Maryland Public Behavioral Health System (PBHS) Level of Care Appendix

Click on the links below for specific information on available Levels of Care:

Mental Health (MH) Services	Substance – related and Addictive Disorders
Behavioral Health Homes	**Substance Related Disorders**
Enhanced Support Services	Early Intervention (ASAM Level 0.5)
Gambling	Assessment and Referral (ASAM Level 1)
Home and Community Based Services (HCBS): Intensive Behavioral Services for Children, Youth and Families-1915(i)	Outpatient Treatment Services (ASAM Level 1)
Home and Community Based Services (HCBS): Traumatic Brain Injury (TBI)	Opioid Treatment Services (ASAM Level 1)
Inpatient (IP)	Intensive Outpatient (ASAM Level 2.1)
Intensive Outpatient Program (IOP)	Partial Hospitalization (ASAM Level 2.5)
Interdisciplinary Team Treatment Planning	Low Intensity Residential (ASAM Level 3.1)
Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)	Medium Intensity Residential Treatment (ASAM Level 3.3)
Nursing Facility Services-Pre-Admission Screening and Resident Review (PASRR)	High Intensity Residential Treatment (ASAM Level 3.5)
Occupational Therapy (OT)	Intensive Residential Services (ASAM Level 3.7)
Outpatient (OP)	Medically Managed Intensive Inpatient Services (ASAM Level 4.0) in Institutions for Mental Diseases (IMDs)
Partial Hospital Program (PHP)	Withdrawal Management (All ASAM Levels of Care)
Psychiatric Rehabilitation Program (PRP)	Behavioral Health Homes
Psychological Testing Services	Maryland RecoveryNet (MDRN)
Residential Crisis Services (RCS)	
Residential Rehabilitation Program (RRP)	
Residential Treatment Center (RTC)	**Non-substance Related Disorders**
Respite Care	Gambling
Supported Employment (SE) Services	
Targeted Case Management (TCM)	
Therapeutic Behavioral Services (TBS)	

Public Behavioral Health System (PBHS) Levels of Care

The following information is provided as an overview of the levels of care offered by the Maryland Public Behavioral Health System (PBHS). Complete **Medical Necessity Criteria, Guidelines and Policies** and **Best Practice Guidelines**, can be found at https://optum.maryland.com

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Behavioral Health Homes

For more information on Behavioral Health Homes see https://mmcp.health.maryland.gov/Pages/Health-Homes.aspx.

Who is eligible to receive this service?	• Health Homes is available to Medicaid beneficiaries who have been diagnosed with: - SMI and are currently receiving PRP or MT services - SED and are currently receiving PRP or MT services - an Opioid SUD and are at risk for additional chronic conditions due to the following risk factors: o Current alcohol, tobacco, or other non-opioid substance use o History of alcohol, tobacco, or other non-opioid substance dependence
Who is eligible to provide this service?	To enroll as a Health Home, providers must be: • enrolled as a Medicaid provider with the State of Maryland • licensed as a PRP, Mobile Treatment, or OTP provider • accredited, or in the process of seeking Health Home accreditation • able to meet minimum Health Home staffing requirements • able to provide Health Home services and meet specified reporting requirements

Eligibility Reminders

- Individuals receiving the following services are excluded from Health Home eligibility:
  - Services via 1915i SPA
  - Targeted Mental Health Case Management

Authorization Reminders

For current information on authorizations please see https://mmcp.health.maryland.gov/Pages/Health-Home-Requirement-Information.aspx

Discharge Reminders

- Discharge from the Health Home primarily results from incidents such as relocation or loss of Medicaid eligibility
- If a participant is discharging from Health Homes due to stabilization, the participant may remain in the program for six months. During the six month period, the provider is responsible for constructing a discharge plan designed to support the participant's transition into the appropriate level of care.

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Mental Health – Enhanced Support Services	
Who is eligible to receive this service?	• Medicaid Participants • Maryland Public Behavioral Health System (PBHS) eligible Medicare recipients • Uninsured Eligible Participants with eligibility span for PRP, RRP, MTS (includes Medicare and State Funded Medicaid participants)
Who is eligible to provide this service?	• Enhanced support services can only be provided by approved Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRP), and Mobile Treatment Services (MTS)

Authorization Reminders

- Prior authorization is required
- Providers must submit a prior authorization request via Provider Connect
- The Core Service Agency (CSA) or Local Behavioral Health Authority (LBHA) reviews requests and makes determinations
- If a CSA or LBHA Care Manager is unable to authorize the service as medically necessary, the request for services will be referred to a CSA or LBHA Physician Advisor for review
- Determinations will be communicated via Provider Connect

Service Reminders

nhanced support services:

- will be provided in the participant's place of residence
- are not available for participants in inpatient facilities, residential treatment center (RTC) settings, or partial hospitalization programs (PHPs)
- are considered short-term and will be reimbursed for a maximum of 10 days per episode/30 days per calendar year
- cannot be authorized in conjunction with respite services
- do not cover the provision of personal care services, which may be reimbursable by Medicaid under a separate funding authority
- are not available for individuals who meet criteria for a Medicaid Home and Community Based Waiver (e.g., DDA Community Pathways Waiver, TBI Waiver, Community Options Waiver - Community First Choice

Billing Reminders

- A unit of enhanced support Services is one hour of services
- The number of units must equal the number of hours enhanced support services were provided (e.g. one unit = one hour, six hours = six units)
- Each day of service must be on a separate claim form line, and claims must specify an ICD-10 code, not DSM 5 code

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Gambling Services

Who is eligible to receive this service?	• All Maryland residents, regardless of insurance coverage type. This includes: Medicaid eligible, Medicaid ineligible, uninsured or privately insured • Participants must be a Maryland resident • Participants may be individuals with problem gambling, and/or loved ones/ concerned others
Who is eligible to provide this service?	• Providers eligible for reimbursement of this service must be either a private practitioner (individual or group) or a community-based provider • Private practitioners must be in good standing with the appropriate professional board(s) • Community-based providers must either be a Federally Qualified Health Center or licensed in accordance with COMAR 10.63 as a substance use, mental health or integrated behavioral health program at the following levels of care: - Ambulatory SUD programs for Level 1 and Level 2.1 - Residential SUD programs for Level 3.1, 3.3, and 3.5 - Outpatient Mental Health Clinics (OMHC) - Mental Health Intensive Outpatient

Maryland Center of Excellence on Problem Gambling

- Private practitioners and community-based providers must ensure the staff is trained and competent to provide services to individuals with problem gambling and/or loved ones/ concerned others
- The Maryland Center of Excellence on Problem Gambling is available to provide problem gambling training and clinical consultation at no cost to programs
- Providers may contact the Center of Excellence on Problem Gambling at www.mdproblemgambling.com or at (667) 214-2120 for further information

Provider Information

Medicaid Providers

- Providers already enrolled in Maryland Medicaid and registered with Optum

  Please register with Maryland Center of Excellence on Problem Gambling:
  - Apply through the Maryland Center of Excellence on Problem Gambling's (COE) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application/
  - An acknowledgement of receipt of the application will be provided to the applicant
  - Following a review of the application information by Center clinical staff, a confirmation notice of enrollment will be sent to the provider. The provider may then register with Optum Provider Connect
  - Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline.

Non-Medicaid Providers

- Providers do not need to be enrolled with Medicaid, and should not enroll with Medicaid if they are only seeking reimbursement for gambling services and do not wish to provide any other Medicaid reimbursed

services

- Providers that are not enrolled, and do not wish to become enrolled, with Maryland Medicaid should follow the approval process detailed below. Please follow the approval process below before registering with Optum Provider Connect:
    - Apply through the Maryland Center of Excellence on Problem Gambling's (COE) website at http://www.mdproblemgambling.com/problem-gambling-treatment-reimbursement-application/
    - An acknowledgement of receipt of the application will be provided to the applicant.
    - Following a review of the application information by Center clinical staff, a confirmation notice of enrollment will be sent to the provider. The provider may then register with Optum Provider Connect.
    - Once approved, the provider may also complete the Provider Referral registration form https://is.gd/DGProviderReferral in order to be included in the Provider Referral Directory posted on the Center's website and used for referrals from the 1-800-GAMBLER Helpline

Authorization Reminders

- Initial and concurrent authorization requests can be requested via Provider Connect.
- Only the following diagnosis are eligible for gambling services:
    - Mental Health:
        - F63.0 Pathological Gambling
    - Substance Use (SGAM):
        - F63.0 Pathological Gambling
        - Z72.6 Gambling and Betting Problems related to Lifestyle
        - Z71.9 Counseling unspecified
- Electronic authorizations are completed by the provider through submission of up to date clinical information in Provider Connect for members registered with the SGAM fund and allowable covered diagnoses. When reviewing the eligible fund sources, a provider should review the participant file for the SGAM funding source. If the provider does not see SGAM listed on the participants file, they will need to register the participant through the Provider Connect site under Member Registration. On this screen you will see a section marked Requested Services and should check the box marked Gambling Services. This will register the participant for this eligible funding source for up to one year.
  Upon discharge, the provider must discharge the participant from their service by going to Provider Connect and entering a discharge. Providers should note that entering discharge information is an important step and is reimbursable.

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Mental Health – Home and Community Based Services (HCBS): Intensive Behavioral Services for Children, Youth and Families – 1915(i)	
Who is eligible to receive this service?	• Medicaid Participants, under 18 years of age at time of enrollment. • Additional clinical and financial eligibility criteria also apply, per COMAR 10.09.89.03. • Termination of enrollment, for a variety of conditions, is also described in COMAR 10.09.89.04.
Who is eligible to provide this service?	• Services may only be provided by approved 1915(i) service providers whose eligibility has been verified by the Maryland Department of Health (MDH) according to the process outlined in COMAR 10.09.89.08.

