Residential Treatment for Individuals with Substance Use Disorder
Frequently Asked Questions #1
May 11, 2017

1) **When will Maryland Medicaid begin reimbursing residential treatment services for individuals with a substance use disorder (SUD) diagnosis?**

The Centers for Medicare and Medicaid Services (CMS) has granted the Department the authority to reimburse for clinical services provided to Medicaid-eligible adults who meet medical necessity criteria to reside in a non-public IMD. Medical necessity criteria used is based on American Society of Addiction Medicine (ASAM) residential levels 3.1, 3.3, 3.5, 3.7, and 3.7-WM (licensed at 3.7D in Maryland).

Effective July 1, 2017, Maryland Medicaid will provide reimbursement for up to two nonconsecutive 30-day stays in a rolling year for ASAM levels 3.7-WM, 3.7, 3.5, and 3.3.

The Department intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019.

2) **Maryland Medicaid will only reimburse for 2 separate 30-day residential treatment stays in a rolling year. Will a person be covered if she/he transfers from one residential treatment level to another within 30 days (i.e. 3.7 and then steps down to Level 3.3)? Will that count as a separate residential stay or as a continuation of the 30-day stay?**

As part of the continuum of care, Medicaid will reimburse for up to 30 days of treatment as an individual step down from 3.7-WM, 3.7, to 3.5 or 3.3 level of care within that initial 30-day period. To prevent a gap in services, providers need to initiate referrals to next levels of care when appropriate if the service needs to be delivered by a different provider. The Department is working on the authorization process to account for a seamless continuum of services when there is a need to transfer to a different provider.

If an individual continues to meet ASAM criteria for residential care beyond 30 days, the cost of both services *and* room and board will be financed by the Behavioral Health Administration (BHA). BHA will closely monitor expenditures for the state portion of these services to ensure that it remains within budget. Depending on expenditure levels in relation to the state budget, additional adjustments may be required over time to remain within budget.

3) **How is a 30-day span defined?**

Beginning on July 1, 2017, Medicaid will provide reimbursement for up to two nonconsecutive stays of up to 30 days without a break in treatment within a rolling year for ASAM levels 3.7WM, 3.7, 3.5, and 3.3. An episode of treatment will qualify as a single 30-day stay, even if an individual receives services at multiple different levels of care. For example, if an individual

requires 14 days of care at an ASAM Level 3.7 and then steps down to 14 days of care at an ASAM Level 3.3 or 3.5 without a gap in care, the full 28 days of treatment services would be paid for by Medicaid.

For each level of care, ASAM (medical necessity criteria) must be met. Transitions to lower levels of care should be considered beginning on the first day of residential SUD service entry. Maryland is invested in a robust continuum of services with the goal of moving individuals from higher levels of care to addressing their needs within the community outpatient setting. Administrative days under the Medicaid span may be used if there is a gap in access to the next level of care and these days' count within the 30-day span of treatment.

4) **For patients who exceed the 30-day limit and will need to use state grant funds to pay for ongoing residential treatment, will the authorizations still come from Beacon or will they come from BHA?**

Continued Authorization approvals and denials will come through Beacon. If approved, the services will be paid through the Fee-For-Service system using state funds.

5) **If an individual requires more than 30 days of treatment, will they be discharged from treatment when Medicaid coverage for the cost of services expires?**

The system will be set up so that treatment is based on ASAM criteria. At launch of the new system on July 1, 2017, state funds will be available to pay for the state-funded portion of the costs so long as ASAM criteria are met. BHA will closely monitor expenditures as time goes on to determine if additional adjustments are required to remain within budget.

6) **Can providers seek payment for new services/locations not currently funded by grant funding?**

To be eligible to deliver this service, providers must be licensed by OHCQ and enrolled with Medicaid as a Provider Type 54. The Department recently released information related to the application process. The application link is here: https://mmcp.dhmh.maryland.gov/pages/Provider-Enrollment.aspx .

7) **Will there be funds available to help providers make the transition from grant-based funding to Fee-For-Service reimbursement?**

The Department is working to identify funds to help with the transition.

8) **Will there be technical assistance available to help providers make the transition to billing in a Fee-For-Service environment?**

Technical assistance will be made available to providers as we implement these services. Additional information and trainings will be announced soon.

9) **Will there be state funds available to cover room and board as well as stays meeting ASAM criteria beyond the two 30 day spans for new services/providers?**

At the July 1, 2017 launch, state funds will be available for both of these costs. BHA will closely monitor the budget after launch to determine if additional funds are needed and/or if adjustments will be required for the state portion of these costs.

10) **What will the reimbursement rate be for providers for the provision of services? Will the rates for Medicaid and state-funded services be the same?**

Medicaid will reimburse for 2 separate up to 30-day residential treatment stays in a rolling year. Medicaid reimbursement rates will be as follows for the different levels of care:

(1) For ASAM Level 3.3 the program shall receive a per diem of $189.44

(2) For ASAM Level 3.5 the program shall receive a per diem of $189.44

(3) For ASAM level 3.7 the program shall receive a per diem of $291.65

(4) For ASAM Level 3.7-WM the program shall receive a per diem of $354.67

The cost of room and board is not eligible for reimbursement through the Medicaid Program.

- The state-funded reimbursement rate for room and board will be $45.84 per diem. State funds will be available to pay for room and board costs so long as ASAM criteria are met. If an individual continues to meet ASAM for residential care beyond 30 days or requires more than 2 30-day stays in a rolling year, the cost of both services *and* room and board will be financed by BHA at the rates described above.

- If an individual is not eligible for Medicaid and receives state-funded care, the cost of both services *and* room and board will be financed by BHA at the rates described above. BHA will closely monitor expenditures for the state portion of these services to ensure that it remains within budget. Depending on expenditure levels in relation to the state budget, additional adjustments may be required over time to remain within budget.

- There will be a separate Medicaid billing code required for clinical services and a separate state funded billing code for "room and board", however both codes will be on

the same claim. Expenditures paid through state funds will be monitored closely by the state. BHA will provide advance notification of any changes. The ASO will be providing training during the month of June, prior to go-live which will cover authorization process and claims submissions.

- Rates described above are all inclusive, per diem. Providers are not permitted to balance bill individuals receiving residential SUD services regardless of coverage under Medicaid or BHA financed services.

****Additional guidance and opportunities for training will be available in the weeks preceding and post go-live.**

Frequently Asked Questions (FAQ)

Residential Treatment for Individuals with Substance Use Disorder

Last Updated: 5/25/2017

The following answers to frequently asked questions are intended to offer clarification for providers who are interested in providing residential treatment services to adults with substance use disorders.

1. What is ASAM?

Founded in 1954, the American Society of Addiction Medicine (ASAM) is a professional society representing over 3,600 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

2. What is the ASAM Criteria?

ASAM's criteria, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. The ASAM criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

3. What are the levels of care reimbursable by Medicaid in Maryland?

Maryland Medicaid reimburses for the following levels of care*:

- Level 3.3 – A residential medium intensity program that provides services in a structured environment in combination with medium-intensity treatment and ancillary services to support and promote recovery for 20 to 35 hours weekly.
- Level 3.5 – A residential high intensity program that provides services in a highly-structured environment, in combination with moderate- to high-intensity treatment and ancillary services to support and promote recovery for a minimum of 36 hours weekly.
- Level 3.7 – A residential intensive program that provides a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting.
- Level 3.7-WM – A withdrawal management service that offers 24-hour medically supervised evaluation and withdrawal management.
- **Level 3.1 is not covered by Maryland Medicaid*. Level 3.1 services are covered through state funds only.

