HEALTHCHOICE MANUAL

FOR

PROVIDERS

OF

SELF-REFERRAL

AND

EMERGENCY SERVICES

August 2010

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INTRODUCTION

PURPOSE

The purpose of this manual is to assist health care providers to identify circumstances under which HealthChoice members may obtain "self-referral" services from an **out-of-plan provider** and to provide guidance on submitting claims to the member's Managed Care Organization.

HealthChoice is the name of Maryland's Medicaid Managed Care Program that was implemented in June of 1997. Under this program, the majority of Medical Assistance recipients receive their benefits through a managed care organization (MCO). There are currently seven MCOs serving Medicaid recipients in Maryland:

*AMERIGROUP, Maryland Inc.
*Diamond Plan/Coventry
*Helix Family Choice
*Jai Medical System
*Maryland Physicians Care
*Priority Partners
*UnitedHealthcare

DEFINITION

Self-referral services as defined in the HealthChoice regulations, Maryland Medicaid Managed Care Program, COMAR 10.09.62, are ***"health care services for which under specified circumstances, the MCO is required to pay, without any requirement of referral by the primary care provider (PCP) or MCO when the enrollee accesses the service through a provider other than the enrollee's PCP."***

While MCO members are required to use in-network providers for most medical services, under certain circumstances, MCOs are responsible for some out-of-network care received by their members. These circumstances and payment requirements are defined in COMAR 10.09.67.28 under Benefits-Self-Referral Services and COMAR 10.09.65.20 under MCO Payment for Self-Referred Emergency and Physician Services.

The circumstances under which MCOs must pay for out-of-network care can be classified into three types:

- Self-referral provisions for all MCO members;
- Continuity of care for new MCO members; and
- Emergency care provisions.

A "classic" example of a self-referral provision is the ability of all MCO members to access family planning services from the provider of their choice.

RESPONSIBILITIES OF MEMBERS AND PROVIDERS

When seeking care without an MCO/PCP referral or authorization for a "self-referral" service, HealthChoice members should present their MCO card to the provider. The MCO is required to have the member's Medical Assistance number on the MCO card. Self-referral providers should call the Eligibility Verification System (EVS) at 1-866-710-1447 prior to rendering care. To use this system you must have a Medicaid provider number.

ELIGIBILITY VERIFICATION SYSTEM

The Maryland Medicaid Eligibility Verification System (EVS) is a telephone inquiry system that enables health-care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status.

A Medical Assistance card alone does not guarantee that a recipient is currently eligible for Medicaid benefits. You can call EVS to quickly verify a recipient's eligibility status. **To ensure recipient eligibility for a specific date of service, you must use EVS prior to rendering service.**

EVS is fast and easy to use, and is available 24 hours a day, 7 days a week. EVS requires only seconds to verify eligibility and during each call you can verify as many recipients as you like.

EVS is an invaluable tool to Medicaid providers for ensuring accurate and timely eligibility information for claim submissions.

Providers may download the EVS/IVR user brochure, which contains additional details about the new system, by accessing the Department's website at www.dhmh.state.md.us/medcareprog.

For providers enrolled in eMedicaid, WebEVS, a web-based eligibility application, is available at www.emdhealthchoice.org. Providers must be enrolled in eMedicaid in order to access WebEVS. To enroll and access WebEVS go to URL above, select 'Services for Medical Care Providers', and follow the login instructions. If you need information, please visit the website or for provider application support call 410-767-5340.

If you have questions concerning the new system, please contact the Provider Relations Division at 410-767-5503 or 1-800-445-1159.

WHAT YOU NEED

1. A touchtone phone
2. The EVS access telephone number

3. Your Medicaid provider number
4. The recipient Medicaid number and name code (or social security number and name code)

HELPFUL TIPS

You must press the pound key twice (##) after entering data requested in each prompt.

If you make a mistake, press the asterisk (*) key once. EVS disregards the incorrect information and repeats the prompt.

If you do not enter data within 20 seconds after a prompt, EVS re-prompts you. If you fail to enter data after the second prompt, EVS will disconnect the call.

If you need to hear a verification a second time, press "1" and the information will be repeated. Press "2" in order to enter the next recipient's information.

To end the call you must promptly press the pound key twice (##). Otherwise, your phone line will remain in service for 20 seconds allowing no other incoming calls.

EVS provides current information up to the previous business day. **Please listen closely to the entire EVS message before ending the call** so that you don't miss important eligibility information.

The EVS message will give you the name and phone number of the recipient's managed care organization (MCO), if he or she is enrolled in "HealthChoice". If the recipient is a member of an MCO, you can press "3" and the call will be transferred directly to the MCO's call center to verify Primary Care Physician (PCP) assignment.

For a recipient in a facility, provider will be given the name and phone number of the facility.

The EVS message for recipients that have Medicaid and are "fee-for-service" (not enrolled in HealthChoice) is "eligible, federal, MCHP".

The EVS message for women in the Family Planning Program is eligible, federal, family planning only".

If you have questions about the different types of eligibility, call the MCHP and Family Planning Program at: 800-456-8900.

If you need further assistance with EVS, call Provider Relations Monday-Friday between 8:00a.m. and 5:00p.m. at 410-767-5503 or 800-445-1159.

HOW TO USE EVS

Call the EVS access telephone number by dialing:

1-866-710-1447

Enter your 9 digit provider number and press the pound key twice (##)
Example: 012345678#

For **current eligibility** enter the 11 digit recipient number and the 2-digit name code (the first two letters of the last name converted into numeric touchtone numbers) and press the pound key twice (##).
Example: For recipient Mary Stern, you would enter:

11223344556 (recipient ID number) and **78##** (7 is for "S" in Stern and 8 is for "T" in Stern)

NOTE: Since the characters Q and Z are not available on all touchtone phones, enter the digit 7 for the letter Q and digit 9 for the letter Z.

EVS will respond with current eligibility information or an error message if incorrect information has been entered.

For **past eligibility** you can search a recipient's past eligibility status for up to one year. To do a search of past eligibility, enter a date of up to one year using the format **MMDDYYYY**
Example: For recipient Mary Stern, where the date of service was January 1, 1995, you would enter:

11223344556 (recipient ID#) AND **78** (last name code) and **01011995#** (service date)

Past eligibility can be obtained by entering the recipient's social security number, name code and date of service.

EVS will respond with eligibility information for the date of service requested or an error message if incorrect information was entered.

NOTE: Should you enter the date incorrectly, EVS re-prompts you to re-enter only the date up to 3 consecutive times. However, at the prompt, you can return to the "ENTER RECIPIENT NUMBER AND NAME CODE" prompt by entering "9" and pressing the pound key twice (##).

If the recipient's number is not available: At the recipient number prompt, press "O" and press the pound key twice (##). In this case, EVS prompts you with the following: "ENTER SOCIAL SECURITY NUMBER AND NAME CODE".

Example: 111223334 (SSN) and **78##** (last name code)

Note: Social Security Numbers are not on file for all recipients. If the Social Security Number is not on file, eligibility cannot be verified until the Medical Assistance number is obtained. If you have entered a valid SSN and the recipient

is currently eligible for Medical Assistance, EVS will provide you with a valid recipient number, which you should record, and recipient's current eligibility status.

To continue checking eligibility for additional recipients, enter another recipient number or immediately press the pound key twice (##) to end the call.

It is important to end the call by pressing the pound key twice (##) to free both your phone line and the EVS line for the next caller.

- If EVS indicates that the recipient is eligible for Medical Assistance on the date of service, but is not enrolled in an MCO, the provider must bill the Medical Assistance Program for the service rendered. In this case, self-referral provisions in this manual do not apply and the provider must follow all established Medicaid fee-for-service policies.

- If EVS says the recipient is enrolled in an MCO on the date of service, and a self-referral service was rendered, as described in this manual, the provider must bill the MCO for the self-referral service.

- For additional information about the EVS call the Medical Assistance Provider Relations Unit at (410) 767-5503 or 800-445-1159.

When the recipient is enrolled in an MCO the provider of a self-referral service should establish communication with the primary care provider (PCP). Look at recipient's MCO card, ask the member for the name of their PCP or, if necessary, call the MCO to determine the name of the PCP (as this information is not on EVS).

