Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Outpatient Substance Use Disorders Treatment Services
PAGE: 1 of 10	**REPLACES:** NA
APPROVED DATE: 1-11-19	**RETIRED:** NA
EFFECTIVE DATE: 10-1-11	**REVIEWED/REVISED:** 10-29-14, 8-19-15, 3-16-16, 3-15-17, 9-20-17,12-5-17, 1-31-18, 2-6-18, 12-10-18
PRODUCT TYPE: Medicare, Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff to make American Society of Addiction Medicine (ASAM) level of care (LOC) determinations for outpatient substance use disorders (SUDS) and to describe the services authorization process.

B. Policy

1. Clinical criteria for outpatient substance use disorders (SUDS) treatment services include:

1.1. A Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) covered substance use diagnosis, supported by an ASAM PPC-2R behavioral health assessment to make:

1.1.1. ASAM LOC determination based on symptomology consistent with:

1.1.1.1. ASAM diagnostic categories including:

1.1.1.1.1. Dimension 1: Acute Intoxication and/or Withdrawal Potential

1.1.1.1.2. Dimension 2: Biomedical Conditions and Complications.

1.1.1.1.3. Dimension 3: Emotional, Behavioral, Cognitive Conditions or Complications.

1.1.1.1.4. Dimension 4: Readiness to Change

1.1.1.1.5. Dimension 5: Relapse, Continued Use or Continued Problem Potential.

1.1.1.1.6. Dimension 6: Recovery Environment.

1.1.1.2. Degree of impairment,

1.1.1.3. Current symptoms,

1.1.1.4. Community supports, and

1.1.1.5. Medical appropriateness to support DSM and ICD covered diagnosis.

1.2. Covered Levels of Care include ASAM Level I Outpatient (OP), Level II.1 Intensive Outpatient (IOP), and Level II.5 Day Treatment.

2. Appropriate available clinical treatment environment characterized by:

2.1. The most normative,

2.2. Least restrictive,

2.3. Least intrusive,

2.4. Culturally and linguistically appropriate,

2.5. Evidenced based and/or evidence informed and extent of family and community supports.

C. Procedure

1. Referrals:

1.1. Referred member must be enrolled in Trillium Community Health Plan.

1.2. Trillium members are able to access OP behavioral health assessments with an in-network provider without a referral.

1.3. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. For outpatient services not requiring a prior authorization (PA) based on Authorization Required Qualifiers (ARQ), participating provider is able to submit claims.

3. For non-participating provider services always requiring a PA, prior to or on the first date of service, provider must submit:

2.1. PA request,

2.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

2.3. Summary, completed within previous sixty (60) days, of:

2.3.1. Current substance use/dependence and symptom description with impact upon functioning, and

2.3.2. Services or LOC to be provided, with

2.4. Clinical justification for requested services including summary of how service modalities would meet treatment goals for current episode of care outside of currently available in-network services.

4. For initial IOP and Partial Hospitalization (PHP), prior to or on the first date of service, provider must submit:

4.1. PA request,

4.2. Updated behavioral health assessment information or addendum completed by qualified program staff, within the previous sixty (60) days, including

4.2.1. Evidence of a covered DSM and ICD diagnosis, and

4.2.2. Current substance use/dependence and symptom description with impact upon functioning.

4.3. Service Plan conducted and/or updated within the previous sixty (60) days reflecting:

4.3.1. Assessment,

4.3.2. LOC to be provided,

4.3.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan:

4.3.3.1. Include the participation of the individual and family members, as applicable.

4.3.4. Be completed and signed by qualified program staff.

4.4. Clinical justification for services requested, including:

4.4.1. How the member would benefit from requested level of care, and

4.4.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

4.5. When medical risks or comorbidities are present, include pertinent medical documentation within previous thirty (30) days evidencing medical stability.

5. For concurrent IOP and PHP authorization requests, provider must submit concurrent authorization request with summary of:

5.1. Diagnostic, medical stability, or medication changes since last review, and

5.2. Recent services/interventions within past two-four (2-4) weeks including:

5.2.1. Member/family participation in services,

5.2.2. Frequency of services,

5.2.3. Response to treatment,

5.2.4. Barriers to treatment progress,

5.2.5. Areas of progress.

5.3. Clinical justification for services requested including:

5.3.1. Current substance use/dependence and symptom description with impact upon functioning,

5.3.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

5.4. Discharge/transition planning information specific to remaining treatment goals.

6. For OP services requiring a contingent PA based on utilization, including acupuncture services:

6.1. Provider is able to submit claims for Current Procedural Terminology (CPT) codes based on ARQ without a PA up to the ARQ limits per member per calendar year,

6.2. Once claims have met a contingent authorization ARQ limit, provider must submit:

6.2.1. PA request.

6.2.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

6.2.3. Chart notes or session information from the most recent three (3) dates of service prior to PA submission,

6.2.4. Service Plan conducted and/or updated since most recent mental health assessment reflecting:

6.2.4.1. Assessment,

6.2.4.2. LOC to be provided,

6.2.4.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others, to be updated as circumstances change. The safety plan may be a separate document from the service plan:

