"Getting In the Know"

TECHICAL HELP GUIDE TO ASSIST RESIDENTIAL PROVIDERS WITH STREAMLINING THE SUBMISSION AND REVIEW OF CLINICAL AUTHORIZATION REQUESTS

REQUEST OF INFORMATION (ROI)

- Consent form is compliant with CFR42
- Members give consent for the Provider and Managed Care Organization, **Beacon** to discuss:
  - Treatment concerns
  - Coordination of Care
  - Billing/Claims

REQUEST OF INFORMATION (ROI)

Tip:

Include this form in your admission process when gathering insurance information.

AUTHORIZATION TO DISCLOSE SUBSTANCE USE TREATMENT INFORMATION FOR COORDINATION OF CARE

Name of Patient:____**DOB**: _____________

Address:____**Phone Number:** __________

Medical Assistance Number: ____

Section 1: **Purpose of Authorization**

This Authorization to disclose is for the purpose of permitting the Maryland Medical Assistance Program (the Medicaid program), my substance use treatment provider, and any other providers identified in this form to coordinate my care so that it is more beneficial to me. By giving my consent, my Medicaid Managed Care Organization and any other providers specifically identified on this form will have access to information about substance use treatment I am receiving, which will help avoid conflicts in medication or treatment and improve the care I am receiving. By giving this consent, I may also gain access to other case management services offered through the Medicaid program.

REQUEST OF INFORMATION (ROI)

Section 2: <u>Name of Substance Use Treatment Provider</u> **[TO BE COMPLETED BY PROVIDER]**

____

Address: ______________________________________

____

Section 3: <u>Duration and Revocation of Authorization</u>

I may revoke this Authorization at any time either verbally or in writing, by informing my substance use treatment provider of my wish to revoke authorization. I may also revoke this authorization by writing to the Maryland Medicaid Program's administrative services organization, Beacon Health Options, at:

Beacon Health Options

EDI Helpdesk / PO Box 1287, Latham, NY 12110

Phone: 800.888.1965

Fax: 877.502.1044

This Authorization's effective date is:________. This Authorization expires when (1) I revoke the Authorization; (2) I am no longer enrolled in a Medicaid Managed Care Organization; or (3) I am no longer receiving treatment from a substance use treatment provider.

Tip:

Administrative staff can fax the completed form
or
Clinical staff can attach the form when submitting the initial authorization request

REQUEST OF INFORMATION (ROI)

Tip:

Don't forget the signature!
Form is not valid without the Member's signature

Section 4: Authorization

I hereby authorize my substance use treatment provider to disclose to the Maryland Medicaid Program (including its administrative services organization, Beacon Health Options), claims and authorization data resulting from my treatment, for purposes of coordination of my care. If you want to identify the kind or amount of information that you are authorizing for disclosure, you may do so here: ________________________________. I also authorize the Maryland Medicaid Program (including Beacon Health Options), to re-disclose my claims and authorization data to the Medicaid Managed Care Organization in which I am enrolled, and with any additional health care providers listed on this form below, for purposes of coordinating my health care. I further authorize my substance use treatment provider to disclose medical records requested by my MCO's patient care coordination team, for purposes of coordinating my care.

I understand that the information that may be disclosed as a result of this authorization may not be re-disclosed to any entity other than those entities identified in this authorization. I also understand that, for two years following the date of my signature, I have the right to find out who in the MCO actually saw my information.

I have been provided a copy of this Authorization.

________________________________ ____________
Patient Signature Date

________________________________ ____________
Parent or Guardian Signature* (if applicable) Date

REQUEST OF INFORMATION (ROI)

Additional health care provider(s) with whom information about my care may be shared:

Name:____

Address:____

Name:____

Address:____

* NOTE: If you are signing as the member's Legally Authorized Representative, attach a copy of the legal document(s) granting you the authority to do so. Examples are a health care power of attorney, a court order, guardianship papers, etc.

The following are the Maryland Medicaid Managed Care Organizations (MCOs):

Amerigroup Community Care
Compliance Officer
7550 Teague Road, Suite 500
Hanover, MD 21076
410-859-5800

Jai Medical Systems
Compliance Officer
5010 York Road
Baltimore, MD 21212
410-433-2200

Kaiser Permanente
Compliance Officer
2101 East Jefferson Street
Rockville, MD 20852
301-816-2424

Maryland Physicians Care
Compliance Officer
509 Progress Drive
Linthicum, MD 21090-2256
800-953-8854

MedStar Family Choice
Compliance Officer
5233 King Avenue, Suite 400
Baltimore, MD 21237
410-933-2204

Priority Partners
Compliance Officer
Baymeadow Industrial Park
6704 Curtis Court
Glen Burnie, MD 21060
410-424-4400

Riverside Health of Maryland
Compliance Officer
1966 Greenspring Dr., 6th Floor
Timonium, MD 21093
410-878-7709

UnitedHealthcare
Compliance Officer
Lyndwood Executive Center
6095 Marshalee Dr, Suite 200
Elkridge, MD 21075
410-379-3457

