6.32. Medium Intensity Residential (ASAM Level 3.3)

DESCRIPTION OF SERVICES

Beacon utilizes ASAM criteria to determine medical necessity for all substance use disorder (SUD) service requests. The description of services provided at a Medium Intensity Residential (ASAM Level 3.3) setting and its applicable criteria can be accessed here: http://maryland.valueoptions.com/provider/manual/Appendix-C-ASAM-Criteria.pdf.

SERVICE RULES

Medium Intensity Residential services are provided in a structured residential environment, in combination with medium intensity treatment and ancillary services to support and promote recovery to participants. Therapeutic services in an ASAM Level 3.3 setting provides structured SUD treatment to adults needing between 20 to 35 hours of therapeutic activities per week; and meeting all expectations as outlined in COMAR 10.09.06.

Effective July 1, 2017, Centers for Medicare and Medicaid Services approved Maryland Medicaid, through the 1115 Health Choice Waiver Renewal, to reimburse for therapeutic services of up to two 30-day stays, or episodes of care, per rolling year for certain Medicaid –eligible participants over age of 18. All additional days beyond the two stays and all room and board costs will be paid out of state funds for individuals that are authorized as continuing to meet medical necessity for treatment at this level.

PARTICIPANT ELIGIBILITY

Covered individuals include:

- Medicaid enrollees
- Non-Medicaid, uninsured individuals meeting the uninsured criteria (Beacon Provider Manual Chapter 3). Residential SUD treatment for adults includes those with dual eligibility (full Medicaid and Medicare) as well as Qualified Medicare Beneficiaries (QMB) and Specified Low Income Beneficiaries (SLMB).

Individuals must meet the ASAM Criteria for level 3.3 which includes:

- Has a diagnosis of moderate or severe substance use disorder;
- Has no signs or symptoms of withdrawal or withdrawal needs can be safely managed in a Level 3.3 setting;
- Biomedical problems, if any are stable and do not require skilled nursing care;
- The intensity of the substance use disorder has resulted in cognitive impairments that would necessitate this level of care
- Has physical or mental disabilities resulting from a prolonged substance-related disorder; and has been identified as requiring a controlled environment and supportive therapy to remain engaged with the therapeutic venue

- Does not recognize relapse triggers and insight into the benefits of continuing care or continued substance use poses an imminent danger or harm to self or others in the absence of 24-hour monitoring; and

- Recovery environment, social network, or ability to cope poses a high risk of neglect, physical, sexual, emotional, or substance use.

For more information, review the ASAM criteria (https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria).

PROVIDER ELIGIBILITY

In order to be eligible for reimbursement from Medicaid or State-Only funding for residential substance use disorder treatment for adults, providers must:

1) Be licensed as an Adult Residential SUD provider by the Behavioral Health Administration and be in compliance with COMAR 10.63;

2) Review and comply with COMAR 10.09.06;

3) Enroll as a Medicaid Provider Type 54 (PT 54 application can be found here) and attest to meeting staffing components required for this level of care; and

4) Follow the authorization process outlined below.

Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in Beacon's Provider Connect system in order to obtain an uninsured eligibility exception. If the participant does not qualify for an uninsured exception, providers are to contact their Local Addictions Authority (LAA) or Local Behavioral Health Authority (LBHA) in order to explore alternative funding spans to support any participant who does not qualify for an approved eligibility category.

Providers seeking reimbursement for rendering ASAM Level 3.3 must enroll with Maryland Medicaid as a provider type 54. Providers must meet the license requirements stated in COMAR 10.09.06, COMAR 10.09.36, and after April 1, 2018, COMAR 10.63.01.05.

AUTHORIZATION PROCESS

Authorizations for ASAM level 3.3 services can be requested telephonically or electronically through Beacon. Telephonic authorizations available 24/7 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. Provider Connect requests for authorization can be accessed 24/7, including weekends and holidays through the Beacon website: http://maryland.beaconhealthoptions.com/provider-main.html. 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 Provider Connect.

To request initial authorizations for ASAM level 3.3 services, providers are expected to submit the authorization request up to 7 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 7 days prior to the last covered day but no later than the first uncovered day.

If a Beacon Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Beacon 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 ProviderConnect and telephonically to the provider (refer to Chapter 10 on Grievances and Appeals for further information).. Initial and Concurrent authorizations may be approved for up to 30 days if Medical Necessity Criteria is met.

Providers are expected to plan for discharge from residential services at the beginning of service delivery. Providers should work with State Care Coordinators funded by the local behavioral health authorities or local addiction authorities to coordinate transition from residential to community services. Providers should be working towards linking consumers to outpatient level services and all needed social determinants (such as housing, community supports and vocational endeavors) in the community throughout the residential stay.

CLAIMS PROCESS

Claims for this service will deny if there is no authorization on file. To submit claims for services, 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 specific for Intermediate Care Facility (generally this is used for 16 beds or more); POS 55 is for Residential Substance Abuse Treatment Facility (generally used for under 16 bed facilities).

The fee schedule for ASAM Level 3.3 services may be found below:

<table>
<tr><th>Procedure Code</th><th>Service Description</th><th>Rate</th><th>Unit</th><th>Service Limits</th><th>Combination of Service Rules</th></tr>
<tr><td>H0001</td><td>Alcohol and/or Drug Assessment</td><td>$ 144.84</td><td>Per assessment</td><td>Can only be billed if the patient is NOT assessed to meet ASAM Residential Levels of Care 3.3, 3.5, 3.7, or 3.7WM.</td><td>Cannot be billed within 7 days of W7330, W7350, W7370, or W7375</td></tr>
<tr><td>W7330</td><td>ASAM Level 3.3</td><td>$ 189.44</td><td>Per diem</td><td colspan="2" rowspan="2">Cannot be billed with any community based SUD codes on this fee schedule with the exception of H0020 and H0047. Cannot be billed with any mental health community based services except for date of admission or for services rendered by a community based psychiatrist.</td></tr>
<tr><td>RESRB</td><td>Room and Board (state only funds)</td><td>$ 45.84</td><td>Per diem</td></tr>
</table>

Please note that all residential SUD for adults rates are inclusive of drug screening and testing. PT 54s and laboratories may not bill Medicaid separately for these services.

On the CMS 1500 form, providers will bill a daily rate for ASAM Level 3.3 and on the second line bill the room and board code. Providers cannot bill date spans; all days must be billed individually.

All services must be authorized by Beacon in order for claims to be reimbursed regardless of source of funds.