrating training in the EBP or fidelity measurements of EBP implementation.

    a) **Acceptance and Commitment Therapy (ACT)** is a contextually focused form of cognitive behavioral psychotherapy that uses mindfulness and behavioral activation to increase clients' psychological flexibility--their ability to engage in values-based, positive behaviors while experiencing difficult thoughts, emotions, or sensations. ACT has been shown to increase effective action; reduce dysfunctional thoughts, feelings, and behaviors; and alleviate psychological distress for individuals with a broad range of mental health issues.
    b) **Cognitive Behavioral Therapy (CBT)** addresses harmful thought patterns, which help clients' recognize their ability to practice alternative ways of thinking, and regulates distressing emotions and harmful behavior. CBT is effective in treating SUDs.
    c) **Medication Assisted Treatment (MAT)** is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
        a. Note that per ASAM all SUD providers should assess for the need and potential benefit for MAT, and if they do not provide it directly as an EBP, they should ensure referral to a provider who can or will.
    d) **Motivational Enhancement Therapy (MET)** is an adaptation of motivational interviewing (MI) that includes normative assessment feedback to clients that is presented and discussed in a non-confrontational manner. MET aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the client's own motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.
    e) **Motivational Interviewing (MI)** is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues.
    f) **Psychoeducation** is designed to educate clients about substance abuse, and related behaviors and consequences.

g) **Psychotherapy** is a general term for treating behavioral health issues by talking with a psychiatrist, psychologist or other behavioral health professional.
h) **Relapse Prevention (RP)** focuses on the identification and prevention of high-risk situations in which a patient may be more likely to engage in substance use.
i) **Solution-Focused Group Therapy (SFGT)** is a strengths-based group intervention for clients in treatment for mental or substance use disorders that focuses on building solutions to reach desired goals. SFGT is an application of Solution-Focused Brief Therapy (SFBT) in a group setting. It emphasizes what the client wants to achieve through therapy rather and aims to build on the client's resources, strengths, and motivation.
j) **Supportive Expressive Psychotherapy (SE)** is an analytically oriented, time-limited form of focal psychotherapy that has been adapted for use with individuals with heroin and cocaine addiction. Particular emphasis is given to themes related to drug dependence, the role of drugs in relation to problem feelings and behaviors, and alternative, drug-free means of resolving problems. SE helps patients explore the meanings they attach to their drug dependence and address their relationship problems more directly, thus allowing the patients to find better solutions to life problems than drug use.
k) **Trauma Informed Treatment** is an approach that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.

Clinical

17. **How do ASAM levels of care crosswalk to clinical indications? Are there any additional resources that can be shared?**

The Behavioral Health Administration shared the following information during the June 5, 2017 Provider Interest Meeting.

- ***Typical participant in 3.3 level:***
    - Intensity of an addictive disorder with or without a comorbid mental health condition is so severe that it has resulted in significant cognitive impairment
    - This cognitive impairment makes it unlikely that participant would benefit from another residential level of care
    - The cognitive limitations could be temporary or permanent
    - Given participant population, treatment should be at a slower pace, more concrete and repetitive until cognitive impairment improves
    - When cognitive impairment no longer present, participant can be transferred to a higher or lower Level of Care, based on reassessment and rehabilitative needs
    - Individuals with chronic cognitive deficits, older adults, patients with traumatic brain injuries and developmental disabilities should continue receiving treatment at ASAM level 3.3 until appropriate community supports are in place

