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

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.

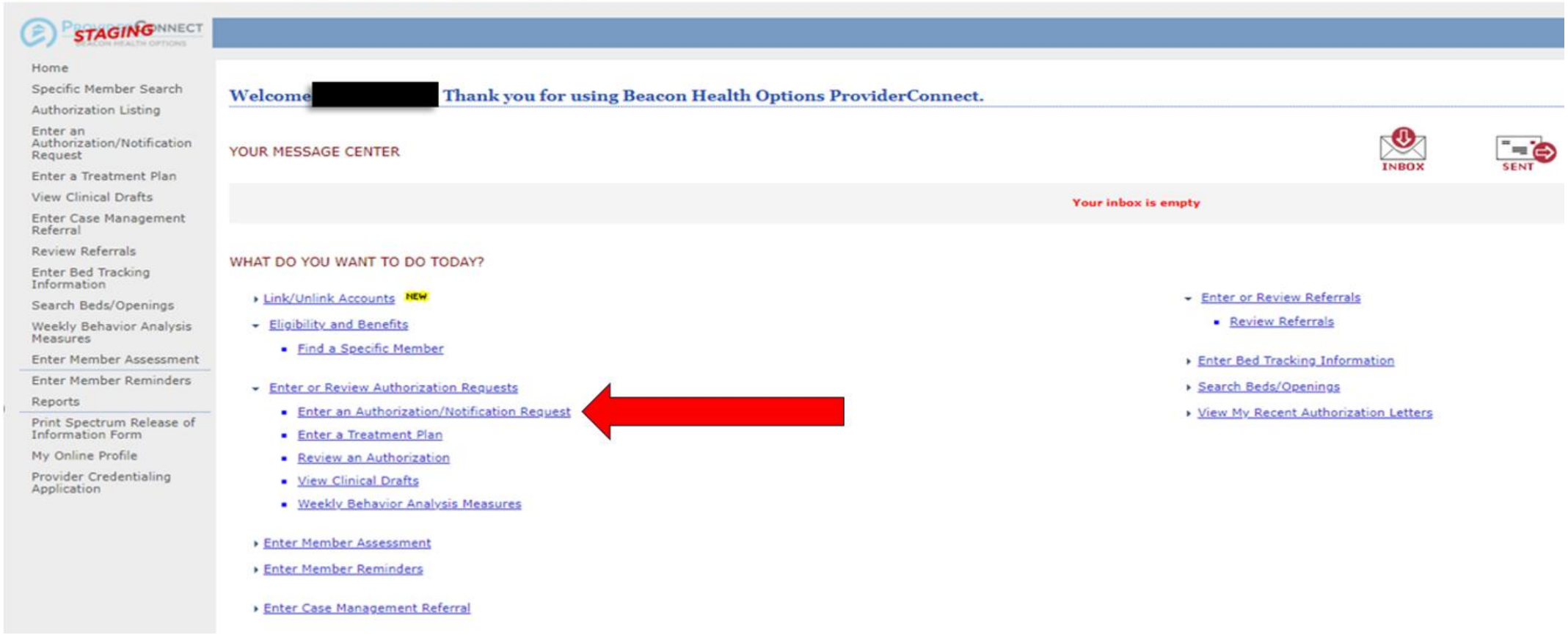
How do I get access to ProviderConnect?
Contact our Help Desk to get set up with log in information
EDI Help Desk
1-888-247-9311 Mon – Fri 8am-6pm ET