4. What is the process to be certified as an adult residential SUD provider?

The program must obtain licensure for the levels of care they are qualified to provide from the Office of Health Care Quality.

5. How can I enroll in Medicaid and be reimbursed for my services?

Providers are required to apply as a Provider Type 54. To access the PT 54 Medicaid application see: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx.

In order to complete the Medicaid application you will need:

a. An Office of Health Care Quality (OHCQ) license for each ASAM level of care you provide.
b. A copy of your facility's/ organization's NPI printout from the National Plan and Provider Enumeration System (NPPES). One NPI is required for each location. For more information about NPI number or to apply for a number, please visit the NPPES website here: https://nppes.cms.hhs.gov/NPPES/Welcome.do.

6. What if I am already enrolled as an ICF-A for children (Provider Type 55)?

Provider type 55s (residential services for under 21 year olds) who do **not** provide services to individuals 22 years or older do **not** need to enroll as a provider type 54.

If you would like to enroll to be reimbursed for services provided to adults, please follow the instructions on the residential SUD treatment for adults webpage (https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx) to enroll as a provider type 54 (Residential SUD for Adults) with a separate MA/NPI from your provider type 55.

7. Can a residential treatment program be eligible to deliver more than one ASAM level of care?

Yes, a facility can offer multiple ASAM levels of care. Each level of care will need to be licensed by OHCQ and abide by the regulations set forth in COMAR 10.09.06 and 10.63.

8. Does a facility need a separate MA/NPI number for each ASAM level of care?

No, a facility only needs one MA/NPI number. But each facility needs one MA/ NPI number per service per location. For example, if have a Provider Type 50 at the same location, you will need an additional MA/ NPI number for a Provider Type 54.

9. Can a patient continue to receive methadone while in residential care?

Yes. The weekly administrative fee (H0020 – HG) for Opioid Treatment Programs (OTPs) includes the cost of delivering Methadone from the OTP to participants in residential settings. The OTP can continue to be reimbursed for the administrative level of service while the patient is receiving care in a residential setting.

10. Will buprenorphine induction and/ or maintenance be a separately billed service?

No. The rate for an Adult residential SUD service is all inclusive. The exception to this is if a patient is receiving buprenorphine maintenance from an OTP, the OTP can continue to be reimbursed for the

administration level of service while the patient is receiving care in a residential setting. The administrative fee includes the cost of delivery for medications from the OTP to the SUD residential setting.

11. Can providers balance bill individuals who are enrolled in Medicaid or who receive state-funded services?

Providers are never permitted to balance bill Medicaid recipients for covered services. Providers are also not permitted to balance bill individuals who receive state-funded services financed by BHA.

12. Why are Level 3.3 and Level 3.5 being reimbursed at the same rate?

While there are fewer clinical services at level 3.3 versus level 3.5, there is a medical component that is included in level 3.3. The identical rate is a reflection of the service shift from higher level of clinical need to higher level of medical need.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 3

June 9, 2017

1. **My program has submitted an application to OHCQ for a license and was told it would not be processed until July 1st.**

   There is a difference between being licensed by OHCQ (under COMAR 10.63) and certified by OHCQ (under COMAR 10.47). Medicaid will accept OHCQ licenses and/ or certifications during the implementation of the Residential SUD for Adults benefit.

2. **Where can I find the list of Evidence-Based Practices (EBPs) that are required for enrollment?**

   The Medicaid provider application can be found here: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx. The EBPs are listed on page 3 of the attestation (page 26 of the document). Providers should include a brief description of each EBP they attest to as well as a description of training and supervision of staff related to the EBP.

3. **What are the minimum hour requirements per week for the recovery coach?**

   Please see the most up to date version of the proposed regulations here: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx. The requirement for a recovery coach has been amended to state that aftercare coordination services may be provided by a peer support specialist or licensed clinician. The regulations do not specify weekly hour requirements.

4. **ASAM level 3.5 is a more intensive level of care than 3.3, yet the staffing requirements are less. Why is this?**

   A typical participant receiving ASAM Level 3.3 services has an addictive disorder that is so severe it has resulted in significant temporary or permanent cognitive impairment. Treating the cognitive impairment and associated medical conditions requires additional medical services that are not necessary for participants receiving ASAM Level 3.5. Clinical services tend to be less beneficial for participants receiving Level 3.3 than for the typical participant receiving Level 3.5 and therefore less clinical staff and more medical therapeutic support would be appropriate at Level 3.3.

5. **What are the minimum duties of the physician/CRNP? Of the psychiatrist or CRNP psych? Of the recovery coach?**

Information on required services and staffing can be found in the proposed regulations here: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx. Providers requiring additional assistance should request technical assistance from BHA by email to trina.ja'far@maryland.gov.

6. **What plans have been made to account for possible implementation glitches during the initial transition period?**

   The Department and Beacon Health Options are working closely with providers to ensure they are prepared for the July 1, 2017 implementation date.

   Maryland Medicaid is placing a priority on enrolling Residential SUD for Adults programs. All programs who submit a complete application before Jun 26, 2017 will be able to receive authorizations for July 1, 2017. For more information on the provider enrolment process please see the Res SUD for Adults webpage here: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx.

   Beacon is providing regional trainings across the state over the next few weeks that focus on residential ASAM, authorizations, and claims. For more information see the provider alerts here: http://maryland.beaconhealthoptions.com/provider/prv_alerts.html. Beacon will also be providing additional training through webinars with a focus on authorizations and the ProviderConnect system. Sign up for provider alerts by emailing mdproviderrelations@beaconhealthoptions.com to receive information as it is released. Beacon also provides one-on-one trainings with providers who are unfamiliar with billing fee for service or have not submitted authorizations through Beacon previously. Providers who have questions may contact provider relations at 800-888-1965 or at mdproviderrelations@beaconhealthoptions.com.

   The Behavioral Health Administration is offering technical assistance for Residential SUD for Adults providers upon request. For additional information please email trina.ja'far@maryland.gov for a TA request form.

7. **There is a holiday within the first week of implementation. Holidays historically delay payments. What accommodations could be made to account for this holiday falling within the first few days of the transition?**

   Providers should continue to submit claims as usual despite the weekend and holiday falling at the time of transition. Beacon will issue payment on schedule with our customary cycle of reimbursement, however due to a holiday falling on Tuesday July 4th, Beacon Health Options will be completing the check run on Monday July 3rd. A Provider Alert will be issued specifically regarding this issue.

8. **Will there be real time supports available to assist providers during the period of transition?**

Providers with questions/ issues regarding authorizations or billing may contact provider relations at 800-888-1965 or at mdproviderrelations@beaconhealthoptions.com.

BHA, Medicaid, and Beacon will be implementing a Joint Operations Team for post implementation. Providers will send questions/ issues to the JOT and answers will be provided during a weekly call that will include representatives of the provider community. More information on this process will come out through provider alert in the coming weeks.