Providers of "self-referral" services need to be familiar with the scope and frequency of services allowed under the self-referral provisions prior to rendering care. When the provider determines that services beyond the scope of the self-referral provisions are medically necessary, preauthorization should be sought from the MCO. As required by COMAR 10.09.66.07 B(4), the MCO must approve the preauthorization in a timely manner so as not to adversely affect the health of the member, but no later than 72 hours after the initial request. The MCO must notify the provider in writing whenever the provider's request for preauthorization for services is denied.

QUALITY ASSURANCE REQUIREMENTS

Providers who render self-referral services must cooperate with the Department's quality assurance reviews. This means that if an MCO informs the provider that a HealthChoice member's medical record has been selected for quality assurance review, the provider must provide the record to the MCO.

PHARMACY AND LABORATORY SERVICES

MCOs require enrollees to utilize in network pharmacy and laboratory services ordered by out-of-plan providers. The HealthChoice regulations provide for an exception to this requirement when:

- Medically necessary pharmacy or laboratory services are provided in connection with a self-referral service; **and**

- The pharmacy or laboratory services are provided on-site by the out-of-plan provider at the same location where the self-referral service was delivered.

The MCO must pay the Medicaid rate for pharmacy or laboratory services provided on-site by an out-of-plan provider at the same location where the self-referral service was delivered. When a self-referral provider is unable to render or chooses not to render the pharmacy or laboratory service at the same location where the self-referral service was delivered, the provider must refer HealthChoice members to in-network providers of pharmacy and laboratory services.

BILLING INSTRUCTIONS AND LIMITATIONS

Providers who have agreed to provide a self-referral service to a HealthChoice member may not balance bill the member or charge for any service that is covered by the Medical Assistance Program. Providers must use the billing codes in this manual, where specified, for submitting claims for self-referral services to the MCO. Where no specific codes have been designated, requests for payments should be submitted using the procedure codes and invoice forms specified in the MCO provider manual. The member's MCO card will have information on where to call for claims information or where to submit claims. If additional billing information is needed, call the MCO provider relations unit. Refer to the MCO Resource List on pages **59-62**

Providers rendering self-referral services must submit claims to the MCO within six (6) months of the date of service.

MCO REIMBURSEMENT

An MCO, or in some instances its subcontracted medical management group, must reimburse out-of-plan providers for self-referred services to its enrollees at the established Medicaid rate, unless specifically noted otherwise in this manual or COMAR regulations. MCOs must reimburse out-of-plan providers for undisputed self-referral claims within thirty (30) days of receipt.

The MCO is also responsible for reimbursing out-of-plan providers at the Medicaid rate for medically necessary pharmacy and laboratory services when the pharmacy or laboratory service is provided on site by the out-of-plan provider at the same location where the self-referral service was delivered. The Specialty Mental Health System (Value Options) is responsible for assisting a state supervised child to access specialty mental health services and payment of the mental health screen and a medical examination necessary for an inpatient psychiatric admission.

CHILD IN STATE-SUPERVISED CARE-INITIAL MEDICAL EXAM

Type of Provision: Self-Referral

A child in State supervised care is a child in the care and custody of a State agency pursuant to a court order or voluntary placement agreement, including, but not limited to HealthChoice-eligible children that are:

- Under the supervision of the Department of Juvenile Services,
- In kinship or foster care under the Department of Human Resources, or
- In residential treatment centers or psychiatric hospitals for the first 30 days after admission.

Prior to rendering care to a child in State supervised care a provider must receive EPSDT certification from the Department of Health and Mental Hygiene.

The MCO is required to permit the self-referral of a child in State-supervised care for an initial examination and is obligated to pay for all portions of the examination except for the mental health screen. Eligible providers should bill the child's MCO utilizing the age appropriate preventative CPT code (see code list below) in conjunction with the modifier **-32** (Mandated Services). Eligible providers will be reimbursed by MCOs at the current Medicaid Fee for Service rate.

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL, ON LINE AT:

http://www.dhmh.state.md.us/mma/providerinfo/

CPT Code	Description
Initial Comprehensive Preventive Medicine (New Patient)	
99381	Infant (age under 1 year)
99382	Early Childhood (age 1 through 4 years)
99383	Late Childhood (age 5 through 11 years)
99384	Adolescent 9 (age 12 through 17 years)
	or
Periodic Comprehensive Preventive Services (Established Patient)	
99391	Infant (age under 1 year)
99392	Early Childhood (age 1 through 4 years)
99393	Late Childhood (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)

Contact the staff specialist for Children's Services for additional information at (410) 767-1903.

EMERGENCY SERVICES

Type of Provision: Emergency Care

The HealthChoice regulations require MCOs to reimburse a hospital emergency facility and provider, which is not required to obtain authorization or approval for payment from an MCO in order to obtain reimbursement under this regulation, for:

(1) Emergency services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

(2) The medical screening services that meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act;

(3) Medically necessary services which the MCO authorized, referred, or instructed the enrollee to be treated at the emergency facility or medically necessary services that relate to the condition which presented when the enrollee was allowed to use the emergency room facility; and

(4) Medically necessary services that relate to the condition presented and that are provided by the provider in an emergency facility to the enrollee, if the MCO fails to provide 24-hour access to a physician.

Hospital emergency room staff should <u>not</u> call MCOs for authorization to provide services that meet the above criteria. Instead, they should deliver the services then bill the enrollee's MCO. The MCOs have the right to ask the hospitals to provide information to document that emergency services met one of the above criteria. MCOs do <u>not</u> have the right to refuse payment for a service that meets any of the above criteria on the grounds that a hospital did not request preauthorization. In addition, MCOs may <u>not</u> deny payment for medically necessary diagnostic services that the hospital ordered in their effort to determine if the presenting condition is emergent.

The claim must be submitted to the MCO within **six (6) months of the date of service.** The MCO shall reimburse the emergency facility and the provider at the Medicaid rate. The hospital should bill the MCO by submitting a UB 04 claim form using revenue code 450 and any other appropriate revenue code. Providers should bill the MCO by submitting a CMS 1500 claim form.

The following CPT codes must be used by **providers** to bill for these services:

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL, ON LINE AT:
http://www.dhmh.state.md.us/mma/providerinfo/

CPT Code	Description/Presenting Problem
99281	Emergency department visit, minor
99282	Emergency department visit, low-moderate
99283	Emergency department visit, moderate severity
99284	Emergency department visit high severity
99285	Emergency department visit, immediate threat
99288	Physician directed EMS

For additional information regarding the facility charges, contact the Health Services Cost Review Commission at (410) 764-2605 for specific hospital discounts relating to graduate medical education.

FAMILY PLANNING SERVICES

Type of Provision: Self-Referral

Family Planning Services are services which provide individuals with the information and means to prevent an unwanted pregnancy and maintain reproductive health, including medically necessary office visits and the prescription of contraceptive devices. Federal law permits Medicaid recipients to receive family planning services from any qualified provider. HealthChoice members may self-refer for family planning services without prior authorization or approval from their PCP with the exception of sterilization procedures.

The scope of services covered under this provision is limited to those services required for contraceptive management. The diagnosis code **(V25)** must be indicated on the claim form in order for the MCO to recognize that the Evaluation and Management code is related to a Family Planning Service. The following CPT codes must be used to bill MCOs for these services:

CPT Code	Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated
99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated
99384	Child office visit, new patient, preventative (age 12-17)
99385	Adult office visit, new patient, preventative (age 18-39)
99386	Adult office visit, new patient, preventative (age 40-64)
99394	Child office visit, established patient (age 12-17)

99395	Adult office visit, established patient (age 18-39)
99396	Adult office visit, established patient (age 40-64)
57170	Diaphragm fitting with instructions
58300	Insert Intrauterine Device
58301	Remove Intrauterine Device
58565	Essure (procedure)
11976	Remove contraceptive capsules
11981	Insert Drug Implant
11982	Remove Drug Implant
11983	Remove/insert Drug Implant
J1055	Depo-Provera-FP
J7300	IUD Kit
J7302	Mirena System
J7303	Contraceptive Vaginal Ring
J7304	Contraceptive Hormone Patch
J7307	Implanon
A4261	Cervical Cap
A4266	Diaphragm
99070	Other Contraceptive Product

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL, ON LINE AT:

http://www.dhmh.state.md.us/mma/providerinfo/

Special contraceptive supplies not listed above should be billed under procedure code 99070.