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

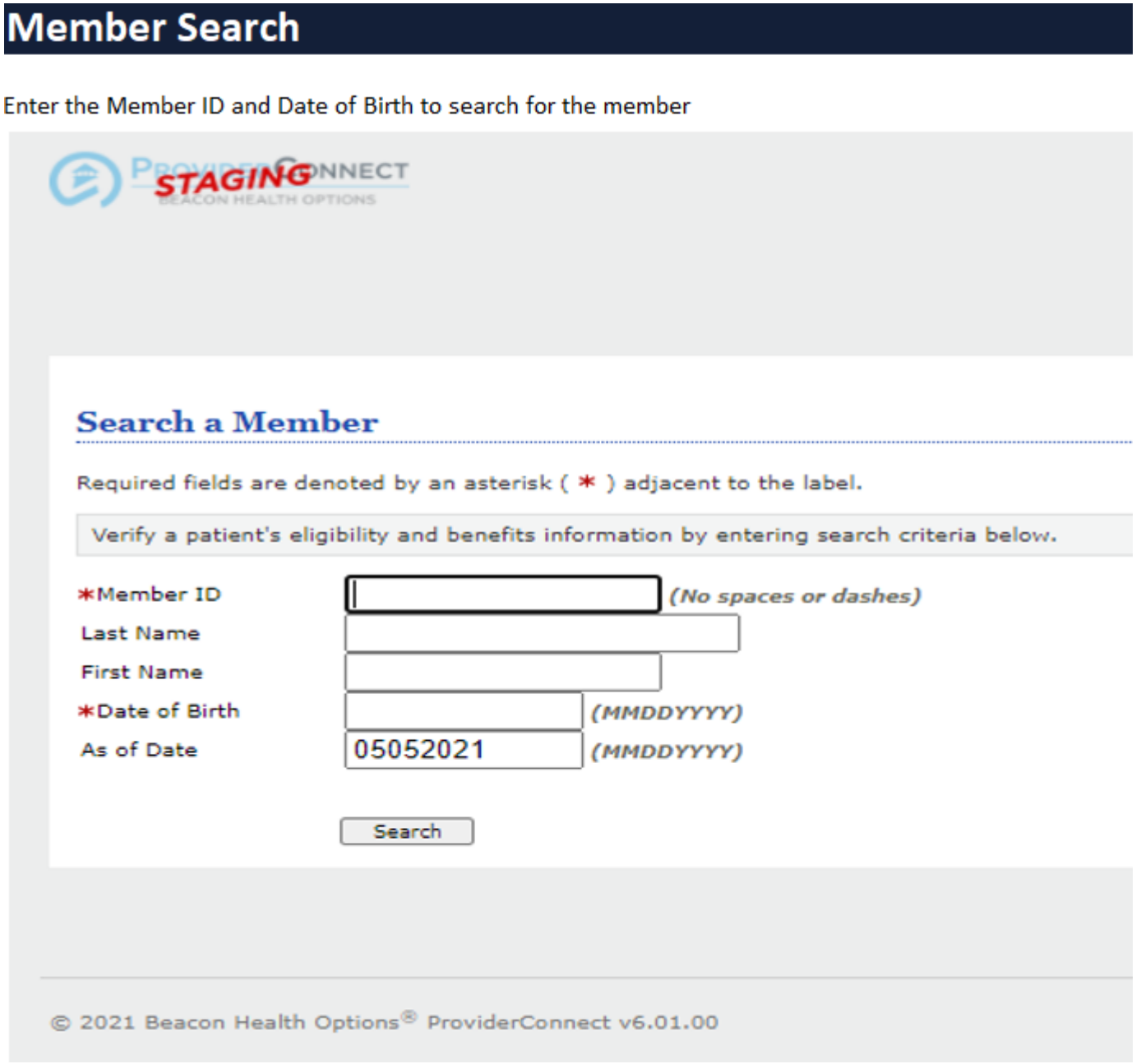
Provider Connect - Main Menu

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



Search for the Member

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

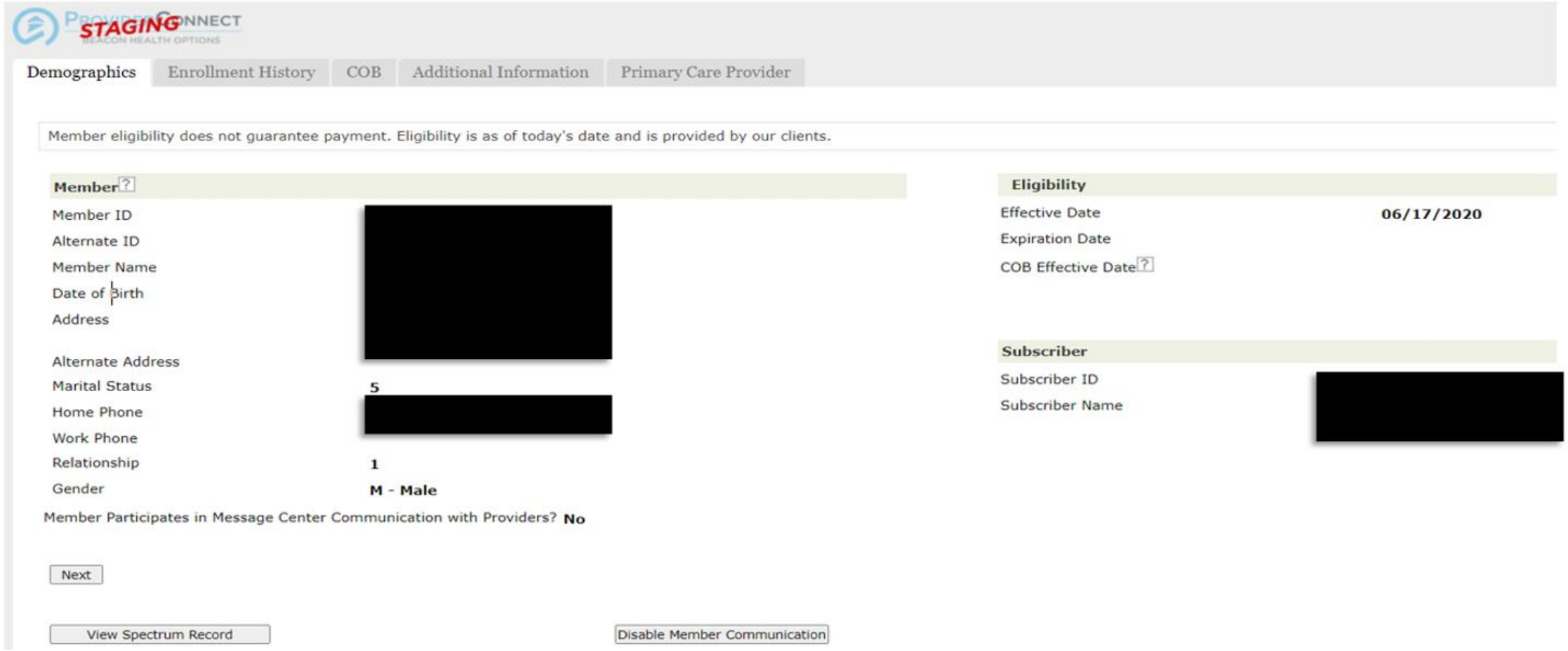


beacon | NORTHEAST HEALTH PARTNERS, LLC | Health COLORADO

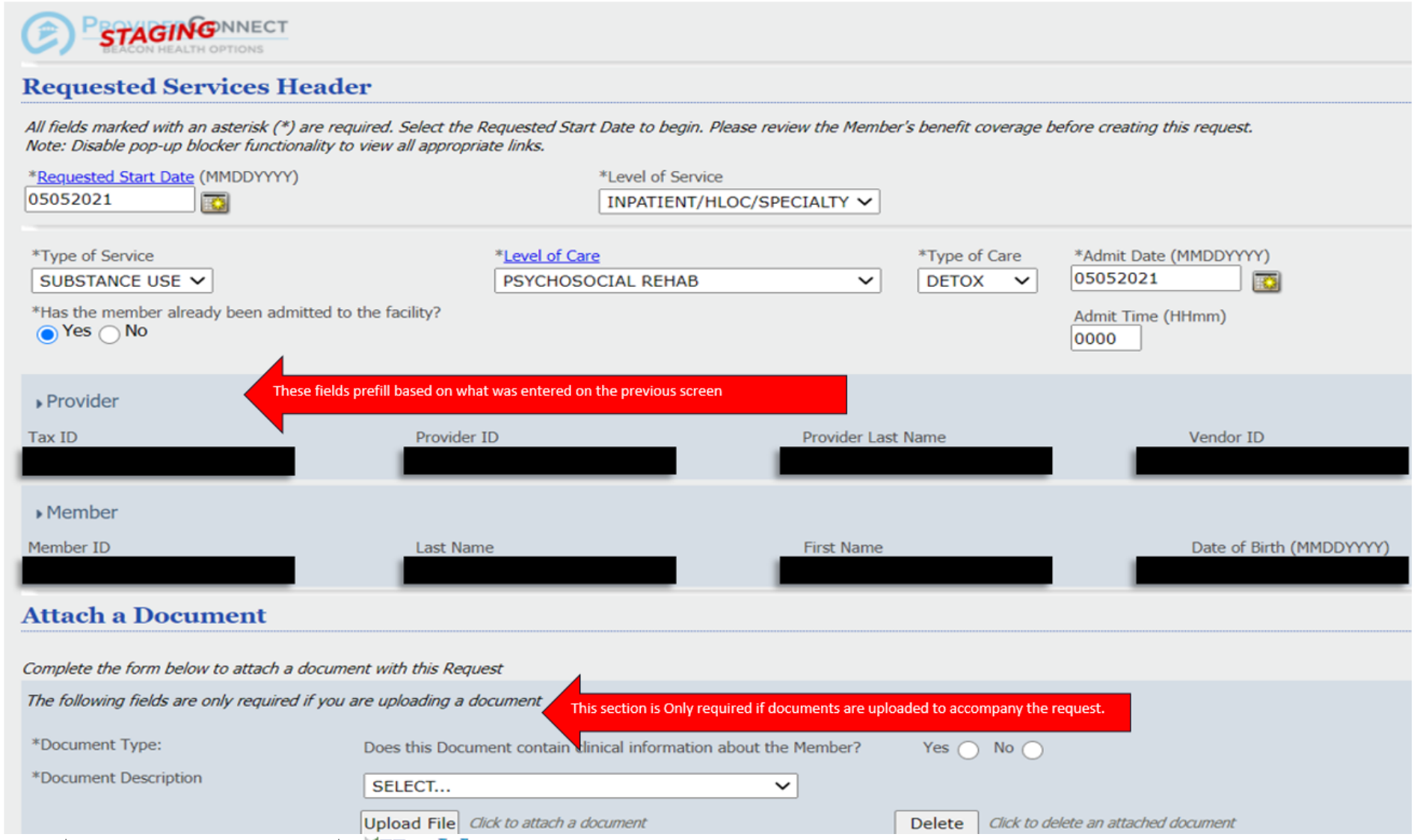
Verify Member Information

Member Demographics

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



Requested Service Information



Requested Services Header

Requested Start Date
05/06/2021

Member Name [redacted]

Provider Name [redacted]

Vendor ID [redacted]

Save Request as Draft

Type of Request
INITIAL

Member ID [redacted]

Provider ID [redacted]

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...

Only required if the PCP was contacted and a status selected

PCP Contacted Name

Date Contacted

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 (mer 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 outlin 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:

Low = member's motivation to engage in treatment and move through the stages of change

ASAM Criteria

Dimension 1	Dimension 2	Dimension 3
Intoxication/Withdrawal Potential	Biomedical Conditions	Emot/Beh/Cogn Conditions
◯ Low ◯ Medium ◯ High	◯ Low ◯ Medium ◯ High	◯ Low ◯ Medium ◯ High
Dimension 4	**Dimension 5**	**Dimension 6**
Readiness To Change	Relapse Potential	Recovery Environment
◯ Low ◯ Medium ◯ High	◯ Low ◯ Medium ◯ High	◯ Low ◯ Medium ◯ High

