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.