

# **OPTIMA HEALTH PLAN ADDICTION AND RECOVERY TREATMENT SERVICES PROGRAM (ARTS) PROVIDER MANUAL**

## **SUPPLEMENTAL INFORMATION**

**This Supplement to the Optima Health Provider Manual is available for Providers who provide services for the Virginia ARTS Program through participation in Optima Family Care and Optima Health Community Care. Information contained in this Supplement details additional information and exceptions that are specific to the ARTS program.**

**Unless otherwise indicated in this Supplement, information in the core Provider Manual or the applicable OFC and OHCC Provider Manual Supplements applies to ARTS. Providers should continue to refer to the core Provider Manual and Supplements on the Provider web portal or contact Provider Relations or their Network Educator for policies and procedures not addressed in this Supplement.**

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## **ARTS OVERVIEW**

The Addiction and Recovery Treatment Services (ARTS) benefit is an enhanced substance use disorder treatment benefit of the Virginia Medicaid program. The ARTS benefit provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS and FAMIS MOMS. This treatment includes community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment. Goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a substance use disorder.

Optima Health's ARTS criteria are consistent with the American Society for Addiction Medicine (ASAM) criteria as well as DMAS's criteria for the ARTS benefit. ARTS Providers are responsible for adhering to requirements and regulations from ARTS, this Provider Manual Supplement, and their Optima Health Provider Agreement, and State and Federal governments.

### **American Society of Addiction Medicine (ASAM) Standards**

Optima Health applies the treatment criteria for addictive, substance-related conditions published by the ASAM (Third edition) for the ARTS program. The ASAM provides criteria for many levels and types of care for addiction and substance-related conditions. It also establishes clinical guidelines for making the most appropriate treatment and placement recommendations for Members who demonstrate specific signs, symptoms, and behaviors of addiction.

### **Disclosure of Protected Health Information**

Federal law requires federally assisted alcohol or drug abuse treatment Providers to protect a Member's identifying health information, whether direct or indirect. This is to protect Members from being identified as having a current or past drug or alcohol problem or as being a participant in a covered program without his/her written consent. With limited exceptions, this law requires a patient's consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Providers can consult their legal counsel for more information regarding this requirement.

ARTS covers the following services according to ASAM level-of-care standards:

<b>ASAM Level of Care</b>	<b>ASAM Description</b>
<b>4.0</b>	Medically Managed Intensive Inpatient
<b>3.7</b>	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)
<b>3.5</b>	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
<b>3.3</b>	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
<b>3.1</b>	Clinically Managed Low-Intensity Residential Services
<b>2.5</b>	Partial Hospitalization Services
<b>2.1</b>	Intensive Outpatient Services
<b>1.0</b>	Outpatient Services
<b>OTS</b>	Opioid Treatment Program (OTP)
<b>OTS</b>	Office-Based Opioid Treatment (OBOT)
<b>0.5</b>	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
<b>n/a</b>	Substance Use Case Management/Peer Support Services

## **PROVIDER PARTICIPATION REQUIREMENTS**

Addiction and Recovery Treatment Services (ARTS) Providers, must be qualified as defined in the ASAM Criteria; Treatment Criteria for Addictive, Substance-Related and Co-occurring Conditions, Third Edition, as published by the American Society of Addiction Medicine. For providers to participate Optima Health managed care programs (CCC Plus and Medallion 4.0) the Provider must be credentialed and contracted by DMAS and the health plan. Providers must be licensed by the Virginia Department of Behavioral Health and Disability Services and registered with the Department of Health Professions, these providers include:

- Opioid Treatment Programs
- Office-Based Opioid Treatment
- Case Management
- Peer Recovery Supports
- Inpatient Detox
- Residential Treatment
- Partial Hospitalization
- Intensive Outpatient Programs

### **Contracting and Credentialing**

For ARTS contracting and credentialing options and provider specific information please visit: <https://www.optimahealth.com/providers/provider-support/education/behavioral-health-provider-resources> or call:

- Contracting: 877-865-9075 x 4 or OptimaContract@sentara.com
- Credentialing: 877-865-9075 x 3 or BHCredentialing@Sentara.com

The Optima Behavioral Health New Provider Application Packet for Practitioners can be found at <https://www.optimahealth.com/documents/provider-manuals/behavioral-health-credentialing-packet.pdf>.

### **Community Service Boards (CSBs)**

In accordance with DMAS guidelines and DBHDS licensure and certification standards, CSBs may participate as a mental health clinic for physician directed Psychiatric services and as agency for Mental Health Services under the facility NPI.

**Direct Supervision of Residents and Supervisees**

Residents, Residents in Psychology and Supervisees in Social work can provide plans of care and psychotherapy or counseling services under supervision. The plan of care must be approved and signed by the licensed supervisor. Therapy or counseling sessions rendered by a Resident or Supervisee must be provided under the direct, personal supervision of a qualified, Participating Provider. The therapy session must contain:

- The dated signature of the Resident or Supervisee rendering the service
- The dated signature of the qualified, participating, licensed supervising Provider.
- Each therapy session must contain the dated co-signature.

<b>Residents</b>	<b>Residents in psychology</b>	<b>Supervisees in social work</b>
Under the supervision of a licensed professional counselor, licensed marriage and family therapist, or licensed substance abuse treatment practitioner approved by the Virginia Board of Counseling	Under the supervision of a licensed clinical psychologist approved by the Virginia Board of Psychology	Under the supervision of a licensed clinical social worker approved by the Virginia Board of Social Work

**UTILIZATION MANAGEMENT**

**Patient Utilization Management & Safety Program (PUMS)**

The Patient Utilization Management and Safety Program (PUMS) is a DMAS requirement for all Medicaid managed care organizations. It is designed to keep Members safe from misuse and overdose of controlled substances. This tiered program monitors Members who are using controlled substances: Members in the program are only able to fill their prescriptions at one pharmacy and may be only able to receive controlled prescriptions from their designated PUMS Provider. Members may be locked into the PUMS program due to:

- Multiple pharmacies use
- Multiple prescribers
- Complex drug regimen
- Suboxone use

Providers that are assigned to be the sole prescriber of controlled substances for a Member must:

- Be the only one able to prescribe controlled substances
- Ensure these Members have been prescribed necessary medications when they plan to be out of the office

## **Medical Necessity Criteria**

In order to receive reimbursement for ARTS services, the Member must meet the following medical necessity criteria below:

1. The Member must demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (except for tobacco-related disorders, caffeine use disorder or dependence, and non-substance-related addictive disorders). Otherwise, the Member must be assessed to be at risk for developing a substance abuse disorder (for children under 21 using the ASAM multidimensional assessment).
2. The Member must be assessed by a credentialed addiction treatment professional, who will determine if he/she meets the severity and intensity of treatment requirements for each service level defined by the most current version of the ASAM Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition):
  - a) Medical necessity for ASAM Levels of Care 2.1 to 4.0 (Intensive Outpatient and Partial Hospitalization Programs, Residential and Inpatient Services) must be based on the outcome of the Member's documented multidimensional assessment.
  - b) Opioid Treatment Programs (OTP), Office Based Opioid Treatment (OBOT) including Substance Use Care Coordination, and Substance Use Outpatient Services (ASAM Level 1) do not require a complete multi-dimensional assessment using the ASAM theoretical framework to determine medical necessity. These ASAM levels do require an assessment and development of a documented individualized service plan (ISP) by a credentialed addiction treatment professional.
  - c) A substance use case manager Provider will develop the Substance Use Case Management assessment and ISP.
3. A second individualized review by a licensed physician must be conducted to determine if a Member 21 years or younger who does not meet ASAM medical necessity criteria upon initial assessment, needs medically necessary treatment under the EPSDT benefit to correct or improve defects and physical and mental illnesses and conditions including a substance abuse disorder.