Note: A copy of the invoice for the contraceptive product must be attached to the claim when billing under procedure codes 99070, A4261, A4266, J7302 J7303, and J7304.

MCOs must pay providers for pharmacy items and laboratory services when the service is provided on-site in connection with a self-referral service. For example, MCOs must reimburse medical providers directly for the administration of Depo-Provera from a stock supply of the drug. This eliminates unnecessary barriers to care which are created when members are asked to go to an outside pharmacy to get a prescription for Depo-Provera filled and then are required to return to the provider's office for the injection. Contact the staff specialist for Family Planning services for additional information at (410) 767-6750.

HIV/AIDS ANNUAL DIAGNOSTIC AND EVALUATION SERVICE

Type of Provision: Self-Referral

HealthChoice members diagnosed with human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS) are entitled to one self-referral annual diagnostic and evaluation service (DES) assessment provided by an approved HIV DES provider.

MCOs are responsible for reimbursing DES providers for an annual HIV assessment provided to MCO members with HIV/AIDS. The following conditions must be met:

- A comprehensive medical and psychosocial assessment or reassessment must be provided.
- A written, individualized plan of care by a multi-disciplinary team convened by an approved HIV DES provider must be developed or revised and completed on a form approved by the Program.
- A copy of the completed pediatric or adult plan of care, which has been signed by all members of the multi-disciplinary team and the recipient or legally authorized representative, must be sent to the recipient's primary medical provider (PCP) and MCO.
- The procedure code to be used for billing the annual diagnostic and evaluation service (DES) is: S0315. The DES provider should bill the MCO on the invoice form specified by the MCO within 6 months.
- The MCO must reimburse the DES provider the current Medicaid rate.
- All children ages 0-20**,** including infants, with a diagnosis of inconclusive HIV result (042.x all; V08; 795.71, 0-12) are eligible for enrollment in the Rare and Expensive Case Management Program (REM). A recipient who becomes eligible for REM while enrolled in an MCO may chose to remain enrolled in the MCO.
- Most children diagnosed with HIV/AIDS are enrolled in REM except for those who elect to remain in the MCO. All adult recipients with HIV/AIDS will remain enrolled or be enrolled in MCOS.

NEWBORNS INITIAL MEDICAL EXAMINATION IN A HOSPITAL

Type of Provision: Continuity of Care

Newborns of HealthChoice members must have access to an initial newborn examination in the hospital. Babies born to HealthChoice members will be enrolled in the mother's MCO effective on the date of birth. In order to assure continuity of care the following actions must be taken:

- Prenatal care providers should instruct pregnant women to call their MCO/PCP. She should inform the MCO of her pregnancy and request that the MCO link her with a pediatric provider prior to delivery;

- OB, pediatric and hospital providers should encourage the woman to notify her MCO as soon as possible after delivery;

- Hospitals should fax a completed Hospital Report of Newborn form, DHMH 1184 to the Department at: 410-333-7012 within 24 hours.

- The MCO is responsible for arranging subsequent newborn care, including routine and specialty care;

- The MCO is responsible for arranging for specialty care and the emergency transfer of newborns to tertiary care centers.

The MCO must reimburse out-of-plan providers for an initial medical examination of a newborn when:

(1) The examination is performed in a hospital by an on call physician; and

(2) The MCO failed to provide for the service before the newborn's discharge from the hospital.

When an out-of-plan provider bills the MCO for newborn care, history and examination **CPT 99460** should be used. The MCO should pay the on-call provider, the in-network rate but no less than the Medicaid rate for this service. Contact the nurse consultant in the Division of Outreach and Care Coordination at (410) 767-6750 for additional information.

The newborn coordinator at each MCO will assist providers with newborn related issues or problems.

MCO Newborn Coordinators

MCO	Newborn Coordinator Phone Number	Newborn Coordinator Fax Number
AMERIGROUP Maryland Inc. 7550 Teague Road, Suite 500 Hanover, MD 21076 (410) 859-5800	1-800-981-4085	877-855-7559
Diamond Plan **Coventry Health Care of Delaware, Inc.** 6310 Hillside Court Suite 100 Columbia, MD 21244 1-866-212-5305	410-910-7118	410-910-6980
Jai Medical Systems, Inc. 5010 York Road Baltimore, MD 21212 (410) 433-2200	410-433-2200	410-433-4615
Maryland Phys. Care MCO 509 Progress Drive Linthicum, MD 21090-2256 800-953-8854	410-401-9532	410-609-1915
MedStar Family Choice 8094 Sandpiper Circle, Suite 0 Baltimore, MD 21236 (410) 933-3021	410-933-3002	410-933-2264
Priority Partners MCO Baymeadow Industrial Park 6704 Curtis Court Glen Burnie, MD 21060 (410) 424-4400	410-424-4960	410-424-4991
UnitedHealthcare 6095 Marshalee Dr., Suite 200 Elkridge, MD 21075	410-540-4312	410-540-5977

PREGNANCY-RELATED SERVICES INITIATED PRIOR TO MCO ENROLLMENT

Type of Provision: Continuity of Care

All pregnant women must have access to early prenatal care. When a HealthChoice member suspects she is pregnant, she should contact her MCO/PCP. MCOs are responsible for scheduling an initial prenatal or postpartum visit within 10 days of the enrollee's request. If a newly enrolled pregnant woman has already established care with an out-of-network provider and that care included a full prenatal examination, risk assessment, and related laboratory tests, then the provider may choose to continue providing prenatal care and the MCO must pay the provider.

There are approximately 13,000 women a year who become eligible for Medicaid because they are pregnant. When a low-income or uninsured woman seeks care for pregnancy diagnosis and prenatal care, she should apply for the Maryland Children's Health Program (MCHP) at her local health department or call 1-800-456-8900 for information. Providers may wish to keep a supply of the simple mail-in applications on hand to distribute to potentially eligible women. The pregnant woman should send the completed MCHP application to the local health department; the application will be processed within 10 days. After their eligibility for Medicaid or MCHP is established most of these women will be required to enroll in HealthChoice and must select an MCO. If they fail to select an MCO they will be auto-assigned.

OB Providers can assist in assuring continuity of prenatal care by following the steps outlined below:

- Because early prenatal care is such a vital service, we encourage you to provide care to pregnant women who are in the Medical Assistance application and MCO selection process. You are not required to continue providing prenatal care to pregnant women who subsequently enroll in an MCO in which you do not participate. However, we encourage you to continue to see these women through the self-referral option.

- If you participate in HealthChoice, let potential HealthChoice members know which MCO(s) your practice participates in and whether you will accept women for out-of-network prenatal care; and

- If you participate in one or more MCOs and have initiated prenatal care for a pregnant woman who has Medical Assistance but is not in an MCO, encourage her to select an MCO in which you participate. She should call the enrollment broker at 1-800-977-7388 to choose an MCO.

In the event that an out-of-network provider has provided pre-enrollment care and initiated prenatal care **prior** to the pregnant woman's enrollment in an MCO, the prenatal care provider **may choose** to continue rendering out-of-network prenatal care under these self-referral provisions. The MCO is responsible for the payment of comprehensive prenatal care for a non high-risk pregnancy, including prenatal, intrapartum and postpartum care at the established Medicaid rate without preauthorization. The prenatal care provider should follow these guidelines for the provision of self-referral pregnancy-related services:

- Inform the member's MCO that you plan to continue to provide prenatal care to the member as an out-of-network provider.

- Refer the member to the MCO's OB case management services or special needs coordinator (MCOs are required to have these services for pregnant women);

- Screen the member for substance abuse using a screening instrument which is used for the detection of both alcohol and drug abuse, recommended by the Substance Abuse and Mental Health Services Administration (SAMSA) of the U.S. Department of Health and Human Services, and appropriate for the age of the patient. Refer to the MCO's Behavioral Health Organization, if indicated.

