

# 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 Chat box



# May

# SUD Expanded Benefit

# Provider Forum

---

# Agenda

01

Welcome & Introductions

---

02

3.2WM Authorization Process New!

---

03

Updates & Information

---

04

Questions and Open Forum

---

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](mailto:COProviderRelations@BeaconHealthOptions.com)

Chapter

# 02

## 3.2WM Authorization Process NEW!

# New Process

Beginning Monday May 17, 2021 Requests for authorization for 3.2WM levels of care will be submitted and approved through ProviderConnect.

## What is ProviderConnect?

ProviderConnect is Beacon Health Options provider portal which makes routine tasks such as processing claims, obtaining claims information, and verifying eligibility status easy and convenient.

## How do I get access to ProviderConnect?

Contact our Help Desk to get set up with log in information

EDI Help Desk

1-888-247-9311 Mon – Fri 8am-6pm ET

## How do I find ProviderConnect?

You can access ProviderConnect from either the Health Colorado RAE or Northeast Health Partners websites as well as on the Beacon Health Options website


<https://providerconnect.beaconhealthoptions.com/pc/eProvider/providerLogin.do>



# Provider Connect Main Menu

## Provider Connect - Main Menu

From the Provider Connect Main Menu, select Enter an Authorization/Notification Request





STAGINGCONNECT  
BEACON HEALTH OPTIONS

- Home
- Specific Member Search
- Authorization Listing
- Enter an Authorization/Notification Request
- Enter a Treatment Plan
- View Clinical Drafts
- Enter Case Management Referral
- Review Referrals
- Enter Bed Tracking Information
- Search Beds/Opening
- Weekly Behavior Analysis Measures
- Enter Member Assessment
- Enter Member Reminders
- Reports
- Print Spectrum Release of Information Form
- My Online Profile
- Provider Credentialing Application

Welcome [REDACTED] Thank you for using Beacon Health Options ProviderConnect.

YOUR MESSAGE CENTER

 INBOX

 SENT

Your inbox is empty

WHAT DO YOU WANT TO DO TODAY?

- ▶ [Link/Unlink Accounts](#) NEW
- ▼ [Eligibility and Benefits](#)
  - [Find a Specific Member](#)
- ▼ [Enter or Review Authorization Requests](#)
  - [Enter an Authorization/Notification Request](#)
  - [Enter a Treatment Plan](#)
  - [Review an Authorization](#)
  - [View Clinical Drafts](#)
  - [Weekly Behavior Analysis Measures](#)
- ▶ [Enter Member Assessment](#)
- ▶ [Enter Member Reminders](#)
- ▶ [Enter Case Management Referral](#)

- ▼ [Enter or Review Referrals](#)
  - [Review Referrals](#)
- ▶ [Enter Bed Tracking Information](#)
- ▶ [Search Beds/Opening](#)
- ▶ [View My Recent Authorization Letters](#)

## Member Search

# Search for the Member

Enter the members ID and date of birth, click on Search

Enter the Member ID and Date of Birth to search for the member



### Search a Member

Required fields are denoted by an asterisk ( \* ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID	<input type="text"/>	(No spaces or dashes)
Last Name	<input type="text"/>	
First Name	<input type="text"/>	
*Date of Birth	<input type="text"/>	(MMDDYYYY)
As of Date	<input type="text" value="05052021"/>	(MMDDYYYY)


Search



# Verify Member Information

## Member Demographics

The next screen will prefill with the eligible members information, confirm you have the correct member information selected.



STAGING

BEACON HEALTH PARTNERS

Demographics

Enrollment History

COB

Additional Information

Primary Care Provider

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member?

Member ID

Alternate ID

Member Name

Date of Birth

Address

Alternate Address

Marital Status

Home Phone

Work Phone

Relationship

Gender

Member Participates in Message Center Communication with Providers?

5

1

M - Male

No

Next

View Spectrum Record

Disable Member Communication

Eligibility

Effective Date

Expiration Date

COB Effective Date?


