REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Substance Use Disorder Residential		PY-0137	01/01/2021-5/31/2022
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Substance Use Disorder Residential

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Substance Use Disorder (SUD) services are provided on a continuum of care where the level of care varies dependent on the type and intensity of services provided. This policy address the Residential level of care. This type of care provides an intensive residential program for members with SUD. It is considered transitional with the goal of returning the member to the community with a less restrictive level of care.

C. Definitions

- **Residential level of care for SUD** -
  A residential program must meet all of the following:
  - Staffed 24 hours a day
  - Follow nationally recognized medical standards
  - Be an Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified/licensed facility to provide residential SUD treatment
  - Have an active provider agreement with ODM
  - All practitioners of the SUD treatment service must meet applicable state requirements
  - Establish individualized treatment plans
  - Start discharge planning at time of admission
  - Schedule a follow-up visit within 7 days of discharge for aftercare
  - Provide Medication Assisted Treatment (MAT) or linkage to a prescriber for MAT
  - Ensure accessibility to all behavioral and physical health medication upon discharge

  CareSource does not consider a residential program appropriate for:
  - Intensive medical monitoring needed for severe or life threatening medical or physical condition
  - A member who is unable to actively participate due to
    - Severe symptoms of co-existing mental or physical condition; or
    - Severe withdrawal symptoms

D. Policy

I. CareSource requires a prior authorization (PA) for the following:
   A. For the first and second admission per calendar year, a prior authorization is only required for an admission exceeding 30 consecutive days.
   B. For admissions exceeding the two admissions per calendar year, a prior authorization is required from the first day of admission.
   C. Changes in level of care:
      1. When step-up or step-down occurs between two SUD residential level of care codes within the same residential provider agency, and there is consecutive billing, it is counted as a single event . When step-up or step-down occurs between two SUD residential level of care codes and billing is not consecutive, the events will be considered separate events and PAs may be required depending on the member's utilization in that calendar year.
         a. If the step-up or step-down occurs during the first 30-days of 1st or 2nd of the 2 allowed SUD Residential events, no PA is required for the step-up or step-down.
         b. If the step-up or step-down occurs after a PA has been authorized, either because the LOS has exceeded 30-days or this is the 3rd or more event in a calendar year, then the step-up or step-down **does** require a new/updated PA.
   D. SUD Residential Facility Transfers –
      1. Prior Authorization is required for a same level-of-care admission/transfer between two SUD Residential Facilities (NPIs and/or TINs) when the total number of days at that level-of-care exceeds 30-calendar days and there is not a break in stay that is greater than 24-hours between admissions, indicating two separate events. If the admission has already required prior authorization, for any reason, the transition admission will require prior authorization be obtained by the receiving facility from the date of admission.
      2. Same level-of-care admissions/transfers between two SUD Residential Facilities (NPIs and/or TINs) without a break in stay of greater than 24-hours is not considered a separate event and will not accumulate as a separate events.
      3. If there is a break in stay that is greater than 24-hours between a same level-of-care admission/transfer between two SUD Residential Facilities (NPIs and/or TINs), the admission to the receiving facility is considered a separate event and is subject to prior authorization from date of admission, beginning with the third admission in a calendar year and will accumulate as separate events.

   NOTE: It is the responsibility of the facility to check the annual service usage to avoid getting a claim denial for no prior authorization.

II. Documentation
   A. At least one documented face-to-face interaction must be provided by a clinical/treatment team member with the member at the substance use residential site in order to bill per diem.
   B. Member's medical record must show evidence of medical necessity of services.
   C. The residential program has a written Affiliation Agreement so that members are

connected/ensured access to outpatient care in timely manner upon discharge. The residential program has policies and procedures in place to monitor its affiliations.

III. Medical Necessity Criteria
   A. CareSource follows The ASAM Criteria® as required by the Ohio Department of Medicaid.