A care coordinator, physician, or Medical Director will perform an independent assessment of all requests for ARTS residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) and ARTS inpatient treatment services (ASAM Level 4.0). The length of treatment and service limits will be determined by the care coordinator, a physician, or Medical Director who is applying the ASAM criteria.

## **Multidimensional Assessment**

For ASAM Levels of Care 2.1 through 4.0, a credentialed addiction treatment professional must complete and document a multidimensional assessment (based on a biopsychosocial assessment). The Provider must maintain the multidimensional assessment in the Member's medical record. Medical necessity for all ASAM levels of care will be determined based on the outcome of the Member's multidimensional assessment. The multidimensional assessment is individualized, person-centered, and includes the following six dimensions:

- Acute intoxication or withdrawal potential, or both;
- Biomedical conditions and complications;
- Emotional, behavioral, or cognitive conditions and complications;
- Readiness to change;
- Relapse, continued use, or continued problem potential; and
- Recovery/living environment.

The Level of Care determination, Individual Service Plan (ISP), and recovery strategies development are based upon this multidimensional assessment.

## **Co-occurring Addictive and Mental Health Disorders**

For persons with co-occurring psychiatric and substance use conditions, Providers are expected to integrate the treatment needs for both conditions. There may be concurrent authorizations for psychiatric services and substance abuse services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners must be documented. Providers must:

- Use ASAM recommendations in evaluating and treating Members.
- Incorporate the goal of identifying independent co-occurring disorders (both substance use and mental health disorders) for all Members entering treatment in their multidimensional assessment or service specific Provider intake (whichever is required for the service).
- Use the ASAM Criteria to determine the appropriate levels of care.



## **ARTS Service Authorization and Registration**

Providers need to verify the Member's benefit eligibility before providing services to ensure the service being requested is covered. For initial requests, Providers should complete the ARTS Service Authorization Review Form.

To request an extension for the same ASAM level, they should complete the ARTS Service Authorization Extension Review Form.

***To find both of these forms please visit:*** <http://www.dmas.virginia.gov/#/artsregistration>

Providers should submit the completed service-authorization forms before or at initiation of services. Requests for service authorizations that do not meet the ASAM requirements for the requested Level of Care will not be approved. Submission of ARTS and CMHS / Service Authorization and Registration Requests Providers should fax the completed forms to Optima Health at 844-895-3231. Providers will be notified of Approvals/Denials via fax and/or letter. Providers should expect a standard turnaround time on all request(s) at 7 business days, urgent request can be turned around in 24 to 48 hours.

Providers must submit a Registration Form Required for all ASAM Levels of Care ARTS level 2.1/2.5/3.1/3.3/3.5/3.7/4.0.

For questions concerning the Registration process Please contact:

**Optima Health (Behavioral Health)**  
888-946-1168

**ARTS Questions**  
ARTS Helpline number: 804-593-2453  
Email: SUD@dmas.Virginia.gov

**\*NOTE:** for denials, a letter will be sent by the MCO to both the provider and member, in accordance with NCQA requirements.

## **Prior Authorization**

- Pre-authorization fax numbers are specific to the type of authorization request. Please submit your request to the fax number listed on the request form with a fax coversheet. Prior Authorization Forms include:
  - Behavioral Health Requests (Outpatient)
  - Urgent Requests (Inpatient)
  - Urgent Requests (Outpatient)

## **Addiction and Recovery Treatment Services (ARTS), Mental Health Services, Behavioral Health and Other Forms/Resources**

All ARTS authorization request(s) forms can be found at:

<https://www.optimahealth.com/providers/medical-authorizations/prior-authorization-forms>

- ARTS DMAS Provider Attestation Form (ASAM Levels 2.1 to 3.7)
- ARTS Peers Registration Request
- ARTS Peers Service Authorization Guidelines
- ARTS Service Authorization Review - Extensions
- ARTS Service Authorization Review - Initial Request
- ARTS Substance Use Case Management Registration

## **Behavioral Health**

- ABA Authorization
- Behavioral Health Discharge Summary
- Behavioral Health Inpatient Authorization Request
- Behavioral Health Outpatient Authorization Request
- Electroconvulsive Therapy (ECT) Authorization Request
- Transcranial Magnetic Stimulation (rTMS) Authorization Request Form

## **Community Mental Health Recovery Services (CMHS CCC+ Standard Forms)**

- CCC Plus Registration Form
- Continued Stay Request - MHS and Behavior Therapy
- MH-PHP Mental Health Partial Hospitalization
- EPSDT Behavior Therapy
- Assertive Community Treatment (ACT)
- Intensive In-Home (IIH)
- Mental Health Skill Building (MHSS)
- Psychosocial Rehabilitation (PSR)

## **Authorization Request for Inpatient and Observation Services**

- Authorization Request for Currently Hospitalized Members (Inpatient or Observation)
- Authorization Request for Future Inpatient or Outpatient Services

ARTS Service Authorization Requirements are detailed in the following table:

<b>ASAM Level of Care</b>	<b>ASAM Description</b>	<b>Service Authorization Required</b>
<b>4.0</b>	Medically Managed Intensive Inpatient	Yes
<b>3.7</b>	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Yes
<b>3.5</b>	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)	Yes
<b>3.3</b>	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Yes
<b>3.1</b>	Clinically Managed Low-Intensity Residential Services	Yes
<b>2.5</b>	Partial Hospitalization Services	Yes
<b>2.1</b>	Intensive Outpatient Services	Yes
<b>1.0</b>	Outpatient Services	No
<b>OTS</b>	Opioid Treatment Program (OTP)	No
<b>OTS</b>	Office-Based Opioid Treatment (OBOT)	No
<b>0.5</b>	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
<b>n/a</b>	Substance Use Case Management/Peer Support Services	Registration Required

### **Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5)**

Early intervention (ASAM Level 0.5)/Screening, Brief Intervention, and Referral to Treatment (SBIRT) services may be provided in a variety of settings including: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/Behavioral Health Authorities (BHAs), hospital emergency departments, pharmacies, and physician offices

Early intervention/SBIRT (ASAM Level 0.5) service components must include:

- Identifying Members who may have alcohol or other substance use problems using an evidence-based screening tool.
- Following the evidence-based screening tool, a brief intervention by a licensed professional, must be provided to educate Members about substance use, alert these Members to possible consequences and, if needed, begin to motivate Members to take steps to change their behaviors.

SBIRT services do not require service authorization. There are no annual service limits.

## **INDIVIDUALIZED SERVICE PLAN (ISP)**

The Individualized Service Plan (ISP) is a comprehensive, person-centered, recovery oriented treatment plan specific to the Member's unique treatment needs as identified in the assessment or the multidimensional assessment as applicable to the ASAM Level of Care. The written ISP contains the following:

- Member's treatment or training needs
- Member's goals
- Measurable objectives and recovery strategies to meet the identified needs
- Services to be provided with the recommended frequency to accomplish the measurable goals and objectives
- Estimated timetable for achieving the goals and objectives
- Individualized discharge plan that describes transition to other appropriate services

For persons with co-occurring psychiatric and substance use conditions, Providers should integrate the treatment needs in the Member's ISP.

