6.37. Outpatient Individual, Group, and Family Therapy (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 Outpatient Individual, Group, and Family Therapy (ASAM Level 1) and its applicable criteria can be accessed here: http://maryland.valueoptions.com/provider/manual/Appendix-C-ASAM-Criteria.pdf.

SERVICE RULES

Preauthorization is required before Initial or continued stay services are provided.

Initial Evaluation/Diagnostic Interview (CPT Code 90791/90792)

This procedure is not time defined. The initial evaluation/diagnostic interview session is expected to include face-to-face participant contact, and encompasses activities critical to the evaluation process, such as communicating with the participant and the primary care physician and ordering laboratory tests when clinically appropriate. Only one initial evaluation/diagnostic interview (90791/90792) may be rendered per year.

All PBHS services require preauthorization except emergency services and some initial psychiatric consults on a medical floor. Please refer to March 2, 2009 memorandum. No exceptions will be granted.

Before providing Level I services, the provider will develop a written individualized treatment plan, with the participation of the participant, based on the comprehensive assessment and placement recommendation. This plan will be updated every 90-days. It will be reviewed and approved by a licensed behavioral health practitioner. It will include:

- An assessment of the participant's needs
- Long-range and short-range treatment plan goals
- Specific interventions for meeting the treatment plan goals
- Target dates for completion of treatment plan goals
- Criteria for successful completion of treatment
- Referrals to ancillary services, if needed
- Referrals to recovery support services, if needed

Each individual and group counseling session will be documented in the participant's record through written progress notes, after each counseling session. Before discharge, the provider will give the participant a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.

PARTICIPANT ELIGIBILITY

Participants who have a Medicaid or are Dually Eligible (Medicare and Medicaid) are eligible for Level 1 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 providing Level 1 Outpatient services must be Medicaid eligible and 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
- 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

Outcomes Measurement System (OMS)

Participants ages 6 to 64, who are treated in Provider Type 50 Programs, will receive authorizations for outpatient services through the OMS. The provider will initially receive an authorization for two visits (up to 12 fifteen minute units). Prior to the third visit, and every six months thereafter, the provider must complete an OMS interview questionnaire with the participant in order to obtain authorizations. Authorizations will be granted in a service bundle that includes 75 visits (up to 300 fifteen minute units) for six months. For services included in the OMS service bundle, refer to the Service Matrix. For continued stay authorization requests, the end date of the previous authorization will be changed to end one day before the start date of the new authorization.

For services outside of the OMS service bundle, a separate authorization request must be submitted.

For complete information on OMS, refer to the Outpatient section (Chapter 6.17) and OMS Appendix in this Provider Manual, as well as any updates that are posted on the Beacon Maryland website.

The request for authorization must be submitted to Beacon through the ProviderConnect system. When submitted through ProviderConnect, Beacon will make their determination available to the provider, through ProviderConnect, immediately.

Non-OMS Authorizations (Private and Group Practice Clinicians)

Participants ages 0 to 6 and 65+ who are treated in Provider Type 50 Programs, as well as participants of any age who are treated by private and group practice clinicians, will need clinical information submitted through the Beacon ProviderConnect system. The provider must notify and submit a treatment plan to Beacon prior to the start of treatment.

Initial requests for authorization may be auto-approved and can be backdated by Beacon's system, after the initial date of service, for up to 29 days. The provider will initially receive an authorization for 12 visits (up to 48 fifteen minute units). Prior to the 13th visit, and every 12 months thereafter, the provider must

submit updated clinical information in order to obtain authorizations. Authorizations will be granted in a service bundle that includes 24 visits (up to 96 fifteen minute units) for 12 months.

A new authorization is required when either the number of units is exhausted or the time span has expired. The start date for the new authorization will be the date the request is submitted or another, future date requested by the provider. Providers are required to submit updated clinical information to receive continued stay authorizations for up to 24 visits, over the next 12 months.

Authorizations are given in service code blocks (see Service Matrix) for specific time frames. The services must be used within the given time frame and the number of sessions may not exceed the number of sessions authorized.

When submitted through ProviderConnect, Beacon will make their determination available to the provider, through ProviderConnect, immediately.

If Beacon determines that a participant does not meet the ASAM placement criteria, Beacon will work with the provider to determine the appropriate, alternative level of care.

DISCHARGE

The above-described process is continued for authorizations until the participant is no longer in treatment. Upon discharge, the provider must discharge the participant from their service by going to ProviderConnect and entering a discharge by searching for the participant authorization and choosing the discharge participant option.

CLAIMS PROCESS

In order for a provider to bill for family counseling, the participant must be present for an appropriate length of time but does not need to be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the participant.

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.

Private practitioners of any discipline are not allowed to bill for services delivered by non-licensed/certified mental health professionals (e.g. students or interns).

The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician and other treatment (e.g., substance use treatment) providers when clinically indicated and with appropriate releases of information.

Providers may not bill for:

- Services provided at no charge to the general public
- More than one comprehensive substance use assessment for a participant per provider per 12 month period unless the participant was discharged from treatment with that provider for more than 30 days

- More than one Level I group counseling session per day per participant
- More than six Level I individual counseling units as measured in 15-minute increments per day per participant
- More than four sessions of intensive outpatient treatment per week
- Services rendered but not appropriately documented
- Services rendered by mail, telephone, or otherwise not one-to-one, in person
- Completion of forms or reports
- Broken or missed appointments
- Travel to and from site of service