Behavioral Health Administration
Lisa A. Burgess, M.D.
(Acting) Deputy Secretary/Executive Director
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

MDRN WORK PLAN – PAYMENT TRANSITION

December 31, 2019

Dear Maryland RecoveryNet (MDRN) Providers:

Maryland's administrative service organization (ASO) will transition from Beacon Health Options to Optum on January 1, 2020. The proposed redesign of Maryland RecoveryNet (MDRN) will not be implemented at this time. MDRN approved care coordination agencies will continue the current referral and application process, which includes verifying the client's eligibility to receive recovery housing and non-recovery housing services. Maryland has the following guidance for MDRN Providers:

➢ **Authorization requests for non-recovery housing services (MDRN Billing Codes 3-0)** will be completed by the State Care Coordinator or MDRN approved care coordination agency through a manual paper process and submitted to mdrn.info@maryland.gov for approval. BHA will collect the paper authorization (form below) according to the procedure outlined below. *Please read this entire document carefully as some service codes have been altered or eliminated.* This authorization will remain on file and will be submitted when payment is rendered. Providers are expected to submit accurate information to obtain valid authorizations for services to be rendered and claims paid. However, the Department recognizes that transition-related issues may delay authorizations and so during January, BHA will have the ability to process claims regardless of authorization issues as long as an authorization request was submitted. All claims paid will be subject to heightened audit and post-authorization review—*we will have an update on how to submit claims next Monday, January 6th*.

If you have any questions, please send an email to mdrn.info@maryland.gov.

Respectfully,

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Lisa A. Burgess, MD
Acting Deputy Secretary, Behavioral Health Administration
MDRN services are billed according to the following procedure:

- The State Care Coordinator or MDRN approved care coordination agency sends the completed **authorization request form** to the Regional Area Coordinator (RAC) at BHA for initial review and approval. The form should be sent to mdrn.housinginfo@maryland.gov.

- The RAC reviews and then sends the approval back to the MDRN approved and certified recovery residence provider and the State Care Coordinator or MDRN approved state care coordination agency. During this transition period, we will continue to track authorizations in this manner on the basis of an initial authorization request form submitted to the RAC. The only difference now is that the authorization will not be entered into the Optum system post-initial approval. The paper authorization request process will continue until the system can support an electronic process (see attached form).

- The RAC determines general eligibility for MDRN based on the following criteria:
  - Has a substance use diagnosis;
  - Meets poverty level criteria;
  - Has not ever been enrolled in MDRN before; and
  - Has not exceeded the lifetime service cap ($2500) or any individual service caps.

MDRN Grant Program Fee Schedule FY20

CPT Code	Service Description	Billing Unit	Rate	Max Day/Monthly Unit	Service Limits	Place of Service
MDRN2	Recovery/Supported Housing	Daily	$25.00	30 days	60 days	99
MDRN3	MDRN Intake Interview	Unit	$75.00		1 unit	99
MDRN4	Care Coordination Check-ins	Unit	$15.00		24 units	99
MDRN5	Transportation	Unit	$1.00		To be approved by the RACs	99
MDRN6	Vital Documents	Unit	$1.00		50 units	99
MDRN7	Gap Services-Transitional, Clothing, Support Services **(Gift cards must not be used for the purchase of gap services as of 1/1/20; original receipts of all pre-approved purchases must be submitted with claims.)**	Unit	$1.00		250 units	99
MDRN0	Gap Services-Medical	Unit	$1.00		250 units	99
	Maximum payment per service recipient per lifetime=$2,500.00 (effective 10/1/16)					

*additional services must be authorized by the Regional Area Coordinator (RAC)

Service Category Descriptions:

- **MDRN2 Maryland RecoveryNet Housing:** Recovery Housing means a MDRN approved and certified residence that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders, addictive disorders, co-occurring mental health and substance-related disorders, or addictive disorders.

- **MDRN3 Intake Interview:** Interview conducted by care coordinator with client upon approval into the MDRN program to complete MDRN application, ensuring that all requests (to enroll, for initial and additional services) have been approved prior to onset of service delivery, and for submitting claims for reimbursement, completing all required documentation for program enrollment, filing all documentation in a service recipient's record.

- **MDRN4 Care Coordination Check-ins:** tracking service recipients' progress through the program, obtaining the service recipients' signature on receipts for verification of service delivery.