Projected Duration and Frequency of Treatment

Projected Date of Discharge

Estimated Number of Units

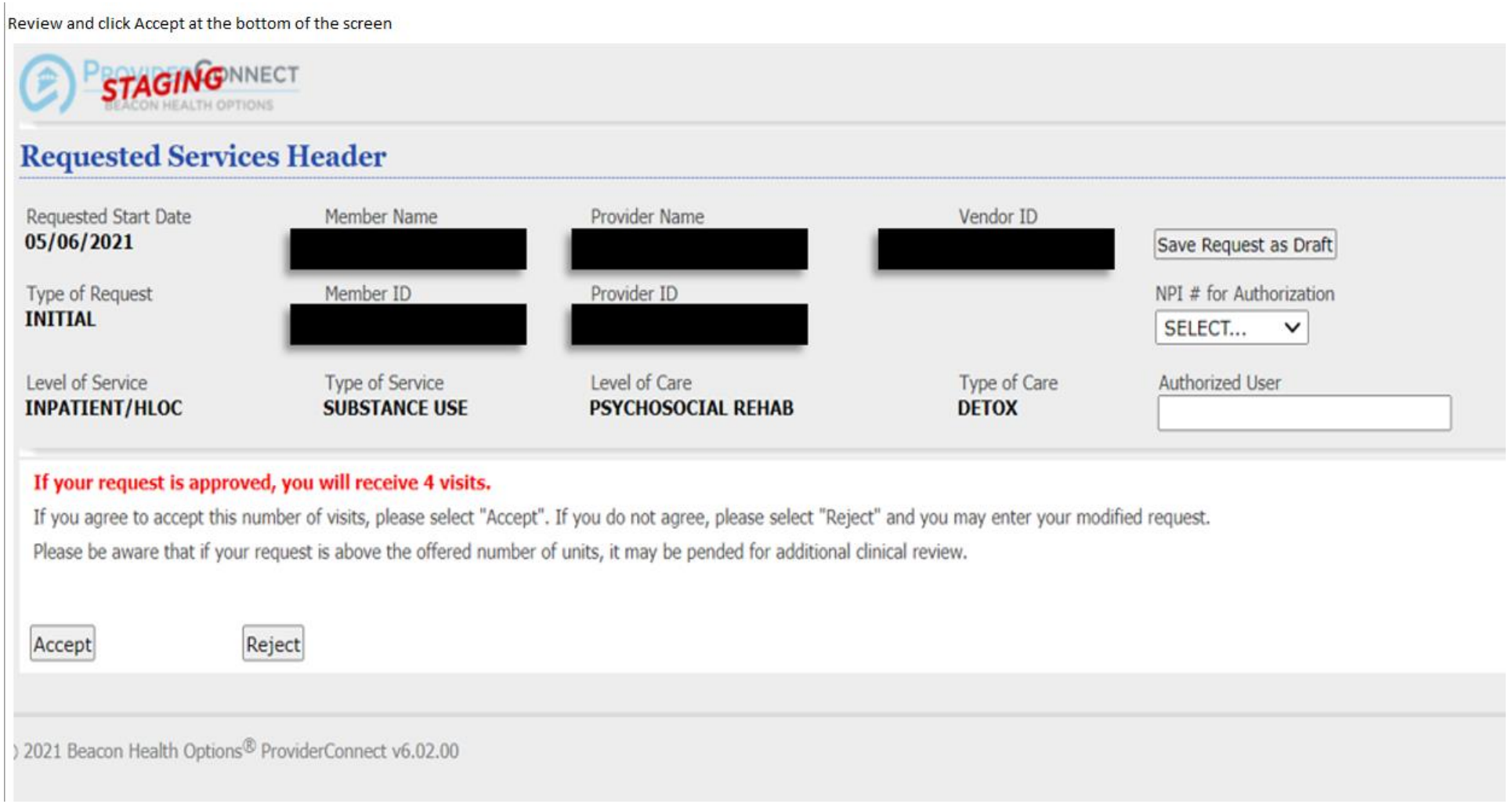
Please provide any additional information that would be beneficial in processing your request.