    - With medical and nursing coverage, these programs can address certain medical needs of their patients (e.g. sliding scale insulin coverage for diabetes, wound dressing changes)
    - This may avoid placement in skilled nursing facilities for some patients who would otherwise meet criteria for such intervention
    - The cognitive impairment could be the result of an organic brain syndrome resulting from a substance use disorder (e.g. memory difficulties from hypoxic brain injury in setting of overdose)
    - Medical (as a broad term) complexity higher than participant in Level **3.5**
- ***Typical participants in Level 3.5:***
    - Have multiple limitations including addictive disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values
    - May have inadequate self-management skills including poor social skills, extreme impulsivity, emotional immaturity and/or antisocial value system
    - Some have MH conditions such as schizophrenia, bipolar disorder and major depressive disorder, and may have personality disorders (PD) such as borderline and antisocial PDs
    - May need more habilitative treatment rather than rehabilitative treatment focus
    - Treatment is directed to ameliorate health-related conditions through targeted interventions
    - Because treatment plans are individualized, fixed lengths of stay are inappropriate
- ***Typical participant in Level 3.7:***
    - Moderate to severe withdrawal risk, which can be safely managed at this LOC. No need for services of an acute general hospital.
    - Many have comorbid chronic medical problems that may or may not be well controlled or co-occurring mental health conditions or symptoms that may or may not be diagnosed or well managed.
    - A licensed physician and/or NP/PA oversees the treatment process and assures quality of care.
    - Many participants receive addiction pharmacotherapy integrated with psychosocial therapies.
    - With medical and nursing coverage, these programs can address certain chronic and subacute medical/psychiatric needs of participants that do not require the resources of an acute care hospital.
- ***Typical participants in Level 3.7WM:***
    - Moderate to severe signs or symptoms of withdrawal, which can be safely managed at this LOC. No need for services of an acute general hospital.

For more information please review the ASAM criteria (https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Additionally, providers who require technical assistance may request it from Trina Ja'far at trina.ja'far@maryland.gov.

18. **Are clients in ASAM Level 3.3 or 3.5 permitted to work while in treatment and still have Medicaid pay for their treatment?**

    It is up to the program to determine if the individual is able to maintain recovery while employed. The individual would need to be assessed as having no/low risk factors across all six ASAM dimensions and still meet MNC for this level of care in order for it to be appropriate for them to work while in treatment. Employment does not necessarily preclude someone from receiving a residential level of treatment. However, for Medicaid to reimburse for therapeutic services the individual must meet medical necessity criteria for that level of care and they must medically require the level of programming that is required for each of the levels of care.

    For ASAM level 3.3 at least 20-35 hours weekly (of combined treatment and recovery support services) are required and for ASAM level 3.5 a minimum of 36 hours weekly of therapeutic activities are required. These service requirements for the level of care must still be met by the program if the individual is employed. Based upon the ASAM criteria, it would be difficult to foresee situations where an individual would need this level of programming and be able to continue to work. Once an individual stabilizes, outpatient treatment and recovery housing is a more appropriate level of care.

19. **Can a patient continue to receive methadone while in residential care?**

    Yes. The weekly administrative fee (H0020 – HG) for Opioid Treatment Programs (OTPs) includes the cost of delivering Methadone from the OTP to participants in residential settings. The OTP can continue to be reimbursed for the administrative level of service while the patient is receiving care in a residential setting.

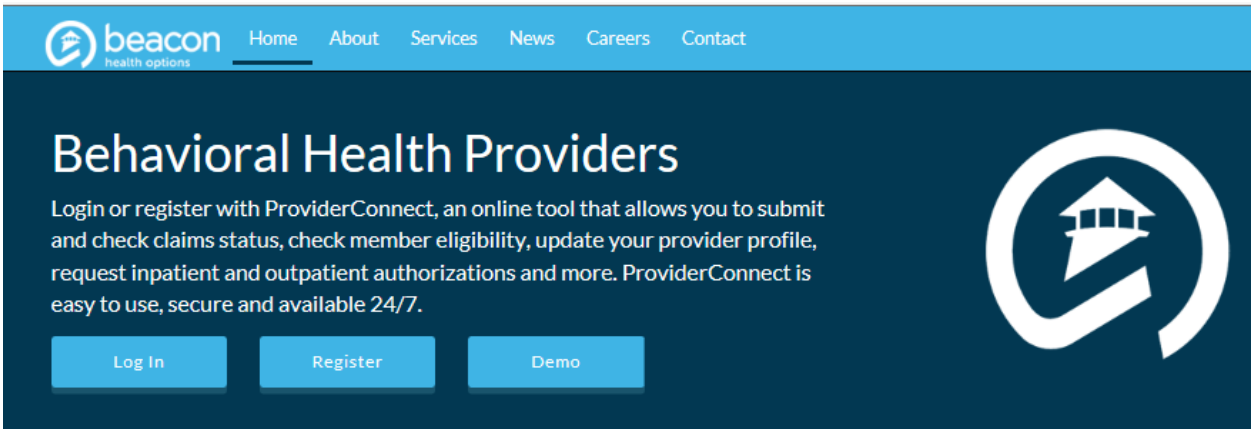
Authorizations

20. **Do all services need authorization, for both Medicaid and uninsured populations?**