9. **What will happen with the participants who are currently in residential beds on July 1, 2017?**

   Programs that have enrolled with Medicaid as a Provider Type 54 who have participants in their care as of July 1st must ensure that they have supplied Beacon with all information for determination of medical necessity. This determination is an authorization which needs to be in place as of July 1st for those in care who will be continuing in care. Beacon Health Options will be releasing additional instructions through provider alerts and webinar trainings on when providers may begin submitting authorizations for participants who are currently receiving services.

10. **What is the estimated time processing authorization? Originally we heard authorizations would take 14 days to get for new clients, now we are hearing 3 days. Which is accurate?**

    For ASAM levels 3.7 and 3.7WM, reviews for medical necessity are made at the time of the call. For all other non-urgent levels of care requested online in ProviderConnect, almost all determinations are made within the first 3 days with the majority being made within 24 hours. If there is a reason to do an expedited review a provider can telephonically call in the request and Beacon will process it at the time of the call. Providers are reminded that discharge planning from higher levels of care should be initiated on day one of admission. Plans to step down care are part of the treatment planning process.

11. **How soon can a provider request a concurrent authorization?**

    Authorizations should not be submitted so early that the clinical information will not be relevant when the service begins. For ASAM level 3.3 and 3.5 most of the time authorizations could be submitted up to 7 days before the requested dates of service. For ASAM level 3.7 and 3.7WM authorizations should not be submitted more than a day or two before the requested continuation of service dates.

12. **How many days at a time are authorized?**

    See the chart below for the maximum number of days of authorizations for each level of care under each authorization request. Please note that providers should submit requests based on clinical need. For example, if a patient requires Level 3.7WM for 5 days, the provider should request 5 days, not the maximum of 7 days.

ASAM Level	Initial Authorization	Concurrent Authorizations

Level 3.3	Up to 30 days	Up to 30 days
Level 3.5	Up to 30 days	Up to 30 days
Level 3.7	Up to 15 days	Up to 15 days
Level 3.7WM	Up to 7 days	Up to 7 days

13. **What is the uninsured eligibility criteria for residential services?**

    The provider is required to document and verify the person meets all seven uninsured eligibility criteria provided below:
    1) The individual requires treatment for a behavioral health diagnosis covered by the Public Behavioral Health System (PBHS);
    2) Must meet the American Society of Addiction Medicine (ASAM) criteria for the level of care.
    3) The individual is under 250% of the Federal Poverty Level (FPL) and not covered by Medicaid (MA) or other insurance; Individuals who are dually eligible must be under 500% of FPL.
    4) The individual has a verifiable Social Security number;
    5) The individual is a Maryland resident;
    6) The individual has applied to Medicaid; the Health Care Exchange; Social Security Income (SSI) or Social Security Disability Income (SSDI), if they have an illness/disability for a period of 12 months or more); and
    7) The individual meets the U.S. citizenship requirement.

    Exceptions to the above requirement may be made by the designated local authority under extenuating circumstances. Should the local behavioral health authority approve the request, then an uninsured eligibility span is established according to the same timeframes indicated in question #12. BHA will collect data on exceptions made to determine if future adjustments to the uninsured workflow are indicated.

14. **If an individual needs residential services for the third time in a rolling year, what happens? Can they receive services?**

    If the individual meets MNC they will be authorized for services. Any stays beyond what is reimbursable by Medicaid will be covered by state only dollars. The process of determining which source of funds will be used will be managed by Beacon and will be mostly invisible to providers.

15. **What will happen in situations when there is a need for a break in care due to a hospital admission?**

    Administrative days may be used for individuals admitted to a hospital for a short period of time. These situations will be handled on a case by case basis.

16. **What will happen if a patient no longer meets MNC for a higher level of care but a bed is not yet available at a lower level?**

    For each level of care, MNC must be met. Transitions to lower levels of care should be considered beginning on the first day of residential SUD service entry. Maryland is invested in a robust

continuum of services with the goal of moving individuals from higher levels of care to addressing their needs within the community outpatient setting. Administrative days under the Medicaid span may be used if there is a gap in access to the next level of care and these days count within the 30-day span of treatment under Medicaid.

17. **Can PT 54s be reimbursed for assessments?**

    The rates for ASAM levels 3.7 WM, 3.7, 3.5, and 3.3 are all inclusive. Based on provider feedback, we will be reviewing this question during the regulations comment period.

18. **Are mental health services inclusive in the rate or can providers bill separately for mental health services?**

    The rates for ASAM levels 3.7 WM, 3.7, 3.5, and 3.3 include all counseling and therapeutic services and include services delivered by licensed therapists who may not be separately reimbursed from the per diem for the program. Services that may be separately reimbursed include visits with a psychiatrist for a co-occurring psychiatric condition, and visits made by opioid treatment providers who deliver methadone or buprenorphine, to the facility during the patient's stay. Those OTPs would be reimbursed their weekly medication assisted treatment maintenance rate.

19. **Will advances be available for small providers who are more dependent on regular and timely fee for service revenue to meet financial obligations?**

    Beacon operates a customary weekly check disbursement cycle to Providers. Beacon recommends billing as frequently as necessary to meet your organization's financial needs. Beacon will issue payment on schedule with our cycle of reimbursement. If there are substantially severe extenuating circumstances that would require special consideration, please contact Beacon Health Options who will consult directly with the Department on a case by case basis. Please be aware, Beacon will be providing continuing Provider training on claims and authorizations submission processes.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 4

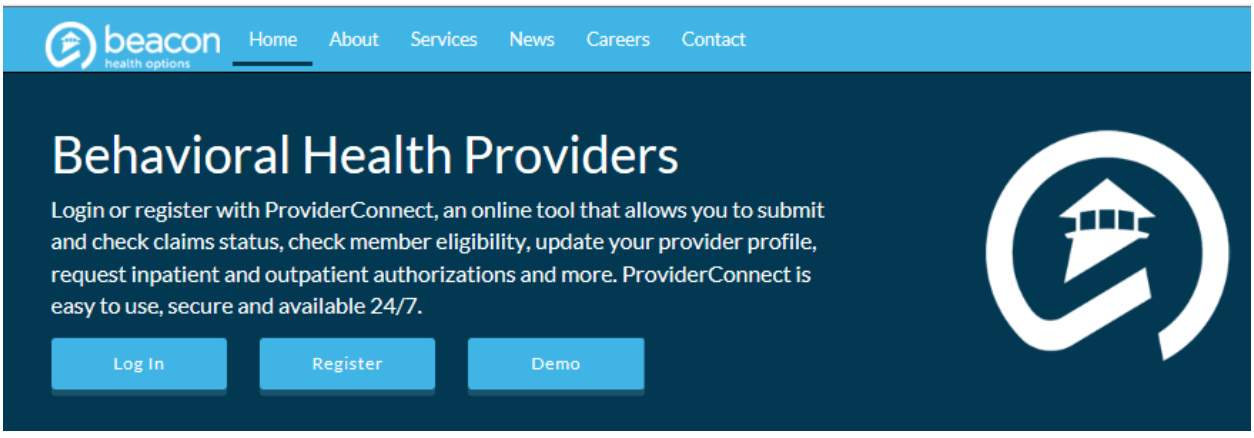
Please note that only providers who have enrolled with Medicaid as a provider type 54 will be able to obtain authorizations. Please get your applications to: mdh.bhenrollment@maryland.gov to initiate this process. Applications received after 6/26 may not be able to obtain authorizations or payment for services on 7/1/2017.

