

2025 State of the Substance Use Treatment Industry



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President

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Healthcare Consultant

- 9 Years On \$1.8 Billion Hospital Board
- Leading Substance Use Treatment Consultant
- Millions of Dollars in Substance Use Treatment Settlements and Denial Reversals
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THE ORANGE COUNTY
REGISTER



Agenda

Industry Overview in 60 seconds

1. What Services Can You Provide?
2. Ever-Changing Health Plans
3. Move to Evidence-Based Treatment
4. Billing = Denial Management
5. Medical Record Review = Denial
6. Physicians Make Decisions Act SB 1120
7. Appeals = Financial Security
8. Non-Transparent Financial Models
9. MAT, MAT, MAT!
10. Final Ask

What Services Can You Provide?



Department of Health Care Services (DHCS)

- **California Licensing Authority for Sub-Acute Facilities**
 - Does Not License ASAM 3.7
 - You Can Lose Your License Providing ASAM 3.7 Services
 - Any ASAM 3.7 Services Billed to Payers Subject to Recoupment
- **ASAM 3.7 and 4.0**
 - ACUTE Services not Sub-Acute
 - California Department of Public Health Issues License
 - CARF or TJC Accreditation Does Not Allow Provision of Services
- **PHP and IOP Services Now Required to Be Certified**

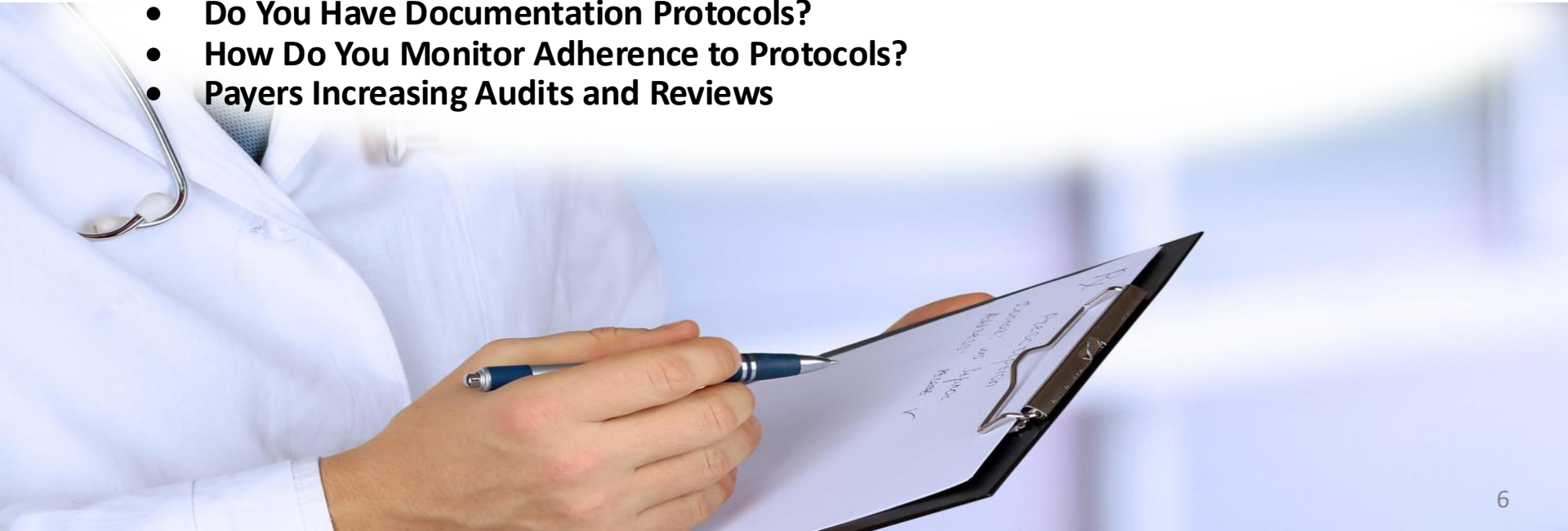
Ever-Changing Health Plans

- **Increasing Catastrophic Coverage**
 - Higher Patient Responsibility
- **Provider Contracts Designed to Prevent Out-Of-Network Referrals**
- **Bundled Per Diems**
 - Includes Laboratory Services
 - Individual Sessions
- **PPOs Becoming More Like EPOs**
 - Narrow Networks
 - Geographic Limitations