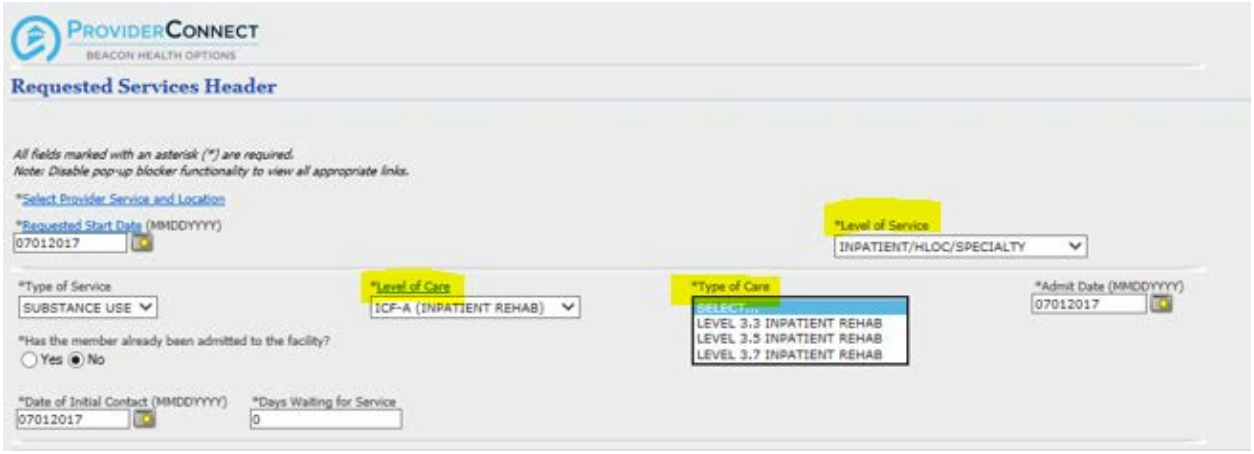
    Yes, all services need to be authorized by Beacon in order for claims to be reimbursed regardless of source of funds. Requests for authorization must be submitted prior to treatment. This includes all levels of SUD residential care 3.7 WM, 3.7, 3.5, and 3.3.

21. **How do we request authorization for SUD Residential treatment?**

    Authorizations can be requested telephonically, or electronically. Telephonic authorizations are initiated by calling the Beacon customer service line (800-888-1965) & 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 Provider Connect. ProviderConnect can be accessed 24/7, including weekends and holidays through the Beacon website: http://maryland.beaconhealthoptions.com/provider-main.html



Upon completing the necessary log on information & pulling the member file needed, providers will select e the Inpatient/HLOC/Specialty drop down option found in the Level of Service field to submit for authorization requests.

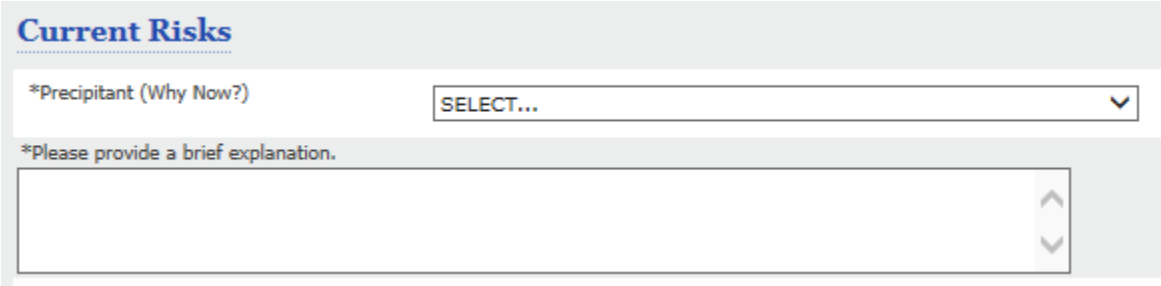


After selecting the appropriate Level of Service, Type of Service, Level of Care, Type of Care & completing each asterisked item, providers will follow the prompts to the next screen.