1. **Do all services need authorization, for both Medicaid and uninsured populations?**

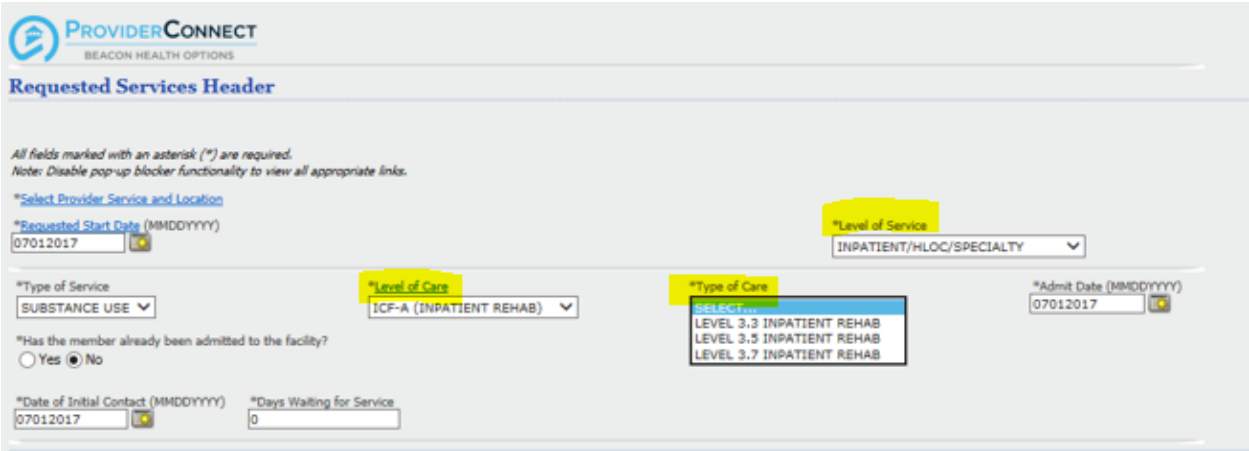
   Yes, all services need to be authorized by Beacon in order for claims to be reimbursed regardless of source of funds. Requests for authorization must be submitted prior to treatment. This includes all levels of SUD residential care 3.7 WM, 3.7, 3.5, and 3.3.

2. **How do we request authorization for SUD Residential treatment?**

   Authorizations can be requested telephonically, or electronically. 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. ProviderConnect can be accessed 24/7, including weekends and holidays through the Beacon website: http://maryland.beaconhealthoptions.com/provider-main.html



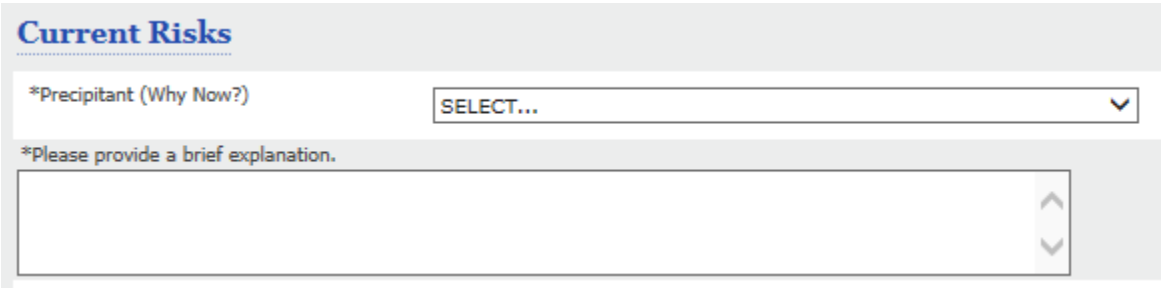
Upon completing the necessary log on information & pulling the member file needed, providers will select e the Inpatient/HLOC/Specialty drop down option found in the Level of Service field to submit for authorization requests.



After selecting the appropriate Level of Service, Type of Service, Level of Care, Type of Care & completing each asterisked item, providers will follow the prompts to the next screen.

Providers will click on each of the tabs, and complete the asterisked items found in each tab. The asterisked items are needed to complete the request for authorization.

Beacon Health Options has developed a new form to assist providers in reviewing and updating the 6 ASAM dimensions. (See attached). Upload the form with the clinical information on the 6 ASAM dimensions. The Clinical Care Manager will review the information submitted in the request, to include the attached form, & will authorize the number of days based upon clinical need &ASAM criteria. If unable to upload the attached form, providers can detail rationale for request in the narrative text box found under the Current Risk Tab:



More detailed information on the authorization submission process & how to upload the attached form will be discussed at the upcoming provider trainings.

3. **What is the number of days that will be authorized at one time for each level of care?**

Level of Care	Number of Days Authorized Initial	Number of Days Authorized Concurrent
3.7 WM	Up to 7 days	Up to 7 days
3.7	Up to 15 days	Up to 15 days
3.5	Up to 30 days	Up to 30 days
3.3	Up to 30 days	Up to 30 days

Please be aware that the number of days authorized will be based upon ASAM medical necessity criteria. Authorizations may be less than the maximum number of days based upon case complexity.

4. **How long will it take to get an authorization?**

Requests made online through the Beacon ProviderConnect system are processed rapidly with the majority being done within 1 day. Beacon is committed to making certain that providers receive accurate and timely information on authorizations. Telephonic requests will be processed at the time of the call. If there is an urgent need for a clinical review, please feel free to call in to provide the clinical information to Beacon Health Options 24 hours per day at 1-800-888-1965.

5. **If a program is reimbursed under grant funds for an individual currently, what should be done if the member is still meeting MNC on 7/1/17?**

The consumer may remain in treatment if they meet medical necessity criteria. Please submit a request for authorization to the Beacon system for that consumer with the new start date of 7/1/17 for the appropriate level of care. Authorizations will be based upon medical necessity using ASAM criteria. Requests for individuals who are expected to meet ASAM Medical Necessity Criteria on 7/1/17 may begin requesting authorization through ProviderConnect on 6/26/17. All consumers need to have an authorization as of 7-1-17.

Note: Providers that currently submit data for patients receiving residential SUD treatment should discharge their patients in the Beacon system as of 6/30/2017.

6. Are discharges needed for residential levels of care?

To assist in the care coordination efforts of state and local jurisdictions, please submit all discharges into the Beacon system within 24 hours of discharge.

7. Who can request for authorizations?

Any provider may call in the request for authorization. The request for authorization should include the current clinical information that would support ASAM medical necessity criteria to support the residential level of care.

8. When should requests for authorization be submitted?

To request authorizations for services, for 3.7WM and 3.7 please provide clinical within 24 hours of admission.

To request concurrent reviews for 3.7WM and 3.7 please request the concurrent review on the last covered day.

To request initial authorizations for 3.5 and 3.3, please submit the clinical information up to 7 days prior to admission.

To request concurrent authorization for 3.5 and 3.3, please submit the clinical information up to 7 days prior to the end of the authorization.

For those individuals that are currently in treatment that you anticipate to continue to meet ASAM medical necessity criteria for residential treatment, please start submitting the requests for authorizations, either telephonically or through ProviderConnect, starting 6/26/17.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 5

June 16, 2017

Please note that only providers who have enrolled with Medicaid as a provider type 54 will be able to obtain authorizations. Please get your applications to: mdh.bhenrollment@maryland.gov to initiate this process. Applications received after 6/26 may not be able to obtain authorizations or payment for services on 7/1/2017.