Eligibility Reminders

1. **Age:**
    a. Youth must be under 18 years of age at the time of enrollment although they may continue in 1915(i) HCBS benefit up to age 22.
2. **Residence**:
    a. Youth must reside in a home and community-based setting.
    b. Youth must reside in one of the geographic areas where the 1915(i) HCBS benefit is available
    c. Excluded community programs in which a youth may not reside while receiving the HCBS 1915(i) benefit are: group home; psychiatric respite care facility located on the grounds on an IMD for the purpose of placement; residential program for adults with serious mental illness licensed under COMAR 10.21.22.
3. **Consent:**
    a. Youth under 18 must have consent from the parent or legal guardian to participate; for young adults who are 18 or older and already enrolled, the young adult must consent to participate.
    b. Youth over 18 who are in the care and custody of the State, require consent from their legal guardian.
4. **Behavioral Health Disorder:**
    a. Youth must have a behavioral health disorder amenable to active clinical treatment. The evaluation and assignment of a DSM diagnosis must result from a face-to-face psychiatric evaluation that was completed or updated within 30 days of submission of the application to Optum.
    b. There must be clinical evidence the child or adolescent has a serious emotional disturbance and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment. Because of the clinical requirement that the young person have a serious emotional disturbance, it will be required for the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) HCBS benefit services.
5. **Impaired Functioning & Service Intensity:**
    a. A licensed mental health professional must complete a comprehensive psychosocial assessment within 30 days of the submission of the application to Optum. The psychosocial assessment must outline how the youth's functioning presents potential danger to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature.
    b. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity

Instrument (CASII) for youth ages 6-21.

c. Early Childhood Service Intensity Instrument (ECSII)
   i. Youth must receive a score of 4 (High Service Intensity) or 5 (Maximal Service Intensity)
   ii. Youth who are younger than six years old who have a score of 4 on the ECSII must:
      - Be referred directly from an inpatient hospital unit

-or-

      - If living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months

d. Child and Adolescent Service Intensity Instrument (CASII)
   i. Youth must receive a score of 5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24- Hours Medially Managed Services)
   ii. Youth with a score of 5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:
      - Transitioning from a residential treatment center (RTC)
      - Living in the community and:
         - If 13 years old or older, have:
         - Three or more inpatient psychiatric hospitalizations in the past 12 months

           -or-
         - Resided in an RTC within the past 90 days
         - If ages 6 through 12 years old and have:
           - Two or more inpatient psychiatric hospitalizations in the past 12 months

             -or-
           - Resided in an RTC within the past 90 days

- Youth will not be eligible for HCBS services if they meet any of the following criteria. Youth:
  - is hospitalized for longer than 30 days.
  - moves out-of-state for more than 30 days.
  - moves out of a geographic area within the state of Maryland where the youth cannot reasonably access services and supports during the initial phase-in of the 1915(i) HCBS benefit.
  - is admitted to and placed in an RTC for longer than 60 days.
  - is admitted to and placed in a group home setting licensed under COMAR.
  - is placed in a psychiatric respite care program, a non-medical group residential facility located on the grounds of an IMD primarily for the purpose of placement.
  - losses eligibility for Maryland Medicaid for more than 30 days.
  - turns 22 years old.
  - is detained, committed to a facility, or incarcerated for longer than 60 days.
  - has annual medical review that does not meet medical re-certification criteria.
  - has no CFT meeting held within 90 days.
  - is no longer actively engaged in ongoing mental health treatment with a licensed mental health professional.

Available Services

Intensive behavioral health services are provided by a program approved and operated under the provision of COMAR 10.09.89 and are provided in the participant's home or in an approved community-based setting.Services are designed to support the participant remaining in their homes by providing a

wraparoundservice delivery model. Services can include:

- **Care Coordination Organization (CCO)** – provides case management services to 1915(i) participants and families as described in COMAR 10.09.90.
- **Child and Family Team (CFT)** - a team of participants selected by the participant and family to work with them to design and implement a plan of care.
- **Intensive In-Home Services (IIHS)** - strengths-based interventions with the youth and their family that include a series of components described in COMAR 10.09.89.14.
- **Mobile Crisis and Stabilization** – services offered in response to urgent mental health needs and are available on a short-term basis, 24-hours per day, seven days per week. These services are coordinated with the CCO and CFT; and are incorporated in the participant's plan of care.
- **Community-Based and Out-of-Home Respite Care** – services offered to provide stabilization and relief to caregivers from the stress of care giving. These services may be provided in the home or community. In-home services offer additional temporary support, in the home and overnight. Out-of-home respite services provide a temporary overnight living.
- **Peer-to-Peer Support** - services are offered to ensure that family and participant opinions and perspectives are incorporated into the CFT process and plan of care. Services are provided by a family support organization (FSO) as described in COMAR 10.09.89.10.
- **Expressive and Experiential Behavioral Services** - use of art, dance, music, equine, horticulture or drama to accomplish individualized goals as part of the plan of care. Services may be provided individually or in a group
- **Customized goods and services** - expenditures requested COMAR 10.09.89.09.
- **Behavioral Health Consultation –** services to health care professionals

Authorization Reminders

- Initial and concurrent authorization for services should be requested via Provider Connect.
- An initial assessment session (via mobile crisis services) is pre-approved for all participants and should be completed within the first week of CCO services to develop a crisis response plan. Subsequent to a crisis, services are pre-approved for up to a three-day stabilization period. Additional services require further documentation, review, and prior authorization.
- To obtain authorization for 1915(i) services, the CCO, working with the participant and family, must request a prior authorization. The clinical information required consists of the list of applicable DSM 5 diagnoses and the current need for requested service. The description of the requested services should be identified in the participant's individualized plan of care. The plan of care should be developed through the CFT process.
- Applicants shall have a face-to-face, psychiatric evaluation completed within 30 days of the submission of the enrollment application.
- IIHS, community-based respite services and in-home respite services are automatically authorized for 60 days. Thereafter, the services will be authorized in six-month increments.
- Peer-to-peer support services are automatically authorized for one year. Thereafter, the services will be authorized in six-month increments.
- A prior authorization request is required for any additional mobile crisis and stabilization, expressive and experiential behavioral services, and customized goods and services.

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Mental Health – Home and Community Based Services (HCBS): Traumatic Brain Injury (TBI)

Who is eligible to receive this service?	• Technical, medical, and financial eligibility for the program is established in COMAR 10.09.46 • Technical eligibility is based on the type of injury, age at injury, and location where the applicant is residing. • Technical eligibility is limited to an individual with a TBI that has occurred after the age of 21 who is in a state psychiatric hospital, an out-of-state placement funded through Maryland Medicaid, a state-owned and operated nursing facility, or a chronic hospital that is CARF accredited for inpatient brain injury rehabilitation.
Who is eligible to provide this service?	• Services may only be provided by approved 1915(i) service providers whose eligibility has been verified by the MDH) according to the process outlined in COMAR 10.09.89.08.

Available Services

The following four services are available through the TBI Waiver:

1. **Residential Habilitation:** Residential habilitation services provide participants assistance with acquisition, retention, or improvement in skills related to activities of daily living (ADLs) and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting. The services provided in a residential program are provided and reimbursed at one of the following three levels of service, as preauthorized in the participant's waiver plan of care approved by the Behavioral Health Administration (BHA):
    a. Level 1 requires a staff to participant ratio of 1:3, at a minimum, during day and evening shifts and non-awake supervision during an overnight shift or an awake staff person covering more than one site during the overnight shift.
    b. Level 2 requires a staff to participant ratio of 1:3, at a minimum, during day and evening shifts and awake, onsite supervision during an overnight shift.
    c. Level 3 requires a staff to participant ratio of 1:1 during day and evening shifts and awake onsite supervision during an overnight shift.
2. **Day Habilitation:** Day habilitation services provide participants with assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides, normally furnished four or more hours per day. The services provided in a day habilitation program are provided and reimbursed at one of the following three levels of services, as pre-authorized in the participant's waiver plan of care approved by BHA:
    a. Level 1 requires a staff to participant ratio of 1:6, at a minimum.
    b. Level 2 requires a staff to participant ratio of 1:4, at a minimum.
    c. Level 3 requires a staff to participant ratio of 1:1, at a minimum.
3. **Supported Employment:** Supported employment services include activities needed to support paid work by individuals receiving waiver services, including supervision and training. The services are provided and reimbursed at one of the following three levels of service, as pre-authorized in the participant's waiver plan of care approved by BHA:
    a. Level 1 requires staff members to provide daily contacts to the waiver participant.
    b. Level 2 requires staff members to provide a minimum of one hour of direct support per day.

c. Level 3 requires staff members to provide continuous support for a minimum of four hours of service per day.

4. **Individual Support Services:** Individual support services means assistance provided to an individual to enable them to fully participant in the community. This may include, but not be limited to, supports involving:
   - Budgeting
   - Medication administration
   - Counseling
   - Helping an individual to access and complete his or her education
   - Participation in recreational and social activities
   - Accessing community services
   - Grocery shopping
   - Behavioral and other services and support needed by the family of the individual
   - Developing relationships

Authorization Reminders

- TBI Waiver services are authorized, and must be approved by, BHA's Office of Older Adults and Long-Term Services and Supports in accordance with COMAR 10.09.46.

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Mental Health - Inpatient (IP)	
Who is eligible to receive this service?	• Medicaid Participants
Who is eligible to provide this service?	• Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. • Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.

Authorization Reminders:

- Providers are expected to submit the authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day from date of admission.
- Crisis services, hospital diversion programs, or CSA or LBHA crisis response systems will be explored prior to admission, when applicable, and available in the area.
- Concurrent authorization requests should be submitted via Provider Connect with supporting clinical information on the first uncovered day. For example, after an initial authorization span of March 1st to March 4th, if needed, the continued stay request should be submitted on March 4th.
- A courtesy review can be requested for uninsured participants

Discharge/Aftercare Planning

- Providers are expected to initiate discharge planning at the beginning of service delivery. A discharge plan should be included with the authorization request
- Providers are responsible for entering a discharge when the participant completes treatment.
- The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1st at 11:45 p.m., March 1st is a covered day. If the participant is discharged on March 4th at 4:00 p.m., March 4th is not a reimbursable day. March 3rd would be considered the last day covered.

Billing Reminders:

- During an IP stay, Maryland PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant.
- Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric IP day is covered. An additional authorization for professional fees is not needed.
- Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland PBHS for one history and physical per admission, and authorization is not required.
- Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric IP unit and requires discharge to a nursing home or residential treatment center, however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized IP day.