- Complete the Maryland Prenatal Risk Assessment Form (DHMH 4850) and forward the form to the appropriate local health department's Healthy Start Program. Prior to the pregnant women's enrollment in an MCO, completion of the risk assessment is billed to MA using billing code H1000.

- Refer the member to the WIC Program at 1-800-242-4WIC.

- Providers should document in the medical record that health education and counseling appropriate to the needs of the pregnant woman was provided. The provider may then bill the MCO for an "Enriched" maternity service at each visit using billing code **H1003.**

- When consultation or referral for high-risk prenatal care is indicated, make referrals to the member's MCO network providers only.

- Bill the member's MCO for laboratory, radiology, and pharmacy services when they are provided on-site in conjunction with the pregnancy-related services.

- When it is necessary to refer off-site for laboratory, radiology, and pharmacy services, use only those providers who are in the member's MCO network.

- Prior to the eighth month of pregnancy, the prenatal care provider should instruct the pregnant woman to contact her MCO for assistance in choosing a primary care provider for the newborn.

- For all non-pregnancy-related medical services, refer pregnant women to their primary care provider (PCP).

Prenatal care providers typically bill MCOs by using CPT codes (99201-99205 and 99211-99215) and two Healthy Start codes (H1000 AND H1003). The most commonly used codes are listed below:

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL, ON LINE AT:

http://www.dhmh.state.md.us/mma/providerinfo/

CPT Code	Description
99201	Office visit, new patient, minimal
99202	Office visit, new patient, moderate
99203	Office visit, new patient, extended
99204	Office visit, new patient, comprehensive
99205	Office visit, new patient, complicated
99211	Office visit, established patient, minimal
99212	Office visit, established patient, moderate
99213	Office visit, established patient, extended
99214	Office visit, established patient, comprehensive
99215	Office visit, established patient, complicated
H1000	Prenatal care at risk assessment
H1003	Prenatal care at risk assessment-Enhanced Service
59410	Vaginal delivery including postpartum care
59515	Cesarean delivery including postpartum care
59430	Postpartum care

MCOs are responsible for payment of circumcisions performed by an obstetrician who provided delivery services for a woman under the self-referral provision. When billing for newborn circumcisions (CPT 54150 and 54160), you must use the newborn's name and Medical Assistance number. Contact the nurse consultant in the Division of Outreach and Care Coordination at (410) 767-6750 for additional information.

RENAL DIALYSIS SERVICES PROVIDED IN A MEDICARE-CERTIFIED FACILITY

Type of Provision: Self-Referral

HealthChoice members with end stage renal disease (ESRD) need access to renal dialysis services provided in Medicare-certified facilities. Renal dialysis services substitute for the loss of renal function for those individuals with chronic kidney disease. Renal dialysis services include: chronic hemodialysis; chronic peritoneal dialysis; home dialysis and home dialysis training; and laboratory testing and physician services which are not included in the composite Medicare rate for dialysis.

Enrollment in REM or MCO:

- Most recipients diagnosed with ESRD are now enrolled in Rare and Expensive Case Management Program (REM) except those who have elected to enroll or remain in the MCO with the Program's approval.

- Out-of-network providers must coordinate referrals to specialists and hospitals through the MCO Utilization Management services.

For those renal dialysis patients remaining in HealthChoice, MCOs are responsible for reimbursing for renal dialysis services in Medicare-certified facilities at the Medicaid rate. Medicaid reimbursement is consistent with the rates paid by the Medicare program. The list of codes for free-standing dialysis facilities are as follow:

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL, ON LINE AT:

http://www.dhmh.state.md.us/mma/providerinfo/

Maryland Medicaid Program Created Dialysis Facility Services Codes
Composite Rate Codes In

Medicare Revenue Code	Original Description	Medicaid Revenue Code
HEMODIALYSIS		
821-71	Hemodialysis staff assisted	0821
821-72	Hemodialysis self care in unit	0821
821-76	Hemodialysis, back-up in facility	0821
821-73	Hemodialysis, self care training	0820
821-74	Hemodialysis, home care	0825
821-75	Hemodialysis, home care 100%	0829
PERITONEAL DIALYSIS		
831-71	Peritoneal staff assisted	0831
831-72	Peritoneal self care in unit	0831
831-76	Peritoneal self care back-up in facility	0831
831-73	Peritoneal self care training	0830
831-74	Peritoneal home care	0835
831-75	Peritoneal home care 100%	0839
CAPD (Continuous Ambulatory Peritoneal Dialysis)		
841-71	CAPD, staff assisted	0841
841-72	CAPD, self care in unit	0841
841-76	CAPD, back-up in facility	0841
841-73	CAPD, self care training	0840
841-74	CAPD, home care	0841
841-75	CAPD, home care 100%	0849
CCPD (Continuous Cycling Peritoneal Dialysis)		
851-71	CCPD, staff assisted	0851
851-72	CCPD, self care in unit	0851
851-76	CCPD, back-up in facility	0851
851-73	CCPD, self care training	0850
851-74	CCPD, home care	0851
851-75	CCPD, home care 100%	0859

When billing the MCO, the facility must attach a copy of the dialysis facility's Medicare Carrier Rate Letter to the initial UB04 claim form. Requests for MCO payment should be submitted on the invoice and using the procedure codes specified by the MCO.

Contact the staff specialist for dialysis services at (410) 767-1426. For additional information related to reimbursement of the physician services provided during a dialysis session, please call (410) 767-1482.

SCHOOL BASED HEALTH CENTER SERVICES

Type of Provision: Self-Referral

SBHCs will establish relationships with the MCOs and their network primary care providers in order to effectively utilize a co-management model of care to improve student-enrollees' access to quality health and mental health services. SBHC's will be reimbursed by the student-enrollees' MCO under the self-referred provision for the following medically necessary primary care services:

- Comprehensive well-child care when performed by Early and Periodic Screening Diagnosis and Treatment (EPSDT) certified providers and rendered according to Healthy Kids/EPSDT standards as described in the Healthy Kids Manual published at: http://www.dhmh.state.md.us/epsdt/healthykids/manual/table_contents.htm

- Follow-up of positive or suspect EPSDT screening components without approval of the PCP except where referral for specialty care is indicated;

- Diagnosis and treatment of illness and injury that can be effectively managed in a primary care setting;

- Family planning services as specified under the self-referred family planning section of this manual.

Requirements

SBHCs must:

- **Meet all the requirements established in COMAR 10.09.68- Maryland Managed Care Program: School-Based Health Centers, and 10.09.08 Freestanding Clinics, and Early and Periodic Screening Diagnosis and Treatment 10.09.23;**

- Follow the guidelines and periodicity schedule established by the Maryland Healthy Kids Program for well-child care and immunizations as published at: http://www.dhmh.state.md.us/epsdt/healthykids/manual/table_contents.htm

- Utilize the American Academy of Pediatrics guidelines and other pertinent medical guidelines to develop protocols and procedures for the management of common illnesses, chronic disease and injuries, including the prescribing and management of prescription drugs;

- Participate in the Vaccines For Children Program (VFC) and submit vaccination information through the Maryland immunization registry, ImmuNet;

- Keep medical records in compliance with Medicaid and MCO standards and procedures; and

- Participate in the Department's quality assurance activities and allow MCOs and the Department to conduct medical record reviews.

Communication with the MCO and PCP

- The MCO will continue to assign each student-enrollee a primary care provider. The receipt of self-referred services in a SBHC shall be communicated to the PCP and shall not impact the student-enrollee's ability to access care from the PCP.

- The MCO and SBHC must establish a mutually agreeable communication protocol which addresses care coordination and co-management protocols. At a minimum communication will occur within three business days of service provision as follows:

    1. The SBHC will transmit a Health Visit Report to the MCO and the PCP for inclusion in the recipient's medical record. Information may be transmitted by email, fax, or mail.
    2. The SBHC will document communication details in student's health center medical record.
    3. If follow-up care with the PCP is required within one week and the Health Visit Report is mailed, the SBHC must also telephone, email or fax the Health Visit Report to the PCP on the day of the SBHC visit.
    4. When a Healthy Kids/EPSDT preventive care service is rendered, the SBHC is required to use the age-appropriate preventive care form developed by the Program. The completed form is to be sent to the PCP's office for inclusion in the enrollee's medical record.