* Narrative Entry (0 of 2000)

Back | Save Request as Draft | Submit

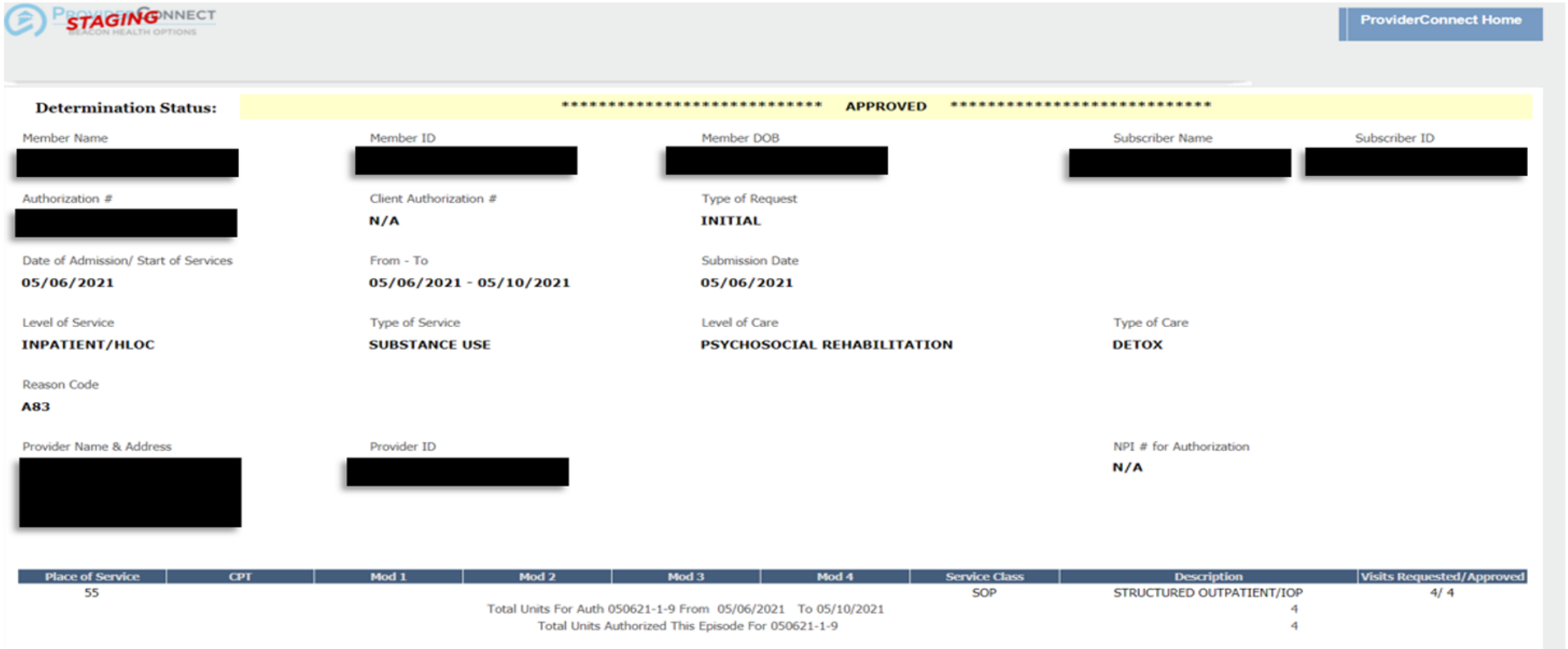
Automated Confirmation of Number of Visits