06/17/2020

Subscriber

Subscriber ID


Subscriber Name

# Requested Service Information

**PROVIDER CONNECT**  
STAGING  
BEACON HEALTH OPTIONS

## Requested Services Header

All fields marked with an asterisk (\*) are required. Select the Requested Start Date to begin. Please review the Member's benefit coverage before creating this request.  
Note: Disable pop-up blocker functionality to view all appropriate links.


\*Requested Start Date (MMDDYYYY)  

\*Level of Service

\*Type of Service

\*Level of Care

\*Type of Care

\*Admit Date (MMDDYYYY)  

\*Has the member already been admitted to the facility?  
☒ Yes ☐ No

Admit Time (HHmm)

Provider

Tax ID

Provider ID

Provider Last Name

Vendor ID

Member

Member ID

Last Name

First Name

Date of Birth (MMDDYYYY)

## Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

\*Document Type:

Does this Document contain clinical information about the Member? Yes ☐ No ☐

\*Document Description

Click to attach a document  Click to delete an attached document

## Requested Services Header

Requested Start Date  
**05/06/2021**

Member Name

Provider Name

Vendor ID

Type of Request  
**INITIAL**

Member ID

Provider ID

NPI # for Authorization

SELECT... 

Level of Service  
**INPATIENT/HLOC**

Type of Service  
**SUBSTANCE USE**

Level of Care  
**PSYCHOSOCIAL REHAB**

Type of Care  
**DETOX**

Authorized User

*\* At least one contact name and phone number is required.*

**Note - Only one of these contacts needs to be filled in**

Admitting Physician

Phone #

Ext

Attending Physician

Phone #

Ext

Preparer

Phone #

Ext

Utilization Review Contact

Phone #

Ext

Fax

### Primary Care Coordination

PCP Contacted Status

SELECT... 

PCP Contacted Name

Date Contacted



**Only required if the PCP was contacted and a status selected**

Is the Member in active treatment with a behavioral health provider?

☐ Yes ☐ No ☐ Unknown

Is there documentation of Member's consent to allow communication with PCP and aftercare providers?

☐ Yes ☐ No

## Diagnosis

Documentation of **primary behavioral condition** is **required**. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is **strongly recommended** to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the members plan and/or summary plan description including covered diagnoses.

### Behavioral Diagnoses

#### Primary Behavioral Diagnosis

\* Diagnostic Category 1  
SELECT... \* [Diagnosis Code 1](#) \* [Description](#)

After entering the Code the Description will prefill

#### Additional Behavioral Diagnosis

Diagnostic Category 2  
SELECT... [Diagnosis Code 2](#) [Description](#)

Blue Headers are hyperlinks with information

Diagnostic Category 3  
SELECT... [Diagnosis Code 3](#) [Description](#)

Diagnostic Category 4  
SELECT... [Diagnosis Code 4](#) [Description](#)

Diagnostic Category 5  
SELECT... [Diagnosis Code 5](#) [Description](#)

### Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

\* Diagnostic Category 1  
SELECT... [Diagnosis Code 1](#) [Description](#)

Diagnostic Category 1 is a required field, You can

Diagnostic Category 2  
SELECT... [Diagnosis Code 2](#) [Description](#)

Diagnostic Category 3  
SELECT... [Diagnosis Code 3](#) [Description](#)

### Social Elements Impacting Diagnosis

#### \* Check all that apply

☐ None

☐ Problems with access to health care services

☐ Housing problems (Not Homelessness)

☐ Problems related to the social environment

☐ Educational problems

☐ Problems related to interaction w/legal system/crime

☐ Occupational problems

☐ Homelessness

☐ Financial problems

☐ Problems with primary support group

☐ Unknown

☐ Medical disabilities that impact diagnosis or must be accommodated for in treatment