Limitations and Excluded Services

Services to non-students (e.g., school employees, students' parents, or individuals from the community) are not covered under these provisions.

MCOs will not reimburse SBHCs for services such as:

- Nursing services provided to enable a student to be safely maintained in the school setting, such as: gastroesphogeal tube (GT) feedings; catheterization; oral nasal or tracheal suctioning; and nebulizer treatments;

- Nursing or other health services provided as part of a student's IEP/IFSP;

- School health services which are required in all school settings, such as: routine assessment of minor injuries; first aid; administration of medications, including the supervision of self-administered medications; general health promotion counseling; and review of health records to determine compliance with school mandates, such as immunization and lead requirements;

- Mandated health screening services performed at specific intervals in all public schools such as hearing, vision, and scoliosis screening;

- Routine sports physicals;

- Vaccines supplied by VFC;

- Visits for the sole purpose of: administering vaccines; administering medication; checking blood pressure; measuring weight; interpreting lab results; or group or individual health education;

- Services provided outside of the physical location of the approved SBHC;

- Services not covered by MCOs such as dental services and specialty mental health services; and

- Services provided without prior authorization when prior authorization is required by the MCO.

All reimbursement limitations described in COMAR 10.09.08.07- Freestanding Clinics and COMAR 10.09.68.03B- Maryland Medicaid Managed Care Program: School- Based Health Centers apply.

MCO and School-Based Health Center Policies and Procedures

Clear communication between the MCO, the PCP and the SBHC will ensure that medically necessary care and treatment are given to recipients utilizing self-referred services.

The MCO is required to provide the following information to SBHCs in their service area:

- The contact information (name, phone number, e-mail, and fax numbers) of:
    - The Special Needs/Care Coordinator and other relevant contacts needed to facilitate co-management of student-enrollees;
    - The MCO billing representative and the address for submitting paper claims to the MCO; and
- Information on how to identify and contact the student-enrollee's PCP.
- Policies and procedures regarding the MCO's pharmacy coverage and formulary;
- Policies and procedures for the MCO's contracted laboratory services with LabCorp; and

The SBHC is required to adhere to the following:

- When the SBHC is unable to render or chooses not to render the pharmacy or laboratory service in the SBHC, the SBHC must use the MCO's formulary and in-network pharmacy and contracted laboratory services with Lab Corp; and

- SBHCs must follow all MCO preauthorization requirements.

Billing Requirements

The SBHC must:

- Assure that no claims are submitted for services that the SBHC provides free of charge to students without Medicaid coverage;

- Verify eligibility and MCO assignment through EVS on the day of service;

- If the client has other third party insurance, SBHCs must bill third party insurers before billing the MCO, with the exception of well-child care and immunizations;

- Submit claims using the CMS-1500 or an EDI and HIPAA compliant electronic submission according to the SBHC Instructions Manual provided by the Department;

- Use place of service code "03" – School – on all claims;

- Submit claims within 180 days of performing a self-referred service;

For complete billing instructions consult the Billing Instructions for School-Based Health Centers and Billing Instructions for Healthy Kids/EPSDT Providers.

Payment

- MCOs will reimburse SBHCs at the rates specified in the Maryland Medicaid physician fee schedule, with the exception of FQHCs; and

- MCO's will reimburse CPT code 99070, special contraceptive supplies, at cost.

For current fee schedule, consult the Medicaid Provider Fee Manaual at:
http://www.dhmh.state.md.us/mma/providerinfo/

For a list of SBHCs, county locations and sponsors, or for additional information, contact (410) 767-1490.

SUBSTANCE ABUSE

Type of Provision: Self-Referral

Effective January 1, 2010**,** The Substance Abuse Improvement Initiative (SAII) allows Medicaid enrollees to select their own provider for substance abuse treatment even if the provider does not have a contract with a Managed Care Organization (MCO). The initiative uses the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria – a widely used and comprehensive national guideline for placement, continued stay, and discharge of patients with alcohol and other drug problems – to evaluate level of care (LOC).

This section provides a narrative description of the revisions to the notification and authorization requirements for self-referred services under HealthChoice. Self-referral protocols are listed by ASAM level. It is important to note that these protocols do not lay out any benefit limitations. Rather, services beyond these must be justified based on medical necessity according to ASAM.

Comprehensive Substance Abuse Assessment

Under the self-referral initiative, an MCO or the Behavioral Health Organization (BHO) which administers the substance abuse services for certain MCOs will cover a Comprehensive Substance Abuse Assessment once per enrollee per provider per 12-month period, unless there is more than a 30-day break in treatment. If a patient returns to treatment after 30 days, the MCO/BHO will pay for another CSAA. This is a new feature of the initiative which begins on January 1, 2009.

ASAM Level I.D – Ambulatory Detox

In regards to the self-referral option under HealthChoice, ambulatory detox refers to detox services provided in the community or in outpatient departments of hospitals or outpatient programs of intermediate care facilities-alcohol (ICF-A).

Provider Communication Responsibility

Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.

MCO/BHO Communication Responsibility

The MCO/BHO will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation/ authorization number if approved.

Approval Protocol

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 not meet ASAM LOC, the MCO/BHO will pay for care up to the point where they formally communicate their disapproval.

ASAM Level: I – Outpatient Services - Individual, family and group therapy

Self-referred individual or group therapy services must be provided in the community (not in hospital rate regulated settings).[1] Hospital-based providers must seek preauthorization to be reimbursed for these services from an MCO/BHO.

Provider Communication Responsibility

Provider must notify (by fax or email) the MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services.

MCO/BHO Communication Responsibility

The MCO/BHO must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.

Approval Protocol

The MCO/BHO will pay for 30 sessions (any combination of individual, group, and family therapy) within 12-month period per client (family sessions are billed under the individual enrollee's number). The 30 visits are not a benefit limitation. Rather, the provider must seek preauthorization for additional individual or group therapy services during the year. Medicaid MCOs will pay for additional individual and group counseling services as long as medically necessary.

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.

ASAM Level: II.1 – Intensive Outpatient (IOP)

[1] Hospital rate regulated clinics must seek preauthorization to provide such services under HealthChoice.

Self-referred intensive outpatient only applies to care delivered in community-based settings. Providers must seek preauthorization to provide such services. In preauthorizing, MCOs may refer to in-network community providers if those providers are easily available geographically and with out waiting lists.

Provider Communication Responsibility

The Provider must notify and provide treatment plan to MCO/BHO (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.

MCO/BHO Communication Responsibility

The MCO/BHO will respond to provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.

Approval Protocol

If the treatment plan is approved, MCO will pay for 30 calendar days. At the end of week three (3), for care coordination purposes, the provider must notify the MCO/BHO of discharge plan or need for remaining treatment. Continuing treatment beyond the 30 days must be preauthorized as being medically necessary.

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.

ASAM Level: II.5 – Partial Hospitalization

This service is provided in a hospital or other facility setting.

Provider Communication Responsibility

By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider must submit progress report **and** assessment for justification of continued stay beyond day five (5). Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.

MCO/BHO Communication Responsibility

MCO/BHO will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.

Approval Protocol

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/BHO based on medical necessity.

2) If the MCO/BHO is **not available or does not respond** 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.

Providers shall seek the least restrictive level of care for clients. If the client does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.

ASAM Level: III – Residential and Inpatient – ICF-A, under 21 years

ICF-A services are only available for children and adolescents under age 21 for as long as medically necessary and the enrollee is eligible for the service. Medicaid does not pay for services if they are not medically necessary, even if a Court has ordered them. HealthChoice MCOs do not cover other residential services.

Provider Communication Responsibility

Within two (2) hours, provider calls MCO/BHO for authorization.

MCO/BHO Communication Responsibility

MCO/BHO will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability.

Approval Protocol

1) If MCO/BHO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized.

2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized.

3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.