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Mental Health – Intensive Outpatient	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid)
Who is eligible to provide this service?	• Partial hospitalization programs (PHP) (Psychiatric Day Treatment Programs (PDTP)) approved under COMAR 10.63.03.08 and OMHCs approved under COMAR 10.63.03.05 may provide IOP services.

Authorization Reminders

- Initial and concurrent authorization requests can be requested via Provider Connect or telephonically.

Service Reminders

- Services for participants with co-occurring needs should be integrated and individualized to meet the needs of the participant.

Billing Reminders

- One day equals one unit, date spans will not be accepted.
- When IOP is provided by:
  - an OMHC, physician services are included in the rate
  - a hospital-based program, physician services may be billed separately.
- It is considered duplicative to bill two IOP units for the same participant/same day (i.e. substance use IOP and mental health IOP).
- The MarylandPBHS does not reimburse for non-mental health services such as 12-step programs.

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Mental Health – Interdisciplinary Team Treatment Planning Service	
Who is eligible to receive this service?	• Medicaid Participants • Uninsured Eligible Participants
Who is eligible to provide this service?	• Interdisciplinary team treatment planning meetings are provided by OMHCs approved under COMAR 10.63.03.05.

Authorization Reminders

- Authorization for this service is not required.

Service Reminders

- This service is only available for OMHCs.
- A participant may receive up to two interdisciplinary team treatment planning meetings per calendar year.
- The participant is actively engaged in this process and must sign agreement with the plan.
- If the participant is unwilling to sign agreement with the plan, the participant's treatment coordinator will verify the participant's verbal agreement with the plan and document the rationale for the participant's refusal to sign.
- If the participant is a minor, the minor's parent or guardian, or the minor's primary caretaker, must sign agreement with the plan. With proper consent, family or others designated by the participant, including the participant's caregivers, may sign the plan.
- The plan should include the participant's diagnosis, presenting needs, strengths, recovery and treatment expectations and responsibilities. Descriptions of treatment and interventions to be provided, as well as a description of how identified treatments will help the participant manage the psychiatric disorder and support recovery, should also be included. Measureable short-term and long-term treatment goals should be documented, including targeted completion dates for each goal.
- At least two licensed mental health professionals who collaborate about the participant's treatment must sign the plan.
- If the participant is receiving medication management prescribed through the OMHC, whoever prescribes the medication, the OMHC psychiatrist or certified psychiatric nurse practitioner in psychiatry, must sign the plan.

Billing Reminders

- Meetings may only be billed only once every 120 days.
- The participant must be present and seen face-to-face in order to submit a claim for this service.

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Mental Health - Mobile Treatment Services (MTS)/ Assertive Community Treatment (ACT)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Maryland PBHS-eligible Medicare recipients • Uninsured Eligible Participants • Adult participants in MTS/ACT must have a priority population diagnosis. • Permission to treat a minor is required from the legal guardian. Adolescents age 16 and over may consent to treatment for themselves.
Who is eligible to provide this service?	• MTS providers must be approved under COMAR 10.63.03.04 • ACT providers

Authorization Reminders

- Prior authorization is required and can be requested via Provider Connect.
- MTS/ACT is authorized in monthly blocks. Regardless of when in the month a request for MTS is authorized, the first day of the month is used as the beginning date of authorized service. For example, if the service begins mid-month, the provider will receive payment for the full month.

Visit Reminders

- Participants should be seen for four face-to-face visits each month. The four visits are a minimum requirement with the expectation additional visits will be provided as clinically indicated.
- The minimum four visits are to be provided on separate days.
- Occasionally, the MTS/ACT team attempts to meet with a participant and the participant is not at home or may refuse to see the team. In these instances, the BHA has indicated the program may count the attempted visits toward the four visits required per month. The MTS/ACT team is to document in the medical record the unsuccessful outreach attempts to see the participant.
- When participants are hospitalized for brief periods of time, MTS may see the participant in the hospital but may not count the visit towards the required four visits.
- Optum will contact the MTS/ACT provider for the purpose of service coordination when a participant served by the MTS/ACT site is hospitalized.
- The MTS/ACT provider is expected to exchange information and coordinate care with the participant's PCP or other somatic treatment providers.

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Mental Health – Nursing Facility Services and Pre-Admission Screening and Resident Review (PASRR)

- This screening assessment requirement applies regardless of payer type

Pre-Admission Screening and Resident Review (PASRR)

a. Pre-Admission Screening and Resident Review (PASRR) determinations will be reviewed to ensure that participants with serious mental illness are not unnecessarily institutionalized, but can live in the least restrictive environment where their needs may be met. If a nursing facility is the least restrictive environment that can meet their needs, then services will be identified for their optimal functioning.

b. Persons seeking admission to a nursing facility must be screened for the presence of serious mental illness (SMI), or an intellectual or developmental disability.

c. The PASRR process is outlined below:

- PASRR Level I screen is completed by the discharging hospital or admitting nursing facility. The Level I screen identifies persons who have or may have a PASRR related condition, and requires them to receive a further physical and psychosocial evaluation, known as a PASRR Level II assessment.
- PASRR Level II assessment is completed by the local Health Department, Adult Evaluation and Review Services (AERS) within 5 business days. The Level II Evaluation will include specific and clear recommendations by the AERS Reviewer for nursing facility services.
- The completed PASRR Level II assessment is submitted to the ASO via Provider Connect and a review of the Level II assessment will be completed by the ASO within three business days of a completed request.
- The ASO PASRR Nurse will review all requests and communicate the determination to AERS and the requesting facility.
    - If approved, the PASRR Nurse will send a determination letter to the AERS office.
    - If a denial is rendered by an ASO psychiatrist, then the ASO shall notify in writing the applicant of his/her right to appeal the determination.

d. Both the baseline and the comprehensive care plans required for nursing facility residents must include any “specialized services” identified in the Level II PASRR certification.

e. Behavioral health services may also be arranged for a nursing facility resident who did not require the Level II evaluation yet may need services of a lesser frequency or intensity. The same process applies: the facility identifies a BH provider who requests a prior authorization for services from Optum via Provider Connect.

Authorization Reminders

- Initial and concurrent authorization for services can be requested via Provider Connect or telephonically.
- Some services require a denial from Medicare before the ASO can authorize the specific service for a dual eligible (Medicare/Medicaid) participant.

Service Reminders

- The ASO may recommend “specialized services” as part of an individualized plan of care to treat the behavioral health conditions of persons admitted to the nursing facility.

Billing Reminders

- Maintenance mental health services for participants in nursing homes are expected to be covered by the nursing homes under the day rate paid by Medicaid.
- Nursing home psychiatric consultation services are not covered by the Medicaid day rate. These services will be paid for by the Maryland PBHS if prior authorization is obtained from Optum and medical

necessity criteria are met.

- The Division of Long Term Care Services will conduct post-utilization audits of behavioral health claims to evaluate the provision of these services in the nursing facility setting and appropriate utilization, and also determine compliance with PASRR requirements, by matching recipients of services with documentation of PASRR reviews.

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Mental Health – Occupational Therapy	
Who is eligible to receive this service?	• Medicaid Participants under age 21 • Dual Participants (Medicare/Medicaid) • The PBHS does NOT reimburse PHP services rendered to uninsured eligible participants.
Who is eligible to provide this service?	• Occupational therapy may be needed in any service setting in conjunction with other treatment modalities.

Additional Information:

- Occupational therapy performed in an inpatient unit by a hospital-based partial hospitalization program, or a hospital-based outpatient program, is provided as medically necessary, and does not require authorization.
- Occupational therapy services are not included in the daily rate for private psychiatric hospitals (Institutes of Mental Disease). Consequently, occupational therapy services provided in private psychiatric hospitals must be billed by a professional or professional group.
- Occupational therapy performed in an inpatient unit by a hospital-based partial hospitalization program, or a hospital-based outpatient program, is provided as medically necessary, and does not require authorization.

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Mental Health - Outpatient Services	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants
Who is eligible to provide this service?	• OMHCs regulated under COMAR 10.63.03.05. • Individual mental health professionals authorized and/or licensed by the appropriate practice boards. • All providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with the MDH.

Authorization Reminders

- Outpatient services require registration via Provider Connect.
- Outpatient services will only be authorized for registered PBHS participants who have a mental health diagnosis covered by the PBHS. For a list of diagnosis, see https:\\optum.maryland.com.

Service Reminders

- Family psychoeducation (FPE) is a reimbursable service under the PBHS only if the agency/provider is an approved OMHC and meets the eligibility requirements outlined by the Maryland Behavioral Health Administration (BHA). FPE is not age-restricted and is available to both Medicaid participants and uninsured eligible participants. The groups meet bi-weekly and may extend for up to two years. Prior authorization is required.
- OMHCs, individual practitioners, and those in private group practice may provide services in any location except a hospital medical unit, an adult medical daycare center, and emergency rooms (if included in the hospital rate). However, the fee remains the same as on-site service rates.

Billing Reminders

- The Maryland PBHS will not reimburse, as the primary payer, for services covered by Medicare for Medicare recipients served by OMHCs or individual practitioners.
- Only providers rendering services in an OMHC or HSCRC regulated outpatient service may be reimbursed for extended sessions (CPT 90839).

Mental Health - Outpatient Services - In the School Setting	
Who is eligible to receive this service?	• Participants are currently enrolled in the school at which mental health services are being provided and are eligible as defined in COMAR 10.09.59.05. • In order to be reimbursed by Medicaid, the participant must meet required medical necessity criteria and at least one of the diagnoses outlined in COMAR 10.09.70.02.J.
Who is eligible to provide this service?	• Licensed mental health professionals practicing as individual providers and appropriately licensed staff under OMHCs are eligible per their respective COMAR. • Providers should ensure all clinicians assigned to work in the school setting have completed background checks/fingerprinting.

Authorization Reminders

- Authorization requirements can be found in COMAR 10.09.59.08.