An adult Member must sign his or her own ISP and if unwilling or unable to sign the ISP, then the Provider must document the reasons why. The child or adolescent's ISP must have a parent/legal guardian's signature except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance abuse services.

Providers should document the ISP review in the Member's medical record within than 7 days from the calendar date of the review. The review date is the dated signatures of the credentialed addiction treatment professional as noted above, and the Member and/or guardian, when a minor child is the recipient.

The ISP must be updated in writing annually and/or as the Member's needs and progress change. The ISP must be reviewed with the Member present, and the outcome of the review documented in the Member's medical record. Documentation of the ISP review must include the dated signatures of the credentialed addiction treatment professional and the Member. If the review identifies any changes in the Member's progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the Member's progress and treatment needs as well as any newly identified problems.

## **ISP Discharge Planning**

All ISPs for all levels of care must include an individualized discharge plan. Anticipated discharge plans are documented at the start of treatment. This plan describes the discharge planning activities, summarizes an estimated timetable for achieving the goals and objectives in the service plan, and includes updated discharge plans current and specific to the needs of the Member. The discharge plan must include plans for transitioning through appropriate levels of care until the Member reaches a point where they may exit the continuum of care and resume daily activities without the need for any ARTS intervention.

At least 15 calendar days before discharge for ASAM levels 2.1, 2.5 and 3.1-3.7 and five calendar days before discharge for ASAM 4.0, the Provider must submit an active discharge plan to Optima Health for review. Once approved, the provider must begin collaborating with the Member or legally authorized representative and the treatment team to identify behavioral health and medical Providers and to schedule appointments as needed. The provider must then inform Optima Health of all scheduled appointments within seven calendar days before discharge and notify Optima Health within one business day of the Member's discharge date from their facility.

## **Therapeutic Passes**

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the credentialed addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or two consecutive days of passes of eight hours or more require service authorization. Any unauthorized therapeutic passes will result in retraction for those days of service.

## **ISP Specific Requirements for ASAM Levels 4.0/3.7/3.5/3.3/3.1/2.5/2.1**

Providers must follow specific requirements for the ISP in the following settings:

- Medically managed intensive inpatient services (ASAM 4.0)
- Substance use residential/inpatient services (ASAM levels 3.1, 3.3, 3.5, and 3.7)
- Substance use intensive outpatient and partial hospitalization programs (ASAM levels 2.1 and 2.5)

The initial ISP must be developed and documented within 24 hours of admission to these services:

- ASAM Level 4.0: The physician or the physician extender must develop and document the initial ISP for inpatient services (ASAM Level 4.0).
- ASAM Level 3.7 to 3.1: The credentialed addiction treatment professional(s), in collaboration with the physician or physician extender overseeing the treatment process, must complete and document the initial ISP.
- ASAM Level 2.1 to 2.5: For substance use intensive outpatient and partial hospitalization programs, the credentialed addiction treatment professional(s) must develop and document the ISP and include the physician and physician extender as necessary.

In cases where the Member is unable to participate in the assessment process due to an acute medical condition and/or acute intoxication or impairment, the Provider should note this in the Member's record and include the Member when they can participate.

The comprehensive ISP must be fully developed and documented within 14 calendar days of initiating services. The credentialed addiction treatment professional(s) and the physician and/or physician extender must sign and date the ISP, as necessary. The Provider must include the Member and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the Member's condition requires assistance for participation, assistance must be provided.

### **ISP Specific Requirements for Opioid Treatment Services and ASAM Level 1.0**

The initial ISPs must be developed during the first appointment to address the Member's immediate health and safety needs for the following services:

- Opioid Treatment Services (OTP)
- Office Based Opioid Treatment (OBOT)
- Substance Use Outpatient Services (ASAM Level 1)

The provider must include the Member and the family/caregiver in the development of the ISP or treatment plan as appropriate. To the extent that the Member's condition requires assistance for participation, assistance must be provided. The comprehensive ISP must be:

- Fully developed and documented within 30 calendar days of the start of services and signed and dated by the credentialed addiction treatment professional preparing the ISP.
- Reviewed every 90 calendar days and modified as the needs and progress of the Member changes. If the review identifies any changes in the Member's progress and treatment needs, then the goals, objectives, and strategies of the ISP must be updated to reflect those changes.

### **ISP Specific Requirements for Substance Use Case Management**

ISPs for Substance Use Case Management must assess needs and plan services with the Member and their family as appropriate. ISPs for these services must:

- Be completed within 30 calendar days of initiation of this service with the Member in a person-centered manner.
- Document the need for active Substance Use Case Management before such case management services can be billed.
- Require a minimum of two distinct Substance Use Case Management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days.

The substance use case manager must review the ISP with the Member at least every 90 calendar days for evaluating and updating the Member's progress toward meeting the ISP objectives.



## **ARTS COVERED SERVICES AND LIMITATIONS**

ARTS services must meet medical necessity criteria based upon the multidimensional assessment to be covered. These ARTS services are covered:

- Medically Managed Intensive Inpatient Services (ASAM Level 4)
- Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7)
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5)
- Opioid Treatment Services (OTS) including Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT) (ASAM Level OTS)
- Substance Use Outpatient Services (ASAM Level 1)
- Early Intervention Services/SBIRT (ASAM 0.5)
- Substance Use Care Coordination
- Substance Use Case Management Services

Withdrawal management services are covered when medically necessary if paired with the following:

- Medically Managed Inpatient Services (ASAM Level 4)
- Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7)
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5)
- Opioid Treatment Services (OTS) including Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT) (ASAM Level OTS)
- Substance Use Outpatient Services (ASAM Level 1)

### **Crisis Intervention**

Crisis Intervention is covered for both ARTS and/or mental health crises through the CMHS program for all eligible Members.

### **Telemedicine**

Telemedicine services are covered under specific criteria. Providers should contact their Provider Services with questions or for specific policies and requirements.

### **Transportation**

Transportation to non-emergency ARTS Covered Services is a covered benefit. For specific questions or to coordinate transportation services for Members, please contact Provider Services.

## **ASAM Level OTS: Opioid Treatment Services**

Opioid treatment services and Medication Assisted Treatment (MAT) are covered and can be billed separately in community-based settings providing ASAM Levels 1.0 through 3.7 (excluding inpatient services). Practitioners of MAT must follow the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment and collaboration must occur between the community-based Provider and the buprenorphine-waivered practitioner.

Practitioners who are not licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as an Opioid Treatment Program (OTP) or approved as an Office Based Opioid Treatment (OBOT) Provider and credentialed as an OTP or OBOT will have service authorization requirements for prescribing buprenorphine products. This includes oral buprenorphine, short-acting opioids, and long acting opioids.

