

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director-Medicaid Director

Transmittal # 21-23

TO: District of Columbia Medicaid Providers

FROM: Melisa Byrd
Senior Deputy Director and State Medicaid Director, DHCF

DATE: June 11, 2021

SUBJECT: Managed Care Program Authorization Guidance for SUD Residential Treatment Services

Purpose

This guidance provides direction to SUD residential treatment providers to assess beneficiaries (aged 21-64) for IMD stays, obtain an authorization from the appropriate payer, and bill the appropriate health plan utilizing the “In Lieu of” benefit under the Managed Care plans or Fee for Service (FFS) when the “In Lieu of” benefit is exceeded.

Background

On November 6, 2019, the Centers for Medicare and Medicaid Services (CMS) approved the District’s Behavioral Health Transformation demonstration with an effective date of January 1, 2020. The demonstration allows the District’s Medicaid program to pay for services provided to adults, aged 21-64, with serious mental illness (SMI)/serious emotional disturbance (SED) or substance use disorder (SUD) residing in an institution for mental disease (IMD).

Assessment and Level of Care

An individual enrolled in one of the District’s Medicaid managed care organizations (MCOs) may present for an assessment and level of care determination for SUD at any Department of Behavioral Health (DBH) certified SUD treatment provider.

The provider shall check the DC Medicaid eligibility of each individual through DHCF’s Interactive Voice Response (IVR) system (Attachment A) and/or Medicaid Web Portal, and will perform the initial intake and assessment as described in DBH’s Chapter 63 to determine the clinically appropriate level of care for the individual. The provider shall use the Co-Triage assessment tool to determine the initial level of care for individuals seeking SUD treatment.

If the individual requires a residential level of care, the provider shall verify the SUD residential treatment providers within the respective MCO network by contacting the MCO (Attachment B) and then shall perform the activities necessary to check bed availability at the in-network SUD residential facility of choice. If there is no bed availability at any SUD residential provider in the

MCO's network for the determined level of care, the intake and assessment site shall call the Utilization Management Department of the MCO for next steps (Attachment B).

If there is bed availability with an in-network provider, the intake and assessment site will immediately communicate the initial level of care determination and SUD residential facility of choice to the MCO by fax and/or phone (Attachment B).

The intake and assessment site proceeds with the established procedures for connecting the individual to the SUD residential provider in DATA/WITS, in accordance with DBH Policies, Rules, and Bulletins.

SUD Residential Treatment Providers

Within 48 hours of the individual presenting at the SUD residential treatment provider, the accepting SUD residential treatment provider shall perform the Continuum Assessment, in accordance with DBH's Chapter 63, and submit the initial clinicals (described below) to the MCO's Utilization Management Department in order to request an authorization. Providers shall send clinicals to the MCO according to the MCO's protocol. For more information, or to request technical assistance, with submitting authorization requests to an MCO, contact the MCO directly (Attachment B).

The SUD residential treatment provider shall include the following documents in the request for authorization:

1. A completed Continuum Assessment which will include:
 - a. Documentation of an active moderate to severe Substance Use and/or Addictive Disorder per the DSM-V;
 - b. An individualized, comprehensive biopsychosocial assessment of the patient's Substance Use and/or Addictive Disorder;
 - c. An evaluation by a Qualified Provider (QP) (i.e., Physicians; Psychologists; Licensed Independent Clinical Social Workers (LICSWs); Licensed Independent Social Workers (LISWs); Licensed Professional Counselors (LPCs); Licensed Marriage and Family Therapists (LMFTs); and Advanced Practice Registered Nurses (APRNs)) confirming medical necessity of the requested services;
 - d. A medical history detailing the individual's medical conditions; and
 - e. For level 3.3 ONLY, description of cognitive deficits of moderate to severe intensity.
2. Additional medical information, including:
 - a. Comprehensive urine toxicology screen results;
 - b. Pregnancy test results for women (If a woman refuses a pregnancy test, the refusal must be documented and submitted to the MCO. The MCO may require additional information.); and
 - c. The glucose level to validate medical clearance for admission into the SUD residential treatment provider.

Failure to submit all the required documentation may lead to an adverse benefit determination (denial) from the MCO. The MCO may also request additional clinicals from the SUD residential treatment provider.

The SUD residential treatment provider shall also perform all required Room & Board authorization requests, documentation, and procedural activities in DATA/WITS, as required by DBH. DBH remains responsible for covering SUD Residential Treatment Room & Board. MCOs do not cover SUD Residential Treatment Room & Board and will not perform reviews or respond to authorization requests for Room & Board.

Managed Care Organizations (MCOs)

Once the MCO receives the authorization request, the MCO shall conduct medical necessity reviews and communicate the authorization decisions to SUD residential treatment providers as contractually required, and in accordance with 42 C.F.R. § 438.404, including an oral decision within 24 hours.