Service Reminders

- Substance use disorder (SUD) treatment programs (Provider Type 50s) may be reimbursed by Medicaid for outpatient SUD services provided in the school setting when billed with the place of service (POS) 03 for schools. This includes:
    1. SUD assessment (H0001)
    2. Level 1 group and individual SUD counseling (H0004, H0005)
- Licensed professionals practicing as individual providers as defined in COMAR 10.09.59.04 and appropriately licensed staff under outpatient mental health centers (OMHCs) as defined in COMAR 10.63.03.05 may provide services in the school setting and be reimbursed by Medicaid (through CPT codes) when billed with the POS 03 for schools. This applies to schools with a School-Based Health Center, as well as those in formal partnership with a community-based provider. Services should be consistent with those provided to individuals in the community and be appropriate to the school setting, such as:
    1. Psychiatric diagnostic evaluation (initial assessment)
    2. Individual and group therapy (ongoing)
- Services delivered in the school setting may not duplicate services delivered by programs or counselors out of the school setting on the same day.

Billing Reminders

- Providers should use Place of Service (POS) 03 when billing for services located in the schools.

Additional School Based Services Reminders

- If a school opts to participate, they should alert their school staff and teachers through an official memorandum that mental health treatment is now available in their school and should include appropriate information about process and contacts.
- The school and clinicians are responsible for identifying a space that ensures confidentiality for identified participants.
- All clinical notes should be maintained in the provider's office using storage standards set forth by the HIPAA and 42 CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.

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Mental Health - Partial Hospitalization (PHP)*	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • The PBHS does NOT reimburse PHP services rendered to uninsured eligible participants.
Who is eligible to provide this service?	• Services may or may not be hospital-based and have applicable reimbursement rates depending on their site. • A multidisciplinary team, including a psychiatrist, a nurse, and other professionals, should be available to provide this service. • See COMAR 10.63.03.08 for more information.

Additional Information:

- Psychological testing for participants enrolled in a PHP requires a separate authorization and must be administered outside of the hours billed for PHP. A physician's service may be billed for a Medicaid recipient, in addition to the PHP stay, when provided in a hospital setting.
- One psychiatric visit per day is allowed without a separate authorization.
- Non-hospital-based PHPs do not have a provision for this additional physician payment as it is already included in the PHP rate.
- Occupational therapy performed in a PHP setting, by the PHP staff, does not require an authorization.
- Private occupational therapists or occupational therapy groups require authorization.
- In order to receive reimbursements through the PBHS, all providers under COMAR 10.63.03.08 must also be Medicare providers or compliant with Medicare rules if in a freestanding PHP.

*Also known as Psychiatric Day Treatment Program (PDTP)

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Mental Health – Psychiatric Rehabilitation Program (PRP)

Who is eligible to receive this service?	• Participants with federally-funded Medicaid • Fully dual eligible participants (Medicare/Medicaid) • Those who were receiving PRP services when they lost their federally-funded insurance. • State funded Medicaid and uninsured eligible participants are eligible for PRP services only when they meet medical necessity criteria and have been discharged from: - a state hospital and are on conditional release - an acute care hospital or institution for mental disease (IMD) within the last six months - a RRP bed within the last six months - jail or incarceration within the last six months
Who is eligible to provide this service?	• PRP services may only be performed by PRPs approved according to COMAR 10.63.03.09 and COMAR 10.63.03.10. • PRP providers must have an active Maryland Medicaid provider number and a signed provider agreement with BHA.

PRP Levels of Care

The following are four different levels of care a participant may be authorized to receive:

1. Community PRP
    a. Services provided to:
        - Children in foster homes in which psychiatric services are not part of the day rate
        - Participants ages 18-25 (transition age youth [TAY]), if provided by a BHA-designated Transition-Age Youth Program.
        - Adults under legal guardianship
    b. Services are provided to participants at a minimum of two visits per month.
2. Supported/Independent Living PRP
    a. Services provided to adults who are their own legal guardian.
    b. Services are provided to participants at a minimum of two visits per month.
3. Residential – General Support PRP
    a. Services provided to participants receiving PRP services from a licensed RRP with staff that is available on-call 24/7
    b. Services are provided to participants at a minimum of three face-to-face contacts per week, or 13 face-to-face contacts per month.
4. Residential – Intensive Support PRP
    a. Services provided to participants receiving PRP services from a licensed RRP with staff that is available on-call 24/7
    b. Services are provided at a minimum of daily support onsite in the residence, with a minimum of 40 hours per week, up to 24 hours a day, seven days a week.

Authorization Reminders

- PRP providers must complete an individualized rehabilitation plan (IRP) according to the requirements of COMAR COMAR 10.63.03.09 and COMAR 10.63.03.10.
- Optum makes the medical necessity determinations for all levels of PRP and RRP services, except

those of transitional PRP.

- Optum makes all initial determinations on the level of the service and whether the service will be onsite, off-site, or blended.

Service Reminders

- Children and adolescents placed in a crisis bed program may attend a PHP or PRP during the day, depending upon the clinical needs of the participant. Services are authorized separately based on the participant's needs and medical necessity.
- PRP services are not to be utilized for family therapy.
- Transportation is not a PRP service and cannot be counted as a visit.
- BHA will not authorize or pay for PRP for a child residing in a therapeutic group home, or therapeutic foster care setting if similar support services are part of the per diem rate of that youth in placement. There may be limited reimbursement for a child residing in a regular group home. These residential settings are responsible for promoting the skills required for daily living and may at times need to provide intensive support or supervision to youth in their care.
- BHA will not authorize or reimburse a provider for onsite only PRP services for a participant who is receiving Medicaid-covered medical day care services during the same month. However, the provider may submit the blended rate PRP services provided to a participant also receiving medical day care as long as the minimum service requirements are met by providing only off-site services. The off-site PRP services may not be delivered at the medical day care program.
- Participants receiving PRP services are expected to receive within the provision of PRP services. basic case management services, such as assistance in securing entitlements and accessing transportation to appointments, coordination of services, and liaison with external services (somatic, substance use, and mental health. Therefore, requests for targeted case management or mobile treatment for participants enrolled in PRPs will not be approved.
- Onsite services provided by two different PRP programs, as well as off-site services provided by two different PRP programs, is a duplication of services and is not allowed.
- No more than one transitional PRP service per day, for a minimum requirement of four PRP services, while a participant is in a state psychiatric hospital or crisis bed may be authorized, as medically necessary. These visits must be pre-authorized by the CSA and are paid out of State general funds.
- Participants authorized for RRP services receive, at a minimum, off-site PRP services in the RRP residence. Off-site PRP services cannot be reimbursed to providers if services are provided in an adult day care center. For off-site PRP services to be covered, the participant must be seen in their own home or outside of hours spent in the adult day care center. When a service begins onsite at the PRP facility, goes off-site, and then returns to the PRP facility, it is considered an onsite service.
- All adult and child/adolescent PRP services must be referred to by the licensed mental health provider who is treating the participant. There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional every six months

Billing Reminders

A unit of PRP services is one month. Each level of PRP service stipulates a minimum number of face-to-face visits to be provided. Encounter data for face-to-face visits must be submitted. Providers may submit claims once monthly for this service *and the submission must occur after the provider has met the minimum threshold to support the claims payment*. For more information see PBHS Provider Billing Appendix https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/pbhs/PBHS%20Provider%20Billing%20Appendix.pdf

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Mental Health – Psychological Testing	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible *(PBHS reimburses if/when state funds are available)*
Who is eligible to provide this service?	• Licensed psychologists and psychological associates contracted with Maryland Medicaid to perform psychological testing. • In limited situations, such as in an OMHC or in a hospital with a psychology training program, interns and externs may administer psychological testing under the supervision of a licensed psychologist.

Authorization Reminders

- Prior authorization is required and can be requested via Provider Connect.
- Providers can request time for a clinical interview prior to the administration of a psychological test. Units for initial interview and feedback session with the participant and family member or caregivers to discuss the results of the psychological testing and its implications are processed at the same time the number of hours of testing is authorized.
- Psychological testing requires a separate authorization request and is not included with other outpatient authorization requests

Service Reminders

- There is a maximum eight hour limit for psychological testing per participant, per calendar year.
- Testing regarding basic intellectual, cognitive, academic, developmental, psycho-motor and visual-motor functioning is usually considered educational. Testing that is partially or primarily for educational purposes is not a covered benefit.
- Testing for a medical condition is the responsibility of the Managed Care Organization (MCO) and should be referred to the MCO for authorization.

Billing Reminders

- The use of psychological interns, externs, or graduate students for psychological testing is not reimbursed by the PBHS to private practitioners. In limited situations this may be reimbursable, such as in an OMHC or in a hospital with a psychology training program.
- Psychological testing performed while the participant is at an Inpatient level of care, should not be billed If the inpatient day rate includes psychological testing.

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Mental Health – Residential Crisis Services (RCS)	
Who is eligible to receive this service?	• Medicaid Participants • Maryland PBHS-eligible Medicare recipients • Uninsured Eligible
Who is eligible to provide this service?	• Approved residential crisis programs, according to COMAR 10.63.04.04.

Authorization Reminders

- Prior authorization is required and can be requested via Provider Connect.
- A face-to-face assessment should be completed prior to requesting services.
- A participant is not eligible if the individual requires immediate involuntary inpatient psychiatric admission; has a sole diagnosis of substance use disorder, intellectual disability, or neurocognitive disorder; or is not medically stable.
- Providers can request additional authorizations by submitting a concurrent authorization request through Provider Connect. Concurrent authorization requests will be routed to the CSA or LBHA, in the area which the participant resides, for review. Provider must submit the concurrent request prior to the expiration of the previous authorization span.

Service Reminders

- RCS is intended to be used on a short-term basis to treat mental health conditions and not to be used solely to meet an individual's housing needs.
- A participant may need additional clinical services (e.g., a partial hospitalization program or an onsite psychiatric rehabilitation program) while in RCS. These additional services are authorized separately by Beacon and must meet medical necessity criteria. Enhanced support services are authorized only in rare circumstances when extreme clinical need exists

Billing Reminders

- In general, the only mental health professionals who may bill separately are psychiatrists. Services by other professionals are included in the RCS rate and will not be authorized or reimbursed separately.
- If the participant has insurance other than Medicaid, the provider is expected to bill the primary carrier for RCS and go through all appeals processes with the primary carrier prior to submission to Optum.
- The PBHS will not pay for RCS for individuals with private insurance. The provider is to contact the private insurer directly to seek reimbursement.

