

Summary of HealthChoice Substance Use Disorder Treatment Self-Referral Protocols – in ASAM Order

April 2013

Billing Codes: Sub Use Disorder TX & Procedure Codes	Provider Communication Responsibility	MCO/ASO Communication Responsibility	Approval Criteria
H0001	NA	NA	A Managed Care Organization (MCO) or the Behavioral Health Organization (BHO) which administers the substance use disorder services for certain MCOs will pay for a Comprehensive Substance Use Disorder Assessment once per enrollee per provider per 12-month period, unless there is more than a 30-day break in treatment. If a participant returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.
H0014 for community-based providers using CMS 1500 0944 and 0945 revenue codes for facility-based providers using UB-04	Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.	MCO or BHO liaison will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation number if approved.	<ol style="list-style-type: none"> 1) If MCO/BHO does not respond to provider's notification, MCO/BHO will pay up to five (5) days. 2) If MCO/BHO responds by approving authorization, a LOS of five (5) days will automatically be approved. Additional days must be preauthorized as meeting medical necessity criteria. 3) If MCO/BHO determines client does <u>not</u> meet ASAM LOC, MCO/BHO will pay for care up to the point where they formally communicate their disapproval.

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<p>H0004 for individual or family therapy</p> <p>H0005 for group therapy</p>	<p>Provider must notify (by fax or email) MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services</p>	<p>MCO or BHO liaison must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.</p>	<p>MCO/BHO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client.</p> <p>Any other individual or group therapy services within the 12-month period must be preauthorized. Medicaid MCOs/BHOs will pay for additional counseling services as long as deemed medically necessary.</p> <p>In order for a provider to bill for family counseling, the enrollee must be present for an appropriate length of time, but does not need to be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the enrollee. Family therapy is billed under the individual enrollee's Medicaid number.</p>
<p>H0015 for community-based providers using CMS 1500</p> <p>0906 revenue codes for facility-based providers using UB-04</p>	<p>Provider must notify and provide treatment plan to MCO (by fax or email) within three (3) business days of admission to IOP. If they do not notify, they will not be paid for services rendered.</p>	<p>MCO or BHO liaison will respond to provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.</p>	<p>If the treatment plan is approved, MCO/BHO will pay for 30 calendar days of IOP. At the end of week three (3), for care coordination purposes, the provider must notify the MCO of discharge plan or need for remaining treatment. Continuing treatment beyond the 30 days must be preauthorized as being medically necessary.</p> <p>If determined that client does not meet ASAM LOC, MCO/BHO will pay for all services delivered up until the point that they formally notify the provider of the denial. If the client does not qualify for IOP, the MCO/BHO will work with the provider to determine the appropriate level of care.</p>

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0912 and 0913 revenue codes for facility-based providers using UB-04	<p>By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone.</p> <p>Provider must submit progress report and assessment for justification of continued stay beyond day five (5).</p> <p>Provider obtains participant consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.</p>	<p>MCO or BHO liaison will respond to providers within two (2) hours of review. Confirmation number will be provided.</p> <p>MCO/BHO must have 24/7 availability for case discussion with provider.</p>	<p>1) Two (2) day minimum guaranteed. If ASAM is met, MCO/BHO will authorize an additional three (3) days. Any additional days must be preauthorized by the MCO based on medical necessity.</p> <p>2) If the MCO/BHO is <u>not available or does not respond</u> to provider within two (2) hours, they will pay the extra three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity.</p> <p>Providers shall provide the least restrictive level of care. If the client does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.</p>
Providers should speak to MCOs/BHOs about appropriate codes to use within their billing systems	Within two (2) hours, provider calls MCO or BHO for authorization.	<p>MCO/BHO liaison will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved.</p> <p>MCO/BHO must have 24/7 availability.</p>	<p>1) If MCO <u>does not</u> respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized.</p> <p>2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized.</p> <p>3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.</p>

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H0020	<p>Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan.</p> <p>The provider will submit an updated treatment plan to the MCO/BHO by the 12th week of service to promote the coordination of care.</p> <p>Next approvals will be at six-month intervals.</p>	<p>MCO or BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation/ authorization number if approved.</p> <p>The provider will inform the PCP that participant is in treatment after obtaining the participant 's consent.</p>	<p>If approved, MCO/BHO will pay for 26 weeks under the self-referral option.</p> <p>Continued eligibility for coverage will be determined by medical necessity.</p> <p>Additional approvals beyond the first 26 weeks will be at six-month intervals.</p> <p>Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO.</p>
0126 and 0136 revenue codes for facility-based providers	<p>Within two (2) hours, provider calls MCO/BHO for authorization.</p>	<p>MCO or BHO will respond to provider within two (2) hours with a final disposition, including confirmation number if approved.</p> <p>MCO/BHO must have 24/7 availability.</p>	<p>If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized as medically necessary.</p> <p>If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.</p> <p>If an MCO/BHO does not respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized as medically necessary.</p>

Footnotes

1. MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute.
2. MCOs/BHOs will honor substance use disorder authorizations for all services made by an enrollee's previous MCO provided the ASAM level of care continues to be 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.
4. An MCO/BHO may not require a peer-to-peer review for a pre-certification in cases where the participant is new and has not been seen by the provider's physician.
5. An MCO/BHO may not require written approval from a commercial insurer before deciding on a preauthorization in cases where the participant has dual insurance.
6. Proof of notification is the faxed confirmation sheet and/or a documented phone conversation (date, time and person spoken to).
7. "One session" means a face-to-face meeting with a provider.
8. For providers, there is a period when an individual becomes eligible for Medicaid but is not yet enrolled in an MCO. Check the Eligibility Verification System (EVS) to determine the person's status. For information about the EVS, call (410) 767-5503.
☞ Note: HealthChoice regulations require the use of 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 for most services covered under this protocol.