Providers who are licensed as an OTP or approved as an OBOT and meet service components and risk management requirements, detailed below, will have the following additional benefits:

- No service authorization for buprenorphine products
- Higher reimbursement of Practitioner Induction – Day 1 and psychotherapy sessions
- Eligibility for reimbursement for Substance Use Care Coordination

## **Opioid Treatment Programs (OTP)**

OTPs must meet the service components and risk management requirements outlined below. OTP services do not require service authorization. OTP service components must be documented in the Member's medical record and include the following activities:

- Link the Member to necessary psychological, medical, and psychiatric consultation
- Ensure access to emergency medical and psychiatric care through connections with more intensive levels of care
- Ensure access to evaluation and ongoing primary care.
- Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Ensure appropriately licensed and credentialed physicians are available to evaluate and monitor use of methadone, buprenorphine products, or naltrexone products and of pharmacists and nurses to dispense and administer these medications
- Ensure buprenorphine monoproducs are prescribed only to pregnant women or for 7 days while transitioning Members from methadone to buprenorphine/naloxone. All Providers must follow the Virginia Medical Society PMP process.
- Ensure medication for other physical and mental health conditions are provided as needed either on-site or through collaboration with other Providers.
- Provide individualized, patient-centered assessment and treatment.

- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the Member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the Member on an individual, group, or family basis.
- Provide optional substance use care coordination
- Provide a referral or on-site screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis during the initial treatment for Members who have not been screened for infectious diseases within previous 12 months. Continue with annual screenings based on risk factors.
- Administer medication via a Registered Nurse (RN) on site during the induction phase. During the maintenance phase, medication may be administered either by a RN or Licensed Practical Nurse (LPN).

OTP risk management must clearly and adequately document the following activities in each Member's record:

- Random urine drug screening for all Members, which must be conducted at least eight times during a twelve-month period.
- Quarterly checks on the Virginia Prescription Monitoring Program for all Members.
- Opioid overdose prevention education including the prescribing of naloxone.

*To find ARTS Reimbursement Structure for billing codes and units for OTP services:* <http://www.dmas.virginia.gov/#/arts> under ARTS Billing Information.

### **Office Based Use Opioid Treatment (OBOT)**

Office-Based Opioid Treatment (OBOT) must be provided by a buprenorphine-waivered practitioner. The treatment may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHCs), Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs), local health department clinics, and physician offices.

Substance use care coordination cannot be provided simultaneously with Substance Use Case Management. CSBs/BHAs that are licensed as Substance Use Case Management Providers should provide Substance Use Case Management services (H0006) instead of substance use care coordination.

OBOT service components include the following activities, which Providers must document, as rendered, in the Member's medical record:

- Ensure access to emergency medical and psychiatric care.
- Establish affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable Members can be referred to when clinically indicated.

- Provide individualized, patient-centered multidimensional assessment and treatment.
- Assess order, administer, reassess, and regulate medication and dose levels appropriate to the Member; supervise withdrawal management from opioid analgesics; and oversee and facilitate access to appropriate treatment for opioid use disorder and alcohol use disorder.
- Ensure medication for other physical and mental illnesses are provided as needed either on-site or through collaboration with other Providers.
- Ensure buprenorphine products are only dispensed on-site during the induction phase. After induction, buprenorphine products should be prescribed to the Member.
- Ensure buprenorphine monoproducts are only prescribed in the following scenarios: when a patient is pregnant, when converting a patient from methadone or buprenorphine monoproduct to buprenorphine containing naloxone for a period not to exceed 7 days, or in formulations other than tablet form for indications approved by the FDA (pursuant to Board of Medicine regulations). All other Members should be prescribed buprenorphine/naloxone or naltrexone products. All Providers must follow the Virginia Medical Society PMP process.
- The maximum daily buprenorphine or buprenorphine/naloxone dose should be 16 mg unless there is documentation of an ongoing, compelling, clinical rationale for a higher maintenance dose up to maximum of 24 mg.
- Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber may only co-prescribe these substances when there are reasonable circumstances. Providers must document these circumstances in the medical record with a tapering plan to achieve the lowest possible effective doses if these medications are prescribed (pursuant to Board of Medicine regulations).
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, to the Member on an individual, group, or family basis by credentialed addiction treatment professionals, practicing within the scope of their license, working in collaboration with the prescribing buprenorphine- waived practitioner. The credentialed addiction treatment professional must be co- located at the same practice site and provide counseling when the buprenorphine- waived practitioner is prescribing buprenorphine or naltrexone to Members with moderate to severe opioid use disorder.
  - Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs) and Federally-Qualified Health Centers have different requirements; please contact your Network Educator for details.
  - Counseling can be provided via telemedicine in rural areas if the nearest credentialed addiction treatment professional is located more than 60 miles away from the buprenorphine-waivered practitioner. The credentialed addiction treatment professional must develop a shared care plan with the buprenorphine- waived practitioner and the Member and take extra steps to ensure that substance use care coordination and interdisciplinary care planning are occurring.

- For Members who have not been screened for infectious diseases within 12 months, screening provided on-site or referral for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.
- A Registered Nurse (RN) must provide medication administration on site during the induction phase.

OBOT risk management must include the following activities, clearly and adequately documented in each Member's record:

- Routine and/or random urine drug screens, conducted a minimum of eight times per year for all Members with at least some tests unannounced or random.
- Virginia Prescription Monitoring Program checked at least quarterly for all Members.
- Opioid overdose prevention education including the prescribing of naloxone for all Members.
- When initiating treatment (during the first three months), Members must be seen at least weekly by the buprenorphine-waivered practitioner or credentialed addiction treatment professional. The Member must have been seen for at least three months with documented clinical stability before changing to a minimum of monthly visits with buprenorphine-waivered practitioner or credentialed addiction treatment professional. The Individualized Plan of Care must be updated to reflect these changes.
- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

## **Home Inductions in OBOT Setting**

Buprenorphine waived practitioners may consider home induction for Members if it is determined by the practitioner to be feasible and safe. The practitioner must maintain close telephone contact with the Member during the unobserved induction. The practitioner must review steps to access emergency medical and psychiatric care clinic hours if needed with the Member.

Preferred OBOTs may bill the H0014 MAT induction code for three separate inductions per 365 calendar days per member that must be at least 90 calendar days apart. The first day of each separate induction is billed using H0014. Additional physician/nurse practitioner/physician assistant follow up and maintenance visits within a 365 calendar day period should be billed using the appropriate evaluation and management code. Providers should submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after.

Providers can bill for additional inductions beyond 3 separate inductions per 365 calendar days using the appropriate evaluation and management codes. If a member fails three buprenorphine or buprenorphine/naloxone inductions within a 365 calendar day period in a Preferred OBOT setting, the provider should consider referring the member to an OTP or higher level of care for assessment for treatment.

Buprenorphine waived practitioners should **not** bill for physician services (MAT induction H0014 or E&M physician visits) and psychotherapy or opioid counseling (H0004 or H0005) if provided by the same practitioner on the same date of service.

Buprenorphine waived practitioners who are providing physician services and psychotherapy or opioid counseling within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined below, may provide these services as long as they are separate days and there is supporting documentation.

A different credentialed addiction treatment professional can provide opioid counseling and bill for H0004 or H0005 on the same date of service that the physician services are delivered by the buprenorphine waived practitioner.

***To find ARTS Reimbursement Structure for billing codes and units for OBOT services:*** <http://www.dmas.virginia.gov/#/arts> under ARTS Billing Information.

## **Substance Use Case Management**

Substance use case management services must be person-centered, individualized, culturally, and linguistically appropriate to meet the Member's and family Member's needs. Substance use case management includes an active ISP, which requires at least two Substance Use Case Management service activities each month and at least one face-to-face contact with the Member at least every 90 calendar days.

Substance use case management is reimbursable monthly only when the minimum Substance Use Case Management service activities are met as detailed below. Only one type of case management may be billed at one time. Substance use case management can be provided as a stand-alone service.