6.2.4.3.1. Include the participation of the individual and family members, as applicable.

6.2.4.4. Be completed and signed by qualified program staff.

7. For OP concurrent (Recertification) for additional codes or units within current approved date range, and/or an extended or new date range, additional clinical justification must be submitted. Clinical justification to include:

7.1. Concurrent authorization request,

7.2. Updated behavioral health assessment information or addendum completed by qualified program staff, within the previous sixty (60) days, including:

7.2.1. Evidence of a DSM and ICD SUDS diagnosis,

7.2.2. Behavioral presentation with current symptom description and impact upon functioning.

7.3. Service plan information completed within the previous sixty (60) days,

7.4. Clinical justification for requested services including:

7.4.1. How the member would benefit from requested services,

7.4.2. Why alternate services or levels of care have been ruled out by provider/treatment team.

8. ASAM Level I: Outpatient Authorizations.

8.1. Clinical criteria for ASAM Level I include:

8.1.1. Evidence of a DSM and ICD SUDS diagnosis,

8.1.2. Evidence of symptoms requiring:

8.1.2.1. Fewer than nine (9) hours of treatment contact weekly for adults or

8.1.2.2. Fewer than six (6) hours of treatment contact weekly for adolescents aged twelve-seventeen (12-17).

8.2. Expected Outcomes include:

8.2.1. Decrease in substance use,

8.2.2. Abstinence from substance use,

8.2.3. Improvement/stabilization of daily functioning,

8.2.4. Improvement of symptoms associated with substance use such as recurrent substance use, social impairment, illness, emotional dysregulation, and/or

8.2.5. Prevention of need for higher ASAM LOC, trauma/victimization, legal involvement, family violence or disruption, or homelessness.

9. ASAM Level II.1: Intensive Outpatient Authorizations.

9.1. Clinical criteria for ASAM Level II includes:

9.1.1. Evidence of a DSM and ICD SUDS diagnosis,

9.1.2. Evidence of symptoms requiring:

9.1.2.1. Nine (9) or more hours of treatment contact weekly for adults or

9.1.2.2. Six (6) or more hours of treatment contact weekly for adolescents aged twelve-seventeen (12-17).

9.2. Expected Outcomes include:

9.2.1. Decrease in substance use,

9.2.2. Abstinence from substance use,

9.2.3. Improvement/stabilization of daily functioning,

9.2.4. Improvement of symptoms associated with substance use such as cravings, tolerance, illness, emotional dis-regulation, and withdrawal, and/or

9.2.5. Prevention of need for higher ASAM LOC, trauma/victimization, legal involvement, family violence, or homelessness.

10. ASAM Level II.5 Day Treatment.

10.1. Clinical criteria for ASAM level II.5 Day Treatment includes:

10.1.1. Evidence of a DSM and ICD SUDS diagnosis,

10.1.2. Twenty (20) or more hours of treatment contact weekly for adults.

10.2. Expected Outcomes:

10.2.1. Improvement/stabilization of substance use symptoms,

10.2.2. Improvement/stabilization of daily functioning,

10.2.3. Abstinent from substances of abuse at time of discharge,

10.2.4. Prevention of Residential Treatment.

11. TBH Licensed Utilization Management (UM) staff will make LOC determination:

11.1. Ensuring DSM and ICD supported diagnosis is covered by Trillium benefits,

11.2. Ensuring appropriateness of requested ASAM LOC determination supported by the following guidelines:

11.2.1. Documented substance dependence and physical, mental and emotional symptoms, which have been evident and are likely to continue without intervention,

11.2.2. Evidence of previous failed attempts to reduce or stop substance use, and

11.2.3. Recent evidence within the last six (6) months showing severe functional limitations in two (2) or more of the following areas:

11.2.3.1. Diagnostic changes from original assessment,

11.2.3.2. Acute intoxication and/or withdrawal potential**,**

11.2.3.3. Biomedical conditions/complications,

11.2.3.4. Emotional, behavioral/cognitive conditions or complications,

11.2.3.5. Readiness to change,

11.2.3.6. Relapse/continued use of potential,

11.2.3.7. Recovery environment, or

11.2.3.8. Legal.

12. TBH Licensed UM Staff:

12.1. Determine clinical appropriateness and medical necessity of requested LOC for treatment, indicated by:

12.1.1. Review of clinical information submitted, including behavioral health assessment information and pertinent medical justification.