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Mental Health – Residential Rehabilitation Program (RRP)	
Who is eligible to receive this service?	• Medicaid Participants • Maryland PBHS-eligible Medicare recipients • Uninsured Eligible Participants
Who is eligible to provide this service?	• Service providers are RRPs approved by the MDH under COMAR 10.63.04.05.

Authorization Reminders

- Provider ConnectAll referrals for RRP services must be completed using the Statewide RRP application which must be sent with supporting documentation to the CSA or LBHA of the applicant's jurisdiction of origin.
- The CSA or LBHA screens referrals for RRP and also determines if other services are needed to support the participant. When other services are needed, the CSA or LBHA directs the referral source or the applicant to Optum. Optum may refer and authorize an array of support services. These services may negate the need for RRP or may sustain the applicant until RRP services are available.
- The CSA or LBHA reviews the application within two working days, and if appropriate, refers the applicant to an RRP that has an available bed.
- The CSA or LBHA authorizes an assessment for the RRP, the RRP has five working days to evaluate, accept, or deny the applicant. The RRP notifies the CSA or LBHA of the disposition and, if the participant is accepted for admission to the RRP, the CSA or LBHA signs a Certificate of Determination (COD) to document their approval of the placement and the requested level of care.
- After the RRP has evaluated and accepted the participant, the RRP electronically submits a Provider Connect prior authorization request for the required general or intensive PRP services and RRP bed days for review by Optum, to include the RRP application and the Certificate of Determination signed by the CSA/LBHA. Optum reviews the prior-authorization request and approves the RRP services if medically necessary. An authorization request will not approved in the absence of an RRP application signed by the participant a COD signed by the LBHA or CSA.
- Concurrent authorization requests should be submitted via Provider Connect prior to the expiration of the previous authorization time span.
- Changes in level of care must be requested via Provider Connect for medical necessity review.
- Changes in place of service (i.e. change from blended service to off-site only) do not require a medical necessity review. This type of request can be submitted via Provider Connect, or called in to Optum for a change to the authorization's place of service.

Wait List

- For participants in need of RRP who are unable to access the service due to lack of beds, the CSA or LBHA maintains a waiting list.
- The CSA or LBHA reviews and updates the waiting list monthly, checking to see if the participant has been linked to other PBHS services to support the participant, and if RRP is still needed.
- At all times, the CSA or LBHA decision is based on the need of the participant. Each CSA or LBHA has a written policy, approved by BHA that addresses waiting lists, including prioritizing for state hospital referrals, community referrals, and other services.

Out of County RRP

- The CSA or LBHA may refer the participant to an out-of-county RRP only for the following reasons:
  1. Participant Preference
     a. The participant requests to live in a particular jurisdiction.

b. The participant's family has relocated to another county and the participant wishes to be near their family.

2. Provider Capacity
    a. The current RRP agencies in the CSA or LBHA jurisdiction are at capacity and are not in a position to expand services.
3. Provider Capability
    a. The current RRP agencies in the CSA or LBHA jurisdiction lack special programming to meet the needs of particular participants referred (e.g., individuals who are deaf or hard of hearing, individuals who have a mental illness or substance use disorder).

- When the participant meets out-of-county criteria, the originating CSA or LBHA will forward the RRP application and supporting documentation to the CSA or LBHA of the jurisdiction in which the participant prefers to reside. The receiving jurisdiction acts on the request within two days of receipt.
- To obtain authorization for transitional visits, also known as trial visits, the provider must submit a prior authorization request through Provider Connect. The CSA or LBHA will review and authorize as appropriate.

Individual Rehabilitation Plan (IRP)

- Within the first 30 days of starting RRP services, RRP staff, in collaboration with the participant, should complete an assessment that includes the need for services, any behaviors that are potentially dangerous to self or others, the ability to perform basic self-care and to maintain personal safety.
- An IRP should also be completed within the first 30 days of the start of RRP services. RRP staff should specify the goals of RRP, the frequency of residential services, and the intensity of staff support.
- If the participant's service needs change, RRP staff should provide and document in the participant's record the services required by the change, notify relevant staff of the change initiated, and incorporate this information in the next IRP review.
- IRPs should take place at least every six months, but as frequently as is needed.

Service Reminders

- The participant must need, and be willing to participate in, off-site PRP services provided in the RRP residence.
- Attendance at an onsite PRP program is not a requirement for the participant to receive RRP services, and may not be mandated.
- Participants in RRP will not be authorized for case management services as a separate authorization.
- Participants in RRPs are not eligible for simultaneous mobile treatment services. Some clinical exceptions may apply.
- Participants may attend an onsite PRP with a provider which is different than where the participant receives the off-site residential services.
- Enhanced support services are available in certain situations and are authorized by the CSA or LBHA via electronic submission through Provider Connect.
- For supported employment (SE)participants in RRP, income derived from SE may be reviewed to determine if the individual has sufficient earned income to contribute to RRP cost of care without jeopardizing the individual's motivation for employment. Providers are expected negotiate with the individual regarding contributing to the cost of care so as to preserve the financial incentive for employment.

Discharge Reminders

- Providers are required to develop discharge plans for participants.
- Discharge of participants from RRPs, who are dropped off at emergency rooms while hospitalized is not

acceptable. Providers shall instead complete the following procedures:

- The Program Director shall collaborate with Optum to arrange for discharge from the program when services are no longer authorized by Optum or to discontinue residential services to a participant whose clinical needs exceed the RRP's ability to secure the safety and welfare of the participant or others.
- The Program Director shall maintain clearly written policies and procedures for the following processes:
  - discharge from the program
  - temporary suspension from a residence
  - discontinuing residential services when a participant's clinical needs exceed the RRP's ability to secure the safety and welfare of the participant or others, including criteria for discontinuation, and the progressive steps and interventions that the program will enact prior to discontinuing services

- Please contact the CSA or LBHA in advance of any discharge plans for those participants with complex clinical, medical, and rehabilitation needs who are at-risk of being discharged from the RRP. CSAs or LBHAs will assist community programs to access consultation in order to develop and implement a managed intervention plan (MIP) to further support the participant in the placement and to mitigate the risk of an unplanned discharge.

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Mental Health - Residential Treatment Center (RTC)	
Who is eligible to receive this service?	• Medicaid participants under the age of 21 • Some participants with a private insurance carrier may find it necessary to seek Medicaid when fiscal or time period limitations on their private policies have been exhausted. These participants will be reviewed at the time of the application for Medicaid.
Who is eligible to provide this service?	• All RTCs must have a Maryland or other state license to provide residential treatment services. • The RTC must also have an active Maryland Medicaid provider number.
Billing Codes	• Revenue code 100 or 101

Authorization Reminders

- Prior to admission an authorization request must be made via Provider Connect.
- A federally-mandated Certificate of Need (CON) for services is required. See Certificate of Need section below for more information.
- Concurrent authorization requests should be submitted via Provider Connect with supporting clinical information on the first uncovered day.

Discharge/Aftercare Planning

- Discharge planning must be considered prior to placement in an RTC and the discharge plan must be actively reviewed throughout the treatment process.
- Active discharge planning requires effective collaboration with the participant, the participant's family (or legal guardian), and other appropriate agencies and services providers.

Certificate of Need (CON):

- The CON is time-sensitive in that all elements must be dated within 30 days from when the participant enters the RTC.
- There is no standardized CON form; each provider uses his or her own format and all formats will be accepted if they each recommend an RTC placement. They must also include the following:
  - a **psychiatric evaluation**, completed by a board certified psychiatrist and must include a summary of the participant's presenting problem, current psychiatric symptoms and behaviors, treatment, medication, family, and educational history; all applicable diagnoses and a clear recommendation that the participant be placed in an RTC
  - a **psychosocial evaluation,** completed by a licensed mental health professional; an evaluation completed by a licensed graduate social worker (LGSW) or licensed graduate professional counselor (LGPC) must be co-signed by a licensed mental health professional. The psychosocial evaluation may include the components delineated in the psychiatric evaluation, but will provide further detail regarding: the presenting problem, family involvement, religious, social, educational, and legal history and a clear recommendation that the participant be placed in an RTC.
  - a **history and physical examination** signed by a physician or certified registered nurse practitioner (CRNP) that attests that the participant is medically appropriate and cleared for RTC placement
- The CON must be sent to both the CSA and Optum.

Additional Information:

- Treatment at this level of care requires family involvement. This must be documented in the participant's medical record.

- Enhanced support services are not available in an RTC. All services provided by the RTC must be included in the RTC rate.
- Psychological testing performed while a participant is being treated in an RTC is included in the RTC daily rate.
- Participants with another primary insurer (i.e. a commercial plan, TRICARE, etc.) should seek treatment in RTC facilities that are credentialed by (in-network with) that insurer.
- Admission to a non-participating facility, for any payer, does not make Medicaid the primary payer.
- Information regarding participants' plans and progress toward discharge goals is to be shared with the Child and Adolescent Coordinator at the CSA for that participant's county of residence. Should issues arise which interfere with activating the discharge plan, the CSA Child and Adolescent Coordinator is to be contacted for assistance. A CSA directory is available at: http://www.marylandbehavioralhealth.org/core-service-agency-directory
- The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician (PCP) and other treatment providers when clinically appropriate.

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Mental Health – Respite Services	
Who is eligible to receive this service?	• Medicaid Participants • Uninsured Eligible Participants
Who is eligible to provide this service?	• Approved respite service providers according to COMAR 10.63.03.15.

Authorization Reminders

Adult, child, and adolescent respite services are authorized as follows:

- Facility Based Respite:
  - Facility based respite providers can include licensed foster homes, group homes, or other facilities approved as a respite services provider.
  - Authorized in full-day increments, 12-hour minimum
- In-home Respite:
  - In-home respite services may be provided in the community at a variety of locations through prearrangement with the caregiver and the participant.
  - Authorized in hourly increments, 10 hours a day, maximum

Service Reminders

- Respite services differ from the following services:
  - *PRP services*, which targe active rehabilitation and training in social skills and instrumental activities of daily living.
  - *Residential crisis services*, which target acute psychiatric symptoms in a therapeutic milieu
  - *Shelter care*, provided through the Maryland Department of Social Services (DSS)
- Enhanced support services will not be authorized in conjunction with respite services for adults, children, or adolescents.

