Thank You

Thank you for joining us, we will get started in just a few minutes to allow others to call in.

Please make sure your line is muted.

To receive the slides shared today please enter your name and email address in the Q&A section

beacon health options | NORTHEAST HEALTH PARTNERS, LLC | Health COLORADO

April
SUD Expanded Benefit
Provider Forum

Agenda

01 Welcome & Introductions

02 Questions & Open Discussion

03 Updates & Information

04 Upcoming Events

Chapter

01

Welcome & Introductions

Welcome!

Please enter your name, organization, and email
In the Chat

Beacon / Health Colorado / Northeast Health Partners

- Contact Information
  COProviderRelations@BeaconHealthOptions.com

Chapter

02

Questions & Open Discussion

Chapter

03

Updates & Information

Clinical Request Inbox

Effective immediately you can email your clinical requests instead of faxing them (faxes will still be accepted)

COMedicaidSUD@beaconhealthoptions.com

Sending requests to this email box will ensure that requests are worked timely. If requests are sent to a specific person they could be delayed if that person is out of the office.

Reminder – the Service Authorization Review Form is available to assist you in requesting authorizations

Beacon Health Options
Service Authorization Review Form
ASAM Levels 2.1/3.1/3.3/3.5/3.7/3.7 WM
Initial 3.7 and 3.7 WM requests MUST be called in.
No Service Authorization Needed for ASAM Levels 0.5/1.0/3.2 WM

Fax Completed Form and Current Treatment Plan to Beacon Health Options: 719-538-1439
Email Completed Form and Current Treatment Plan to Beacon Health Options: COMedicaidSUD@beaconhealthoptions.com
PLEASE TYPE INFORMATION IN THIS FORM – MUST BE COMPLETED BY CREDENTIALED ADDICTION TREATMENT PROFESSIONAL
Supporting clinical information may be documented on last page or attached to this form. For adolescents criteria if additional documentation is needed please summarize in the additional clinical documentation section.

MEMBER INFORMATION	
Member Name:	DOB:
Member Medicaid ID:	If retroactively enrolled, provide enrollment date:

PROVIDER INFORMATION	
Provider/Facility:	Clinical Contact:
Servicing Street Address:	Physician Contact:
City | State | Zip:	Provider ID/NPI:
Phone:	Fax:
Email Address:	Utilization Review Contact:
REQUESTED SERVICE START DATE:	☐ Initial Request ☐ Concurrent Request

ICD-10 DIAGNOSIS CODE(S)
(Enter primary and any applicable co-occurring ICD-10 diagnosis codes)

1.	3.	5.
2.	4.	6.

SUBSTANCE USE DISORDER TREATMENT HISTORY
(Describe other ASAM Levels of Care utilized in past 12 months) **(OR ATTACH IN CLINICAL NOTE)**

ASAM Level of Care	Name of Provider	Duration	Approximate Dates	Outcome

MEDICATION
Please list medications, dosage, frequency and prescriber below (**OR ATTACH MEDICATION LIST**). N/A ☐ Unable to Obtain ☐

Name of Medication	Dosage	Frequency	Prescriber

ASAM LEVEL OF CARE REQUESTED AND NUMBER OF UNITS (1 unit = 1 day)

