6.36. Assessment and Referral Programs (ASAM Level 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 Assessment and Referral Programs (ASAM Level 1) and its applicable criteria can be accessed here: http://maryland.beaconhealthoptions.com/provider/manual/Appendix-C-ASAM-Criteria.pdf.

SERVICE RULES

Assessments are limited to one, per provider, per participant, per year. If there is a break in treatment for 30 or more days, an additional assessment (H0001) may be billed.

PARTICIPANT ELIGIBILITY

Participants with federally funded Medicaid or federally funded, dual eligibility (Medicaid and Medicare) are eligible for 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 PARTICIPATION

Assessment and referral programs are state or local government entities who are credentialed with Medicaid and who are registered with Beacon to provide this service. The Assessment and Referral Program has clinical staff authorized under the Health Occupations Article to provide the service. 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
- A community-based substance use program shall:
    - Receive certification by the Office of Health Care Quality in accordance with COMAR 10.47.01
    - Meet the requirements established by the Alcohol and Drug Abuse Administration as described in COMAR 10.47.01

AUTHORIZATION PROCESS

Authorizations for assessments (H0001) are required to be authorized before they are performed, except in urgent situations. Authorizations for assessments can be secured through Beacon's ProviderConnect system. Requests for an urgent assessment must be made to Beacon as soon as possible, but within two business days of the service.

CLAIMS PROCESS

Claims should NOT be submitted for services requiring registration or preauthorization unless there is an initial registration or a continuing authorization for the service. Claims should be submitted on a CMS 1500 form. Date spans will not be accepted. Each date of service must be entered on a separate transaction line. Claims must specify an ICD-10 code, not a DSM 5 code.

Claims for unauthorized services will be denied. If services are provided before an authorization is secured, the provider may not be paid for those dates of service. In this instance, please refer to Chapter 10, Grievances and Appeals.