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Mental Health – Supported Employment (SE) Services	
Who is eligible to receive this service?	• Medicaid Eligible • Uninsured Eligible
Who is eligible to provide this service?	• Supported Employment (SE) Programs licensed under COMAR 10.63.03.16. • PRP-SE services may only be performed by a program jointly approved as a MHVP and a PRP and is regulated according to the provisions of COMAR 10.63.03.09.

Eligibility Reminders

- Services are available for adults in the PBHS with a diagnosis of serious mental illness and transition age youth with a primary mental health diagnosis, who express an interest in competitive employment and desire to work in the community; demonstrate a work history which has been non-existent, interrupted, or intermittent due to a significant psychiatric impairment and requires SE services to choose, obtain, maintain, or advance within competitive employment.
- For SE service recipients, income derived from SE may be reviewed to determine if the individual has sufficient earned income to contribute to RRP cost of care without jeopardizing the individual's motivation for employment. Providers are expected to negotiate with the individual regarding contributing to the cost of care, so as to preserve the financial incentive for employment.
- Participants who are recovering from serious mental illness or are transitioning from PRP services retain access to and eligibility for SE services as their symptoms abate and functioning improves as a means to further support, sustain, or extend their recovery from serious mental illness.

Authorization Reminders

- SE providers must submit the authorization request for SE through Provider Connect.
- Service authorization is determined by the CSA or LBHA.
- Requests are reviewed by the CSA or LBHA within 48 hours of the request.
- The DORS referral and application are completed coincident with the request for authorization of the Pre-placement Phase, and the uploading of a signed copy of the approved Request for Maryland Division of Rehabilitation Services (DORS) and Authorization to Disclose Health Information form. Prior to submitting the initial authorization request for CSA or LBHA approval, the SE provider shall ensure that all fields required for authorization of the SE service have been completed so that the DORS application may be populated.
- With participant consent, upon CSA or LBHA review and approval, the designated DORS is granted access to the Optum system. The DORS counselor's documented review of medical and psychological information found in the Optum system is sufficient for purposes of eligibility determination and disability priority assignment. Provider Connect

Service Descriptions

Non-evidence-based SE service, funded under the PBHS, consists of the following reimbursable service phases:

1. **Pre-Placement Phase (H2023)**:
    a. Authorized as one unit per authorization span.
    b. Includes, at a minimum, MHVP assessment, referral to DORS, entitlements counseling, and discussion of the risks and benefits of disability disclosure and informed choice.
    c. A request for re-authorization of the pre-placement service phase may be approved at the CSA's or LBHA's discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of re-

authorization requests is not guaranteed.

2. **Placement in a Competitive Job (H2024)** *(does not include agency-sponsored employment)*:
    a. Authorized as one unit per authorization span.
    b. Includes assisting the participant in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of employment, including any reasonable accommodations and adaptation requests requested by the individual.
    c. A request for re-authorization of the placement service phase may be approved at the CSA's or LBHA's discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of re-authorization requests is not guaranteed and must reflect the need for a separate and independent job development activity.
3. **Intensive Job Coaching Phase (H2024-21)** *(reimbursed by DORS; special intensive exceptions may be made for PBHS reimbursement):*
    a. One unit=15 minutes of service
    b. Includes the use of systematic intervention techniques designed to assist the supported employee learn to perform job tasks to the employer's specifications, develop the interpersonal skills necessary to assume the employee role and to be accepted as a full-status employee at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention to assist the individual in preserving the job placement, resolving employment crises and in stabilizing the employment situation for continuing employment. Job coaching also includes related job analysis, environmental assessment, vocational counseling, employer education and advocacy, mobility skills training and other support services as needed.
4. **Ongoing Support Services (non-evidenced based) (H2026)**:
    a. One unit per month of authorized service.
    b. Includes proactive employment advocacy, supportive counseling, and ancillary support services at or away from the job site, to assist the individual in maintaining continuous, uninterrupted, competitive employment and to develop an employment related support system. This includes encouraging the use of natural supports to the maximum extent possible.
    c. This service is not time limited and continues until the individual no longer needs or desires the service.
5. **Psychiatric Rehabilitation Program Services to Individuals in Supported Employment (PRP-SE) (S9445)**:
    a. One unit per month of authorized service; minimum of two visits for non-evidenced based providers
    b. Includes psychiatric rehabilitation service interventions needed to assist the individual to restore and improve coping skills, assertiveness skills, interpersonal skills and social skills necessary to function adaptively in the work environment or to develop compensatory strategies to minimize the impact of the individual's mental illness on his or her behavior while on the job.
    c. The service must be provided on the job, unless the individual has chosen not to disclose his or her disability to the employer. At the individual's request, the service may be performed at a mutually agreed upon community-based location, as indicated in the individual rehabilitation plan (IRP) or disclosure plan.
    d. Individuals must be competitively employed to receive this service.

Service Reminders

- The SE provider mast have an active and fully executed cooperative agreement with the Division of Rehabilitation Services (DORS) in order to be eligible for SE authorization and reimbursement. The provider must have capacity to provide all SE service phases and may not selectively limited the provision of SE services to certain SE service phases.

- All SE service recipients within the PBHS must apply for eligibility for DORS- funded job development and job coaching services, within the context of SE program services.
- In rare instances, when the individual refuses to be referred for DORS services and multiple failed attempts to engage the individual in DORS services have been documented and all other avenues to resolution of issues precluding the individual from accessing DORS services have been exhausted, a waiver of the referral requirement may be granted with CSA or LBHA approval and supporting documentation.
- The PBHS may authorize payment for intensive job coaching services if funds are available, with CSA or LBHA approval, when written documentation from the DORS field counselor on DORS letterhead of the DORS denial of service is submitted and sufficient justification exists to support the request.
- The MHVP provider may submit a request for pre-authorization of intensive job coaching services to the relevant CSA or LBHA jurisdiction, and specify the estimated number of units of service required, based on the individual's specific job duties and a corresponding assessment of the expected frequency, intensity, and duration of his or her support needs.
- The CSA or LBHA may grant authorizations up to 400 units of service per participant, with one unit of service equal to 15 minutes of service. All DORS service rules apply. The authorization is in lieu of a DORS authorization, when an official denial of service has been received, and is not intended to supplement the DORS authorization of intensive job coaching hours.
- The MHVP provider must secure a competitive placement prior to seeking authorization from the CSA or LBHA for the placement phase. The CSA or LBHA will review the placement information to screen out requests for authorization for agency-sponsored employment. Any SE placement or related SE services, occurring in a facility, entity, subsidiary, affiliate, or contract site that is owned, operated, or managed by its own approved supported employment program or its umbrella organization, will be considered to be agency sponsored employment, and will not be eligible for supported employment authorization and reimbursement within the PBHS.
- Ongoing support services or PRP-SE services may not be provided concurrent with intensive job coaching services.
- SE service recipients who acquire third party health insurance as a result of employment, obtained by virtue of receipt of SE services through an approved MHVP, may retain eligibility for SE. PRP-SE services must meet all applicable requirements for PRP services, as delineated in COMAR 10.63.03.09. Claims for PRP Services to individuals in SE must be substantiated by the submission of visit data which reflects the provision of a minimum of two discrete service visits per month, separate and apart from the visit data submitted to validate other PRP levels of care.
- The SE program must provide one employer contact per month, with proper consent and only if the individual has disclosed the existence of a disability to the employer.

Billing Reminders

- Before the Maryland PBHS pays for SE services, the SE program must enter into a written agreement with Maryland DORS for the provision of SE services.
- Providers submit claims to Optum for reimbursement.

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Mental Health – Targeted Case Management	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible Participants *(funded by the Maryland PBHS and managed by the local CSA)*
Who is eligible to provide this service?	• TCM may only be provided and reimbursed by programs competitive procured and selected by the LBHA or CSA and approved under COMAR 10.09.36.03, 10.09.45.04, 10.63.03.04, 10.63.03.05, 10.63.03.09, or 10.63.03.10.

Authorization Reminders

- Initial and concurrent authorization requests should be submitted via Provider Connect.

Service Reminders

- TCM is available to adults, adolescents and children.
- Adult TCM offers two levels of service intensity. Child and Adolescent TMC offers three levels of service intensity. The level of TCM services is based on the severity of the participant's mental illness.
- Adult TCM Services:
  - Adult Level I (Adult General): Maximum of two units of service per month. Minimum of 30 minutes face-to-face monthly. Does not include the assessment
  - Adult Level II (Adult Intensive): Maximum of five units of service per month. Minimum of one hour face-to-face monthly. Does not include the assessment
  - One unit of Adult TCM = any service provided on any given date of service where the contact is a minimum of one hour of either face-to-face contact with the participant or contacts with stakeholders and service providers on behalf of the participant.
  - The assessment uses one unit of service and is billed separately. Each participant shall be reassessed after the initial assessment at a minimum of once every six (6) months. A home visit is required at least once every 90 days.
- Child or Adolescent TCM *(also known as Care Coordination Services)*:
  - Child and adolescent, Level I (General)
    - Maximum of 12 units of service per month
    - Minimum of two units of face-to-face contacts with the participant are required
  - Child and adolescent Level II (Moderate)
    - Maximum of 30 units per month
    - Minimum of four units of face-to-face contact with the participant.
  - Child and adolescent Level III (Intensive)
    - Maximum of 60 units per month.
    - Minimum of six units of face-to-face contact with the participant are required.
  - One unit of service for a child or adolescent TCM is any service provided on any given date of service where the contact is a minimum of 15 minutes of face-to-face contact with the participant, the minor's parent/guardian, or contacts with stakeholders and service providers on behalf of the participant.
  - For child and adolescent Level I and Level II TCM services, four additional units of service above and beyond the monthly maximum may be billed during the first month of service to the participant and every six months thereafter to allow for comprehensive assessment and reassessment of the participant.