Department of Health and Mental Hygiene website: <http://dhmh.maryland.gov/SitePages/Home.aspx>

DHMH Provider Hotline: 1-800-766-8692 Or call the **Complaint Resolution Unit** at 1-888-767-0013 or 410-767-6859 from 8:30 AM to 4:30 PM Monday - Friday

MCO/BHO ELECTRONIC BILLING INFORMATION

MCO (BHO)	Status/Procedure
AMERIGROUP	<p>Available with no transaction costs, but setup fees might be charged. Following is contact information to obtain software.</p> <p>Emdeon (formerly WebMD) 1-877-469-3263 Option 3 - AMERIGROUP Payor ID: 27517 MedAdvant (formerly ProxyMed) 1-800-586-6870 - AMERIGROUP Payor ID: 28807</p> <p>For issues with electronic transmission from a Clearinghouse to AMERIGROUP, call AMERIGROUP's EDI Support line at 1-800-590-5745</p>
JAI MEDICAL SYSTEMS	<p>Electronic billing is available through ClaimsNet. Please visit the ClaimsNet website at www.claimsnet.com/jai to register. If you have any technical problems, please contact helpdesk@claimsnet.com. Payor ID: JAI01</p>
MD PHYSICIANS CARE	<p>Emdeon WebMD 800-735-8254, Ext. 17903 MD Physicians Care Payor ID: 22348 ProxyMed 888-894-7888 MD Physicians Care Payor ID: 00247</p>
MEDSTAR FAMILY CHOICE (Value Options)	<p>Providers can access the electronic data interchange (EDI) by downloading the software from www.valueoptions.com/providers/ProCompliance.htm or requesting a CD through VO's EDI Helpdesk 1-888-247-9311 or email: e-supportServices@ValueOptions.com</p>
PRIORITY PARTNERS	<p>JHHC accepts claims from Emdeon (WebMD) and Payer Path (Relay Health). If interested in submitting electronically to JHHC, please contact ProviderRelations@jhhc.com. Upon receipt of your interest e-mail, a member of the EDI Task Force will contact you.</p>
RIVERSIDE HEALTH OF MARYLAND (Value Options)	<p>Providers can access the electronic data interchange (EDI) by downloading the software from www.valueoptions.com/providers/ProCompliance.htm or requesting a CD through VO's EDI Helpdesk 1-888-247-9311 or email: e-supportServices@ValueOptions.com</p>
UNITEDHEALTHCARE (United Behavioral Health)	<p>Network providers can submit bills and members can submit claims on line at www.ubhonline.com. Facilities and large groups can submit electronically via third party vendors such as WebMD, etc.</p>

Office of Health Services
 Department of Health and Mental Hygiene
 February 25, 2014

**TIME LIMITS FOR SUBMISSION AND RESUBMISSION OF CLAIMS TO HEALTHCHOICE
MANAGED CARE ORGANIZATIONS AND THEIR BEHAVIORAL HEALTH
ORGANIZATIONS Information Provided by MCOs and BHOs**

<p>Amerigroup Submission of Claims:</p> <ul style="list-style-type: none"> • 180 days to submit clean claims. • Administrative appeals must be submitted within 90 days of the date on the EOP.
<p>Jai Medical Systems Submission of Claims:</p> <ul style="list-style-type: none"> • 180 calendar days from the date of service. <p>Resubmission/Appeal:</p> <ul style="list-style-type: none"> • 180 calendar days from the Explanation of Payment date.
<p>Maryland Physicians Care Submission of Claims:</p> <ul style="list-style-type: none"> • Claims must be submitted within 180 days from the date of service. <p>Coordination of Benefits:</p> <ul style="list-style-type: none"> • MPC is a secondary payer to all other parties. If there is third-party coverage for a member, the provider shall identify and seek payment from any third party obligated to pay for Member's health care services before submitting claims to MPC. <p>Resubmissions:</p> <ul style="list-style-type: none"> • Claim resubmissions must be submitted within 90 days from the date of denial. <p>Appeals:</p> <p>Providers have 90 business days from the date of claim denial to file an appeal.</p>
<p>MedStar Family Choice (Managed by ValueOptions) Submission of claims:</p> <ul style="list-style-type: none"> • 180 calendar days from the date of service. <p>Resubmissions:</p> <ul style="list-style-type: none"> • 90 calendar days from the Explanation of Payment/Denial date.
<p>Priority Partners Submission of Claims:</p> <ul style="list-style-type: none"> • Claims must be submitted within 180 days from the date of service. <p>Resubmission:</p> <ul style="list-style-type: none"> • Administrative Appeals must be submitted within 90 working days from the date of the denial.
<p>Riverside Health of Maryland (Managed by ValueOptions) Submission of claims:</p> <ul style="list-style-type: none"> • 180 calendar days from the date of service. <p>Resubmissions:</p> <ul style="list-style-type: none"> • 90 calendar days from the Explanation of Payment/Denial date
<p>UnitedHealthcare (Managed by United Behavioral Health) Submission of claims:</p> <ul style="list-style-type: none"> • Participating and nonparticipating providers, 180 days from the date of service. <p>Resubmissions:</p> <ul style="list-style-type: none"> • Participating providers, 365 days, as long as no more than 18 months from the date of service. Timely filing is waived with retroactive authorizations and if the claim was denied incorrectly by UBH • Non-participating providers, 365 days, as long as no more than 18 months from the date of service.

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