1. **Is there a projected length of time the wait list for residential may be before an individual is placed?**

   The ASO and BHA do not maintain a wait list. An adult residential SUD program may have a waitlist for their program if they are at capacity. An individual could contact their local jurisdiction or call Beacon Health Options for assistance in locating a provider with more immediate availability.

2. **Can MA transport clients to III.7 since there is an MD at the placement who will evaluate the individual?**

   Non-emergency medical transportation (NEMT) is available for Medical Assistance recipients who have no other means of getting to their medical appointments. Transportation services are provided by the local jurisdictions. Transportation services must be scheduled a minimum of 24 hours in advance, with the exception of hospital discharges. For more information please see the webpage here: https://mmcp.dhmh.maryland.gov/communitysupport/Pages/ambulance.aspx.

3. **If a client cannot accept a placement due to transportation or location do they stay at the top of the list for the next bed or move down?**

   As described in question # 2, non-emergency transportation is available for Medical Assistance recipients. It is anticipated that programs may expand their businesses as they are able, over time which will reduce the need for wait lists.

4. **How do ASAM levels of care crosswalk to clinical indications? Are there any additional resources that can be shared?**

   The Behavioral Health Administration shared the following information during the June 5, 2017 Provider Interest Meeting.

- ***Typical participant in 3.3 level:***
    - Intensity of an addictive disorder with or without a comorbid mental health condition is so severe that it has resulted in significant cognitive impairment
    - This cognitive impairment makes it unlikely that participant would benefit from another residential level of care
    - The cognitive limitations could be temporary or permanent
    - Given participant population, treatment should be at a slower pace, more concrete and repetitive until cognitive impairment improves
    - When cognitive impairment no longer present, participant can be transferred to a higher or lower Level of Care, based on reassessment and rehabilitative needs
    - Individuals with chronic cognitive deficits, older adults, patients with traumatic brain injuries and developmental disabilities should continue receiving treatment at ASAM level 3.3 until appropriate community supports are in place
    - With medical and nursing coverage, these programs can address certain medical needs of their patients (e.g. sliding scale insulin coverage for diabetes, wound dressing changes)
    - This may avoid placement in skilled nursing facilities for some patients who would otherwise meet criteria for such intervention
    - The cognitive impairment could be the result of an organic brain syndrome resulting from a substance use disorder (e.g. memory difficulties from hypoxic brain injury in setting of overdose)
    - Medical (as a broad term) complexity higher than participant in Level **3.5**
- ***Typical participants in Level 3.5:***
    - Have multiple limitations including addictive disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values
    - May have inadequate self-management skills including poor social skills, extreme impulsivity, emotional immaturity and/or antisocial value system
    - Some have MH conditions such as schizophrenia, bipolar disorder and major depressive disorder, and may have personality disorders (PD) such as borderline and antisocial PDs
    - May need more habilitative treatment rather than rehabilitative treatment focus
    - Treatment is directed to ameliorate health-related conditions through targeted interventions
    - Because treatment plans are individualized, fixed lengths of stay are inappropriate
- ***Typical participant in Level 3.7:***
    - Moderate to severe withdrawal risk, which can be safely managed at this LOC. No need for services of an acute general hospital.
    - Many have comorbid chronic medical problems that may or may not be well controlled or co-occurring mental health conditions or symptoms that may or may not be diagnosed or well managed.
    - A licensed physician and/or NP/PA oversees the treatment process and assures quality of care.

- Many participants receive addiction pharmacotherapy integrated with psychosocial therapies.
- With medical and nursing coverage, these programs can address certain chronic and subacute medical/psychiatric needs of participants that do not require the resources of an acute care hospital.

- ***Typical participants in Level 3.7WM:***
  - Moderate to severe signs or symptoms of withdrawal, which can be safely managed at this LOC. No need for services of an acute general hospital.

For more information please review the ASAM criteria (https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Additionally, providers who require technical assistance may request it from Trina Ja'far at trina.ja'far@maryland.gov.

5. **For patients who are already in treatment prior to the July 1 change-over date, how will their two 30-day yearly treatment episodes be calculated? For example, if a patient enters treatment on June 26 and is discharged on July 3, would that treatment episode be considered the first of their 2 yearly episodes as allowed by Medicaid? Or will episodes begin to be counted for patients admitted after (or on) July 1?**

   Individuals who meet medical necessity for the ASAM level of care for their existing stay as of July 1 will begin their first Medicaid reimbursable stay on July 1. That stay will continue through the end of their authorization for treatment and does count towards the first episode of care reimbursable under Medicaid.

6. **What are the requirements and steps to get recovery specialists certified?**

   Please note the requirements in the regulations have been adjusted to reflect that licensed practitioners or certified peer support may be utilized for aftercare services In order for a peer to be certified as a peer recovery specialist, the following steps must be taken.

   Training:

   a. The peer recovery specialist must obtain 46 hours of training. The required 46 hours are broken down into 4 domains

Hours Required	Domain
16	Ethical Responsibility
10	Advocacy
10	Mentoring and Education
10	Recovery and Wellness

   b. One Core Training is required (CCAR-Recovery Coach Academy, WRAP Facilitator Training, DBSA Peer Specialist Training, Intentional Peer Support)
   c. Training must have been obtained in the past 10 years
   d. Eligible trainings are offered by numerous agencies in Maryland (visit www.mapcb.wordpress.com/cps for updated agencies list)

e. In-service trainings provided by an agency are also eligible. Maximum in-service hours for the CPRS application is 12 hours of the 46 required
f. 5 hours of online training is eligible

Work/Volunteer Requirements:

a. Must be currently working or volunteering in a peer support role
b. 500 hours in a role of peer recovery support (within the past 2 years)
c. 25 hours of the 500 hours must be supervised and documented by a Registered Peer Supervisor (RPS) (www.mapcb.wordpress.com/cprs for RPS list)
d. Supervision must include 5 hours in each of the 4 training domains. 5 additional supervision hours are required and should include discussions regarding the peer's self-care
e. The 500 work/volunteer hours as well as the 25 supervision hours may be completed at multiple settings and under multiple supervisors but will require documentation from each

Application Process:

a. MABPCB's (Maryland Addictions and Behavioral-health Professional Certification Board) website had the full application to download (www.mapcb.wordpress.com/cprs)
b. There is a $100 application fee to initiate the certification process
c. Request high school/GED or college transcripts to be sent directly to MABCPB
d. Request 3 Recovery References to be sent directly to MABPCB and complete the Recovery Reference form on application
e. Submit signed letter(s) from employer(s) on letterhead verifying 500 work/volunteer hours
f. Complete Education/Training Form along with all copies of training certificates

Application Approval:

a. Once documents are verified, dates for the exam will be emailed out to applicant
b. Applicant must schedule a day and time to sit for the certification exam
c. Applicant will be certified upon passing the examination
d. Certified Peer Recovery Specialist will receive a certificate with certification number via mail

7. Will Beacon offer trainings specifically on the completion of Residential Authorizations?

Beacon is offering webinar trainings specific to Beacon's system and Adult Residential SUD Providers beginning on 6/19/17. Please see the schedule and registration links below.