Move To Evidence-Based Treatment

- **Become an ASAM Criteria “Lawyer”**
 - Combat Shortened Treatment Durations
- **What is Your Client Post Treatment Tracking?**
- **Do You Have Documented Clinical Protocols?**
- **Do You Have Documentation Protocols?**
- **How Do You Monitor Adherence to Protocols?**
- **Payers Increasing Audits and Reviews**



Billing = Denial Management

- **What Are Your Denial Percentages?**
 - No Pre-Authorization
 - Medical Necessity (Post Medical Record Review)
 - Incomplete Documentation
 - Utilization Review to Clinician
 - Procedure Authorized Not Procedure Billed
 - Inappropriate Claim Submission
 - Type of Bill
 - Diagnosis Code vs. Revenue Code or HCPCS Code
 - Lack of Timely Appeal Filing (90 -365 Days)



Medical Record Review = Denial

- **Incomplete Treatment Plans**
 - Should Include Discharge Plan
- **No Periodic Treatment Plan Review**
- **Lack of Nurse Monitoring in Detox**
- **No Start/Stop Times for Groups**
- **Client in Two Places at Same Time**
- **Boilerplate Group Notes**
- **Lack of Reason for Toxicology Testing**
 - Test Results Not Reviewed by Doctor
- **Upcoding/Downcoding**
- **No ASAM Assessment**
- **No Meeting with Psychiatrist/Psychologist**

Physicians Make Decisions Act SB 1120

The act mandates that any denial, delay, or modification of healthcare services based on medical necessity must be reviewed and decided by a licensed physician or qualified healthcare provider.

- Must adhere to ASAM Criteria and LOCUS Criteria
- Relevant Information Requirement Reaffirmed
- Must review medical records within 30 days and issue a decision on the claim
- Shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity
- The artificial intelligence, algorithm, or other software tool shall not deny, delay, or modify health care services based, in whole or in part, on medical necessity. A determination of medical necessity shall be made only by a licensed physician or a licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider
- If the Insurance Commissioner DMHC Director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure



TRACK DENIALS AND REPORT TO THE REGULATOR

Appeals = Financial Security

- **Develop Custom Reports to Track Insurance Payments and P2P**
 - To Generate Appeals and Patient Billing
- **Curate What Claims Should Be Appealed**
- **Develop Custom Appeal Letters**
- **Track Effectiveness**



Non-Transparent Financial Models

- **Surprise Bill Legislation**
- **Reimbursement Decreasing**
 - Multiple Scenarios
 - In-Network (Set Rates)
 - Out-of-Network
 - Payers May Reimburse at the “Least of”
 - Per Diem Rates
 - Tied to Percentage of Medicare
 - County DHCS Pricing
 - UCR
 - Internally Determined Rates
 - Negotiated Rates



**WHO ARE YOU
ADMITTING? AT
WHAT COST?**

MAT, MAT, MAT!

IN-PATIENT SUB-ACUTE TREATMENT VERSUS MEDICATION ASSISTED TREATMENT

	IN-PATIENT	MAT
DETOX \$1250/DAY 7 DAYS	\$8,750.00	\$8,750.00
RESIDENTIAL \$1000/DAY 30 DAYS	\$30,000.00	-
TELEMEDICINE - PSYCHIATRY \$150/DAY 17 DAYS		\$2,550.00
TELEMEDICINE – GROUPS \$450/DAY 17 DAYS		\$7,650.00
MEDICATION	<u>\$200.00</u>	<u>\$200.00</u>
TOTAL	\$38,950.00	\$19,150.00

\$19,850.00 SAVINGS

WHAT PROOF DO YOU HAVE THAT THIS DOES NOT MAKE SENSE?