4/2017

Tip:

Member's can consent to share substance abuse and other care services to other providers and Beacon to coordinate care

START DATES & SUBMISSION DEADLINES

3.7 WM

3.7

- Initial Requests MUST be listed and received within 24 HOURS of the Consumer's admission into the facility

Example: If Consumer is admitted on August 11 the authorization request must be received by August 12 to be considered ON-TIME

- Concurrent Requests BEGIN the SAME date of submission

Example: If Consumer's authorization expires October 12 , the concurrent authorization must be received no later than October 12 to be considered a timely submission

Initial requests can be submitted up to 3 days in advance
Concurrent requests no more than 24 hours in advance

START DATES & SUBMISSION DEADLINES

3.5

3.3

- Initial and Concurrent requests for 3.5 and 3.3 levels of care authorization begins the date of submission

  Example: If Consumer is admitted on August 11 the authorization request must be received by August 11 to be considered ON-TIME

- Concurrent Requests BEGIN the date of submission

  Example: If Consumer's authorization expires October 12 , the concurrent authorization must be received no later than October 12 to be considered a timely submission

Initial requests can be submitted up to 7 days in advance of admission
Concurrent requests within 7 days of expiration of the previous request

CURRENT RISKS

- Snap Shot of Presenting Problems
- Brief up-to-date explanation of why Member needs the requested level of care
- Concurrent Reviews – Information must be **CURRENT**, at the time of the request

CURRENT RISKS

SUBMISSION DONT'S

Current Risks

Precipitant (Why Now?)

OTHER - OTHER

Please provide a brief explanation

MR. [redacted] IS A 31 YEAR OLD SINGLE (NEVER MARRIED), BLACK OR AFRICAN AMERICAN, MALE, WHO REPORTED HIS RELIGIOUS PREFERENCE IS OTHER. HE HAS LIVED AT THE ABOVE ADDRESS FOR 0 YEAR(S), 0 MONTH(S) AND IN THE LAST 30 DAYS HE HAS NOT BEEN IN A CONTROLLED ENVIRONMENT. MR. [redacted] HAD A PSYCHIATRIC SEVERITY RATING OF 1. HIS SELF-REPORTED MOOD AND MENTAL STATUS IS PRESENTED AT THE BEGINNING OF THIS SUMMARY. HE REPORTS THAT IN THE LAST 30 DAYS, HE HAS EXPERIENCING PSYCHOLOGICAL OR EMOTIONAL PROBLEMS, 0 DAYS. HE REPORTED BEING NOT AT ALL TROUBLED OR CONCERNED ABOUT PSYCHIATRIC PROBLEMS AND THAT RECEIVING TREATMENT OR COUNSELING FOR PSYCHIATRIC PROBLEMS IS NOT AT ALL IMPORTANT AT THIS TIME. MR. [redacted] HAD A ALCOHOL SEVERITY RATING OF 0. IN THE PAST 30 DAYS HE REPORTED USING ALCOHOL 0 DAYS AND 0 DAYS TO INTOXICATION. HE ALSO REPORTED THAT IN THE LAST 30 DAYS HE HAS SPENT 0 DAYS ATTENDING ANY OUTPATIENT TREATMENT OR COUNSELING, INCLUDING AA/NA MEETINGS. HE ALSO INDICATES THAT HE HAS ENTERED TREATMENT FOR ALCOHOL 0 TIMES IN HIS LIFE AND FOR DRUGS 0 TIMES. OF THESE, (NOT ASKED) TIMES WERE ALCOHOL DETOX AND (NOT ASKED) TIMES WERE DRUG DETOX. MR. [redacted] REPORTED THAT IN THE LAST 30 DAYS HE HAD 0 DAYS OF PROBLEMS RELATED TO DRINKING AND TO BEING NOT AT ALL TROUBLED OR BOTHERED BY ALCOHOL PROBLEMS. HE INDICATED THAT RECEIVING TREATMENT OR COUNSELING FOR ALCOHOL PROBLEMS IS NOT AT ALL IMPORTANT AT THIS TIME.