Substance use case management service activities include the following:

- Assessing needs and planning services to include developing a Substance Use Case Management ISP with the Member and his/her family. The ISP must utilize accepted placement criteria and be fully completed within 30 calendar days of initiation of service.
- Expanding community integration opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the public.
- Making collateral contacts with the Member's significant others with properly authorized releases to promote implementation of the Member's ISP and his/her community adjustment.
- Linking the Member to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the Member as developed in the ISP
- Assisting the Member directly to locate, develop, or obtain needed services, resources, and appropriate public benefits
- Assuring the coordination of services and service planning within a Provider agency, with other Providers, and with other human service agencies and systems, such as local health and social services departments.
- Monitoring service delivery through Member contacts including site and home visits to assess the quality of care and satisfaction of the Member.
- Providing follow-up instruction, education, and counseling to guide the Member and develop a supportive relationship that promotes the ISP.
- Advocating for Members in response to their changing needs based on changes in the ISP.
- Planning for transitions in the Member's life.
- Knowing and monitoring the Member's health status, any medical conditions, medications, and potential side effects, and assisting the Member in accessing primary care and other medical services as needed.
- Understanding the services capabilities to meet the Member's identified needs and preferences and to serve the Member without placing the Member, other participants, or staff at risk of serious harm.

## Service Units and Limitations

- The billing unit for case management is monthly.
- Substance use case management services are not reimbursable for Members while they are residing in institutions, including institutions for mental disease; however, Substance Use Case Management may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods in a 12-month period.
- No other type of case management may be billed concurrently with substance abuse case management including mental health treatment, foster care, or services that include case management activities. Such activities would include Assertive Community Treatment.
- Substance use case management may not be billed concurrently with substance use care coordination.
- Substance use case management does not include:
  - Maintaining service waiting lists or periodically contacting or tracking Members to determine potential service needs that do not meet the requirements for the monthly billing.
  - The direct delivery of an underlying medical, educational, social, or other service to which an eligible Member has been referred.
  - Activities for which a Member may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or ISP.

## **ASAM Level 1: Outpatient Services**

Outpatient services (ASAM Level 1) must be provided by a credentialed addiction treatment professional, psychiatrist, or physician. These services may be performed in the following community-based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, Federally Qualified Health Centers (FQHCs), Community Service Boards (CSBs)/Behavioral Health Authorities (BHSs), local health departments, physician, and provider offices in private or group practices. Reimbursement for Substance use outpatient services are reimbursed for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided face-to-face or by telemedicine.

Outpatient services must include the following components as medically necessary:

- Professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.
- A documented ISP to determine that a Member meets the medical necessity criteria. This documentation must include the evaluation or analysis of substance use disorders; diagnosis of substance use disorders; and assessment of treatment needs to provide medically necessary services.
- A physical examination and laboratory testing as necessary for substance use disorder treatment. Members who have not been screened for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis within 12 months must receive a referral or on-site screening at treatment initiation then at least annually based on risk factors.
- Member counseling between the Member and a credentialed addiction



treatment professional. Services provided face-to-face or by telemedicine are reimbursable.

- Group counseling by a credentialed addiction treatment professional with a maximum of ten Members.
- Family therapy to facilitate the Member's recovery and support for the family's recovery provided by a credentialed addiction treatment professional.
- Evidenced-based Member education on addiction, treatment, recovery, and associated health risks.
- Medication services including prescribed or administered substance-use treatment medication or side-effect assessment provided by authorized staff. A continuity of care system in which Members transitioning to Level 1.0 from a higher Level of Care should receive the initial outpatient appointment within seven business days of discharge.
- Services may be provided on site or through referral to an outside provider. In addition, Outpatient services co-occurring enhanced programs must include:
  - Ongoing Substance Use Case Management for highly crisis-prone Member with co-occurring disorders. Outpatient service Providers may coordinate the Substance Use Case Management services with the licensed Substance Use Case Management provider.
  - Credentialed addiction treatment professionals, trained in severe and chronic mental health and psychiatric disorders, which can assess, monitor, and manage Members with a co-occurring mental health disorder.

***To find ARTS Reimbursement Structure for billing codes and units for outpatient services:*** <http://www.dmas.virginia.gov/#/arts> under ARTS Billing Information.

### **ASAM Level 2.1: Intensive Outpatient Services**

Intensive outpatient services (ASAM Level 2.1) are a structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three service hours per service day to achieve nine to 19 hours of services per week for adults and six to 19 hours of services per week for children and adolescents. This service is provided to Member who do not require the intensive Level of Care of inpatient, residential, or partial hospitalization services, but require more intensive services than outpatient services.

Providers must provide service components as part of intensive outpatient services, as medically necessary, and as indicated in the Member's ISP. The provider must demonstrate the ability to provide these components or provide Member access through referral and monitor the components weekly. These are the service components:

- Psychiatric and other individualized treatment planning.
- Individual, family, and/or group psychotherapy.
- Medication management and psychoeducational activities.
- Requests for a psychiatric or a medical consultation available within 24 hours of the requested telephone consultation. For in-person and telemedicine consultation requests, the preference is within 72 hours. Referrals to external resources are allowed in this setting.
- Psycho-pharmacological consultation.

- Addiction medication management provided on-site or through referral.
- Emergency services available 24/7.
- Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire a Member's motivation to change behaviors.
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral, as indicated in the Member's ISP. For Members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Withdrawal management services may be provided as necessary by qualified staff either on site or through referral. Providers should refer to the ASAM Criteria for Intoxication/Withdrawal Management guidelines for additional information.

In addition, Intensive Outpatient Services co-occurring enhanced programs offer therapies and support systems in intensive outpatient services to Members with co-occurring addictive and psychiatric disorders that are able to tolerate and benefit from a planned program of therapies. Members who are not able to benefit from a full program of therapies, will be offered and provided services or a referral made to enhanced program services to match the intensity of hours in ASAM Level 2.1, including Substance Use Case Management, Assertive Community treatment, medication management, and psychotherapy.

#### Service Units and Limitations

- Intensive outpatient services require service authorization. Optima will respond within three calendar days to the service authorization request. If approved, Optima will reimburse Providers retroactively for this service to allow Members to immediately enter treatment.
- Members must be discharged from this service when other, less-intensive services may achieve stabilization, the Member requests discharge, or the Member ceases to participate.
- Intensive Outpatient services may be provided concurrently with Opioid Treatment Services. Collaboration between the Intensive Outpatient provider and the buprenorphine-waivered practitioner is required.
- Opioid Treatment Services/Medication Assisted Treatment including physician visits and medications, labs, and urine drug screens may be billed separately.
- Staff travel time is excluded.
- One unit of service is one day with a minimum of three service hours per service day to achieve nine to 19 hours of services per week for adults and six to 19 hours of services per week for children and adolescents, with regards to the first and last week of treatment. Maximum of 19 hours may be billed per week. In cases that a Member does not complete the minimum of three service hours per service day, the provider should document any deviation from the ISP in the Member's medical record and the reason for the deviation. They should also notify Optima weekly when the minimum sessions have not been provided. If the Member

consistently deviates from the required services in the ISP, the provider should work with the Optima ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the Member's needs.