Review and click Accept at the bottom of the screen

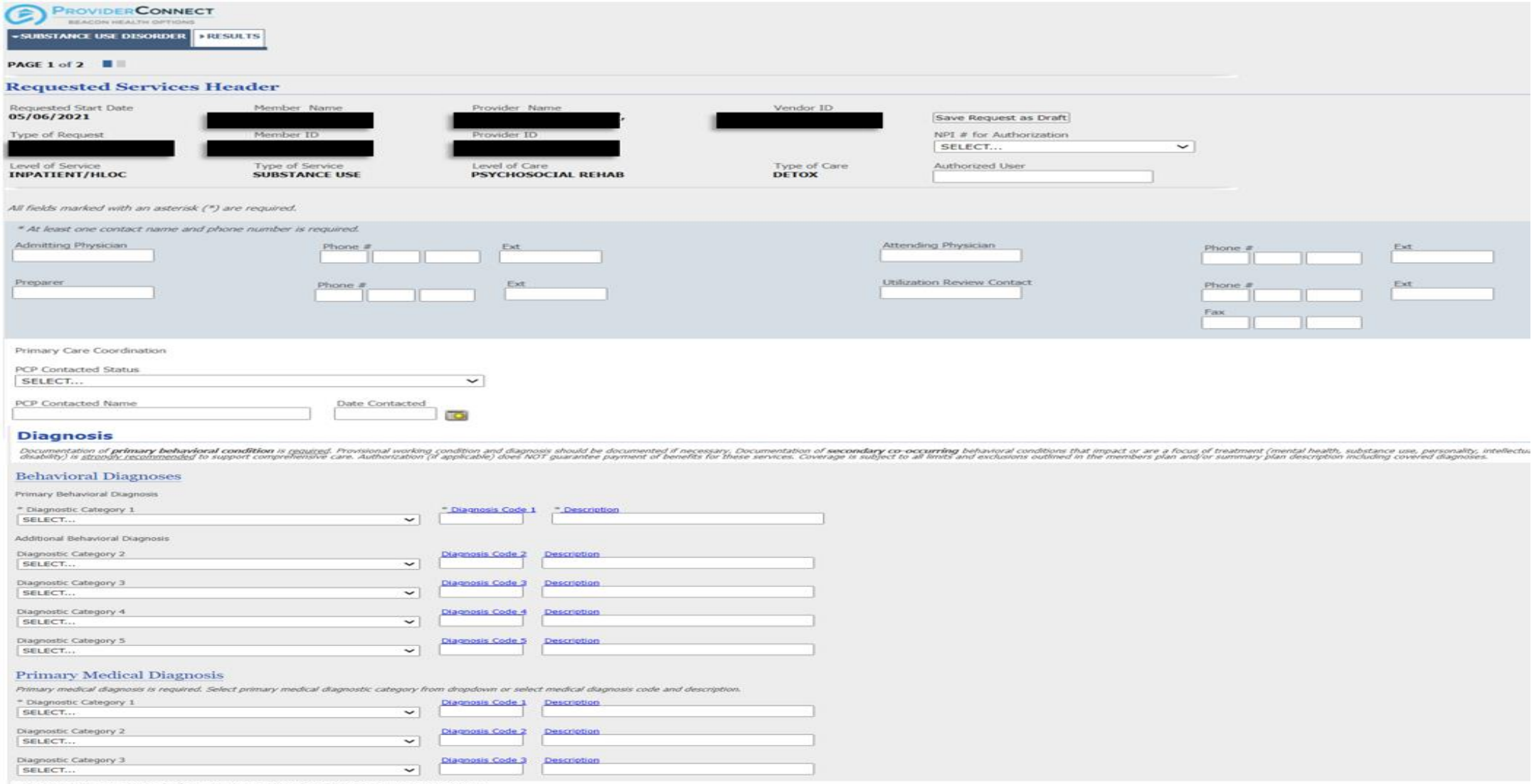


Automated Results

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 represenative 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.



Continued Stay Review



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	Dimension 2	Dimension 3
Acute Intoxication and/or Withdrawal Potential:	Biomedical Conditions and Complications:	Emotional, Behavioral, or Cognitive Conditions and Complications:
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4
Dimension 4	**Dimension 5**	**Dimension 6**
Readiness to Change: *N/A is only applicable to detoxification.*	Relapse, Continued Use, or Continued Problem Potential: *N/A is only applicable to detoxification.*	Recovery/Living Environment: *N/A is only applicable to detoxification.*
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4A ◯ 4B ◯ N/A	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4A ◯ 4B ◯ N/A	◯ 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

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

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: meet.google.com/ypv-vtau-kfp	Meeting link: meet.google.com/jsw-mjwf-khk
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
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 3rd Tuesday of the month

June 15th at 10am

Chapter

04

Questions
&
Open Discussion

Thank You

Contact Us

888-502-4189

www.northeasthealthpartners.org

northeasthealthpartners@beaconhealthoptions.com

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

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