Providers will click on each of the tabs, and complete the asterisked items found in each tab. The asterisked items are needed to complete the request for authorization.

Beacon Health Options has developed a new form to assist providers in reviewing and updating the 6 ASAM dimensions, which can be found on the Beacon website at http://maryland.beaconhealthoptions.com/provider/alerts/2017/063017-ASAM-Six-Dimensions-

Clinical-Information.pdf. Upload the completed form as outlined providing the most up to date clinical information on the individual based on the six ASAM dimensions. The Clinical Care Manager will review the information submitted in the request, to include the attached form, & will authorize the number of days based upon clinical need &ASAM criteria. If unable to upload the attached form, providers can detail rationale for request in the narrative text box found under the Current Risk Tab:



22. **What is the number of days that will be authorized at one time for each level of care?**

Level of Care	Number of Days Authorized Initial	Number of Days Authorized Concurrent
3.7 WM	Up to 7 days	Up to 7 days
3.7	Up to 15 days	Up to 15 days
3.5	Up to 30 days	Up to 30 days
3.3	Up to 30 days	Up to 30 days

Please be aware that the number of days authorized will be based upon ASAM medical necessity criteria. Authorizations may be less than the maximum number of days based upon case complexity.

23. **What is the estimated time frame for processing authorizations? Originally we heard authorizations would take 14 days to get for new clients, now we are hearing 3 days. Which is accurate?**

For ASAM levels 3.7 and 3.7WM, reviews for medical necessity are made at the time of the call. For all other non-urgent levels of care requested online in ProviderConnect, almost all determinations are made within the first 3 days with the majority being made within 24 hours. If there is a reason to do an expedited review a provider can telephonically call in the request and Beacon will process it at the time of the call. Providers are reminded that discharge planning from higher levels of care should be initiated on day one of admission. Plans to step down care are part of the treatment planning process.

24. **How soon can a provider request a concurrent authorization?**

Authorizations should not be submitted so early that the clinical information will not be relevant when the service begins.

To request authorizations for services, for 3.7WM and 3.7 please provide clinical within 24 hours of admission.

To request concurrent reviews for 3.7WM and 3.7 please request the concurrent review on the last covered day.

To request initial authorizations for 3.5 and 3.3, please submit the clinical information up to 7 days prior to admission.

To request concurrent authorization for 3.5 and 3.3, please submit the clinical information up to 7 days prior to the end of the authorization.

25. **Who can request authorizations?**

    Any provider may call in the request for authorization. The request for authorization should include the current clinical information that would support ASAM medical necessity criteria to support the residential level of care.

26. **What happens if an individual needs residential services for the third time in a rolling year or for a stay that is longer than 30 days? Can they receive the services? How will the authorizations work?**

    If the individual meets MNC they will be authorized for services. Any stays beyond what is reimbursable by Medicaid will be covered by state only dollars. The process for determining which source of funds will be used is managed by Beacon and will be mostly invisible to providers.

27. **What is the uninsured eligibility criteria for residential services?**

    The provider is required to document and verify the person meets all seven uninsured eligibility criteria provided below:

    1) The individual requires treatment for a behavioral health diagnosis covered by the Public Behavioral Health System (PBHS);
    2) Must meet the American Society of Addiction Medicine (ASAM) criteria for the level of care.
    3) The individual is under 250% of the Federal Poverty Level (FPL) and not covered by Medicaid (MA) or other insurance; Individuals who are dually eligible must be under 500% of FPL.
    4) The individual has a verifiable Social Security number;
    5) The individual is a Maryland resident;
    6) The individual has applied to Medicaid; the Health Care Exchange; Social Security Income (SSI) or Social Security Disability Income (SSDI), if they have an illness/disability for a period of 12 months or more); and
    7) The individual meets the U.S. citizenship requirement.

