

**HealthChoice Substance Abuse Treatment Self-Referral Protocols – in ASAM Order
Substance Abuse Improvement Initiative (SAII)
April 2005**

Billing Codes: Sub Abuse TX & Procedure Codes	ASAM Level	If patient presents for:	Minimum number of days or visits automatically approved	Provider Communication responsibility (phone, fax)	MCO/BHO Communication and Feedback responsibility	Notes or Comments	Medicaid/HealthChoice Coverage
0919 or H0014 H0012, H0013	I-Outpatient Services	Ambulatory detox By an ICF-A	Minimum of five days will be paid	Within 72 hours of admission to detox program or service, provider submits a verbal or written treatment plan to the MCO or BHO.	MCO or BHO liaison will respond to provider within 48 hours. Confirmation number will be provided.	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of five (5) days will be automatically approved. If the MCO does not respond to the call, up to five days will be paid without contention.	Medicaid covers for as long as medically necessary.
90801, 90804- 90809, 90847, 90853, 90857. H0005-H0007, H0016, H0022, H2035, H2036 T1006, T1007, T1012 Out of network Local Health Departments (LHDs) use 90899 for individual and 90899.HQ for group services.	I-Outpatient Services	Individual, family and group therapy, and all other traditional outpatient services	30 sessions within six months per episode of care (see comments - end of row)	Within 72 hours, notify MCO or BHO by either faxing in the first page of the Initial Treatment Plan or telephoning in the information. Treatment plan will be submitted within 24 hours after the fourth session.	MCO or BHO liaison will respond to provider within 48 hours. Confirmation number will be provided.	An episode of care lasts for six months. If there is a break in services for more than 30 days, treatment is considered terminated, or ended. The next visit after the 30-day break would be considered a new episode of care, and requires a re-notification and authorization process.	Medicaid pays for individual and group counseling for as long as medically necessary. The service is delivered to the enrollee, who must be present for an appropriate length of time but not need 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 enrollee.
0906 and H0015 preferred, but 0919, 0944, and 0945 accepted. Out of network LHDs use 90899.HQ .	II-Intensive Outpatient	IOP – intensive outpatient	30 Calendar Days without pre- certification	Within 72 hours of admission, the provider submits a verbal or written Treatment Plan to the MCO or BHO. At the end of week three, the provider notifies the MCO of the discharge plan or the need for additional, continued treatment.	MCO or BHO liaison will respond to provider within 48 hours with confirmation number.	While this service is only covered (by Medicaid) for pregnant women and children under 21; some MCOs cover this service for all members, regardless of age. Medicaid does not compensate the MCOs for rendering services to those members.	Covered only for children and adolescents under age 21 and pregnant and postpartum women for as long as medically necessary and the enrollee is eligible for the service. Postpartum means within eight weeks of delivering a child. Adolescents under 18 receive a maximum of 9 (nine) hours per week, decreasing to a minimum of 6 hours per week. Pregnant and postpartum women receive a maximum of 20 hours per week, decreasing to a minimum of 6 hours per week. This is not a Medicaid covered service for individuals older than 21 or who are not pregnant or postpartum. However, an MCO or BHO, at its discretion, might choose to cover it.

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911, 912	II- Partial Hospital- ization	Partial hospitalization (adults and children)	2 day minimum guaranteed	By morning of second day of admission, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider will submit progress report <i>and</i> assessment for justifi- cation of continued stay beyond day five. Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.	MCO or BHO liaison will respond to providers within 2 hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	Providers will aim for the least restrictive level of care. If the client does not qualify for partial hospitalization, the BHO will work with the provider to determine the appropriate level of care. If ASAM is met, and MCO/BHO has provided confirmation or authorization, an additional three days will be automatically approved. If the MCO does not respond to the call, three additional days will be paid without contention.	Medicaid reimburses this service only when it occurs in a hospital.
0123, 0124, 0126, 0136, 0138, 1002 Out of network LHDs use 90899.	III- Residential and Inpatient	ICF-A (under 21) Pre-authorization required.	Requires ASAM assessment	Within 2 hours, provider calls MCO or BHO for authorization, using a beeper or special phone number.	MCO/BHO liaison will respond to provider within 2 hours with a final authorization or disposition. RN or MD can be empowered to make the decision. MCO/BHO must have 24/7 availability.	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of three days will be automatically approved. If the MCO does not respond to the urgent call, up to three days will be paid without contention. If the client does not qualify for ICF-A, the BHO will work with the provider to determine the appropriate level of care.	Covered only for children and adolescents under age 21 for as long as medically necessary and the enrollee is eligible for the service. (This service is available to parents over 21, but MCOs are not responsible for the cost.) Medicaid does not pay for these services if they are not medically necessary, even if a Court has ordered them.
H0020 Out of network LHDs use 90899.HG.	Opioid Maintenance Treatment	Methadone	13 weeks initially, then an additional 13 weeks following submission of treatment plan (total is 26 weeks to start)	Within 72 hours of admission, provider notifies MCO or BHO by either faxing in the first page of the Initial Treatment Plan or telephoning in the information. Next approvals will be at six-month intervals.	MCO or BHO will respond to provider within 48 hours. Confirmation number will be provided. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	The provider will submit treatment plan to the MCO by the 12 th week of service.	Medicaid coverage determined by medical necessity. Unit of service is one week.
0126, 0128, 0136 0138, H0008, H0009, DRGs 433-437 H0010, H0011	IV-Medically Managed Patient Or III.7.D- Inpatient Detox in	Inpatient detox in an inpatient setting Or Inpatient detox in a rehabilitation or ICF-A facility	Requires ASAM assessment	Within 2 hours, provider calls MCO or BHO for authorization, using a beeper or special phone number.	MCO or BHO will respond to provider within 2 hours with a final authorization or disposition. RN or MD can be empowered to make the decision.	If ASAM is met, and MCO/BHO has provided confirmation or authorization, a LOS of three days will be automatically approved. If the MCO does not respond to	

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	other settings	Pre-authorization required.			MCO/BHO must have 24/7 availability.	the urgent call, up to three days will be paid without contention. If the client does not qualify for inpatient detox, the BHO will work with the provider to determine the appropriate level of care.	