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

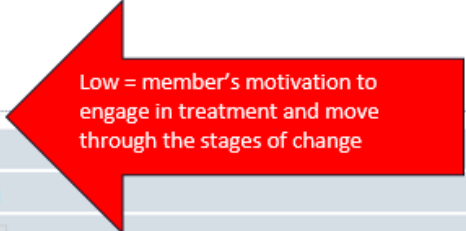
Assessment Measure  
SELECT... ▼

Assessment Score

Secondary Assessment Measure  
SELECT... ▼

Assessment Score

ASAM Criteria



<u>Dimension 1</u>	<u>Dimension 2</u>	<u>Dimension 3</u>
Intoxication/Withdrawal Potential	Biomedical Conditions	Emot/Beh/Cogn Conditions
<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High
<u>Dimension 4</u>	<u>Dimension 5</u>	<u>Dimension 6</u>
Readiness To Change	Relapse Potential	Recovery Environment
<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High	<input type="radio"/> Low <input type="radio"/> Medium <input type="radio"/> High

Projected Duration and Frequency of Treatment

Projected Date of Discharge

Estimated Number of Units

Please provide any additional information that would be beneficial in processing your request.

▼\* Narrative Entry (0 of 2000)

Back


Save Request as Draft

Submit



# Automated Confirmation of Number of Visits

Review and click Accept at the bottom of the screen

**STAGING**  
BEACON HEALTH OPTIONS

---

## Requested Services Header

Requested Start Date <b>05/06/2021</b>	Member Name [REDACTED]	Provider Name [REDACTED]	Vendor ID [REDACTED]	<input type="button" value="Save Request as Draft"/>
Type of Request <b>INITIAL</b>	Member ID [REDACTED]	Provider ID [REDACTED]		NPI # for Authorization <input type="text" value="SELECT..."/>
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>SUBSTANCE USE</b>	Level of Care <b>PSYCHOSOCIAL REHAB</b>	Type of Care <b>DETOX</b>	Authorized User <input type="text"/>

**If your request is approved, you will receive 4 visits.**

If you agree to accept this number of visits, please select "Accept". If you do not agree, please select "Reject" and you may enter your modified request.

Please be aware that if your request is above the offered number of units, it may be pended for additional clinical review.


© 2021 Beacon Health Options® ProviderConnect v6.02.00



# Automated Results

If the system is able to approve the request (which should be the majority of cases) this will be the next screen.  
If the system is not able to automatically approve the request this screen will showing pending and it will go to a clinical representative for review.  
You can print or upload this approval screen.

\*\*\*Authorizations will automically prefill with a place of service of 49, please bill these services with a place of service of 49. Should you need a different place of service code listed you will need to call and adjust the authorization prior to billing claims.



ProviderConnect Home

Determination Status:

\*\*\*\*\* APPROVED \*\*\*\*\*

Member Name

Member ID

Member DOB

Subscriber Name

Subscriber ID

Authorization #

Client Authorization #

Type of Request

Date of Admission/ Start of Services

From - To

Submission Date

Level of Service

Type of Service

Level of Care

Type of Care




Reason Code

Provider Name & Address

Provider ID


NPI # for Authorization

Place of Service	CPT	Mod 1	Mod 2	Mod 3	Mod 4	Service Class	Description	Visits Requested/Approved
55						SOP	STRUCTURED OUTPATIENT/IOP	4/ 4
							Total Units For Auth 050621-1-9 From 05/06/2021 To 05/10/2021	4
							Total Units Authorized This Episode For 050621-1-9	4



17

# Continued Stay Review

 **PROVIDERCONNECT**  
BEACON HEALTH PARTNERS

[SUBSTANCE USE DISORDER](#) [RESULTS](#)

PAGE 1 of 2

### Requested Services Header

Requested Start Date <b>05/06/2021</b>	Member Name [REDACTED]	Provider Name [REDACTED]	Vendor ID [REDACTED]	<a href="#">Save Request as Draft</a>
Type of Request [REDACTED]	Member ID [REDACTED]	Provider ID [REDACTED]		NPI # for Authorization <b>SELECT...</b>
Level of Service <b>INPATIENT/HLOC</b>	Type of Service <b>SUBSTANCE USE</b>	Level of Care <b>PSYCHOSOCIAL REHAB</b>	Type of Care <b>DETOX</b>	Authorized User [REDACTED]

All fields marked with an asterisk (\*) are required.

\* At least one contact name and phone number is required.