    Exceptions to the above requirement may be made by the designated local authority under extenuating circumstances. Should the local behavioral health authority approve the request, then

an uninsured eligibility span is established according to the same timeframes indicated in question #16. BHA will collect data on exceptions made to determine if future adjustments to the uninsured workflow are indicated.

28. **How should the ASAM dimensions be properly documented to demonstrate medical necessity criteria?**

    Below are some examples of how the 6 ASAM Dimensions could be relayed to the Beacon clinical team for review and approval. All services must be authorized in order for the provider to receive payment. When submitting requests via ProviderConnect, document ASAM/ clinical rationale in the narrative text box found under the Current Risk tab similar to example below:

    > "Requesting 3.7WM services for this 36 yo male d/t high frequency of current substance use, severity of current withdrawal symptoms, severity of emotional and MH factors impacting SUD treatment, severity of motivational factors and deficits to recovery environment preventing engagement in treatment at ALOC. Refer to attachment for more information regarding ASAM criteria."

    Below you will find a one-page worksheet to assist providers in documenting the ASAM criteria for the appropriate residential level of care. This completed form should be uploaded to your authorization request as an attachment. An example of a completed form can be found below:

ASAM Six Dimensions Clinical Information

Please provide the clinical information in narrative form for each of the six ASAM Dimensions to support that dimension's rating as Low, Medium or High. These ratings are used to determine Risk and appropriate ASAM Level of Care. **Participant's Name:** Member X **M# and DOB:** M000000000 **Date of Request:** 7/1/2017
Dimension 1 (Acute Intoxication and/or Withdrawal Potential): (High) Consumer maintained 18 months of abstinence until December 2016. Using fifth of vodka and $80 heroin daily for past 6 months. Consumer had overdosed on heroin 3 weeks earlier and treated in ED at Univ of MD Hosp. Last used heroin and ETOH 6 hours ago and beginning to exhibit severe ETOH withdrawal symptoms;
Dimension 2 (Biomedical Conditions and Complications): (Moderate) HTN managed successfully with medication; however, mbr has not adhered to blood pressure regimen for past few weeks. Currently shows elevated vital signs.
Dimension 3 (Emotional, Behavioral or Cognitive Conditions and Complications): (High) Diagnosed with bipolar disorder and currently endorsing intermittent SI. Mbr hospitalized recently for inpatient psychiatric admission d/t command auditory hallucinations (AH) telling him to kill self. Mbr has not been adherent to psychotropic medications or OP f/u since discharge.
Dimension 4 (Readiness to Change): (Moderate) Presents in contemplative stage of change and currently shows moderate internal motivation for treatment. Recognizes detrimental impact of substance use on daily functioning. Participated in Vivitrol MAT during previous period of abstinence, then stopped treatment reporting "I want to do this myself and don't want this medicine to keep me clean." Comes to treatment now after family intervention blocked continued financial support and ability to live in their home d/t continued substance use.
Dimension 5 (Relapse, Continued Use or Continued Problem Potential): (High) Continues to use substances heavily with severe medical and social consequences. Reports loss of control over substance use and notes using increased amount of substances to prevent withdrawal or gain desired effect.
Dimension 6 (Recovery/Living Environment):(High) Mbr currently homeless, unemployed and denies lack of sober supports. Has been staying with substance using peer group for past week since being evicted from parent's home. Participated actively in 12 step recovery and worked with a sponsor during previous period of extended abstinence.

When completing requests telephonically, this same form can be used by the caller as a guide to provide the Beacon clinician with the necessary clinical information to justify the requested residential service.

29. **If a patient transfers from one level of care to another within the same facility, is the provider required to request an authorization and enter the same information, even if it hasn't changed?**

    Yes. Authorizations are required for all residential substance use disorder services. When an individual changes level of care, a new authorization will be required. When a member transitions from one level of care to another, whether it is within the same provider's spectrum of services or to a new provider, updated clinical information justifying reason for requested service, to include supporting ASAM criteria, must be provided at the time of the request.

30. **Our UR person will only be in the office on T-W-Th. If an admission comes in Thursday and he does not submit the authorization until Tuesday, will that be ok?**

No. Providers must obtain authorization from Beacon Health Options prior to providing residential SUD services for adults. All services must be authorized in order for the provider to receive payment.