Member`s Risk to Self

NONE

Member`s Risk to Others

NONE

CURRENT RISKS

Current Risks

Precipitant (Why Now?)
OTHER - OTHER
Please provide a brief explanation
****REQUESTING 15 DAYS (30 UNITS) 3.7 LOC (10/13-10/27)** COUNSELOR PROGRESS NOTE: PATIENT STATES THAT HE NEEDS TO LEARN ABOUT THE DISEASE CONCEPT OF ADDICTION WHICH PC IS CURRENTLY FACILITATING. PATIENT IS ALSO WORKING ON DEVELOPING COPING SKILLS. HE PRESENTED WITH SIGNIFICANT HEALTH CONCERNS AND APPEARS TO BE MAKING PROGRESS WITH THAT. HE IS CURRENTLY HOMELESS AND PC IS COMMUNICATING WITH PROBATION AND HEALTH DEPARTMENT TO GET PATIENT IN THE WELLS HOUSE IN HAGERSTOWN MD. PATIENT APPEARS TO BE IN THE CONTEMPLATIVE STAGE OF CHANGE. PATIENT WISHES TO REMAIN ON SUBOXONE MAINTENANCE FOR CRAVINGS. DIMENSIONS: I. LOW; POST ACUTE II. HIGH; UNTREATED HEPATITIS C, INSULIN DEPENDENT DM, HX OF MULTIPLE HEART ATTACKS, REPORTS HE IS BLIND IN HIS RIGHT EYE, ARTHRITIS, NEUROPATHY, CHIPPING/ BREAKING OF TEETH III. MEDIUM; STABILIZING ON NEW MEDICATIONS PRESCRIBED BY PSYCH. NP, DX: DEPRESSION, ANXIETY, AND ADHD IV. LOW V. HIGH; LACKS COPING SKILLS, LACKS SKILLS TO CONTROL IMPULSES TO USE, LACKS KNOWLEDGE OF TRIGGERS, LACKS RELAPSE PREVENTION PLAN VI. HIGH ; HOMELESS, REPORTS PAROLE/ PROBATION FOR DESTRUCTION OF PROPERTY (COURT DATE 10/19/17), LACKS VEHICLE, LACKS DRIVER'S LICENSE, DRIVES WHILE IMPAIRED**

Member`s Risk to Self
NONE

Member`s Risk to Others
NONE

SUBMISSION DO'S

PREPARING ASAM ATTACHMENTS

SUBMISSION DONT'S

Avoid:

- Outdated data on initial or concurrent reviews
- Ambiguous Clinical information

PREPARING ASAM ATTACHMENTS

Include:

- Current & Relevant Data
- Specify data in each dimension
- Be Specific (ie: Withdrawal Sx, Psych Sx, Detox protocols, Rx mgmt.)

SUBMISSION DO'S

Improving Clinical Submissions

Dimension 1 (Potential for Withdrawal): **3.7WM** – Drugs of use, frequency, last day of use, PAWS/COWS/CWA- Withdrawal Sx, toxicology reports. Hx: DT, tremors, seizures, overdoses, ect **3.7 ICFA** - PAWS/COWS/CWA- Post Withdrawal Sx, continued detox protocol, Rx adjustments **3.5 ICFA** – Stable **3.3 ICFA** - Stable
Dimension 2 (Biomedical Conditions and Complications): **3.7WM –** Medical Issues that can worsen/unstable related to SA use, (vitals: BP- top#: <160, bottom#:<100; Heart rate: 60-100) **3.7 ICFA –** Stabilized health, (vitals: BP- top#: <160, bottom#:<100; Heart rate: 60-100), Rx adjustments **3.5 ICFA –** Stabilizing, Rx complaint **3.3 ICFA –** Specify cognitive deficiencies or concerns

Improving Clinical Submissions

Dimension 3 (Emotional, Cognitive and Behavioral):

3.7WM - Psych Issues that can worsen/unstable (non Rx-compliant, no medication; active psychosis related to SA use, SI/HI or Hx, trauma, grief, Rx list)

3.7 ICFA – Stabilized health, (vitals: BP- top#: <160, bottom#:<100; Heart rate: 60-100), Rx adjustments

3.5 ICFA – Stabilizing – Clinically managed (cognitive impairment, Axis I & II) Rx complaint

3.3 ICFA – Specify comorbidity of cognitive deficits and mental health

Dimension 4 (Readiness to Change):

What happened? What is initiating Tx? Identifying current motivational stage, program compliance, progress, meeting goals in treatment?

Improving Clinical Submissions

Dimension 5 (Relapse and Continued Use Potential): Progress with relapse prevention, Meeting goals in treatment, Skills/Inventions needed
Dimension 6 (Recovery Environment): Challenges with recovery environment, Needs, Specify interventions - Referrals? Discharge Planning?

Use Of Administrative Days

Provider Alert from 9/29/17 was the SUD Fee schedule effective 9/1/17

Administrative Days for Residential SUD for Adults				
Procedure Code	Service Description	Rate	Unit	Service Limits
W7330-HG	ASAM Level 3.3 Admin Day for Consumer Awaiting Community Services	$ 189.44	Per diem	Provider to use this service code/ modifier combination for a short-term, clinically indicated bed hold if the consumer is awaiting community services.
W7350-HG	ASAM Level 3.5 Admin Day for Consumer Awaiting Community Services	$ 189.44	Per diem	Provider to use this service code/ modifier combination for a short-term, clinically indicated bed hold if the consumer is awaiting community services.
W7370-HG	ASAM Level 3.7 Admin Day for Hospitalized Consumer	$ 291.65	Per diem	Provider to use this service code/ modifier combination to hold the bed if the consumer has been hospitalized for a short-term stay. Short term stay decided by clinical services.
W7370-SC	ASAM Level 3.7 Admin Day for Consumer Awaiting 3.5 or 3.3 Bed	$ 189.44	Per diem	Provider to use this service code/ modifier combination for a short-term, clinically indicated bed hold if the consumer is awaiting a 3.5/3.3 bed.