Code/Description Check Appropriate Code		Units	Code/Description Check Appropriate Code		Units
☐	**Non-hospital:** H0015 ASAM 2.1 Mod HE HF| Intensive Outpatient		☐	**Non-hospital:** H2036 ASAM 3.7 MOD HF U7| Medically Monitored Intensive Inpatient Services	
☐	**Hospital:** Rev 0906 ASAM 2.1 | Intensive Outpatient		☐	**Hospital:** Rev 1000 ASAM 3.7 | Medically Monitored Intensive Inpatient Services	
☐	**Non-hospital:** H2036 ASAM 3.1 Mod HF U1 | Clinically Managed Low-Intensity Residential Services		☐	**Non-hospital:** H0010 ASAM 3.2 WM Mod HF | Clinically Managed Residential Withdrawal Management	
☐	**Non-hospital Special Connections:** H2036 ASAM 3.1 Mod HF U1 HD | Clinically Managed Low-Intensity Residential Services		☐	**Non-hospital:** H0011 ASAM 3.7 WM Mod HF| Medically Monitored Inpatient Withdrawal Management	
☐	**Non-hospital:** H2036 ASAM 3.5 Mod HF U5| Clinically Managed High-Intensity Residential Services		☐	**Hospital:** Rev 1002 ASAM 3.7 WM | Medically Monitored Inpatient Withdrawal Management	
☐	**Non-hospital Special Connections:** H2036 ASAM 3.5 Mod HF U5 HD| Clinically Managed High-Intensity Residential Services				
			ESTIMATED DURATION OF THIS EPISODE OF CARE FOR REQUESTED ASAM LEVEL (days)		

Member's treatment plan is required. Please submit with your request.

ASSESSMENT AND SCORING

DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential	
☐	No withdrawal
☐	Minimal Risk of severe withdrawal (ASAM Level 2.1)
☐	Moderate risk of severe withdrawal (ASAM Level 2.5)
☐	No withdrawal risk, or minimal or stable withdrawal (ASAM Level 3.1)
☐	At minimal risk of severe withdrawal (ASAM Level 3.3 or 3.5)
☐	**ASAM LEVEL 3.7 ONLY:** Patient has the potential for life threatening withdrawal **(must meet at least two of the six dimensions, at least one of which is within dimension 1, 2, or 3)**
☐	**ASAM LEVEL 3.7 WM ONLY:** Patient has life threatening withdrawal symptoms, possible or experiencing seizures or DT's or other adverse reactions are imminent

Provide brief summary of the member's needs/strengths for Dimension 1(OR ATTACH CLINICAL NOTE WITH ASAM ASSESSMENT):
For members with an Opioid Use Disorder, please describe the plan to offer medication assisted treatment (MAT):

ASAM Level:

Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).

MAT Toolkit

The Centers for Medicare and Medicaid Services (CMS) requires that all providers receiving Medicaid reimbursement for residential and inpatient SUD services offer Medication Assisted Treatment (MAT) onsite, or facilitate access to MAT offsite.

The Department has partnered with the Office of Behavioral Health (OBH) at the Colorado Department of Human Services to develop a **MAT Toolkit for providers incorporating MAT into their programs**.

https://drive.google.com/file/d/1vAcsES96vAG9JTj2gawjJokbTgSidM2q/view

Chapter

04

Upcoming Events

HCPF Provider Office Hours

The Department of Health Care Policy and Financing, in conjunction with its partners at the Colorado Office of Behavioral Health, Regional Accountable Entities, and Managed Services Organizations, will host a series of 60-minute Provider Office Hour sessions, where residential and inpatient SUD treatment providers may ask questions and receive support on issues relating to the SUD benefit expansion.

To submit a question or for more information visit
https://www.colorado.gov/pacific/hcpf/ensuring-full-continuum-sud-benefits

FIRST Wednesday of the month

Meeting link: meet.google.com/ypv-vtau-kfp

Call-in number: (419) 812-2582

PIN: 931 626 035#

April 7, 2:00 - 3:00 p.m.

May 5, 2:00 - 3:00 p.m.

THIRD Wednesday of the month

Meeting link: meet.google.com/jsw-mjwf-khk

Call-in number: (916) 836-2601

PIN: 951 467 943#

April 21, 2:00 - 3:00 p.m.

May 19, 2:00 - 3:00 p.m.

Join Us Next Month!

The 3rd Tuesday of the month

May 18th at 10am

Chapter

06

Questions
&
Open Discussion

Thank You

Contact Us

888-502-4189

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northeasthealthpartners@beaconhealthoptions.com

https://www.facebook.com/northeasthealthpartners.org/

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