- ASAM Criteria allows of less than nine hours per week for adults and six hours per week for adolescents as a transition step down in intensity for one to two weeks prior to transitioning to Level 1 to avoid relapse. The transition step-down needs to be approved by Optima and documented and supported by the Member's ISP.
- Group counseling by credentialed addiction treatment professionals has a maximum limit of ten Members.
- There are no maximum annual limits.

#### ASAM Level 2.5: Partial Hospitalization Services

Like ASAM Level 2.1, substance use partial hospitalization services (ASAM Level 2.5), are a structured program of skilled treatment services for adults, children, and adolescents. The minimum number of service hours per week, however, is 20 hours with at least five service hours per service day of skilled treatment services.

Partial hospitalization service components must be provided weekly or as directed by the ISP and must be based on the Member's treatment needs identified in the multidimensional assessment. These are the required components:

- Individualized treatment planning.
- Withdrawal management services may be provided as necessary. Providers should refer to the ASAM Criteria for Intoxication/Withdrawal Management guidelines.
- Family therapies involving family Members, guardians, or his/her significant other in the assessment, treatment, and continuing care of the Member.
- Motivational interviewing, enhancement, and engagement strategies.
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral.
- For Members who have not been screened for infectious diseases within 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Psychiatric and medical formal agreements to provide medical consult within eight hours of the requested consult by telephone, or within 48 hours in person or via telemedicine. Referrals to external resources are allowed in this setting.
- Emergency services available 24/7.
- Close coordination through referrals to higher and lower levels of care and supportive housing services such as in a Clinically Managed Low Intensity Residential Services (ASAM Level 3.1).

For each day the Member attends therapy, he/she must receive access to service components as listed below (more needed components may be provided in accordance with multidimensional assessment):

- Skilled treatment services with a planned format including Member and group

- psychotherapy
- Medication management
- Education groups
- Occupational, recreational therapy, and/or other therapies

In addition, partial hospitalization services co-occurring enhanced programs must include:

- Therapies and support systems to Members with co-occurring addictive and psychiatric disorders who can tolerate and benefit from a full program of therapies. Other Members who are not able to benefit from a full program of therapies (who are severely or chronically mentally ill) will be offered/referred/linked to enhanced program services. This is to constitute intensity of hours in Level 2.5, including Substance Use Case Management, Assertive Community Treatment, medication management, and psychotherapy.
- Psychiatric services (as appropriate) to meet the Member's mental health condition. Services may be available by telephone and on site, closely coordinated off site, or via telemedicine.
- Clinical leadership and oversight as well as a capacity (at minimum) to consult with an addiction psychiatrist via telephone, telemedicine, or in person.
- Credentialed addiction treatment professionals with experience assessing and treating co-occurring mental illness.

#### Service Units and Limitations

- Partial hospitalization services require service authorization. Optima will respond within three calendar days to the service authorization request. If approved, Optima will reimburse Providers retroactively for this service to allow Members to immediately enter treatment.
- Members must be discharged from this service when other, less-intensive services may achieve stabilization, the Member requests discharge, or the Member ceases to participate.
- Partial hospitalization services may be provided concurrently with Opioid Treatment Services/Medication Assisted Treatment. Collaboration between the Partial Hospitalization provider and the buprenorphine-waivered practitioner is required.
- Opioid Treatment Services/Medication Assisted Treatment including physician visits and medications, labs, and urine drug screens may be billed separately.
- Staff travel time is excluded.
- Skilled treatment services must amount to 20 hours a week -- one service hour being equivalent to one standard hour. Put another way, this equates to five service hours per day. Note that hours can be partitioned differently for different days; however, the first and last day of the week should each have a total of five hours. The provider should document any deviation from the ISP in the Member's medical record and reason for the deviation and notify Optima weekly when the minimum sessions have not been provided. If the Member consistently deviates from the required services in the ISP, the provider should work with the Optima

ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the Member's needs. Medicaid allows as a transition step-down in intensity for one to two weeks prior to transitioning to Level 2.1 or 1.0 to avoid relapse. The transition step-down needs to be approved by Optima and documented and supported by the Member's ISP.

- Group counseling by credentialed addiction treatment professionals must have a maximum limit of ten Members.
- There are no maximum annual limits.

### **ASAM Level 3.1: Clinically Managed Low Intensity Residential Services**

Clinically managed, low-intensity, residential services (ASAM Level 3.1) must provide at least five hours of clinically directed program activities per week. This service cannot include settings such as sober houses, boarding houses, or group homes where treatment services are not provided.

Clinically managed, low-intensity, residential service components include:

- A face-to-face, multidimensional assessment performed upon admission by a credentialed addiction treatment professional acting within scope of their practice, to determine and document a DSM5/ICD-10 diagnosis.
- An initial ISP within 24 hours and Comprehensive ISP within 14 days.
- Services for the Member's family and significant other, as appropriate to advance the Member's treatment goals and objectives identified in the ISP.
- Weekly face-to-face meetings with the Member and the treatment team will be required to review, discuss, and document treatment progress and progress toward discharge. A week is defined as Sunday through Saturday.
- Clinically directed program activities by credentialed addiction treatment professionals constituting at least five hours per week of professionally directed treatment designed to stabilize and maintain SUD symptoms, and to develop and apply recovery skills, utilizing motivational enhancement, and engagement strategies.
- Counseling and clinical monitoring to support initial or re-involvement in regular productive daily activity and reintegration into family or community living with health education.
- Relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery. Services must promote personal responsibility and re-integration of the Member into the network systems of work, education, family, and community life.
- Physician consultation and emergency services available 24/7.
- Arrangements for medically necessary procedures including laboratory and toxicology tests, which are appropriate to the severity and urgency of a Member's condition.
- Arrangements for pharmacotherapy for psychiatric or anti-addiction medications and drug screenings.
- Arrangements for higher and lower levels of care and other services. Additionally, it includes direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as intensive outpatient, vocational assessment and placement, literacy training, and adult education.
- Regular monitoring of the Member's medication adherence.
- Education on benefits and potential side effects of medication assisted treatment and referral to treatment as necessary. It also includes opportunities for the Member to learn potential benefits of addiction pharmacotherapies as a long-term tool to manage addiction.
- Biomedical enhanced services are delivered by appropriately credentialed medical staff that is available to assess and treat co-occurring, biomedical

disorders and to monitor the Member's administration of medications in accordance with a physician's prescription.

- Coordination with community physicians to review treatment as needed.
- Appropriate arrangements or referrals to all service Providers identified in the discharge plan before the Member's scheduled discharge date.
- Follow-up and monitoring of Member immediately after discharge to ensure continuity of engagement.

In addition to the Level 3.1 service components listed above, Clinically Managed, Low-Intensity, Residential Services co-occurring enhanced programs must include:

- Programs for Members who have both unstable substance use and psychiatric disorders. This includes appropriate psychiatric services, medication evaluation, and laboratory services. Such services are provided either on-site, via telemedicine, or closely coordinated with an off-site provider as appropriate to the severity and urgency of the Member's mental health condition.
- Planned clinical activities (either directly or through affiliated Providers) that are designed to stabilize and maintain the stabilization of the Member's mental health and psychiatric symptoms. Goals of therapy are to apply to both the SUD and any co-occurring mental illness.