Admitting Physician [REDACTED]	Phone # [REDACTED]	Ext. [REDACTED]	Attending Physician [REDACTED]	Phone # [REDACTED]	Ext. [REDACTED]
Preparer [REDACTED]	Phone # [REDACTED]	Ext. [REDACTED]	Utilization Review Contact [REDACTED]	Phone # [REDACTED]	Ext. [REDACTED]
				Fax [REDACTED]	

### Primary Care Coordination

PCP Contacted Status  
**SELECT...**

PCP Contacted Name  
[REDACTED]

Date Contacted  
[REDACTED]

### Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring** behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the members plan and/or summary plan description including covered diagnoses.

#### Behavioral Diagnoses

Primary Behavioral Diagnosis

\* Diagnostic Category 1  
**SELECT...**

\* Diagnosis Code 1  
[REDACTED]

\* Description  
[REDACTED]

Additional Behavioral Diagnosis

Diagnostic Category 2  
**SELECT...**

Diagnosis Code 2  
[REDACTED]

Description  
[REDACTED]

Diagnostic Category 3  
**SELECT...**

Diagnosis Code 3  
[REDACTED]

Description  
[REDACTED]

Diagnostic Category 4  
**SELECT...**

Diagnosis Code 4  
[REDACTED]

Description  
[REDACTED]

Diagnostic Category 5  
**SELECT...**

Diagnosis Code 5  
[REDACTED]

Description  
[REDACTED]

#### Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

\* Diagnostic Category 1  
**SELECT...**

Diagnosis Code 1  
[REDACTED]

Description  
[REDACTED]

Diagnostic Category 2  
**SELECT...**

Diagnosis Code 2  
[REDACTED]

Description  
[REDACTED]

Diagnostic Category 3  
**SELECT...**

Diagnosis Code 3  
[REDACTED]

Description  
[REDACTED]

Please provide any additional information that would be beneficial in processing your request.

 **beacon** |  **NORTHEAST**  
HEALTH PARTNERS, LLC |  **Health**  
COLORADO

18

## Current Risks

Key:

0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

\*Member`s Risk to Self

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

\*Member`s Risk to Others

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

\*Psychosis/ Hallucinations/ Delusions

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CIWA

☐ N/A

COWS

☐ N/A

Pulse

*Pulse Rate is recommended when CIWA is entered.*

\* Is member experiencing symptoms of withdrawal or at risk of experiencing symptoms of withdrawal if not treated? ☐ Yes ☐ No

If yes, describe: (0 of 250)

\* Has Ambulatory Withdrawal Management been considered for placement? ☐ Yes ☐ No ☐ N/A

\* If no, what makes less restrictive placement inappropriate at this time?

☐ Member requires medication and has recent history of not completing withdrawal management at less intensive level of care.

☐ Member has recent history of withdrawal management and has insufficient skills to complete withdrawal management and enter continuing care.

☐ Member has co-morbid physical, emotional, behavioral or cognitive symptoms of such severity that complicate withdrawal management.

☐ Withdrawal management requires monitoring or intervention more frequently than hourly.

\* Does member have any significant medical risks that require 24 hour monitoring by a medical team? ☐ Yes ☐ No

If yes, describe: (0 of 250)

\* Describe member's Current Readiness to Change

☐ [Pre-Contemplative](#)

☐ [Contemplative](#)

☐ [Preparation](#)

☐ [Action](#)

☐ [Maintenance](#)

\* Member's Living Situation

Please select most appropriate member's Living Situation as it relates to member's recovery.

☐ Homelessness

☐ Social supports do not support recovery

☐ Social supports engaged in active substance use

☐ Social isolation

☐ High risk of abuse or neglect

☐ Secure housing

☐ Social supports are supportive of recovery

☐ Secure social network

☐ Other

Note: Disable pop-up blocker functionality to view all appropriate links.

### ASAM Criteria

Please indicate risk rating along the 6 dimensions of the ASAM Criteria. A risk rating of 0 indicates full functioning and no risk in the dimension. Risk ratings 1-4 indicate increasing levels of risk and severity. Note for dimensions 4-6 additional rating of 4A and 4B. N/A is only applicable to detoxification.