Initial authorization requests for 3.7WM & 3.7 services can be submitted 24 hours prior to admission. Initial authorization requests for 3.3 & 3.5 services can be submitted up to 7 days prior to admission. Any staff with access to the required clinical information on the consumer can contact Beacon to complete the request telephonically or submit requests electronically via Provider Connect. A Beacon clinician is available 24 hours per day/ 7 days a week to complete telephonic requests. Additionally, ProviderConnect can be accessed 24 hours per day/ 7 days a week for electronic submissions.

31. **Are discharges needed for residential levels of care?**

    To assist in the care coordination efforts of state and local jurisdictions, please submit all discharges into the Beacon system within 24 hours of discharge.

Reimbursement

32. **How will providers bill for residential SUD for adults?**

    Providers will bill a daily rate for the level of care provided and on the second line bill the room and board code. Providers CANNOT bill date spans. All days must be billed individually.

    Find the appropriate procedure codes and rates below:

ASAM Level	Billing code	Daily rate
Level 3.3	W7330	$189.44
Level 3.5	W7350	$189.44
Level 3.7	W7370	$291.65
Level 3.7WM	W7375	$354.67
Room and Board	RESRB	$45.84

    Example: For a level 3.5 stay (meeting MNC and authorized), providers should bill as follows for each date of service:

Date of Service	Billing Code	Daily Rate
7/1/2017	W7350	$189.44
7/1/2017	RESRB	$45.84
7/2/2017	W7350	$189.44
7/2/2017	RESRB	$45.84
7/3/2017	W7350	$189.44
7/3/2015	RESRB	$45.84

33. **Will there be training on submitting claims for Residential SUD services?**

    Please follow the directions provided in response to question #32 for information on how to bill for residential SUD for adults. Providers who have additional questions or are unfamiliar with billing Beacon may contact Beacon Health Options at 800-888-1965 or at Maryland.providerrelations@beaconhealthoptions.com

34. **I need some clarification for claims submissions. What is the difference between a PT 54 and a PT 55? What forms do we use to submit claims? What place of service do we use to bill?**

    Programs enrolled as provider type 55 render residential SUD services for individuals under 21 and are covered under COMAR 10.09.23. This provider type bills revenue codes on a UB-04 form. The PT 55 has been a provider type under Medicaid for several years. No changes were made to this provider type.

    The adult residential SUD benefit is Provider type 54. This provider type uses HCPCS codes on a CMS 1500 form. A PT 54 may use either place of service (POS) 54 or 55 depending on their classification. POS 54 is for Intermediate Care Facility. POS 55 is for Residential Substance Abuse Treatment Facility. Both places of service are accurate and it is up to the provider to select which place of service applies to your facility.

35. **Do programs have the ability to bill for administrative days if a) a patient is hospitalized and not physically sleeping at the program but the bed is being reserved for when the patient returns or b) the patient no longer meets MNC for a higher level of care but a bed is not yet available a lower level?**

    Yes. Administrative days may be used for individuals admitted to a hospital for a brief period during a medical crisis or when there is a gap in access to the next level of care. However, please remember that transitions to lower levels of care should be considered beginning on the first day of residential SUD service entry. Maryland is invested in a robust continuum of services with the goal of moving individuals from higher levels of care to addressing their needs within the community outpatient setting.

    These situations will be handled on a case by case basis. Providers should contact Beacon Clinical Department at 800-888-1965 with specifics about their case to plan the care for the individual. Additional information about administrative days can be found on the fee schedule on Beacon's website here: http://maryland.beaconhealthoptions.com/provider/prv_info.html.

36. **Does clinical treatment have to be provided every day in order to bill for residential SUD treatment for adults? Do we need to have clinical staff on the weekends?**

    Although residential SUD for adults is billed daily, the service requirements are based on a weekly service array. Providers must meet the requirements laid out in COMAR 10.09.06 for the hours of therapeutic activities provided per week. All residential SUD for adults programs must have a staffing pattern that has the capacity for successful intakes and discharges on the weekends.

37. **Can PT 54s be reimbursed for assessments?**

    The rates for ASAM levels 3.7 WM, 3.7, 3.5, and 3.3 are all inclusive. PT 54s may only be reimbursed for assessments (H0001) if the patient is not assessed to meet ASAM residential level of care and the patient is not enrolled with the program within 7 days of the assessment.