- A unit of service for telephonic contact for a child and adolescent TCM participant may not be reimbursed unless the provider has delivered at least eight minutes of service.

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Mental Health – Therapeutic Behavioral Services (TBS)

Who is eligible to receive this service?	Participants under the age of 21 and: • Medicaid Eligible • Maryland Public Behavioral Health System (PBHS)-Medicare Eligible • Uninsured Eligible
Who is eligible to provide this service?	• TBS are provided by Early and Periodic Screen Diagnosis and Treatment (EPSDT) providers as approved under COMAR 10.09.34. This includes the following provider types: - Developmental Disabilities Administration Providers - Outpatient Mental Health Clinics - Mental Health Mobile Treatment Unit - Psychiatric Rehabilitation Programs

Authorization Reminders

- Prior authorization is required and can be requested via Provider Connect.
- Initial assessment requests must include a TBS referral form, signed by a licensed clinician*, as well as a recent psychosocial assessment. The referral may either be a diagnostic evaluation or a psychosocial summary, signed by a licensed clinician.
- Upon completion of the initial assessment, additional TBS services can be requested via Provider Connect. Providers should propose a number of hours of service per week to serve the participant.

**If the clinician is a graduate-level clinician, i.e. LGSW or LGPC, the form must be co-signed by the supervising, independently licensed clinician, i.e. LCSWC or LCPC.*

Service Reminders

- Initial assessments are authorized for four units (1 hour) and are valid for 30 days, effective from the date of the authorization request submission in Provider Connect.
- TBS Services are authorized for 56 calendar days. The number of units will vary based on the hours requested by the provider, progress towards goals and continued medical necessity.
- Providers may request an additional assessment within two weeks of the end date of the 56 day service authorization. Authorization is requested via Provider Connect. Additional clinical information is not required when requesting an additional assessment.
- TBS is not to be used for participants who need services for habilitative, custodial, or activities of daily living.

Billing Reminders

- TBS units are 15-minute increments of time; therefore, four units is equivalent to one hour.
- TBS Providers may not bill for services:
  - provided in hospitals or crisis residential programs
  - not conducted face-to-face
  - that are part of another service paid for by the State (i.e. respite services, missed appointments, travel)

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Substance Use Disorder (SUD) Services

The ASAM Criteria is designated by MDH as the Medical Necessity Criteria for SUD level of care determinations. See https://www.asam.org/resources/the-asam-criteria. Links to **information regarding *The ASAM Criteria***, developed by the American Society for Addiction Medicine (ASAM), can also be found at https:\\optum.maryland.com

Substance Use Disorder (SUD) – Early Intervention (ASAM Level 0.5)	
Who is eligible to receive this service?	• Those who do not have a substance use related disorder documented, but who are, for a known reason, at-risk for developing a substance use related disorder. • Early Intervention is only reimbursable through the state of Maryland's Gran Funds, which are administered by the Local Addictions Authorities (LAAs) or LBHA. • Early Intervention services are not reimbursable through federally or state funded Medicaid or Dual Eligibility (Medicare/Medicaid).
Who is eligible to provide this service?	• Providers who have been approved by Medicaid to provide the service. • Community-based SUD programs shall: - meet and comply with all requirements set forth in COMAR 10.09.36. - receive certification by the BHA in accordance with COMAR 10.63.05.06. - meet the requirements established by the BHA as described in COMAR 10.63.05.06.
Authorization Reminders	
• Prior authorization is required and can be requested via Provider Connect.	
Billing Reminders	
• Providers should seek the direction and assistance of their LAAs or LBHAs who may be able to pay for services, depending on the availability of funds.	

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Substance Use Disorder (SUD) – Assessment and Referral (ASAM Level 1)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Providers should contact their LAA or LBHA in order to explore the possibility of using grant funds to support anyone not in one of these eligibility categories.
Who is eligible to provide this service?	• Community-based SUD programs that: - meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80. - receive certification by the BHA in accordance with COMAR 10.63.05.04. • Enrolled with Maryland Medicaid as Provider Type 50.
Authorization Reminders	
• Authorization requests can be submitted via Provider Connect.	
Billing Reminders	
• Assessments are limited to one, per provider, per participant, per year. • If there is a break in treatment for 30 or more days, an additional assessment (H0001) may be billed.	
Assessment and Referral (ASAM Level 1) - In the School Setting	
Who is eligible to receive this service?	• Participants who are currently enrolled in the school at which SUD services are being provided. • Participants served by a SUD treatment program are eligible as defined in COMAR 10.09.80.04. In order to be reimbursed by Medicaid, the participant must meet required medical necessity criteria and at least one of the SUD diagnoses outlined in COMAR 10.09.70.02.I. • Participants served by individual and OMHC practitioners are eligible as defined in COMAR 10.09.59. • For individual practitioners, the participant must be diagnosed with at least one of the SUD diagnoses outlined in COMAR 10.09.70.02.I. • For OMHCs, the participant is eligible if they have a primary diagnosis of a SUD (COMAR 10.09.70.02.I) and a secondary diagnosis of mental health (COMAR 10.09.70.02.J).
Who is eligible to provide this service?	• Certified or accredited SUD treatment providers are eligible as defined in COMAR 10.09.80.02 and 10.09.80.03. • Appropriately licensed professionals practicing as individual providers and appropriately licensed staff under OMHCs are eligible as defined in COMAR 10.09.59.04 and COMAR 10.63.03.05 respectively.
Authorization Reminders	
• Authorization requirements can be found in COMAR 10.09.80.07.	
Service Reminders	
• Substance use disorder (SUD) treatment programs (Provider Type 50s) may be reimbursed by Medicaid	

for outpatient SUD services provided in the school setting when billed with the place of service (POS) 03 for schools. This includes:

1. SUD assessment (H0001)
2. Level 1 group and individual SUD counseling (H0004, H0005)

- Licensed professionals practicing as individual providers as defined in COMAR 10.09.59.04 and appropriately licensed staff under OMHCs as defined in COMAR 10.63.03.05 may provide services in the school setting and be reimbursed by Medicaid (through CPT codes) when billed with the POS 03 for schools. This applies to schools with a School-Based Health Center, as well as those in formal partnership with a community-based provider. Services should be consistent with those provided to individuals in the community and be appropriate to the school setting, such as:
    1. Psychiatric diagnostic evaluation (initial assessment)
    2. Individual and group therapy (ongoing)
- Services delivered in the school setting may not duplicate services delivered by programs or counselors out of the school setting on the same day.

Billing Reminders

- There is a maximum of two services per day per participant. Relevant limitations are listed in COMAR 10.09.80.06.
- Providers should use Place of Service (POS) 03 when billing for services located in the schools.

Additional School Based Services Reminders

- If a school opts to participate, they should alert their school staff and teachers through an official memorandum that SUD treatment is now available in their school and should include appropriate information about process and contacts.
- The school and clinicians are responsible for identifying a space that ensures confidentiality for identified participants.
- All clinical notes should be maintained in the provider's office using storage standards set forth by the HIPAA and 42 CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.

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Substance Use Disorder (SUD) – Outpatient Individual, Group, and Family Therapy (ASAM Level 1)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible participants
Who is eligible to provide this service?	• Community-based SUD programs that: - meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80. - receive certification by the BHA in accordance with COMAR 10.63.03.06. • Enrolled with Maryland Medicaid as Provider Type 50.

Authorization Reminders

- Initial and concurrent authorization requests can be submitted via Provider Connect.

Service Reminders

- Only one initial evaluation/diagnostic interview (90791/90792) may be rendered per year.
- Before providing Level I services, the provider will develop a written individualized treatment plan, with the participation of the participant, based on the comprehensive assessment and placement recommendation. This plan will be updated every 90-days. It will be reviewed and approved by a licensed behavioral health practitioner.
- The treatment plan should include:
  - an assessment of the participant's needs
  - Long-range and short-range treatment plan goals
  - Specific interventions for meeting the treatment plan goals
  - Target dates for completion of treatment plan goals
  - Criteria for successful completion of treatment
  - Referrals to ancillary services, if needed
  - Referrals to recovery support services, if needed
- Each individual and group counseling session will be documented in the participant's record through written progress notes, after each counseling session. Before discharge, the provider will give the participant a discharge plan which includes written recommendations to assist the participant with continued recovery efforts, as well as appropriate referral services.

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Substance Use Disorder (SUD) – Opioid Treatment Services (ASAM Level 1)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible
Who is eligible to provide this service?	• Opioid Treatment Programs (Provider Type 32) • Opioid Treatment Services (Provider Type 50) • Office-Based Opioid Treatment Services (Provider Type 20)

Eligibility Reminders

- Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in the Provider Connect system in order to obtain an uninsured eligibility exception.
- If a participant does not qualify for an uninsured exception, providers are to contact their LAA or LBHA in order to explore alternative funding spans to support any participant who does not qualify for an approved eligibility category.

Authorization Reminders

- Initial and concurrent authorization requests can be submitted via Provider Connect.

Provider Type Reminders

- Opioid Treatment Programs (Provider Type 32)
  - OTPs must be licensed by the BHA in accordance with 10.63.03.19 COMAR 10.63.01, maintain approval for the U.S. Drug Enforcement Administration, and be enrolled as a Medicaid Provider Type 32. The Program must comply with the requirements of 42 CFR Part 8, and COMAR 10.63.03.19, COMAR 10.09.36, and COMAR 10.09.80.
- Opioid Treatment Services (Provider Type 50) & Office-Based Opioid Treatment Services (Provider Type 20)
  - Buprenorphine may only be prescribed by a licensed professional with an active DATA 2000 waiver license.
  - Other medication assisted treatments services must be rendered by a licensed prescriber with expertise in addiction treatment.
  - The prescriber must have a valid Medicaid and NPI number.

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Substance Use Disorder (SUD) – Intensive Outpatient (ASAM Level 2.1)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured eligible participants
Who is eligible to provide this service?	• Community-based SUD programs that: - meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80. - receive certification by the BHA in accordance with COMAR 10.63.03.03. - Enrolled with Maryland Medicaid as Provider Type 50.
Authorization Reminders	
• Initial and concurrent authorization requests can be submitted via Provider Connect. • Separate authorization must also be requested if the participant needs ambulatory detoxification.	
Billing Reminders	
• Intensive outpatient programs can bill up to five days of ambulatory detoxification using procedure code H0014.	