- 6/19/17 2:00 pm – 3:30 pm Register here: https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=td74e8bebf13b74e6f8a3c8af23934f3b
- 6/20/17 12:00 pm – 1:30 pm Register here: https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t0a9ad08c4adcfef21b4fc2e5d40354d5
- 6/21/17 10:00 am – 11:30 am Register here: https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t942e4376992255b268cd3df725ec5e72

- 6/23/17 2:00 pm – 3:30 pm Register here: https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t1ff87aa82fefa97bdb42c283616b089b
- 6/26/17 10:00 am – 11:30 am Register here: https://beaconhealthoptions.webex.com/beaconhealthoptions/k2/j.php?MTID=t1ff87aa82fefa97bdb42c283616b089b

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 6

June 23, 2017

IMPORTANT!! PROGRAMS WHO CURRENTLY HAVE INDIVIDUALS IN THEIR CARE: YOU MUST SUBMIT YOUR APPLICATION TO MEDICAID TO BE ENROLLED AS A PROVIDER TYPE 54 IN ORDER TO OBTAIN AUTHORIZATIONS.

*****Please get your applications to: mdh.bhenrollment@maryland.gov to initiate this process. Applications received after 6/26 may not be able to obtain authorizations or payment for services on 7/1/2017.*******

1. **How will providers bill for residential SUD for adults?**

   Providers will bill a daily rate for the level of care provided and on the second line bill the room and board code. Providers CANNOT bill date spans. All days must be billed individually.

   Find the appropriate procedure codes and rates below:

ASAM Level	Billing code	Daily rate
Level 3.3	W7330	$189.44
Level 3.5	W7350	$189.44
Level 3.7	W7370	$291.65
Level 3.7WM	W7375	$354.67
Room and Board	RESRB	$45.84

   Example: For a level 3.5 stay (meeting MNC and authorized), providers should bill as follows for each date of service:

Date of Service	Billing Code	Daily Rate
7/1/2017	W7350	$189.44
7/1/2017	RESRB	$45.84
7/2/2017	W7350	$189.44
7/2/2017	RESRB	$45.84
7/3/2017	W7350	$189.44
7/3/2015	RESRB	$45.84

2. **Some providers have indicated that they are experiencing delays in obtaining new NPI numbers that may cause them not to be able to acquire them in time to include with the**

Residential SUD Medicaid application, due June 26th. What could be done should this indeed turn out to be the case?

Providers should submit their applications to mdh.bhenrollment@maryland.gov as soon as possible. The Department and Beacon Health Options will work with these providers on a case by case basis.

3. **Will there be training on submitting claims for Residential SUD services?**

   Please follow the directions provided in response to question #1 for information on how to bill for residential SUD for adults. Providers who have additional questions or are unfamiliar with billing Beacon may contact Beacon Health Options at 800-888-1965 or at Maryland.providerrelations@beaconhealthoptions.com

4. **After reviewing the most recent FAQs, it is still not clear to us why the staffing requirements are set up the way they are for 3.3 and 3.5 and what is meant by the descriptions of the needs of individuals in these levels of care?**

   While there are fewer clinical services at level 3.3 versus level 3.5, there is a medical component that is included in level 3.3. The identical rate for 3.3 and 3.5 is a reflection of the service shift from higher level of clinical need to higher level of medical need.

   For more information about ASAM levels of care please review the ASAM criteria (https://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria). Additionally, providers who require technical assistance may request it from Trina Ja'far at trina.ja'far@maryland.gov .

5. **Is all mental health counseling, including that which would normally be included in an outpatient mental health service, to be provided (or paid for) by the residential SUD provider as a part of the package of services included in the residential rate? Is there any outpatient mental health counseling that can be reimbursed separately from the residential SUD provider?**

   The residential SUD for adults rate is inclusive of all counseling and therapeutic services. Residential SUD providers are required per the proposed regulations and the Department's agreement with CMS to have licensed clinicians on staff. Counseling services may not be billed to Maryland Medicaid outside of the all-inclusive residential SUD for adults rate. Visits with a psychiatrist for a co-occurring psychiatric condition may be reimbursed separately.

6. **In reviewing the current process and forms for uninsured exceptions, it appears that the form may need to be revised. For example, there is no indication of level of care requested on the form. Also, will we be using the same eligibility criteria?**

The Behavioral Health Administration will update the form and follow-up with Beacon. Additional information will be shared before or during the June 28 transfer of grants meeting.

7. **When should providers request authorizations for those individuals who are currently in treatment and meet ASAM medical necessity criteria on July 1, 2017?**

   To reduce the administrative burden on providers for those individuals who are currently in treatment and the individuals continue to meet ASAM medical necessity criteria for residential treatment on or after 7/1/17, providers can request authorizations for those individuals during the following time-frames:

   - ASAM Level 3.7 and Level 3.7WM: Between 6/26/17 and **7/7/17**
   - All other levels including 3.5 and 3.3 Between 6/26/17 and **7/15/17**

   NOTE: **Programs must obtain prior authorization for individuals entering treatment on or after 7/1/17.**

   Providers must also be registered in the Beacon Health Options ProviderConnect system. If you are not sure if you have been registered, please send an email to: marylandproviderrelations@beaconhealthoptions.com .

8. **I have been entering data for the admissions to my residential program as instructed by Beacon/BHA for levels 3.3, 3.5 and 3.7. What do I do with those authorizations?**

   Beacon Health Options will discharge those authorizations on your behalf, so that you may receive an initial authorization starting 7-1-17 for the new residential program. From now until 7-1-17 you will no longer need to enter authorizations for data entry purposes.

9. **Update on 10.09.06 regulations:**

   10.09.06 regulations post in the Maryland Register (http://www.dsd.state.md.us/MDR/mdregister.html) today, June 23, 2017. The formal comment period begins, although the Department has been accepting comments already. Except for comments that require immediate clarification related to enrollment, all comments will be responded to after the close of the comment period (July 24). If you have already submitted a comment during the informal comment period, you do NOT need to re-submit the comment during the formal process. All comments received will be responded to.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 7

June 30, 2017

1. **If a patient transfers from one level of care to another within the same facility, is the provider required to request an authorization and enter the same information, even if it hasn't changed?**

   Yes. Authorizations are required for all residential substance use disorder services. When an individual changes level of care, a new authorization will be required. When a member transitions from one level of care to another, whether it is within the same provider's spectrum of services or a new provider, updated clinical information justifying reason for requested service, to include supporting ASAM criteria, must be provided at the time of the request.

2. **Our UR person will only be in the office on T-W-Th. If an admission comes in Thursday and he does not submit the authorization until Tuesday, will that be ok?**

   No. Providers must obtain authorization from Beacon Health Options prior to providing residential SUD services for adults. All services must be authorized in order for the provider to receive payment.

   Initial authorization requests for 3.7WM & 3.7 services can be submitted 24 hours prior to admission. Initial authorization requests for 3.3 & 3.5 services can be submitted up to 7 days prior to admission. Any staff with access to the required clinical information on the consumer can contact Beacon to complete the request telephonically or submit request electronically via Provider Connect. A Beacon clinician is available 24 hours per day/ 7 days a week to complete telephonic requests. Additionally, ProviderConnect can be accessed 24 hours per day/ 7 days a week for electronic submissions.