- **MDRN5 Transportation:** Monthly/Reduced Fare passes for service recipients to get to and from recovery support services. It also may be used to purchase specialized transportation including mobility vouchers. May also be used for cab services under certain conditions; must be approved by the Regional Area Coordinator.

- **MDRN6 Vital Documents:** Critical documents for service recipients (and children if a recipient is receiving Women/Men with Children services; should be billed under GAP support) such as birth certificates, photo ID's, and driver's license. It also includes care coordinator time for document acquisition.

- **MDRN7 Gap Services:**
    - Transitional - used for basic needs such as food and toiletries.
    - Clothing - seasonal changes, weight gains/losses, employment/uniforms
    - Support Services- services that are not covered by any other program

- **MDRN0 Medical:** covers medical costs that are not being paid for by another source such as prescription costs, durable medical equipment, eye glasses, etc.

Authorization Request for MARYLAND RECOVEY NETWORK

Note: This form is to be used by the MDRN care coordinator to submit requests for authorization for non-recovery housing services. An incomplete request will not be processed and will be denied. Please send this request to mdrn.info@maryland.gov.

Today's Date: _____/_____/_____

Requested Support:

☐ MDRN Intake Interview ☐ Care Coordination Check-Ins ☐ Transportation

☐ Vital Documents ☐ Gap Services-(Transitional, Clothing, Support Services)

☐ Gap Services-Medical

CLIENT INFORMATION

Date you met with the individual? ___/___/_____

Client's Name: _____ SS#____-____-_____ DOB:___/___/_____

Client's Address:_____

Phone Number: ___-____-____ Gender: ☐ Male ☐Female ☐Transgender ☐Other _____

Does client have Medicaid? ☐Y ☐N If no, please submit Documentation of Uninsured Eligibility Form

Does the client have private insurance? _____

Does the client receive services from the Public Behavioral Health System? ☐Y ☐N

Does the client meet financial eligibility? ☐Y ☐N

Has the client received MDRN supports previously? ☐Y ☐N

Is the applicant enrolled in State Care Coordination (SCC)? ☐Y ☐N

If yes, where: _____

The client was referred from (identify agency)

_____

What type of recovery supports are the client connected to?

_____

Is this client working with a peer? ☐ Yes ☐ No

If working w/ a peer, peers name:

_____

Substance Use Information:

Is this individual attending an outpatient substance use treatment program? ☐ Yes ☐ No

Are there any obstacles to participation in outpatient treatment? ☐ Yes ☐ No

Explain:_____

Name of program/contact

info:_____

Primary Substance Problem: _____ Usual Route of Administration: _____

Frequency of use: _____Date Last Used ___/___/_____

Secondary Substance Problem: _____ Usual Route of Administration: _____

Frequency of use: _____ Date Lasted Used ___/___/_____

Tertiary Substance Problem: _____ Usual Route of Administration: _____

Frequency of use: _____ Date Lasted Used ___/___/_____

Ethnicity: Is the client of Hispanic, Latina/o or Spanish Origin? ☐ Y ☐N

Race (check all that apply):

    ☐ White   ☐ American Indian or Alaskan Native   ☐ Black or African American

    ☐ Asian   ☐ Native Hawaiian or Other Pacific Islander   ☐ Not Available

Marital Status: Choose an item.

Number of Dependent Children: _____

Living Situation: Choose an item.

Employment Status: _____

Primary Source of Income: Choose an item.

Mental Health Problems: Yes ☐ No ☐ Not Available ☐   Diagnosis (if available): _____

Is the client seeing a psychiatrist or mental health therapist? Yes ☐ No☐

Who?_____   Where?_____   Date of last visit_____

Is the client currently on any psychotropic medications? Yes ☐ No ☐

Medication/dosage? Explain: _____

_____

Does the client have a history of self-injurious behavior? (suicidal, self- inflicted injury, etc.)

Yes ☐ No ☐

Explain_____

Does the client have history of violent behavior expressed towards others? Yes ☐ No ☐

Explain_____

What is the plan for managing mental health issues?

Explain:_____

Somatic Health Issues: Yes ☐ No ☐ Not Available ☐   Diagnosis (if available): _____

Explain_____

What is the plan for managing somatic health issues?