When Medical Necessity is Met, and Services are Authorized:

The MCO shall share authorization information with the SUD residential treatment provider by established procedures in the MCO Provider Agreements. The MCO shall only authorize treatment services up to fifteen days per calendar month.

MCOs shall ensure that authorization information shared with the SUD residential treatment provider includes the managed care authorization span, including the last date of the authorization for covered services.

MCOs are encouraged to align authorizations by unbundled units for provider continuity and to mitigate any potential administrative burden for SUD residential treatment providers.

When Medical Necessity is Not Met:

The MCO shall communicate the adverse benefit determination to the SUD residential provider in accordance with 42 CFR § 438.404 and shall provide options for treatment in an approved level of care. The MCO shall also communicate appeal rights for any Adverse Benefit Determination. The MCO's Discharge Planning staff will work with the SUD residential treatment staff to coordinate a safe discharge from the facility and transition into medically necessary service(s).

In order for the SUD treatment provider to safely discharge the individual, DBH will cover Room & Board for a period of up to 24 hours after the MCO issues an adverse benefit determination. Medicaid does not cover SUD Residential Treatment Room & Board. Failure to discharge the individual and coordinate alternate services may result in non-payment to the SUD residential treatment providers for any services rendered beyond the discharge related authorization period.

Exceeding MCO “In Lieu of” Coverage

MCOs cover services in an IMD under the “In Lieu of” scope of coverage per 42 CFR § 438.3. The “In Lieu of” benefit requires the MCO to cover up to 15 days of IMD services per calendar month. MCO authorizations are valid for no more than 15 days per calendar month.

If an individual continues to meet medical necessity for residential level of care beyond 15 days in a calendar month, the SUD residential treatment provider must secure a FFS authorization for the entirety of the individual’s episode of care through DHCF’s contracted Quality Improvement Organization (QIO), beginning July 1, 2021. The current QIO is Comagine Health. This may require the MCO to recoup any payments made to the provider. The provider then must pursue payment through FFS.

Requesting a FFS Authorization through Comagine Health

The SUD residential treatment provider must request a reauthorization on the behalf of individuals that require treatment beyond the initial MCO authorization. The provider should submit the reauthorization request to Comagine Health three business days before the “In Lieu of” benefit is exhausted.

Beginning July 1, 2021 the SUD residential treatment provider shall submit the following items to DHCF’s QIO, Comagine Health, via the provider portal (<https://comaginepp.zeomega.com/cms/ProviderPortal/Controller/providerLogin>) for authorization for continued stay:

1. A copy of the initial MCO authorization that includes the managed care authorization span dates;
2. The initial treatment plan for the individual;
3. A completed Continuum Assessment which will include:
 - a. Documentation of an active moderate to severe Substance Use and/or Addictive Disorder per the DSM-V;
 - b. An individualized, comprehensive biopsychosocial assessment of the patient’s Substance Use and/or Addictive Disorder;
 - c. An evaluation by a QP (i.e., Physicians; Psychologists; LICSWs; LISWs; LPCs; LMFTs; and APRNs) confirming medical necessity of the requested services;
 - d. A medical history detailing the individual’s medical conditions; and
 - e. For level 3.3 ONLY, description of cognitive deficits of moderate to severe intensity.
4. Additional medical information, including:
 - a. Comprehensive urine toxicology screen results;
 - b. Pregnancy test results for women (If a woman refuses a pregnancy test, the refusal must be documented and submitted to Comagine Health. Comagine Health may require additional information.); and
 - c. The glucose level to validate medical clearance for admission into the SUD residential treatment provider.

Failure to submit all of the required documentation may lead to an adverse benefit determination (denial) from Comagine Health. Comagine Health may also request additional clinicals from the SUD residential treatment provider. For questions regarding access and use of the Comagine Health provider web portal, please submit a portal access request or question to dcmedicaid@qualishealth.org.

Upon approval, Comagine Health will back date the new FFS authorization to the initial date of service from the MCO authorization. DBH remains responsible for covering SUD Residential Treatment Room & Board.

Contact

For questions regarding this transmittal, please contact Alondra Jones, Project Manager, Department of Health Care Finance (DHCF) at alondra.jones@dc.gov or (202) 442-4657.

Cc: DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Health Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers
Medical Society of DC



DC Medicaid Interactive Voice Response (IVR)



District of Columbia
Department of Health Care Finance

ACS Provider Services

Monday - Friday, 8 am - 5 pm

Phone

202-906-8319 (inside DC Metro area)
866-752-9233 (outside DC Metro area)

Fax

202-906-8399

Mailing Address

PO Box 34734
Washington, DC 20043-4734

Provider Enrollment

Monday - Friday, 8 am - 5 pm

Phone

202-906-8318 (inside DC metro area)
866- 752-9231 (outside DC metro area)

Fax

202-906-8399

Mailing Address

PO Box 34761
Washington, DC 20043-4761

EDI Technical Support

Monday - Friday, 8 am - 5 pm

Phone

866-407-2005

Questions regarding eligibility determinations should be directed to the Income Maintenance Administration.