ASAM Level: Opioid Maintenance Treatment - Methadone

In regard to the self-referral option, methadone maintenance refers to services provided in the community or outpatient departments of hospitals.

Provider Communication Responsibility

Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan.

After obtaining the patient's consent, the provider will also inform the patient's Primary Care Provider that patient is in treatment.

The provider will submit an updated treatment plan to the MCO/BHO at the 12th week of service to promote the coordination of care. Next approvals for continued care will be at six-month intervals.

MCO/BHO Communication Responsibility

MCO/BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation number if approved. They will also assist provider with contact information concerning the patient's PCP.

Approval Protocol

If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Medicaid coverage is determined by medical necessity. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO. Additional approvals for continued care beyond the first 26 weeks will be at six-month intervals.

ASAM Level: IV.D: Medically Managed Patient – Inpatient Detox in an Inpatient Hospital Setting or in an ICF-A Facility

This service is provided in a hospital or ICF-A setting.

Provider Communication Responsibility

Within two (2) hours, provider calls MCO/BHO for authorization.

MCO/BHO Communication Responsibility

MCO/BHO will respond to provider within two (2) hours with a final authorization or disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.

Approval Protocol

1) If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized based on medical necessity.

2) If client **does not** meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.

3) If MCO/BHO **does not** respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized based on medical necessity.

MCO/BHO Authorization/Notification Numbers
For Substance Abuse Treatment Services

Managed Care Organization	Behavioral Health Organization (BHO)	Number to call for Authorization/ Notification (For both in- and out- of-network providers)
AMERIGROUP		Providers call 1-800-454-3730 Prompt 9 Members call 1-800-600-4441 Prompt 9 Fax 1-800 505-1193
DIAMOND PLAN Coventry Health Care	MHNet Behavioral Health	1-800-454-0740 Fax: 407-831-0211
MEDSTAR	Value Options	1-800-496-5849
JAI MEDICAL SYSTEMS		410-327-5100 Fax: 410-327-0542
MD PHYSICIANS CARE		1-800-953-8854 Option 7 Fax: 860-907-2649
PRIORITY PARTNERS		1-800-261-2429 Option 3 Fax: 410-424-4891
UNITEDHEALTH CARE	United Behavioral Health	1-888-291-2507 Fax: 1-800-248-8994

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.

HealthChoice Substance Abuse Treatment Self-Referral Protocols – in ASAM Order
Substance Abuse Improvement Initiative (SAII)
January 1, 2010

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
H0001	NA	NA	1) A Managed Care Organization (MCO) or the Behavioral Health Organization (BHO) which administers the substance abuse services for certain MCOs will pay for a Comprehensive Substance Abuse Assessment once per enrollee per provider per 12-month period, unless there is more than a 30-day break in treatment. If a patient 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	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.	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

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
facility-based providers using UB-04			necessity criteria. 3) If MCO/BHO determines client does **not** meet ASAM LOC, MCO/BHO will pay for care up to the point where they formally communicate their disapproval.
H0004 for individual or family therapy H0005 for group therapy	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	MCO or BHO liaison must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.	MCO/BHO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client. 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. 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.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
H0015 for community-based providers using CMS 1500 0906 revenue codes for facility-based providers using UB-04	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.	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.	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. 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.
0912 and 0913 revenue codes for facility-based providers using UB-04	By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider must submit progress report **and** assessment for justification of continued stay beyond day five (5). Provider obtains patient consent and submits progress	MCO or BHO liaison will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	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. 2) If the MCO/BHO is **not available or does not respond** 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.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
	report or discharge summary to PCP for their records and coordination of care within 10 days.		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.
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.	MCO/BHO liaison will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability.	1) If MCO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized. 2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized. 3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
H0020	Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan. The provider will submit an updated treatment plan to the MCO/BHO by the 12th week of service to promote the coordination of care. Next approvals will be at six-month intervals.	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. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Continued eligibility for coverage will be determined by medical necessity. Additional approvals beyond the first 26 weeks will be at six-month intervals. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO.
0126 and 0136 revenue codes for facility-based providers	Within two (2) hours, provider calls MCO/BHO for authorization.	MCO or BHO will respond to provider within two (2) hours with a final disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.	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. If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care. If MCO/BHO does not respond to the

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	Approval Criteria
			provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized as medically necessary.

Footnotes

1. MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute.
2. MCOs/BHOs will honor substance abuse 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 patient 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 patient 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.

☞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://www.dhmh.state.md.us/
DHMH Provider Hotline: 1-800-766-8692
Or call the Complaint Resolution Unit's supervisor, Ellen Mulcahy-Lehnert, or Division Chief, Ann Price, at
1-888-767-0013 or 1-410-767-6859 from 8:30 AM to 4:30 PM Monday - Friday

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

I. Please Circle One

Initial Treatment Plan for:

Ambulatory Detox

Intensive Outpatient Treatment

X.

☐ **Methadone Maintenance**

☐ **Traditional Outpatient Treatment**

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___F_____	4a. Client's MCO Number 4b.Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		
7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number		
9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
13a. Client Pregnant? Yes____No_____ 13b. If Yes, Due Date _____	14. OB/GYN:_____ a. Pre Natal Appt Scheduled:_____ b. Pre Natal Appt Completed:_____ c. OB/GYN Knows of Pregnancy? Yes____No_____		
15. Date Present Treatment Began (mo, day, yr)			
16. Diagnosis (Please complete all axes.) Use DSMIV Codes AXIS I AXIS IV AXIS II AXIS V (GAF) AXIS III			
17. Reason for Seeking Treatment/Motivation for Treatment			

18. Substance Abuse History

Drugs of Choice	Last Use I Route	Date Use Began I Frequency	Toxicology Screen Date I Results
Alcohol_____	_	_____	
Barbiturates_____	___	_____	Cocaine_____
_____	_____	_____	Opioids_____
_____	_____		Other_____ _____
	___ _____		

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

II. HealthChoice/DHMH

Please Circle One

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**

XI.

- ☐ **Methadone Maintenance**
- ☐ **Traditional Outpatient Treatment**

19a. History of Delirium Tremens Seizures	19b. History of Blackouts	19c. Alcohol Related
Yes_____Last date_____ Date_____ No_____	Yes_____Last Date_____ No_____	Yes_____Last Date_____ No_____

20. Substance Abuse Treatment History (Last 3 Years)	21. Medical Complications Allergies_____ Heart_____ Amputee_____ Hepatitis_____ Cirrhosis_____ HIV_____ Diabetes_____ Hypertension_____ Enlarged Liver_____ Jaundice_____ Gunshot_____ Seizures_____ Head Injury_____ STDs_____ Hearing Impaired_____ Other_____

22. List All Medications (including Methadone/LAAM)

Type	Dosage	Start Date	Response

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

III. Please Circle One

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**

XII.

- ☐ **Methadone Maintenance**
- ☐ **Traditional Outpatient Treatment**

23. If medications are being administered by someone other than yourself, please identify.

24. Suicidal/Homicidal Behaviors? No____Yes_____
Clarify_____
If yes, is client able to contract for safety?_____
List recent hospitalization or attempts_____

25. If client has a co-occurring psychiatric diagnosis, is client in treatment? Yes____No_____
26. Client's Mental Health Professional_____Phone Number_____
Release of Information Signed? Yes_____No_____

27. Psychosocial Functioning:

Domestic Violence_____

Drugs in the Home_____

Education_____
Legal

Problems_____
Primary Support

System_____
Recovery

Environment_____

Working_____

Other_____

28. Brief Mental Status

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

IV. Please Circle One

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**

XIII.

- **Methadone Maintenance**
- **Traditional Outpatient Treatment**

29. Assessment Tools

MAST Score_____
POSIT Score_____
ASAM Criteria_____
Dimensions: I_____ II_____ III_____ IV_____V_____VI_____
Level of Placement Assigned_____

30. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
**12 STEP/Community Support/Spirituality

Short term:
1)

2)

3)

Long term:
1)

2)

3)

_____ _____
Client's Signature Date

31. Type of Treatment Requested	Frequency/Week	Duration of **EACH** Session
IOP_____	_____	_____
Methadone Maintenance/LAAM_____	_____	_____
Individual	_____	_____
• 90804 (up to 30 min, non M.D.)_____	_____	_____
• 90806 (up to 60 min, non-M.D.)_____	_____	_____
Group____	_____	_____
Other ____	_____	_____

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

V. **Please Circle One**

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**

XIV.