_____

Is the client currently on any somatic medications? Yes ☐ No ☐

medication/dosage? Explain: _____

Pregnant: ☐ Y ☐ N ☐ Not Available

Does the client have a diagnosis of Tuberculosis: ☐ Y ☐ N ☐ Not Available

Tobacco Use in 30 Days Prior to Admission? ☐ Y ☐ N ☐ Not Available

Highest Level of School Completed: _____

Number of Arrests Within the Past 30 Days: _____ *Number of Arrests in the Last 12 Months:* _____

Number of Times in a Self-Help Group in Last 30 Days: _____

Does this client have a sponsor? ☐ Y ☐ N ☐

Legal Involvement: ☐   No Legal Status   ☐ Pre-Trial   ☐   Probation ☐   Parole ☐   Drug Court

How will the requested support assist the client in their recovery?

_____

_____

_____

_____

_____

CARE COORDINATION AGENCY INFORMATION

County: _____

Name and Title of person submitting request: _____

Agency's Name:_____

Service Address:_____

Email Address: _____

Direct Number: _____-_____-_____   Fax Number: _____-_____-_____

***FOR Behavioral Health Administration USE Only ***

Date Received: _____

Date of Approval_____   Date Sent to Provider_____

Approved Supports:

☐   MDRN Intake Interview   ☐   Care Coordination Check-Ins   ☐   Transportation

☐   Vital Documents   ☐   Gap Services-Transitional, Clothing, Support Services)

☐   Gap Services-Medical

Date of Denial_____   Date Sent to Provider_____

Denied Supports:

☐   MDRN Intake Interview   ☐   Care Coordination Check-Ins   ☐   Transportation

☐   Vital Documents   ☐   Gap Services-Transitional, Clothing, Support Services)

☐   Gap Services-Medical   ☐   Peer Support Intake Interview

☐   Peer Support Encounter   ☐   Peer Support Leisure Activity

☐   Peer Support Recovery Call   ☐   Follow-Up Questionnaire Gift Card

☐   Six-month follow-up survey/MDRN satisfaction survey

Denied Reason:

_____

_____

_____

_____

COMMENTS/NOTES:

_____

_____

_____

_____

Signature: _____ Dated: _____

Instructions on how to complete Authorization Request for MARYLAND RECOVERY NETWORK (MDRN)

1. Fill out date you are completing authorization request.

2. Select the support being requested in the authorization request. ***Only supports that are selected will be reviewed.***

3. Fill out all client demographic information: Legal First and Last Name, Social Security Number, Date of Birth, current address, phone number to contact client.

4. Select gender of the client.

5. Select either yes or no if the client has Medicaid. ***Provide source documentation of Medicaid.***

6. If the client has private insurance please document the private insurance. ***Provide source documentation of private insurance.***

7. Select either yes or no if the client receives services through the Public Behavioral Health System.

8. Select either yes or no if the client meets MDRN financial eligibility? ***Provide source documentation of financial eligibility.***

9. Select either yes or no if the client received MDRN supports previously.

10. Fill out the entire Substance Problem Section for the primary substance problem, usual route of administration, frequency of use and date last used. If the individual uses more than one substance fill out the secondary and tertiary section if needed.

11. Select either yes or no if the client of Hispanic, Latina/o or Spanish Origin.

12. Select the race of the individual. Check all that apply.

13. Choose from the dropdown list the marital status of the client.

14. Write in the number of dependent children the client has. If the client has no dependent children write in "None."

15. Choose from the dropdown list the current living situation of the client.

16. Write in the Employment Status of the individual. *Please note if the individual is not working and looking for employment.*

17. Write in the referring source to MDRN. *The referring source can be the entity or individual who referred the client to care coordination.* ***Provide source documentation.***

18. Choose from the dropdown list the primary source of income. ***Provide source* documentation.**

19. Select yes, no or not available to the following questions: Mental Health Problems, pregnant, Does the client have a diagnosis of Tuberculosis, and Tobacco Use in 30 Days Prior to Admission?

20. Write in the highest level of school completed by the client.

21. Write in the number of Arrests Within Past 30 Days.

22. Write in number of Arrests in the Last 12 Months.

23. Write in the number of times the client attended a self-help group in the last 30 days. This should be documented by number of times in a week, ie. 5x a week.

24.   Write in the reason for the support request and how it will assist the individual in their recovery.

25.   Care Coordination Agency Information. Fill out all information for the contact individual at the agency requesting the authorization.