Ground Rules

- All communication between providers and MCOs or BHOs will be via phone, fax or email. Additional information is needed regarding confidentiality protections for the patient if email is used (i.e. use of passwords or identification via Medicaid ID number rather than member name)
- ASAM criteria will be used to assess need for all levels of service.
- If the enrollee presents to a non-network provider, the provider is not required to provide treatment. However, the provider will notify the enrollee's MCO/BHO that its enrollee is seeking substance abuse treatment.
- Within 10 days of discharge or release from treatment, the substance abuse treatment provider will send a discharge summary to the MCO or BHO.
 - Within 10 days of discharge or release from treatment, the substance abuse treatment provider, having obtained the patient's consent, will send a discharge summary to the PCP.

☞ **Note:** MCOs/BHOs stress the importance of speedy notification when their enrollees complete treatment or leave treatment prematurely. Providers should contact the MCO/BHO immediately rather than wait until they complete discharge summaries.
- The following guidelines are for when to report to the appropriate MCO (see last column of Attachment 2) should be used when an enrollee either fails to keep appointments or is noncompliant:
 - A provider should report to the appropriate MCO within two business days any Medicaid enrollee who fails to appear for an intake or assessment appointment.
 - A provider should report to the appropriate MCO within two business days any enrollee who misses two consecutive counseling appointments.
 - A provider should report to the appropriate MCO any enrollee who in the provider's judgment shows a pattern of inconsistent attendance even though the enrollee has not missed consecutive appointments.
- Out-of-network providers will be reimbursed at the Medicaid fee-for-service rate for the service and provider type.
- All providers, MCOs and BHOs will use standard HealthChoice/DHMH forms (Attachments 3a-e).
- Please refer to the attached document for the procedures that must be adhered to for Continued Stay with ICF-As.
- If all of the communication and response timeframes have been met, there will be no retrospective denials of care for the minimum number of days or services. Furthermore, the providers and managed care organizations agree to the following "IF-THEN" Scenarios for notification and payment responsibilities

Notification and Response Scenarios...	Result	And
If the provider does not meet the agreed upon notification timeline.....	Then the MCO or BHO is not responsible for the cost of treatment on those days	The provider may bear the cost for those unauthorized days or services (rendered before they contacted the MCO or BHO)
If the MCO does not meet the agreed upon response timelines.....	Then the MCO will reimburse the provider for those services or days of care in accordance with the policy guidelines.	
If the provider contacts the MCO after the agreed upon time lines.....	Then the MCO is financially responsible for services approved for the remaining period of time or number of units.	The MCO or BHO has the option of paying for the first unauthorized days or units of services on a case by case basis

Footnotes

- Days or Hours used in descriptions of the communication and response timeframes are intended to mean Business Days and Business Hours. The exception to this is that MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute.

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2. MCOs/BHOs will honor substance abuse authorizations for all services made by an enrollee's previous MCO provided the ASAM level of care is met and there is no break in service. The provider must submit written verification of this authorization to the new MCO within 72 hours of receiving it from the previous MCO.
3. MCOs pay the full FQHC per visit rate for services rendered on and after January 1, 2005, except Three Lower Counties will receive \$64.66 from the MCOs and a supplemental payment from the DHMH.
4. A comprehensive substance abuse assessment is considered part of treatment and is not generally separately reimbursable. However, separate reimbursement is permitted in the following circumstances:
 - *Provider determines that enrollee does not need substance abuse treatment.* Bill using CPT Code 90801 (except for Local Health Departments using 90899), with diagnostic code 799.9 to indicate "no diagnosis/diagnosis" referral.")
 - *Provider does not offer level of care that the enrollee requires.* Bill using CPT Code 90801 (except for Local Health Departments using 90899). Notify the enrollee's MCO/BHO with information on the appropriate level of care and appropriately document the referral on the UB 92 or HCFA 1500 form.
 - *Provider conducts assessment but enrollee does not return for treatment.* Bill using CPT Code 90801 (except for Local Health Departments using 90899),

☞ **Note:** *MCOs are not required to pay for more than one self-referred assessment for an enrollee per year.*

☞ **Note:** HealthChoice regulations require the use of the Problem Oriented Screening Instrument for Teenagers (POSIT) for enrollees under age 20 and the Addiction Severity Index (ASI) for enrollees age 20 and older, as well as a placement appraisal to determine the appropriate level and intensity of care for the enrollee-based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration.
5. Proof of notification will be the faxed confirmation sheet and/or a documented phone conversation (date, time and person spoken to).
6. The postpartum period is 8 weeks.
7. "One session" means a face-to-face meeting with a provider.

C: SubsAbuse\SAII\Documents\Attach1 March 28, 2005