#### [Dimension 1](#)

Acute Intoxication and/or Withdrawal Potential:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

#### [Dimension 2](#)

Biomedical Conditions and Complications:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

#### [Dimension 3](#)

Emotional, Behavioral, or Cognitive Conditions and Complications:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

#### [Dimension 4](#)

Readiness to Change:

N/A is only applicable to detoxification.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4A ☐ 4B ☐ N/A

#### [Dimension 5](#)

Relapse, Continued Use, or Continued Problem Potential:

N/A is only applicable to detoxification.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4A ☐ 4B ☐ N/A

#### [Dimension 6](#)

Recovery/Living Environment:

N/A is only applicable to detoxification.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4A ☐ 4B ☐ N/A

Follows the actual ASAM assessment

Please provide any additional ASAM information.

▼ Narrative Entry

(0 of 2000)

[Back](#) [Save Request as Draft](#) [Submit](#)

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](mailto: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](mailto:COMedicaidSUD@beaconhealthoptions.com)

PLEASE TYPE INFORMATION IN THIS FORM – MUST BE COMPLETED BY CREDENTIALLED 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: <input type="text"/>	DOB: <input type="text"/>
Member Medicaid ID: <input type="text"/>	If retroactively enrolled, provide enrollment date: <input type="text"/>
PROVIDER INFORMATION	
Provider/Facility: <input type="text"/>	Clinical Contact: <input type="text"/>
Servicing Street Address: <input type="text"/>	Physician Contact: <input type="text"/>
City   State   Zip: <input type="text"/>	Provider ID/NPI: <input type="text"/>
Phone: <input type="text"/>	Fax: <input type="text"/>
Email Address: <input type="text"/>	Utilization Review Contact: <input type="text"/>
REQUESTED SERVICE START DATE: <input type="text"/>	<input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent Request
ICD-10 DIAGNOSIS CODE(S) (Enter primary and any applicable co-occurring ICD-10 diagnosis codes)	
1. <input type="text"/>	3. <input type="text"/>
2. <input type="text"/>	4. <input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

MEDICATION			
Please list medications, dosage, frequency and prescriber below (OR ATTACH MEDICATION LIST). N/A <input type="checkbox"/> Unable to Obtain <input type="checkbox"/>			
Name of Medication	Dosage	Frequency	Prescriber
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



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
<input type="checkbox"/> <b>Non-hospital:</b> H0015 ASAM 2.1 Mod HE HF   Intensive Outpatient	<input type="text"/>	<input type="checkbox"/> <b>Non-hospital:</b> H2036 ASAM 3.7 MOD HF U7   Medically Monitored Intensive Inpatient Services	<input type="text"/>
<input type="checkbox"/> <b>Hospital:</b> Rev 0906 ASAM 2.1   Intensive Outpatient	<input type="text"/>	<input type="checkbox"/> <b>Hospital:</b> Rev 1000 ASAM 3.7   Medically Monitored Intensive Inpatient Services	<input type="text"/>
<input type="checkbox"/> <b>Non-hospital:</b> H2036 ASAM 3.1 Mod HF U1   Clinically Managed Low-Intensity Residential Services	<input type="text"/>	<input type="checkbox"/> <b>Non-hospital:</b> H0010 ASAM 3.2 WM Mod HF   Clinically Managed Residential Withdrawal Management	<input type="text"/>
<input type="checkbox"/> <b>Non-hospital Special Connections:</b> H2036 ASAM 3.1 Mod HF U1 HD   Clinically Managed Low-Intensity Residential Services	<input type="text"/>	<input type="checkbox"/> <b>Non-hospital:</b> H0011 ASAM 3.7 WM Mod HF   Medically Monitored Inpatient Withdrawal Management	<input type="text"/>
<input type="checkbox"/> <b>Non-hospital:</b> H2036 ASAM 3.5 Mod HF U5   Clinically Managed High-Intensity Residential Services	<input type="text"/>	<input type="checkbox"/> <b>Hospital:</b> Rev 1002 ASAM 3.7 WM   Medically Monitored Inpatient Withdrawal Management	<input type="text"/>
<input type="checkbox"/> <b>Non-hospital Special Connections:</b> H2036 ASAM 3.5 Mod HF U5 HD   Clinically Managed High-Intensity Residential Services	<input type="text"/>		
		ESTIMATED DURATION OF THIS EPISODE OF CARE FOR REQUESTED ASAM LEVEL (days) <input type="text"/>	