3. **What place of service (POS) should residential SUD providers use when submitting their claims?**

   Residential SUD for adults providers should use POS 55 for Residential Substance Abuse Treatment Facility.

4. **What is the list of approved Evidence Based Practices (EBPs)? Can you provide more information on what each EBP consists of?**

   All Residential SUD Treatment Providers are required to attest to providing a minimum of three of the EBPs listed and defined below as part of the Maryland Medicaid provider enrollment process. Subsequent provider site visits and audits will require demonstration of competence in

the provider's ability to deliver the EBPs attested to. This may include evidence of staff with continuing education units demonstrating training in the EBP or fidelity measurements of EBP implementation.

a) **Acceptance and Commitment Therapy (ACT)** is a contextually focused form of cognitive behavioral psychotherapy that uses mindfulness and behavioral activation to increase clients' psychological flexibility--their ability to engage in values-based, positive behaviors while experiencing difficult thoughts, emotions, or sensations. ACT has been shown to increase effective action; reduce dysfunctional thoughts, feelings, and behaviors; and alleviate psychological distress for individuals with a broad range of mental health issues.
b) **Cognitive Behavioral Therapy (CBT)** addresses harmful thought patterns, which help clients' recognize their ability to practice alternative ways of thinking, and regulates distressing emotions and harmful behavior. CBT is effective in treating SUDs.
c) **Medication Assisted Treatment (MAT)** is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
    a. Note that per ASAM all SUD providers should assess for the need and potential benefit for MAT, and if they do not provide it directly as an EBP, they should ensure referral to a provider who can or will.
d) **Motivational Enhancement Therapy (MET)** is an adaptation of motivational interviewing (MI) that includes normative assessment feedback to clients that is presented and discussed in a non-confrontational manner. MET aims to elicit intrinsic motivation to change substance abuse and other behaviors by evoking the client's own motivation and commitment to change, responding in a way that minimizes defensiveness or resistance.
e) **Motivational Interviewing (MI)** is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues.
f) **Psychoeducation** is designed to educate clients about substance abuse, and related behaviors and consequences.
g) **Psychotherapy** is a general term for treating behavioral health issues by talking with a psychiatrist, psychologist or other behavioral health professional.
h) **Relapse Prevention (RP)** focuses on the identification and prevention of high-risk situations in which a patient may be more likely to engage in substance use.
i) **Solution-Focused Group Therapy (SFGT)** is a strengths-based group intervention for clients in treatment for mental or substance use disorders that focuses on building solutions to reach desired goals. SFGT is an application of Solution-Focused Brief Therapy (SFBT) in a group setting. It emphasizes what the client wants to achieve through therapy rather and aims to build on the client's resources, strengths, and motivation.
j) **Supportive Expressive Psychotherapy (SE)** is an analytically oriented, time-limited form of focal psychotherapy that has been adapted for use with individuals with heroin and cocaine addiction. Particular emphasis is given to themes related to drug dependence, the role of drugs in relation to problem feelings and behaviors, and alternative, drug-free means of resolving problems. SE helps patients explore the meanings they attach to their drug

dependence and address their relationship problems more directly, thus allowing the patients to find better solutions to life problems than drug use.

k) **Trauma Informed Treatment** is an approach that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.

5. **What documentation is required for clinical services associated with residential SUD treatment for adults? Do we need to document the times of all the groups, description of the group and an individual note describing the person's performance in the group?**

   Review the documentation requirements outlined in the proposed regulations for residential SUD treatment for adults here: https://mmcp.dhmh.maryland.gov/Pages/residential-substance-use-disorder-treatment-for-adults.aspx. Programs must maintain adequate documentation of each clinical contact with a participant as part of the medical record, which includes at a minimum:

   a) An individualized treatment plan
   b) The date of all clinical encounters with start and end times and a description of services provided
   c) Documentation of all clinical services received by the participant
   d) Progress notes updated on each day services are provided
   e) An individualized discharge plan
   f) An official e-Signature or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate degree or title on all clinical progress notes

6. **How should the ASAM dimensions be properly documented to demonstrate medical necessity criteria?**

   Below are some examples of how the 6 ASAM Dimensions could be relayed to the Beacon clinical team for review and approval. All services must be authorized in order for the provider to receive payment. When submitting requests via ProviderConnect, document ASAM/ clinical rationale in the narrative text box found under the Current Risk tab similar to example below:

   > "Requesting 3.7WM services for this 36 yo male d/t high frequency of current substance use, severity of current withdrawal symptoms, severity of emotional and MH factors impacting SUD treatment, severity of motivational factors and deficits to recovery environment preventing engagement in treatment at ALOC. Refer to attachment for more information regarding ASAM criteria."

   Attached you will find a one-page worksheet to assist providers in documenting the ASAM criteria for the appropriate residential level of care. This completed form should be uploaded to your authorization request as an attachment. An example of a completed form can be found below:

ASAM Six Dimensions Clinical Information

Please provide the clinical information in narrative form for each of the six ASAM Dimensions to support that dimension's rating as Low, Medium or High. These ratings are used to determine Risk and appropriate ASAM Level of Care.

Participant's Name: Member X

M# and DOB: M000000000

Date of Request: 7/1/2017

Dimension 1 (Acute Intoxication and/or Withdrawal Potential): (High) Consumer maintained 18 months of abstinence until December 2016. Using fifth of vodka and $80 heroin daily for past 6 months. Consumer had overdosed on heroin 3 weeks earlier and treated in ED at Univ of MD Hosp. Last used heroin and ETOH 6 hours ago and beginning to exhibit severe ETOH withdrawal symptoms;

Dimension 2 (Biomedical Conditions and Complications): (Moderate) HTN managed successfully with medication; however, mbr has not adhered to blood pressure regimen for past few weeks. Currently shows elevated vital signs.

Dimension 3 (Emotional, Behavioral or Cognitive Conditions and Complications): (High) Diagnosed with bipolar disorder and currently endorsing intermittent SI. Mbr hospitalized recently for inpatient psychiatric admission d/t command auditory hallucinations (AH) telling him to kill self. Mbr has not been adherent to psychotropic medications or OP f/u since discharge.

Dimension 4 (Readiness to Change): (Moderate) Presents in contemplative stage of change and currently shows moderate internal motivation for treatment. Recognizes detrimental impact of substance use on daily functioning. Participated in Vivitrol MAT during previous period of abstinence, then stopped treatment reporting "I want to do this myself and don't want this medicine to keep me clean." Comes to treatment now after family intervention blocked continued financial support and ability to live in their home d/t continued substance use.

Dimension 5 (Relapse, Continued Use or Continued Problem Potential): (High) Continues to use substances heavily with severe medical and social consequences. Reports loss of control over substance use and notes using increased amount of substances to prevent withdrawal or gain desired effect.

Dimension 6 (Recovery/Living Environment):(High) Mbr currently homeless, unemployed and denies lack of sober supports. Has been staying with substance using peer group for past week since being evicted from parent's home. Participated actively in 12 step recovery and worked with a sponsor during previous period of extended abstinence.