12.2. Offer TBH Care Coordination (CC) via UM approval notification of an initial OP contingent authorization,

12.3. Upon determination of a concurrent OP contingent authorization, refer to TBH CC for member and/or provider outreach,

12.4. Refer to TBH CC staff when necessary to ensure the provision of CC, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

13. When request is approved:

13.2. All initial (Certification) non-par OP and par OP contingent requests will be determined within the fourteen (14) day pre-service timeline. All initial (Certification) non-par OP and par OP contingent PA requests will not exceed twelve (12) months. Par OP contingent PA requests will not exceed twelve (12) months for a date range beyond the end of the current calendar year.

13.2.1. For codes subject to ARQ contingent limits, initial non-par and initial contingent requests will be authorized for up to:

13.2.1.1. Twenty-five (25) units for a combined grouping of 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, and T1006;

13.2.1.2. One hundred and twenty (120) units for a combined grouping of H0004, H0005, H0006, H0036, H0038, H2014, H2027, H2032, and T1016.

13.3. Initial (Certification) and Concurrent (Recertification) PA for IOP and PHP services will not exceed six (6) months and will be determined within the fourteen (14) day pre-service timeline.

14. When request is denied:

14.2. If the initial (Certification) or concurrent (Recertification) review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

14.3. When the decision is to deny request, practitioner may request an expedited appeal if practitioner disagrees with the determination.

15. When request is returned to sender:

15.2. If upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

15.2.1. Member identifying information,

15.2.2. Requesting and Servicing Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:

15.2.2.1. Medicaid Provider/DMAP number for non-par OP services requests,

15.2.3. Start date and end date for services,

15.2.4. ICD diagnostic code(s),

15.2.5. Billing code(s),

15.2.6. Number of units/visits/days for each billing code.

15.3. Upon review, no authorization is required per the ARQ for participating providers.

15.4. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

15.5. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

15.5.1. Catastrophic event that substantially interferes with normal business operations of a provider, or damage or destruction of the provider's business office or records by a natural disaster.

15.5.2. Mechanical or administrative delays or errors by the Contractor or State Office.

15.5.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

15.5.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number,

15.5.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered,

15.5.3.3. The provider submitted the request for authorization within sixty (60) days of the date the eligibility was discovered (excluding retro-eligibility).

15.6. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

15.7. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. Definitions

Word / Term	Definition
ARQ	Authorization Required Qualifier.
ASAM	American Society of Addiction Medicine.
ASAM PPC-2R	ASAM Patient Placement Criteria 2nd Edition Reviewed.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Child	A person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Contingent Prior Authorization	A blank ARQ alerting billing system an authorization could be required depends on whether member and category of service are covered by member's benefit plan.
Day Treatment	20 or more hours of service/week for multidimensional instability not requiring 24 hour care.
Diagnostic and Statistical Manual of	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.

Mental Disorders (DSM)	
ICD	The International Classification of Diseases.
Intensive Outpatient (IOP) Substance Use Disorders (SUDS) Treatment	Structured nonresidential evaluation, treatment, and continued care services for individuals with substance use disorders who need a greater number of therapeutic contacts per week than are provided by traditional outpatient services. Intensive outpatient services may include, but are not limited to, day treatment, correctional day treatment, evening treatment, and partial hospitalization.
Level of Care (LOC)	The type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.
Level of Care Determination	The standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.
Licensed UM Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Mental Health Assessment	A process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
OMT/ORT	Opiate Maintenance Therapy/ Opiate Replacement Therapy.
Outpatient (OP) Substance Use Disorders (SUDS) Treatment	A program that provides assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for individuals with alcohol or other drug use disorders and their family members, or significant others.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post-service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Decision	Assessing necessity of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
SUDS	Substance Use Disorders.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.

	Substance Use Disorders:
	B.2.4.p.(1)(2)(6)
	B.2.4.m.(1)(2)(6)
	Authorization or Denial of Covered Services
	B.2.3.b.c.e
	Covered Services
	B.2.4.a.3.
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity
	E.23.
Code of Federal Regulations	422.101(b)(1)-(5)
	422.566
Current NCQA Health Plan Standards and Guidelines	UM 2: C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
Medicare Managed Care Manual	Chapter 13 (40.1)
Oregon Administrative Rules	309-019-0100
	309-019-0140
	309.019.0175
	309.019.0185
	410.120.1295
	410.141.3160
	410-172-0600
	410-172-0630
	410-172-0670
Oregon Regulatory Statutes	430.630
	430.644

F. Related Material

Name	Location
Detoxification and Substance Abuse Treatment Protocol	TIP 45
TBH Return to Sender Process	TBH Database
Use of Out-of-Network Providers and Steerage	Trillium Database

G. Revision Log

Type	Date
Merged Policy and Procedure into one document.	11-30-17
Added Return to Sender Language	11-30-17
Updated Return to Sender Language	2-6-18
Addition of CCO and CAK Contract Citations	2-6-18
Updated Treatment Plan Requirement Language	12-10-18
Added Contingent and Concurrent Information	12-10-18
Update OARS	12-10-18
Updated Return to Sender Language	12-10-18
Updated Definitions	12-28-18