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Substance Use Disorder (SUD) – Partial Hospitalization (ASAM Level 2.5)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid)
Who is eligible to provide this service?	• Programs providing partial hospitalization services must be enrolled in Maryland Medicaid as a Medicaid Provider Type 50 or as an acute general hospital. • Conditions for program participation include: - A community-based substance use program shall meet and comply with all requirements set forth in COMAR 10.09.36 and COMAR 10.09.80. - A community-based substance use program shall receive a license from the BHA in accordance with COMAR 10.63.03.07.
Authorization Reminders	
• Initial and concurrent authorization requests can be submitted via Provider Connect or by calling Optum.	

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Substance Use Disorder (SUD) – Low Intensity Residential (ASAM 3.1)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid • Uninsured Eligible
Who is eligible to provide this service?	• Halfway Houses are defined in the Health-General Article, §8-101, of the Annotated Code of Maryland.
Authorization Reminders	
• Prior authorization is required and can be requested via Provider Connect.	
Billing Reminders	

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Substance Use Disorder (SUD) - Medium Intensity Residential (ASAM 3.3) & High Intensity Residential (ASAM 3.5)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible
Who is eligible to provide this service?	• Licensed Adult Residential SUD providers in compliance with COMAR 10.09.06, COMAR 10.09.36 and COMAR 10.63.01.05. • Enrolled as a Medicaid Provider Type 54 and attest to meeting the staffing components required for these levels of care.

Eligibility Reminders

- Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in the Provider Connect system in order to obtain an uninsured eligibility exception.
- If a participant does not qualify for an uninsured exception, providers are to contact their LAA or LBHA in order to explore alternative funding spans to support any participant who does not qualify for an approved eligibility category.

Authorization Reminders

- Initial authorizations can be submitted up to seven days prior to the day of admission with supporting clinical information, but no later than the day of admission.
- Concurrent authorizations with supporting clinical information may be requested up to seven days prior to the last covered day but no later than the first uncovered day.

Billing Reminders

- Please note that all residential SUD for adults rates are inclusive of drug screening and testing. Residential SUD providers (provider type 54) and laboratories may not bill Medicaid separately for these services.
- Place of Service (POS) 54 is specific for Intermediate Care Facility (generally used for 16 beds or more).
- Place of Service (POS) 55 is for Residential Substance Abuse Treatment Facility (generally used for under 16 bed facilities).
- Providers cannot bill date spans; all days must be billed individually.
- The 1115 Health Choice Waiver Renewal, allows providers to be reimbursed for therapeutic services up to two 30-day stays, or episodes of care, per rolling year for certain Medicaid eligible participants over age of 18. All additional days beyond the two stays and all room and board costs will be paid out of state funds for individuals that are authorized as continuing to meet medical necessity for treatment at this level.

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Substance Use Disorder (SUD) – Intensive Residential Services (ASAM Level 3.7)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Uninsured Eligible
Who is eligible to provide this service?	• Licensed Adult Residential SUD providers in compliance with COMAR 10.09.06 (for adults) and 10.09.23 (for under 21), COMAR 10.09.36 and COMAR 10.63.01.05. • Enrolled as a Medicaid Provider Type 54 (for adults)/Provider Type 55 (for under 21) and attest to meeting the staffing components required for these levels of care.

Eligibility Reminders

- Providers rendering services to participants without Medicaid are instructed to enter authorization requests through the uninsured registration process in the Provider Connect system in order to obtain an uninsured eligibility exception.
- If a participant does not qualify for an uninsured exception, providers are to contact their LAA or LBHA in order to explore alternative funding spans to support any participant who does not qualify for an approved eligibility category.

Authorization Reminders

- Initial authorizations may be submitted with supporting clinical information upon admission. Providers have up to 24 hours from the date and time of admission to enter their authorizations into Provider Connect.
- Concurrent authorizations may be requested up to 3 days prior to the expiration of the current authorization.
- Medicaid-covered ICF-A (Intermediate Care Facilities for Addiction) services are available for adolescents under the age of 21 that meet ASAM criteria. Medicaid does not pay for services that are not medically necessary, even if court-ordered.

Billing Reminders

- Please note that all residential SUD for adults rates are inclusive of drug screening and testing. Residential SUD providers (provider type 54) and laboratories may not bill Medicaid separately for these services.
- Place of Service (POS) 54 is specific for Intermediate Care Facility (generally used for 16 beds or more).
- Place of Service (POS) 55 is for Residential Substance Abuse Treatment Facility (generally used for under 16 bed facilities).
- Providers cannot bill date spans; all days must be billed individually.
- The 1115 Health Choice Waiver Renewal, allows providers to be reimbursed for therapeutic services up to two 30-day stays, or episodes of care, per rolling year for certain Medicaid eligible participants over age of 18. All additional days beyond the two stays and all room and board costs will be paid out of state funds for individuals that are authorized as continuing to meet medical necessity for treatment at this level.

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Substance Use Disorder (SUD) – Medically Managed Intensive Inpatient Services (ASAM Level 4.0) in Institutions for Mental Disease (IMDs)	
Who is eligible to receive this service?	• Medicaid Participants • Individuals that do not have Federal Medicaid funding are not covered. • Retro-eligibility does not apply to this program.
Who is eligible to provide this service?	• Institutions for Mental Diseases (IMDs) eligible to render and receive reimbursement for ASAM Level 4.0 services are: - Brook Lane (provider type 06) - Sheppard Pratt Hospital (provider type 06/07) These two sites are licensed and regulated by the State of Maryland and operate within the State of Maryland.
Authorization Reminders	
• Providers are expected to submit the initial authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day from date of admission. • Initial and concurrent authorization requests can be submitted via Provider Connect or by calling Optum.	
Service Reminders	
• Effective July 1, 2019, coverage of IMD services at ASAM Level 4.0 for Medicaid adults who have a primary SUD diagnosis and a secondary mental health diagnosis will be a covered Medicaid benefit. - MDH will provide reimbursement for IMD ASAM Level 4.0 for up to 15 days stay per month. - The days authorized will be based on medical necessity but will not exceed 15 days per month. - All other services beyond the 15-day stay will be paid out of state funds. - An episode of care is defined as services received without any break in treatment. - Participants receiving Level 4.0 services at an IMD and then subsequently transferred to a hospital or other facility for somatic care and are then readmitted will have the new admission counted as a second episode of care, or stay. - Facility must be in the State of Maryland.	
Additional Information	
• If assistance is needed from the CSA, LAA, or LBHA, providers should reach out to the jurisdiction that maintains oversight of the services to be rendered by the IMD. For example, if hospitalized in Baltimore County, but residing in Howard County, they should contact the Howard County LBHA.	

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Substance Use Disorder (SUD) – Withdrawal Management (All ASAM Levels of Care)	
Who is eligible to receive this service?	• Medicaid Participants • Dual Participants (Medicare/Medicaid) • Providers should contact their LAA or LBHA in order to explore the possibility of using grant funds to support anyone not in one of these eligibility categories.
Who is eligible to provide this service?	• Medicaid eligible • Provider Type 50, 32, 54, 55 or an acute general hospital
Authorization Reminders	
• Providers must request authorization through the Provider Connect system prior to admission to ambulatory or inpatient detox. • Inpatient detox is a service provided in an Inpatient hospital setting or in an ICF-A facility. Please note, effective July 1, 2017, Medicaid can now reimburse treatment stays for ICF-A admissions for youths under age 21 and adults. • Medicaid can pay for detox services for all age groups in acute care general hospitals. • If the patient is being admitted to a medical/surgical unit rather than a detoxification bed, the hospital should seek authorization from the participant's MCO.	
Billing Reminders	
• Medicaid only reimburses for inpatient detoxification in a hospital setting.	

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Maryland RecoveryNet

Program Overview

Maryland RecoveryNet (MDRN) develops partnerships with State Care Coordination entities and certified recovery residences statewide to provide time-limited access to certified recovery residences for individuals with substance-related or /co-occurring mental health and substance-related disorders , in recovery, for whom no other individual, community, family, private or public resource exists to defray the cost of the recovery residence stay. *Maryland RecoveryNet* funding supplements, but does not replace or supplant, existing services and funding streams. . MDRN eligible individuals may access client support services funding through the Local Behavioral Health Authority or Local Addiction Authority for one-time only or emergency goods and services to alleviate a need that presents a barrier to the individuals' recovery. .

Recovery housing provides alcohol-free and illicit-drug free housing to individuals with substance-related disorders. The purpose of a recovery housing is to provide a safe and healthy living environment for individuals with substance-related disorders to initiate and sustain recovery and to gain improvement in their physical, mental, spiritual, and social well-being.

All State General Funds for certified recovery residences will be administered through the Administrative Service Organization (ASO), Optum. The State Care Coordinators in each jurisdiction will make referrals to BHA's MDRN staff in order to access funding for recovery housing. If an individual is found eligible for services, the MDRN approved and certified recovery residence will enter the authorization request into Optum Provider Connect system. Upon approval, the individual will be granted an initial authorization for recovery housing for 60 days. A recovery residence will submit a concurrent request for additional days for an individual based on the individual's needs through the Optum Provider Connect System.

Provider Application and Approval Process

Recovery Residences that are certified by the Maryland Certification of Recovery Residences(MCORR) may request an application for consideration and approval as a Maryland RecoveryNet Housing Provider by email at mdrn.info@maryland.gov. A separate application must be submitted for each location.

After receiving the *Maryland RecoveryNet* Housing Provider Application Packet, BHA's MDRN staff will review all application documents and submit accepted applications for processing. Potential providers whose applications are not accepted will be contacted and given the opportunity to provide additional documentation. Once an application has been reviewed, accepted and processed, the MDRN team may request a service delivery site visit. Upon successful completion of all administrative and required site reviews, the service provider will complete, sign and return the *Maryland RecoveryNet* Provider Agreement to the BHA MDRN Regional Area Coordinator (RAC) in order to be registered as an MDRN provider in the Optum system.

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