#### Service Units and Limitations

- ASAM Level 3.1 services require service authorization. Optima Health will respond within three calendar days to the service authorization request. If approved, Optima Health will reimburse Providers retroactively for this service to allow Members to immediately enter treatment.
- Members must be discharged from this service when other, less-intensive services may achieve stabilization, the Member requests discharge or the Member moves out of the facility.
- ASAM Level 3.1 services may be provided concurrently with opioid treatment services/Medication Assisted Treatment, partial hospitalization services, Intensive Outpatient Services, and outpatient services. Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens, which may be billed separately in community-based settings. Group counseling by credentialed addiction treatment professionals has a maximum limit of ten Members.
- Staff travel time is excluded. Medicaid does not pay for room and board. One unit of service is one day. There are no maximum annual limits.

### **ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Service**

Clinically managed population-specific high-intensity residential services (ASAM Level 3.3) must include:

- Access to a consulting physician or physician extender and 24/7 emergency services via telephone and in person.
- Arrangements for higher and lower levels of care, including direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as Intensive Outpatient Services (IOS), vocational assessment and placement, literacy training, and adult education.
- Arrangements for laboratory and toxicology services appropriate to the severity of need. Additionally, this includes arrangements for addiction pharmacotherapy involving pharmacotherapy for psychiatric or anti-addiction medications with drug screenings. For Members who have not been screened for infectious diseases within 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Regular monitoring of the Member's medication adherence.
- Weekly face-to-face meetings with the Member and treatment team or credentialed addiction treatment professional who prepared the ISP. The latter will be required to document treatment progress and progress toward discharge.
- Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services must promote personal responsibility and reintegration of the Member into the network systems of work, education, and family life. Daily clinical services are to be provided to improve organization, daily living skills, recovery, personal responsibility, personal appearance, and punctuality.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the Member in initial involvement or re-engagement in regular, productive daily activity.
- Recreational therapy, art, music, physical therapy, and vocational rehabilitation. Though, these services do not constitute the primary mode of treatment.
- Clinical and didactical motivational interventions to address readiness to change and understanding of disorder life impacts. Recovery support services. Services for the Member's family and significant other, as appropriate to advance the Member's treatment goals and objectives identified in the ISP.
- Education on benefits of medication-assisted treatment and referral to treatment as necessary.
- Withdrawal management services as necessary.

Providers should refer to the ASAM Criteria for Intoxication/Withdrawal Management guidelines for additional information. Substance use case management is included in this Level of Care. Substance use case management services are not reimbursable for Members while they are residing in institutions, including institutions for mental disease, except that Substance Use Case Management may be reimbursed during the month before discharge to allow for discharge planning. This is limited to two one-month periods in a 12-month period.



In addition, Clinically Managed Population-Specific High-Intensity Residential Service co-occurring enhanced programs, programs must include the Level 3.3 service components listed in this section, including appropriate psychiatric services, medication evaluation and laboratory services which must be provided on-site or through a closely coordinated off-site provider, as appropriate to the severity and urgency of the Member's mental condition.

#### Service Units and Limitations

- ASAM Level 3.3 requires service authorization. Optima will respond within one calendar day to the service authorization request. If approved, Optima will reimburse Providers retroactively for this service to allow Members to immediately enter treatment.
- Members must be discharged from this service when other, less-intensive services may achieve stabilization, the Member requests discharge, or the Member discontinues services.
- ASAM Level 3.3 services may be provided concurrently with Opioid Treatment Services.
- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings.
- One unit of service is one day.
- There are no maximum annual limits, but treatment must meet ASAM Criteria.
- Group counseling by credentialed addiction treatment professionals has a maximum limit of ten Members.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one, is included in the Optima Health reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs including but not limited to personal care, habilitation, or academic-educational needs of the Member.
- FAMIS/FAMIS MOMS/GAP benefits do not cover residential treatment services.
- Some examples of non-reimbursable services include:
  - Remedial education (tutoring, mentoring)
  - Evaluation for educational placement or long-term placement
  - Daycare
  - Psychological testing for educational diagnosis, school, or institutional admission and/or placement
  - Partial hospitalization programs/Intensive Outpatient Programs
  - Case management for therapy services
  - Team meetings

**ASAM Level 3.5: Clinically Managed, High-Intensity, Residential Services (Adult) and Clinically Managed, Medium-Intensity, Residential Services (Adolescent)**

Clinically managed, high-intensity, residential services (adult) and clinically managed, medium-intensity, residential services (adolescent) (ASAM Level 3.5), are residential treatment services that must include:

- Telephone or in-person consultation with a physician or physician-extender that must be available to perform required physician services. Emergency services must be available 24/7.
- Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.
- Arrangements for needed procedures including medical, psychiatric, psychological, lab, and toxicology services appropriate to the severity of need. For Members who have not been screened for infectious diseases within 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Arrangements for addiction pharmacotherapy.
- Random drug screening to monitor and reinforce recovery.
- Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services must promote personal responsibility and reintegration of the Member into the network systems of work, education, and family life.
- Program activities must be designed to stabilize and maintain symptoms of substance abuse disorder and apply recovery skills. Activities and may also include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- Daily clinical services to improve development and practice of pro-social behaviors: organization, daily living skills, recovery, personal responsibility, personal appearance, and punctuality.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the Member in initial involvement or re-engagement in regular, productive, daily activities including education on medication management, addiction pharmacotherapy, and educational skill building groups to enhance the Member's understanding of substance use and mental illness.
- Clinically directed program activities designed to stabilize and maintain symptoms of substance use disorder, and apply recovery skills. Relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- Counseling and clinical interventions to facilitate teaching Members skills needed for productive living and successful reintegration into family living to include health education.
- Monitoring of adherence to prescribed medications and over-the-counter medications and supplements.
- Daily treatments to manage acute symptoms of biomedical substance use or mental health disorder.

Daily scheduled professional services, interdisciplinary assessments, and treatment designed to develop and apply recovery skills. This includes relapse prevention, interpersonal choices, and development of a social network supportive of recovery. Such services would include Member and group counseling, psychotherapy, family therapy, recreational therapy, art, music, physical therapy, vocational rehabilitation, educational, and skill-building groups.

- Planned community reinforcement designed to foster improved community living skills.
- Motivational enhancements and engagement strategies appropriate to the Member's stage of readiness and desire to change. Counseling and clinical monitoring to assist the Member in initial involvement or re-involvement in regular productive daily activity such as work or school, with successful re-integration into family living with health education. Services for family and significant other, as appropriate, to advance the Member's treatment goals and objectives identified in the ISP.
- Education on benefits of medication-assisted treatment and referral to treatment as necessary. Withdrawal management services as necessary. Providers should consult the ASAM Criteria for Intoxication/Withdrawal Management requirements for additional information. Substance use case management is included in this Level of Care. Substance use case management services (H0006) are not reimbursable for Members while they are residing in institutions, including institutions for mental disease; however, Substance Use Case Management may be reimbursed during the month before discharge to allow for discharge planning. This is limited to two one-month periods in a 12-month period.

Clinically Managed, High-Intensity, Residential Services (adult) and Clinically Managed, Medium-Intensity, Residential Services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs must also include psychiatric services (psychiatric evaluation and/or therapy for the individual, group, or family), medication evaluation, and laboratory services. These services must be available by telephone within eight hours of requested service on-site or via telemedicine, or closely coordinated with an off-site provider. It must be addressed within 24 hours of requested service as appropriate to the severity and urgency of the Member's mental and physical condition. Planned clinical activities are required and must be designed to stabilize and maintain the Member's mental health problems and psychiatric symptoms.