IV. Billing
   A. Residential level of care admission – one admission is considered one length of stay
      1. Any stay under 30 consecutive days counts as a full 30 day occurrence.
      2. Service gaps in excess of 24 hours are considered a termination of one admission.
      3. Leaving the SUD residential treatment facility associated with significant changes in health status such as leaving against medical advice, step-ups (including acute medical admissions) or step-downs in level of care, and/or incarceration are considered a termination of one admission.
      4. Brief leave of absences (24 hours or less, except in rare instances) when supported by member's individualized treatment plan should be documented in the member's treatment plan, and the provider should continue to bill for treatment services during these times.
         a. Brief leave of absences include but are not limited to the following:
            01. Family visits
            02. Religious services
            03. Same day health services
            04. Social support group attendance
   B. The benefit follows the member not the provider's tax identification number.
   C. CareSource only processes claims from
      1. Provider type of 95 – OhioMHAS certified/licensed treatment program;
      2. Provider specialty 954 – OhioMHAS certified/licensed SUD residential facility; and
      3. Place of service code 55 – Residential Substance Abuse Treatment Facility.
   D. Claims billed out of sequence from date of service may cause claims to deny inappropriately for no prior authorization.
   E. Claims are paid as they are received. If member receives services from more than one provider, claims are paid to providers that submit first regardless of date of service.
   F. SUD residential is paid per diem. Per Diem does not include room and board costs/payments.
   G. CareSource does not reimburse separately for services provided by the residential treatment service including:
      1. Ongoing assessments and diagnostic evaluations.
      2. Crisis intervention.
      3. Individual, group, family psychotherapy and counseling.
      4. Case management.
      5. Substance use disorder peer recovery services.

6. Urine drug screens.
7. Medical services.
8. Medication administration

H. A member can only receive services through one level of care at a time.
   1. CareSource considers the following services non-billable when member is in residential level of care
      a. Therapeutic behavioral services.
      b. Psychosocial rehabilitation.
      c. Community psychiatric supportive treatment.
      d. Mental health day treatment.
      e. Assertive community treatment.
      f. Intensive home based treatment.
   2. CareSource does consider select BH services provided to a member from practitioners not affiliated (based on billing group TIN) with the residential treatment program as billable concurrent to the SUD Residential admission when the service is medically necessary and the treatment is outside of the scope of the residential treatment program. Examples include medication assisted treatment (MAT) and psychiatry.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

CPT Code	Description
H2034	Clinically Managed Low-Intensity Residential Treatment ASAM 3.1
H2036	Clinically Managed High Intensity Residential Treatment ASAM 3.5
Procedure Modifier	**Description**
HI	Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults) May be used with H2036.
TG	Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High-Intensity Inpatient Services (Adolescent) ASAM 3.7 May be used with H2036.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2017	
Date Revised	05/15/2019	Updated definition, medical necessary criteria, and billing
Date Effective	09/16/2020 12/28/2020 01/01/2021	Updated definition, added note under D. I. Added D. I. C.; D.1. IV. A. 5 and IV. B. Added related policy. Revised D. IV. H. 2. Revised I. C. D. and E. Provided clarification of policy per ODM – D. 1. C, D, and E; and D. IV. A.
Date Archived	5/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. Lawriter - OAC - 5160-27-01 Eligible provider for behavioral health services. (2019, November 29) Retrieved June 1, 2020 from www.codes.ohio.gov
2. Lawriter – OAC – 5160-27-02 Coverage and limitations of behavioral health services. (2018, May 30) Retrieved June 1, 2020 from www.codes.ohio.gov
3. Lawriter – OAC – 5160-27-09 Substance use disorder treatment services. (2018. January) Retrieved June 1, 2020 from www.codes.ohio.gov
4. Ohio Department of Medicaid. (2020, April 9). Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual. Retrieved June 1, 2020 from www.bh.medicaid.ohio.gov
5. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, Third Edition.

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.