IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201821 MAY 22, 2018

IHCP responds to provider FAQs about residential SUD treatment benefits

As announced in *Indiana Health Coverage Programs (IHCP) Bulletin* BT201801, the IHCP began covering residential substance use disorder (SUD) treatment effective March 1, 2018. As the IHCP has worked to implement this new program, the State and its managed care entities (MCEs) have been working together to respond to provider questions regarding this new benefit. The most frequently asked questions (FAQs) that the IHCP has received are presented in this bulletin.

Are providers that have been designated by the Division of Mental Health and Addiction (DMHA) as offering American Society of Addiction Medicine (ASAM) Patient Placement Criteria Level 3.5 services (High-Intensity Residential) allowed to seek prior authorization (PA) and reimbursement for both Level 3.5 services and Level 3.1 services (Low-Intensity Residential)?

No. If a provider has only been designated as offering ASAM Level 3.5 services, the provider can only seek PA and reimbursement for stays at ASAM Level 3.5. Conversely, providers only designated as offering ASAM Level 3.1 services can only seek PA and reimbursement for stays at ASAM Level 3.1.

If a provider has **separate units** within the facility, distinctly designated for ASAM Level 3.1 services and ASAM Level 3.5 services, the provider may seek PA and reimbursement for both levels, as appropriate. Residential stays for either level will only be approved with evidence of medical necessity.

What does the ASAM designation level mean?

The DMHA ASAM designation process indicates that a provider offers the settings, individual practitioners, treatment goals, and therapies appropriate to an ASAM level of care. This requirement is a key requirement for a provider's enrollment under provider type 35 (Addiction Services) with provider specialty 836 (SUD Residential Addiction Treatment Facility). However, the DMHA ASAM designation does not negate the need for PA for a residential treatment stay; providers are still required to follow the PA process for all residential SUD treatment.

What should a facility do if authorization is approved for only a limited number of residential days?

A request of a residential SUD stay is approved based upon medical necessity; the documentation submitted with the request supports medical necessity. If a facility determines that a member requires more time than was initially authorized, the facility should submit a PA update request showing that the member has made progress but can be expected to show more progress given more treatment time. An additional length of stay can be approved based on documentation of medical necessity.

How can a facility improve their success with PA requests?

Facilities need to include all necessary documentation to demonstrate medical necessity for the SUD level of care being requested. This documentation should include diagnoses, clinical presentation, treatment history, treatment goals, prescriber contact following admission and weekly thereafter, and other relevant information to provide a complete picture of an individual's needs. Providers should incorporate documentation supporting the ASAM six dimensions of multidimensional assessment. When submitting an initial PA request, it is helpful to include documentation of the psychosocial assessment. The State, as well as each of the MCEs, is available to review and discuss what documentation is necessary for each level of service. Cooperative Managed Care Services (CMCS) applies Milliman Care Guidelines to evaluate PA requests through the fee-for-service (FFS) delivery system. Providers can use the following links to learn more about each health plan's PA process and requirements:

- Anthem
- CareSource
- MDwise
- MHS

What should a facility do if the requested SUD level of care is not authorized by the State or an MCE based on the PA request submitted?

If a provider believes the documentation meets the medical necessity criteria for the treatment level requested, the provider should pursue the administrative review process. If the level requested is not appropriate for the member, the provider should refer the individual for other services more appropriate for the level of care needed, such as for partial hospitalization or intensive outpatient services. The provider is encouraged to call 211 on behalf of the member to obtain information about available services in the area. If the member is enrolled in a managed care program, a case manager will reach out to the member to help coordinate a more appropriate treatment level.

Is the maximum length of stay for SUD residential treatment 30 days?

No. The State is required to maintain a statewide average length of stay of 30 calendar days, based upon medical necessity. Some members will require less than 30 days of treatment, but some members will require additional time and can stay beyond 30 days.

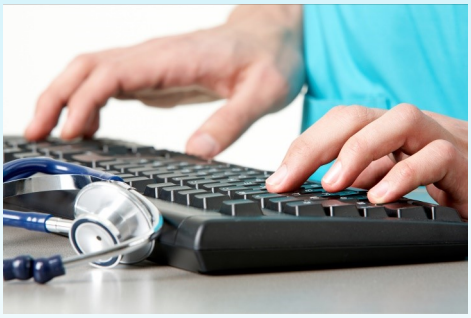
The number of days counted toward the average is calculated by episode; currently, there is no limit to the allowed number of treatment episodes. Each episode can include days at both Level 3.1 and Level 3.5. An individual episode can be longer than 30 calendar days when medically appropriate. However, providers should not expect to receive authorization for 30 calendar days with an initial PA request; the number of days approved is based on medical necessity and what is most appropriate for the member.

Is the 30-day average length of stay calculated separately for ASAM Level 3.1 Services (Low-Intensity Residential) and ASAM Level 3.5 Services (High-Intensity Residential)?

No. The statewide average length of stay includes stays for both treatment levels. An episode can include days at both Level 3.1 and Level 3.5.

If a facility was enrolled with IHCP before Provider Type 35/Specialty 836 (SUD Residential Addiction Treatment Facility) was established, but is now separately enrolled as the new type and specialty, under which enrollment should the facility bill claims for dates of service (DOS) before July 1, 2018?

The State and its MCEs will accept claims from any facility that is able to provide SUD residential treatment for DOS before July 1, 2018. If a facility is enrolled under the new type and specialty as well as under another provider type and specialty, the facility is allowed to bill SUD residential treatment under either enrollment for reimbursement for DOS through June 30, 2018. However, for DOS on or after July 1, 2018, only providers enrolled under the new type and specialty will be allowed to receive reimbursement for SUD residential services. After a facility has received an ASAM designation from DMHA, only requests for stays at that designated level of care will be authorized and reimbursed.



If a facility is not separately enrolled under Provider Type 35, Specialty 836 by July 1, 2018, what will happen to claims submitted for reimbursement?

IHCP's claim-processing systems will be configured to deny payment to any provider billing for SUD residential treatment that is not enrolled under the 35/836 provider type and specialty effective July 1, 2018. Accordingly, it is critical that facilities pursue this separate enrollment in a timely manner.

What happens if a member seeks SUD treatment due to a court order?

The IHCP will not pay for residential SUD treatment services without PA based upon medical necessity even if court-ordered. It is recommended that court orders require individuals to obtain an SUD assessment, which will help to direct treatment based upon medical necessity.

How frequently should a psychiatrist see the member while he or she is in SUD residential treatment?

The psychiatrist should see the member in person (face-to-face) at least every 7 days.

QUESTIONS?

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