Family engagement must also be provided in addition to family therapy/counseling as appropriate. Family engagement is to be provided as outlined in the ISP, and the family or legally-authorized representative must be part of the family engagement strategies in the ISP. Family engagement activities are an intervention and occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions must be documented in, outlined in, and aligned with the treatment goals and objectives in the ISP.

Refer to Service Units and Limitations for ASAM Level 3.3; these same criteria apply for ASAM Level 3.5.

### **ASAM Level 3.7: Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High-Intensity Inpatient Services (Adolescent)**

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) must include:

Clinical staff who are able to provide a planned, 24-hour regimen professionally directed evaluation, care, and treatment including the administration of prescribed medications.

- Addiction-credentialed physician(s) with experience in addiction medicine. That physician must oversee the treatment process and assure quality of care. Licensed physicians or physician extenders must perform physical examinations for all Members who are admitted; except in cases where a Member is admitted to Level 3.7 as a step-down from Level 4.0 within the same facility, in which case the physician/physician extender must review the physical exam that was performed within the previous seven calendar days. Staff must supervise addiction pharmacotherapy integrated with psychosocial therapies. The professional may be a physician, psychiatrist, or physician extender if knowledgeable about addiction treatment. Physician monitoring, nursing care, and observation must be available. A physician must assess the Member in person within 24 hours of admission. They may continue with future assessments if medically necessary.
- A Registered Nurse (RN), under direction of either a physician or medical director, must conduct an alcohol or other drug-focused nursing assessment upon admission. The RN must have the competencies and experience in conducting an alcohol or other drug-focused nursing assessment. The RN performing the alcohol or other drug-focused nursing assessment must report the results to the attending physician, who then directs initiation of the medical-monitored protocol based on the results of the focused assessment. A RN or Licensed Practical Nurse (LPN) is responsible for monitoring the Member's progress and for medication administration duties.
- Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group, and family therapy services. Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the Member's level of understanding and assist in the Member's recovery.
- Planned clinical activities to enhance understanding of substance use disorder. Planned clinical program activities to stabilize acute addictive or psychiatric symptoms. Activities may include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and adapted to the Member's level of comprehension.
- Counseling and clinical monitoring to facilitate re-involvement in regular, productive, daily activities and successful re-integration into family living if applicable. Counseling and clinical monitoring to promote re-involvement in or skill building in regular productive daily activities such as work or school and successful re-integration into family living if applicable.
- Random drug screens to monitor use and strengthen recovery and treatment gains.

- Regular medication monitoring.
- Health education associated with the course of addiction and other potential health-related risk factors including tuberculosis, HIV, Hepatitis B and C, and other sexually-transmitted infections.
- Evidence-based practices such as motivational interviewing to address the Member's readiness to change, designed to facilitate understanding of the relationship of the SUD and life impacts.
- Daily treatments to manage acute, biomedical symptoms of substance use or mental illness. Services to family and significant others as appropriate to advance the Member's treatment goals and objectives identified in the ISP. Additional medical specialty consultation, psychological, laboratory, and toxicology services must be available on site either through consultation or referral. For Members who have not been screened for infectious diseases within 12 months, screening must be provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Coordination of necessary services must be available on-site or through referral to a closely-coordinated, off-site provider to transition the Member to lower levels of care. Substance use case management is included, but services (H0006) are not reimbursable for Members while they are residing in institutions. This includes institutions for mental disease; however, Substance Use Case Management may be reimbursed during the month before discharge to allow for discharge planning. This is limited to two one-month periods in a 12-month period.
- Psychiatric services are available on-site, through consultation or referral when a presenting problem could be attended to at a later time. Such services are available within eight hours by telephone and within 24 hours in-person.
- Medication education and management must be offered.

Medically Monitored Intensive Inpatient Services (adult) and Medically Monitored High Intensity Inpatient Services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs must also include appropriate psychiatric services, medication evaluation, and laboratory services:

- A psychiatric assessment of the Member must occur within four hours of admission by telephone and within 24 hours following admission in person or via telemedicine, as appropriate to the Member's behavioral health condition. If medically necessary, the Member can receive more assessment to follow.
- A behavioral health-focused assessment at the time of admission must be performed by a RN or licensed mental health clinician.
- A licensed registered nurse or LPN supervised by a registered nurse is responsible for monitoring the Member's progress and administering or monitoring the Member's self-administration of medications.
- Planned clinical activities must be offered and designed to promote stabilization and maintenance of the Member's behavioral health needs, recovery, and psychiatric symptoms.

Refer to Service Units and Limitations for ASAM Level 3.3; these same criteria apply for ASAM Level 3.7.

## **ASAM Level 4.0: Medically Managed Intensive Inpatient Services**

Medically managed intensive inpatient services (ASAM Level 4.0) are acute care hospitals and are the designated setting for medically managed intensive inpatient treatment. Medically managed intensive inpatient services must offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, a Member's use of alcohol and other drugs. Such service settings must offer medically directed acute withdrawal management and related treatment designed to alleviate the distress categories mentioned earlier resulting from, or co-occurring with, a Member's use of alcohol or other drugs. This does not include tobacco-related disorders, caffeine abuse or dependence, or non-substance-related disorders.

Medically managed intensive inpatient services include:

- An evaluation or analysis of substance use disorders that must be provided, including the diagnosis of substance use disorder and the assessment of treatment needs for medically necessary services.
- Observation and monitoring of the Member's course of withdrawal, which must be provided. This is to be conducted as frequently as deemed appropriate for the Member and the Level of Care he/she is receiving. This may include, for example, observation of the Member's health status.
- Medication services including the prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff that provides such services within their scope of practice or license.
- For Members who have not been screened for infectious diseases within 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.

The following therapies must be provided for reimbursement:

- Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities must include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and modified to meet the Member's level of understanding. For Members with a severe biomedical disorder, physical health interventions must be available to supplement addiction treatment. For the Member who has less stable psychiatric symptoms, Level 4.0 co-occurring capable programs offer individualized treatment activities designed to monitor the Member's mental health and to address the interaction of the mental health programs and substance use disorder.
- Health education services.
- Planned clinical interventions designed to enhance the Member's understanding and acceptance of illness of addiction and the recovery process.
- Services for the Member's family, guardian, or significant other, as appropriate, to advance the Member's treatment and recovery goals and objectives identified in the ISP.
- This Level of Care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions:

- Acute intoxication or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral, or cognitive conditions and complications

Medically Managed Intensive Inpatient Services co-occurring enhanced programs must be provided by appropriately credentialed mental health professionals who assess and treat the Member's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.

#### Service Units and Limitations

- Medically managed intensive inpatient services (ASAM Level 4.0) require service authorization. On admission, the Member must meet severity of illness and intensity of service criteria for inpatient hospitalization and have a treatment plan in place that requires an inpatient Level of Care. Optima Health will respond within one calendar day to the service authorization request. If approved, Optima Health will reimburse Providers retroactively for this service to allow Members to immediately enter treatment.
- Members must be discharged from this service when other, less-intensive services may achieve stabilization.
- One unit of service is one day.
- There are no maximum annual limits.
- Group counseling by credentialed addiction treatment professionals has a maximum limit of ten members.
- Some examples of non-reimbursable services include:
  - Behavior modification.
  - Remedial education.
  - Daycare.
  - Psychological testing done for any or all of the following purposes: educational diagnosis, school recommendations, institution admission, or institutional placement.