Income Maintenance Administration

Phone

202-724-5506

District of Columbia

Department of Health Care Finance

Phone

202-698-2000

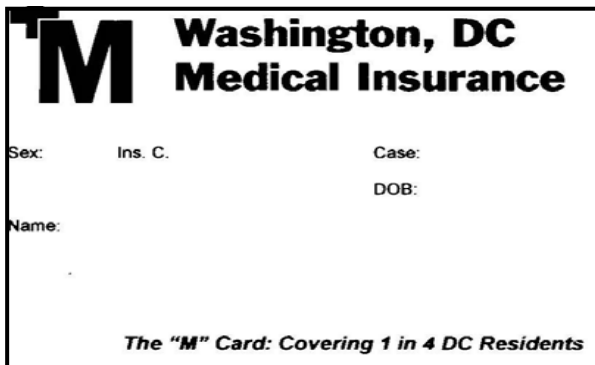
Fax

202-610-3209

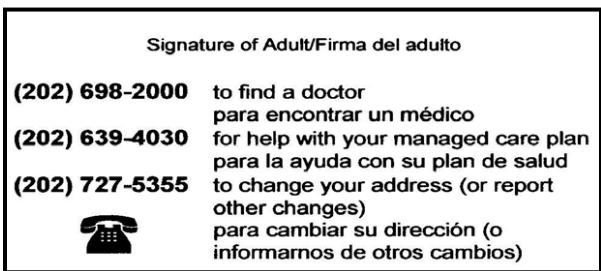
<http://www.dc-medicaid.com>

Attachment A

When first determined eligible, each Medicaid recipient receives a plastic Medical Assistance Card from the Income Maintenance Administration containing his/her name, social security number, date of birth, sex, and an eight-digit identification number, which may include two leading zeroes.



If the recipient has provided this information to the eligibility-determining agency, a provider should ask the recipient if he/she has other health insurance coverage not shown on the card. The provider is obligated to determine that the person to whom care is being rendered is the same individual listed on the eligibility card.



The back of the Medical Assistance Card provides information to the recipient that gives specific information relevant to its use.

It is the responsibility of the provider to always verify that the patient is eligible for Medicaid.

The Bureau of Eligibility Determination, Income Maintenance Administration (IMA) determines eligibility for the DC Medicaid Program.

Providers should verify the recipient's name and identification number, effective dates of eligibility, services restricted to specified providers, and whether other insurance is on file (commonly referred to as third party liability) before rendering services.

Recipient eligibility may be verified by calling the Interactive Voice Response System (IVR) using a touch-tone telephone and entering the recipient identification number found on the recipient's Medical Assistance ID card. Providers should also have their DC Medicaid provider number or NPI ready.

Benefits of the IVR

- ✓ The IVR is available 24 hours a day, seven days a week.
- ✓ Unlimited number of inquiries may be performed per call.
- ✓ The IVR may be used up to 30 minutes per call.

Using the IVR

To access the District of Columbia Government Medicaid Interactive Voice (IVR) Response System, dial **202-906-8319** (inside DC Metro area) or **866-752-9233** (outside DC Metro area) from your touch-tone phone. Select one of the following options and follow the prompts:

Press 1 - To verify recipient eligibility and claims status. The system will prompt you to enter your nine (9)-digit Medicaid provider number or 10-digit National Provider Identifier (NPI) followed by the pound (#) key.

Press 1 - For recipient eligibility

The system will prompt you to enter the recipient's eight (8)-digit ID followed by the pound (#) key and the recipient's eight (8)-digit date of birth in MMDDYYYY format;

Or

Enter the recipient's nine (9)-digit social security number and the recipient's eight (8)-digit date of birth in MMDDYYYY format.

If the recipient number exists in the database, the system will respond with a message about the patient's eligibility.

Press 2 - For claim status

The system will prompt you to enter the 17-digit transaction control number (TCN) followed by the pound (#) key and the recipient's eight (8)-digit ID followed by the pound (#) key;



Or

Enter the recipient's eight (8)-digit ID number followed by the pound (#) key, the recipient's eight (8)-digit date of birth in MMDDYYYY format, the eight (8)-digit date of service begin date in MMDDYYYY format and the eight (8)-digit date of service end date in MMDDYYYY format if different from the date of service begin date.

Press 2 - If you are a new provider and would like to enroll or if you are changing your provider number.

Press 3 - For EDI Technical Support Services

Press 4 - For all other questions

Attachment B: MCO Behavioral Health Utilization Review Contact Information

AmeriHealth Caritas District of Columbia	Behavioral Health Utilization Management (877) 464-2911
CareFirst Community Health Plan DC/Beacon Health	Behavioral Health Services (855) 481-7041
MedStar Family Choice DC/Magellan	Utilization Review (855) 798-4244
HSCSN	Utilization Review (202) 721-7162