38. **Are mental health services inclusive in the rate or can providers bill separately for mental health services?**

    The rates for ASAM levels 3.7 WM, 3.7, 3.5, and 3.3 include all counseling and therapeutic services and include services delivered by licensed therapists who may not be separately reimbursed from the per diem for the program. Services that may be separately reimbursed include visits with a psychiatrist for a co-occurring psychiatric condition, and visits made by opioid treatment providers who deliver methadone or buprenorphine, to the facility during the patient's stay. Those OTPs would be reimbursed their weekly medication assisted treatment maintenance rate.

39. **Will Medication Assisted Treatment induction and/ or maintenance be a separately billed service?**

    No. The rate for an Adult residential SUD service is all inclusive. The exception to this is if a patient is receiving buprenorphine or methadone maintenance from an OTP, the OTP can continue to be reimbursed for the administration level of service while the patient is receiving care in a residential setting. The administrative fee includes the cost of delivery for medications from the OTP to the SUD residential setting.

40. **Will advances be available for small providers who are more dependent on regular and timely fee for service revenue to meet financial obligations?**

    Beacon operates a customary weekly check disbursement cycle to Providers. Beacon recommends billing as frequently as necessary to meet your organization's financial needs. Beacon will issue payment on schedule with our cycle of reimbursement. If there are substantially severe extenuating circumstances that would require special consideration, please contact Beacon Health Options who will consult directly with the Department on a case by case basis. Please be aware, Beacon will be providing continuing Provider training on claims and authorizations submission processes.

Admin/ Other

41. **How is a 30-day span defined?**

    Beginning on July 1, 2017, Medicaid will provide reimbursement for up to two nonconsecutive stays of up to 30 days without a break in treatment within a rolling year for ASAM levels 3.7WM, 3.7, 3.5, and 3.3. An episode of treatment will qualify as a single 30-day stay, even if an individual receives services at multiple different levels of care. For example, if an individual

requires 14 days of care at an ASAM Level 3.7 and then steps down to 14 days of care at an ASAM Level 3.3 or 3.5 without a gap in care, the full 28 days of treatment services would be paid for by Medicaid.

For each level of care, ASAM (medical necessity criteria) must be met. Transitions to lower levels of care should be considered beginning on the first day of residential SUD service entry. Maryland is invested in a robust continuum of services with the goal of moving individuals from higher levels of care to addressing their needs within the community outpatient setting. Administrative days under the Medicaid span may be used if there is a gap in access to the next level of care and these days' count within the 30-day span of treatment.

42. **In our EHR, we start a treatment plan when an individual enters treatment and add to it as an individual moves through the ASAM levels of care. Is this ok or do we need to complete a new treatment plan for each level?**

    The scenario described would be appropriate as long as the treatment plan is reviewed as the individual moves from one level to another. Treatment plans should be closely tied to the individual's short term goals for recovery which will generally change more as they move from one level to another as they move along the continuum of care; their long term goals may or may not change accordingly.

43. **Is there a projected length of time the wait list for residential may be before an individual is placed?**

    The ASO and BHA do not maintain a wait list. An adult residential SUD program may have a waitlist for their program if they are at capacity. Individuals seeking treatment may contact their local jurisdiction or call Beacon Health Options for assistance in locating a provider with more immediate availability.

44. **Can MA transport clients to III.7 since there is an MD at the placement who will evaluate the individual?**

    Non-emergency medical transportation (NEMT) is available for Medical Assistance recipients who have no other means of getting to their medical appointments. Transportation services are provided by the local jurisdictions. Transportation services must be scheduled a minimum of 24 hours in advance, with the exception of hospital discharges. For more information please see the webpage here: https://mmcp.dhmh.maryland.gov/communitysupport/Pages/ambulance.aspx.

45. **If a client cannot accept a placement due to transportation or location do they stay at the top of the list for the next bed or move down?**

    As described in question # 44, non-emergency transportation is available for Medical Assistance recipients. It is anticipated that programs may expand their businesses as they are able, over time which will reduce the need for wait lists.