When completing requests telephonically, this same form can be used by the caller as a guide to provide the Beacon clinician with the necessary clinical information to justify the requested residential service.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 8

July 14, 2017

Staffing Grace Period Announcement:

The Department has extended the staffing grace period to 90 days from the implementation of the benefit such that all adult residential SUD programs must come into full compliance with all regulations no later than October 1, 2017. Providers must attest for the staffing they have at the time of their application regardless of whether they meet the full staffing requirements or not. Providers who are not in full compliance must demonstrate every effort to come into compliance with staffing by including a staffing recruitment plan with their initial application. These providers must also submit an additional attestation prior to October 1, 2017 attesting to meeting the full staffing requirements.

All programs must be licensed by OHCQ to qualify for enrollment with Medicaid. Applications are not back-dated. Programs are still responsible for all clinical and therapeutic requirements to meet ASAM level of care.

1. **In our EHR, we start a treatment plan when an individual enters treatment and add to it as an individual moves through the ASAM levels of care. Is this ok or do we need to complete a new treatment plan for each level?**

   The scenario described would be appropriate as long as the treatment plan is reviewed as the individual moves from one level to another. Treatment plans should be closely tied to the individual's short term goals for recovery which will generally change more as they move from one level to another as they move along the continuum of care; their long term goals may or may not change accordingly.

2. **If a patient is hospitalized and not physically sleeping at our program for multiple days, can we still bill for the room and board since the bed is being reserved for this patient?**

   Administrative days may be used for individuals admitted to a hospital for a brief period during a medical crisis. These situations will be handled on a case by case basis. Providers should contact Beacon Clinical Department at 800-888-1965 with specifics about their case to plan the care for the individual.

3. **Does clinical treatment have to be provided every day in order to bill for residential SUD treatment for adults? Do we need to have clinical staff on the weekends?**

Although residential SUD for adults is billed daily, the service requirements are based on a weekly service array. Providers must meet the requirements laid out in proposed COMAR 10.09.06 for the hours of therapeutic activities provided per week. All residential SUD for adults programs must have a staffing pattern that has the capacity for successful intakes and discharges on the weekends.

Residential Substance Use Disorder Treatment for Adults Frequently Asked Questions # 9

July 28, 2017

1. **What should the patient to counselor ratio be for group counseling provided in a residential SUD treatment for adults program? With larger groups the documentation requirements become burdensome.**

   Therapeutic group activities for adult residential SUD generally consist of no more than 12-14 individuals with one staff member. All clinical services must be documented in each individual record when facilitated by a licensed professional. Residential programs should be diverse in their therapeutic activities.

2. **Can a recovery coach, peer support, or direct care worker conduct a group as part of the weekly hourly service requirement?**

   A clinical group may only be led by individuals outlined in COMAR 10.09.59 (http://www.dsd.state.md.us/comar/comarhtml/10/10.09.59.04.htm). Additional types of groups may include relapse prevention to provide guidance on making choices, educational, occupational, recreational therapies, art, music, movement therapies, and vocational rehabilitation. Peers are a part of the treatment milieu and can provide groups related to their scope of practice.

3. **Are clients in ASAM Level 3.3 or 3.5 permitted to work while in treatment and still have Medicaid pay for their treatment?**

   It is up to the program to determine if the individual is able to maintain recovery while employed. The individual would need to be assessed as having no/low risk factors across all six ASAM dimensions and still meet MNC for this level of care in order for it to be appropriate for them to work while in treatment. Employment does not necessarily preclude someone from receiving a residential level of treatment. However, for Medicaid to reimburse for therapeutic services the individual must meet medical necessity criteria for that level of care and they must medically require the level of programming that is required for each of the levels of care.

   For ASAM level 3.3 at least 20-35 hours weekly (of combined treatment and recovery support services) are required and for ASAM level 3.5 a minimum of 36 hours weekly of therapeutic activities are required. These service requirements for the level of care must still be met by the program if the individual is employed. Based upon the ASAM criteria, it would be difficult to foresee situations where an individual would need this level of programming and be able to continue to work. Once an individual stabilizes, outpatient treatment and recovery housing is a more appropriate level of care.

4. **We understand that audits will require demonstration of competence in delivering the EBP attested to during the application process. We understand that we should document CEUs, but we need some guidance on how fidelity measurements of EBP implementation should be demonstrated.**

   Please find the list of approved EBPs below:
   a) Acceptance and Commitment Therapy (ACT)
   b) Cognitive Behavioral Therapy (CBT)
   c) Medication Assisted Treatment (MAT)
   d) Motivational Enhancement Therapy (MET)
   e) Motivational Interviewing (MI)
   f) Psychoeducation
   g) Psychotherapy
   h) Relapse Prevention (RP)
   i) Solution-Focused Group Therapy (SFGT)
   j) Supportive Expressive Psychotherapy (SE)
   k) Trauma Informed Treatment

   The program should have in its policies and procedures the types of EBP utilized for service delivery. The progress notes and treatment plan should provide evidence that the EBPs are being applied in clinical services. For example, if a provider is facilitating CBT, then it would be expected that in the chart there would be specific references to problematic thinking patterns, behaviors related to those thinking patterns, how this relates to the individuals' recovery process and ways to challenge these thinking patterns and behaviors. For a provider that is utilizing motivational interviewing, it would be expected that the charts will include discussions on the individuals' stage of change, motivators, and specific enhancement techniques that are being utilized to move the individual within the stages of change. Additionally, the personnel files of staff must contain evidence of Continuing Education training.

5. **Client John Doe enters treatment at our program, ASAM Level 3.3 on June 18 under grant funds. Grant funds expired June 30 and he was approved for Medicaid to fund Level 3.3 treatment for 30 days starting July 1. Since Level 3.3, under grant funding, did not require him to have a medical evaluation at the time of his intake on June 18, it was not done. Medicaid requires an initial medical evaluation on Medicaid-funded clients, but at the point Medicaid began paying for his treatment, he had been in ASAM Level 3.3 for 12 days. Does John Doe need a medical evaluation now to comply with Medicaid requirements?**

   Yes, an initial medical evaluation is required for Medicaid reimbursement. For patients that were in care prior to July 1st, providers should close the authorization and open a new one beginning July 1. With a new authorization a medical evaluation is required.

6. **Since all clinical treatment happens in our program from Monday-Saturday, there are no clinical notes entered on Sundays. Our clients are still in group, but no clinical notes are**

entered. Can we bill just the room and board charge or do we need to have a clinical note in conjunction with the room and board?

Providers must document for the dates on which the service occurred and can never be backdated. Although the daily rate is billed for therapeutic services and room and board, the service hours are based on a weekly minimum and documentation should reflect a service array that contributes towards that minimum. Service arrays include combinations of counseling led by licensed or certified providers, as well as symptom reduction activities which may be led by certified and/or experience based providers and recovery activities that assist individual in moving through the continuum of care towards treatment in their community environment. Programs must document in each individual's chart to indicate that the minimum number of service hours per level of care has been met in order to bill for the therapeutic services.

7. **I need some clarification for claims submissions. What is the difference between a PT 54 and a PT 55? What forms do we use to submit claims? What place of service do we use to bill?**

Programs enrolled as provider type 55 render residential SUD services for individuals under 21 and are covered under COMAR 10.09.23. This provider type bills revenue codes on a UB-04 form. The PT 55 has been a provider type under Medicaid for several years. No changes were made to this provider type.

The adult residential SUD benefit is Provider type 54. 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 for Intermediate Care Facility. POS 55 is for Residential Substance Abuse Treatment Facility. Both places of service are accurate and it is up to the provider to select which place of service applies to your facility.