- **Methadone Maintenance**
- **Traditional Outpatient Treatment**

32. Anticipated Discharge Date:_____
After Care Plan:

33. Comments (e.g. employment, family, housing, health status, socialization, support system)

For Ambulatory Detox Only

1. Vital Signs

BP_____ Pulse_____Temperature_____Respiration_____Date taken_____
Time taken_____am/pm

2. Withdrawal Symptoms

Agitation_____

Chills_____ Piloerection (goosebumps)_____

Cramping_____ Rhinorhea (runny nose)_____

Cravings_____Shakes_____

Diarrhea_____ Sweating_____

Dilated pupils_____ Tremors; Fine_____Gross_____

Lacrimation (runny eyes)_ Vomiting_____

Muscle aches_____ Other_____

Nausea_____

PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

VI. Please Circle One

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**

XV.

- **Methadone Maintenance**
- **Traditional Outpatient Treatment**

3. Medical Detox Protocol
(Explain below or attach as a separate sheet)

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Standard Information Required for Progress Report and Assessment of Continued Stay for Partial Hospitalization

_____**Treatment Plan**

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan.This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___F_____	4a. Client's MCO Number 4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		
7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number		
9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
13a. Client Pregnant? Yes____No_____ 13b. If Yes, Due Date _____	14. OB/GYN:_____ d. Pre Natal Appt Scheduled:_____ e. Pre Natal Appt Completed:_____ f. OB/GYN Knows of Pregnancy? Yes____No_____		
15. Date Present Treatment Began (mo, day, yr)			
16. Diagnosis (Please complete all axes.) Use DSMIV Codes AXIS I AXIS IV AXIS II AXIS V (GAF) AXIS III			
17. Reason for Seeking Treatment/Motivation for Treatment			

18. Substance Abuse History

Drugs of Choice	Last Use I Route	Date Use Began I Frequency	Toxicology Screen Date I Results
Alcohol_____	_	_____	
Barbiturates_____	___	_____	Cocaine_____
_____	_____	_____	Opioids_____
_____	_____	_____	Other_____ _____
	___ _____		

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Standard Information Required for Progress Report and Assessment of Continued Stay for Partial Hospitalization

_____Treatment Plan

19a. History of Delirium Tremens	19b. History of Blackouts	19c. Alcohol Related
Seizures Yes_____Last date_____ Date_____ No_____	Yes_____Last Date_____ No_____	Yes_____Last No_____

20. Substance Abuse Treatment History (Last 3 Years)	21.Medical Complications Allergies_____ Heart_____ Amputee_____ Hepatitis_____ Cirrhosis_____ HIV_____ Diabetes_____ Hypertension_____ Enlarged Liver_____ Jaundice_____ Gunshot_____ Seizures_____ Head Injury_____ STDs_____ Hearing Impaired____ Other_____

22. List All Medications (including Methadone)

Type	Dosage	Start Date	Response

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Standard Information Required for Progress Report and Assessment of Continued Stay for Partial Hospitalization

Treatment Plan

23. If medications are being administered by someone other than yourself, please identify.

24. Suicidal/Homicidal Behaviors? No____Yes_____
    Clarify_____
    If yes, is client able to contract for safety?_____
    List recent hospitalization or attempts_____

25. If client has a co-occurring psychiatric diagnosis, is client in treatment? Yes____No_____
26. Client's Mental Health Professional_____Phone Number_____
    Release of Information Signed? Yes_____No_____

27. Psychosocial Functioning:

Domestic Violence_____

Drugs in the Home_____

Education_____

Legal Problems_____

Primary Support System_____

Recovery Environment_____

Working_____

Other_____

28. Brief Mental Status

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Standard Information Required for
Progress Report and Assessment of Continued Stay for
Partial Hospitalization

Treatment Plan

29. Assessment Tools

MAST Score_____

POSIT Score_____

ASAM Criteria_____

Dimensions: I_____ II_____ III_____ IV_____ V_____ VI_____

Level of Placement Assigned_____

30. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
**12 STEP/Community Support/Spirituality

Short term:

1)

2)

3)

Long term:

1)

2)

3)

_____ _____
Client's Signature Date

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Standard Information Required for Progress Report and Assessment of Continued Stay for Partial Hospitalization

_____Treatment Plan

Partial Hospitalization
Per ASAM Level II.5 for Adults
Per ASAM Level II for Adolescents

For Scoring Purposes:
Adults must meet one Dimension from Dimensions 4 or 5 or 6.
Adolescents must meet one Dimension from Dimensions 3 or 4 or 5 or 6.

Justify **specific** behavioral and environmental conditions for level of care.

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

Date contact made to MCO: Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan.This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___F_____	4a. Client's MCO Number 4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		
7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number		
9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
13a. Client Pregnant? Yes____No_____ 13b. If Yes, Due Date _____	14. OB/GYN:_____ g. Pre Natal Appt Scheduled:_____ h. Pre Natal Appt Completed:_____ i. OB/GYN Knows of Pregnancy? Yes____No_____		
15. Date Present Treatment Began (mo, day, yr)			
16. Diagnosis (Please complete all axes.) Use DSMIV Codes AXIS I AXIS IV AXIS II AXIS V (GAF) AXIS III			
17. Reason for Seeking Treatment/Motivation for Treatment			

18. Substance Abuse History

Drugs of Choice	Last Use I Route	Date Use Began I Frequency	Toxicology Screen Date I Results
Alcohol_____			
Barbiturates_____			Cocaine_____
			Opioids_____
			Other_____

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

19a. History of Delirium Tremens	19b. History of Blackouts	19c. Alcohol Related Seizures
Yes Last date_____	Yes Last Date_____	Yes Last date_____
No	No	No_____

*20. Substance Abuse Treatment History (Last 3 Years)	21. Medical Complications Allergies_____ Heart_____ Amputee_____ Hepatitis_____ Cirrhosis_____ HIV_____ Diabetes_____ Hypertension_____ Enlarged Liver_____ Jaundice_____ Gunshot_____ Seizures_____ Head Injury_____ STDs_____ Hearing Impaired____ Other_____

22. List All Medications (including Methadone/LAAM)

Type	Dosage	Start Date	Response

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

23. If medications are being administered by someone other than yourself, please identify.

24. Suicidal/Homicidal Behaviors? No____Yes_____
Clarify_____
If yes, is client able to contract for safety?_____
List recent hospitalization or attempts_____

25. If client has a co-occurring psychiatric diagnosis, is client in treatment? Yes____No_____

26. Client's Mental Health Professional_____Phone Number_____
Release of Information Signed? Yes_____No_____

27. Psychosocial Functioning:

Domestic Violence_____

Drugs in the Home_____

Education_____

Legal Problems_____

Primary Support System_____

Recovery Environment_____

Working_____

Other_____

28. Brief Mental Status

29. Assessment Tools

MAST Score_____
POSIT Score_____
ASAM Criteria_____
Dimensions: I_____ II_____ III_____ IV_____V_____VI_____
Level of Placement Assigned_____

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

30. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
**12 STEP/Community Support/Spirituality

Short term:
1)

2)

3)

Long term:
1)

2)

3)

_____ _____
Client's Signature Date

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

Intermediate Care Facility Per ASAM Level III
For Scoring Purposes: Client must meet two of six Dimensions. For adolescents, client must meet the specifications in two of six Dimensions. Justify **specific** behavioral and environmental conditions for ICF-A level of care.

PLEASE PRINT
Attach additional pages if more space is needed.

HealthChoice/DHMH

Please Circle One

Standard Information Required for Telephonic Authorization for:

- **Intermediate Care Facility Treatment**
- **Acute Inpatient Treatment**

Acute Inpatient Treatment
Per ASAM Level IV

For Scoring Purposes:

Client must meet at least one Dimension from Dimensions 1 or 2 or 3 .

