6.35. Substance Use Disorder, Intensive Outpatient Treatment (ASAM Level 2.1)

DESCRIPTION OF SERVICES

Beacon utilizes ASAM criteria to determine medical necessity for all substance use disorder (SUD) related service requests. The description of services provided by Intensive Outpatient Treatment (ASAM Level 2.1) and its applicable criteria can be accessed here: http://maryland.valueoptions.com/provider/manual/Appendix-C-ASAM-Criteria.pdf.

SERVICE RULES

Intensive outpatient treatment (ASAM Level 2.1 program) provides structured outpatient SUD treatment for adults needing nine or more hours of direct services per week and for adolescents needing six or more hours of direct services per week.

PARTICIPANT ELIGIBILITY

Participants who are appropriate for Intensive Outpatient Treatment must meet the ASAM Level 2.1 criteria and have a physical and emotional status that allows them to function in their usual environment.

Participants who have federally funded Medicaid or Dual Eligibility (Medicare and Medicaid) are eligible to receive services under Medicaid for intensive outpatient services. Providers should contact their Local Addictions Authority (LAA) in order to explore the possibility of using grant funds to support anyone not in one of these eligibility categories.

PROVIDER ELIGIBILITY

Providers delivering intensive outpatient treatment for SUD services must be enrolled with Maryland Medicaid as a Provider Type 50. Conditions for program participation include:

- A community-based substance use program shall meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80 and
- A community-based substance use program shall receive certification by the Office of Health Care Quality in accordance with COMAR 10.47.01.

AUTHORIZATION PROCESS

Authorization requests for initial substance use IOP services can be requested telephonically, or electronically through Beacon. 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. Provider Connect 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 continued stay authorizations through the electronic submission of a continued stay request in Provider Connect. To request initial authorizations, providers can submit the authorization request with supporting clinical information on day of admission but no later than three calendar days from date of admission. Concurrent authorizations can be submitted, with supporting clinical information up to 5 calendar days prior to the end of the previous authorization.

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).

Providers are expected to initiate discharge planning at the beginning of service delivery. Providers are also required to submit the discharge plan in the authorization request.

If approved, authorization will usually be for 35 days of treatment to be delivered within a 60-day period but not to exceed more than four days of treatment per week. Less may be authorized, based on the identified treatment needs of the participant. Authorization must also be requested if the patient needs ambulatory detoxification.

If Beacon determines that this level of care is not medically necessary, Beacon will work with the provider to determine the appropriate, alternative level of care.

CLAIMS PROCESS

The claim should be submitted electronically using the 837P/ CMS 1500 format.

Although it is expected that each intensive outpatient service will typically last three hours, it must last at least two hours in order to be billed. Please note that although the intensive outpatient program must provide the minimum number of hours per week for adults and for children, the intensive outpatient program may bill for individual days that lasted at least two hours for a participant even if the participant failed to attend all offered sessions during the week.

Billing Codes

The procedure code for intensive outpatient services is H0015.

H0015 may be billed to Medicaid on a daily basis, up to four days per week. This code cannot be billed concurrently with Level 1 services (H0004, H0005, H0016, H0020, or H0047) or partial hospitalization (H2036).

Intensive outpatient programs 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.

Intensive outpatient programs can bill up to five days of ambulatory detoxification using procedure code H0014.