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

ASSESSMENT AND SCORING	
DIMENSION 1   Acute Intoxication and/or Withdrawal Potential	
<input type="checkbox"/>	No withdrawal
<input type="checkbox"/>	Minimal Risk of severe withdrawal (ASAM Level 2.1)
<input type="checkbox"/>	Moderate risk of severe withdrawal (ASAM Level 2.5)
<input type="checkbox"/>	No withdrawal risk, or minimal or stable withdrawal (ASAM Level 3.1)
<input type="checkbox"/>	At minimal risk of severe withdrawal (ASAM Level 3.3 or 3.5)
<input type="checkbox"/>	<b>ASAM LEVEL 3.7 ONLY:</b> 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)
<input type="checkbox"/>	<b>ASAM LEVEL 3.7 WM ONLY:</b> 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):	
<input type="text"/>	
ASAM Level:	<input type="text"/>
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>



# HCPF Provider Forums – Version Two

As we move into full operation of the benefit, we are redesigning these meetings. These will now be a partnership between the Department and OBH to host issue focused forums on SUD services in the state. We have cancelled our May 5th meeting to build out our future format but will begin on May 19th.

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

The Forums are scheduled as follows:

FIRST Wednesday of the month	THIRD Wednesday of the month
2:00 - 3:00 p.m.	2:00 - 3:00 p.m.
Meeting link: <a href="https://meet.google.com/ypv-vtau-kfp">meet.google.com/ypv-vtau-kfp</a>	Meeting link: <a href="https://meet.google.com/jsw-mjwf-khk">meet.google.com/jsw-mjwf-khk</a>
Call-in number: (419) 812-2582	Call-in number: (916) 836-2601
PIN: 931 626 035#	PIN: 951 467 943#
May 5th - Cancelled	May 19th
June 2nd	June 16th
July 7th	July 21st

# HCPF Post Award Forum

## Notice of Post Award Forum

### Public comments on the progress of State of Colorado's Section 1115 Substance Use Disorder (SUD) Demonstration

Notice is hereby given that the Colorado Department of Health Care Policy & Financing (Department) is seeking public comments on the progress of the State of Colorado's Medicaid Section 1115 Substance Use Disorder (SUD) Demonstration. The Department welcomes public comments on the progress of the state's Section 1115 SUD Demonstration at the Post Award Forum, as follows. *(Note: due to social distancing requirements in effect at time of this notice, only a virtual meeting option will be offered.)*

Date/time: Thursday, May 20, 2021, 12:30 - 2:00 p.m.

Meeting link: [meet.google.com/dwn-xrwd-rzx](https://meet.google.com/dwn-xrwd-rzx)

Call-in: (240) 763-0081 PIN: 947 177 531#

[Full notice for the Post Award Forum](#)

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Department [504/ADA Coordinator](#) or [Shingo Ishida](#) at least one week before the event date to make arrangements.

**Join Us Next Month!**

The 3<sup>rd</sup> Tuesday of the month

June 15<sup>th</sup> at 10am

Chapter

# 04

## Questions & Open Discussion

# Thank You

---

## Contact Us



 888-502-4189

 [www.northeasthealthpartners.org](http://www.northeasthealthpartners.org)

 [northeasthealthpartners@beaconhealthoptions.com](mailto:northeasthealthpartners@beaconhealthoptions.com)

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

 888-502-4185

 [www.healthcoloradarae.com](http://www.healthcoloradarae.com)

 [healthcolorado@beaconhealthoptions.com](mailto:healthcolorado@beaconhealthoptions.com)

 <https://www.facebook.com/healthcoloradarae/>