

6.33. High Intensity Residential Services (ASAM Level 3.5)

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 High Intensity Residential (ASAM Level 3.5) setting and its applicable criteria can be accessed here:

<http://maryland.valueoptions.com/provider/manual/Appendix-C-ASAM-Criteria.pdf>.

SERVICE RULES

High Intensity Residential services are provided in a structured residential environment, in combination with high intensity treatment and ancillary services to support and promote recovery to participants. Therapeutic services in an ASAM Level 3.5 setting provides structured residential SUD treatment to adults needing a minimum of 36 hours of therapeutic activities per week and meeting all expectations 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 3.5 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 3.5 setting;
- Biomedical problems, if any are stable and do not require 24-hour medical monitoring or need skilled nursing care;
- Has physical or cognitive/ mental disabilities resulting from a prolonged substance-related disorder; and
- Has been identified as requiring a controlled environment and supportive therapy because of limited insight and awareness for continuing care or the existence of substance use or mental health problem and need for treatment, and thus has limited readiness for change;

- Does not recognize relapse triggers and insight into the benefits of continuing care or continued substance use poses a significant danger or harm to self or others in the absence of 24-hour monitoring; Family members or significant others are not supportive, or the individual is unable to cope, for even limited periods of time, outside of 24-hour care.
- Recovery environment, social network, and 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 3.5 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 are required for reimbursement of services. Documentation for the requested level of care must be provided in order to be approved for services at the requested level of services. Level of care must meet medical necessity criteria which is based on ASAM criteria.

To obtain an authorization, providers must submit all pertinent clinical information to a Beacon licensed Clinical Care Manager in the Clinical Department by one of the following methods:

Telephonically: Telephonic authorizations are initiated by calling the Beacon customer service line (800-888-1965) Telephonic requests should be reserved for urgent authorization needs, otherwise please use the electronic submission which is generally reviewed within 24 hours of the initial request.

Electronically: Electronic authorizations are initiated through ProviderConnect. ProviderConnect can be accessed 24/7, including weekends and holidays through the Beacon website: <http://maryland.beaconhealthoptions.com/provider-main.html>.

Initial authorizations for ASAM Level 3.5, may be submitted with supporting clinical information up to 7 days prior to admission.

Providers must obtain concurrent authorizations if the length of stay is beyond the initial authorized number of days. Concurrent authorizations may be initiated up to 7 days prior to the expiration of the current authorization. The request for the continued stay requires supporting clinical information to demonstrate the individual continues to meet medical necessity for this level of care. Concurrent authorizations may be given for up to 30 days (60 units). Additional concurrent authorizations are required prior to the end of each authorized period, for as long as the individual meets MNC. Providers should be considering outpatient level services in the community with supports throughout the residential stay.

If a Beacon Care Manager determines that the supporting documentation indicates the individual does not meet MNC for this level of care, the request is referred to a Beacon Physician Advisor for review. If the Physician Advisor agrees that 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).

Providers are expected to plan for discharge from residential services at the beginning of service delivery. From the initiation of treatment, providers should work with the member to determine community supports and work with state Care Coordinators, to develop a discharge plan to support the member along the continuum of substance use services.

CLAIMS PROCESS

Claims 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 3.5 services can be found below:

Procedure Code	Service Description	Rate	Unit	Service Limits	Combination of Service Rules
H0001	Alcohol and/or Drug Assessment	\$ 144.84	Per assessment	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.	Cannot be billed within 7 days of W7330, W7350, W7370, or W7375
W7350	ASAM Level 3.5	\$189.44	Per diem		Cannot be billed with any community based SUD codes on this fee schedule except for services rendered by a provider type 32 for only codes 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.
RESRB	Room and Board (state only funds)	\$ 45.84	Per diem		Same as above

Please note rates for all residential SUD services for adults 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 3.5 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.