Justify **specific** behavioral and environmental conditions for level of care.

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Outpatient Concurrent Review
Authorization of Care

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan.This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42- Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient..

1.Client's First Name Only	2. Client's Date of Birth ____/____/____ Mo Day Yr	3. Client's Sex M___F____	4a. Client's MCO Number 4b. Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		
7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number		
9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam
13a. Date of Last Communication to Primary Care Physician_____ 13b. Release Signed? Yes____No_____	14. If Primary Care Physician not seen, indicate why:		
15a. Client Pregnant? Yes____No_____ 15b. If Yes, Due Date _____	16. OB/GYN:_____ j. Pre Natal Appt Scheduled:_____ k. Pre Natal Appt Completed:_____ l. OB/GYN Knows of Pregnancy? Yes____No_____		
17. Date Present Treatment Began (mo, day, yr)			
18. Diagnosis (Please complete all axes.) Use DSMIV Codes AXIS I AXIS IV AXIS II AXIS V (GAF) AXIS III			
19. Response to Treatment (List specific gains made since initial treatment plan and all remaining symptoms with frequency and severity.)			
20. Brief Mental Status			

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Outpatient Concurrent Review
Authorization of Care

22. If medications are being administered by someone other than yourself, please identify.
23. Reasons for Continuing Treatment: (Including current ASAM Dimensions met)
24. Statement of Problem/s Goals related to Presenting Problems (use finite / measurable / observable terms)** ** 12 STEP/Community Support/Spirituality Short term: 1) 2) 3) Long term: 1) 2) 3) _____ _____ Client's Signature Date

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Outpatient Concurrent Review
Authorization of Care

25. Urine Drug Screens/Breathalyzer Results Last 6 Tests

Positive Dates	Drug/Alcohol Screens	**Negative** Dates

26. Type of Treatment Requested

	Frequency/Week	Duration of **EACH** Session
IOP_____		
Methadone Maintenance/LAAM_____		
Individual		
• 90804 (up to 30 min, non M.D.)_____		
• 90806 (up to 60 min, non-M.D.)_____		
Group____		
Other ____		

27. Anticipated Discharge Date:

28. After Care Plan

29. Comments (e.g. employment, family, housing, health status, socialization, support system)

PLEASE PRINT
Attach additional pages if more space is needed

HealthChoice/DHMH
Outpatient Concurrent Review
Authorization of Care

30. Methadone Maintenance/LAAM Only

A. Current Dosage_____

B.Discussed Therapeutic Detox with Client?
Yes_____Explain:

No_____Explain:

31.A. Is client currently using alcohol and/or illicit drugs? Yes____No_____

B.List interventions to address usage (e.g. Administrative detox, change in level of care):

HealthChoice
Managed Care Organization
Resource List

AMERIGROUP Maryland, Inc.
7550 Teague Road. Ste 500
Hanover, MD 21076

Telephone Number: 410-859-5800
Fax Number: 410-981-4010

Member Services:
Telephone #: 1-800-600-4441
Fax #: 757-473-2736

Provider Services:
Telephone #:: 1-800-454-3730
Fax #: 757-473-2736

Utilization Review/Preauthorization:
Telephone Number: 1-800-454-3730
Fax Number: 1-800-964-3627

Special Needs Coordinator:
Telephone#: 410-981-4060
Fax#: 410-981-4065

Outreach/Case Management:
Telephone Number: 1-800-454-3730
Fax Number: 1-800-964-3627

Foster Care Liaison:
Telephone#: 410-981-4060
Fax#: 410-981-4065

Diamond Plan
Coventry Health Care of
Deleware, Inc.
Ambassador Center D
6310 Hillside Court
Suite 100
Columbia, MD 21046

Telephone Number: 443-436-3125
Fax Number: 443-436-3123

Member Services:
Telephone #: 1-866-533-5154 or
TDD: 1-877-843-1942

Provider Services
Telephone #: 443-436-3111
Fax #: 1-866-212-5305 ext. 3111

Utilization Review/Preauthorization:
Telephone Number: 1-800-727-9951

Special Needs Coordinator:
Telephone#: 1-800-727-9951 ext. 1730

Outreach:
Telephone Number: 1-866-497-2475

Foster Care Liaison:
Telephone#: 443-436-3159

Jai Medical Systems Inc.
5010 York Road
Baltimore, MD 21212
Telephone Number: 410-433-2200

Member Services:
Telephone#: 1-888-524-1999
Fax#: 410-433-4615

Provider Services:
Telephone #: 410-433-2200
Fax #: 410-433-4615

Utilization Review/Preauthorization:
Telephone #: 410-433-2200
Fax #: 410-433-8500

Special Needs Coordinator:
Telephone#: 410-433-2200
Fax #: 410-433-8500

Outreach/Case Management:
Telephone Number: 410-433-5600
Fax Number: 410-433-8500

Foster Care Liaison:
Telephone#: 410-433-2200
Fax #: 410-433-4615

MedStar Family Choice
8094 Sandpiper Circle
Suite O
Baltimore, MD 21236

Telephone Number: 410-933-3021
Fax Number: 410-933-3019

Member Services:
Telephone #: 1-888-404-3549

Provider Services:
Telephone #: 410-933-3069
Fax #: 410-933-3077

Special Needs Coordinator:
Telephone#: 410-933-2226
Fax #: 410-933-2209

Preauthorization:
Telephone Number: 410-933-2200 or
1-800-905-1722 Option 1
Fax Number: 410-933-2274

Foster Care Liaison:
Telephone#: 410-933-2226
Fax#: 410-933-2209

Outreach/Case Management
Telephone Number: 410-933-2200 or
1-800-905-1722 Option 2
Fax Number: 410-933-2264

Maryland Physicians Care
509 Progress Drive
Suite 117
Linthicum, MD 21090-2256

Telephone Number: 410-401-9400

Utilization Review/Preauthorization:
Telephone Number: 1-800-953-8854
Option 2, Option 1
Fax Number: 1-800-953-8856

Outreach/Case Management
Telephone Number: 1-800-953-8854
Option 2
Fax Number: 410-609-1875

Member Services:
Telephone#: 1-800-953-8854, Option 1
Fax#: 410-401-9015

Provider Services:
Telephone #: 1-800-953-8854 Option 2
Fax #: 410-609-1927

Special Needs Coordinator
Telephone #: 410-401-9443

Fax #: 410-609-1875

Foster Care Liaison:
Telephone#: 301-729-5642
Fax# 410-609-1849

Priority Partners
6704 Curtis Court
Glen Burnie, Maryland 21060
Telephone Number: 410-424-4400
Fax: 410-424-4880 or 4883

Utilization Review/Preauthorization:
Telephone Number: 410-424-4480
1-800-261-2421
Fax Number: 410-424-4603

Outreach
Telephone Number: 410-424-4648 or
1-888-500-8786
Fax Number: 410-424-4884

Member Services:
Telephone #: 410-424-4500 or
1-800-654-9728
Fax #: 410-424-4895
Provider Services:
Telephone #r: 410-424-4490 or
1-888-819-1043
Fax #: 410-424-4895

Special Needs Coordinator:
Telephone#: 410-424-4906
Fax#: 410-424-4887

Foster Care Liaison:
Telephone#: 410-424-4906
Fax#: 410-424-4887

UnitedHealthcare
6095 Marshalee Drive
Elkridge, MD 21075

Telephone Number: 410-379-3400
Fax Number: 410-379-3480

Utilization Review/Preauthorization:
Telephone Number: 1-866-604-3267
Fax Number: 1-800-766-2917

Outreach:
Telephone Number: 410-379-3460
Fax Number: 410-540-5990

Case Management:
Telephone Number: 410-540-4303
Fax Number: 410-540-5977

Member Services:
Telephone #: 1-800-318-8821
Fax #: 410-379-3474

Provider Services:
Telephone #: 1-877-842-3210
Fax#: 410-379-3449

Special Needs Coordinator:
Telephone #: 410-540-4326
Fax #: 410-540-5977

Foster Care Liaison:
Telephone#: 410-379-3460
Fax#: 410-540-5990