REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Substance Use Disorder Residential - OH MCD - PY-0137	06/01/2022-05/31/2023
Policy Type	
REIMBURSEMENT	

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 providers when submitting claims to CareSource. Policies 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, will be established based upon a review of actual services provided to a member, and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility.

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. A residential level of care provides an intensive, residential program for members with SUD and is considered transitional with the goal of returning the member to the community with a less restrictive level of care.

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

C. Definitions

- **Medication Assisted Treatment (MAT)** – The use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA), while MAT programs are clinically driven and tailored to meet each patient's needs.
- **Per Diem** – An allowance or payment made for each day of service based on the sum of the national average routine operating, ancillary and capital costs for each patient day of care.
- **Residential level of care** – Services that are co-occurring capable, co-occurring enhanced, and complexity capable in nature, while being provided by addiction treatment, mental health and general medical personnel in a twenty-four-hour treatment setting, Ohio department of Mental Health and Addiction Services (OhioMHAS)-certified and licensed, permanent facilities which are staffed twenty-four hours a day.

D. Policy

I. A residential program must meet **all** the following criteria:
   - Staffed 24 hours a day
   - Follow nationally recognized medical standards
   - Be certified/licensed by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to provide residential SUD treatment
   - Have an active provider agreement with Ohio Department of Medicaid (ODM)
   - Employ practitioners of SUD treatment services who meet applicable state requirements
   - Establish individualized treatment plans
   - Start discharge planning at time of admission
   - Schedule a follow-up visit for aftercare within seven (7) days of discharge

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

- 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 the following members:

- A member who needs intensive medical monitoring for a severe or life threatening medical or physical condition
- A member who is unable to actively participate due to severe symptoms of a co-existing mental or physical condition or severe withdrawal symptoms

II. CareSource requires a prior authorization (PA) for the following:

A. For the first and second admissions per calendar year, a prior authorization is only required for an admission exceeding thirty (30) consecutive days.

- For example, a member goes into residential treatment for the first time in a calendar year for a period of ten days. No authorization is required. The same member goes into treatment for a second admission during the same calendar year for a period of 38 days. After day 30, the facility is required to submit an authorization for days 31 through 38.

B. For any stay or admission exceeding two admissions per calendar year, a prior authorization is required from the first day of admission.

- The same member above admits for residential treatment for a third time during the same calendar year. A prior authorization for this admission is required, starting day one (1).

C. Changes in level of care:
When a 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, the step-up or step-down 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. 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 thirty (30) days of the first or second of the two (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 length of stay (LOS) has exceeded thirty (30) days or this is the third 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:

- Prior Authorization is required for a same level-of-care admission or transfer between two SUD residential facilities (national provider identifiers (NPI) and/or tax identification numbers (TIN)) 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 that prior authorization be obtained by the receiving facility from the date of admission.

- Same level-of-care admissions or 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 event.
- If there is a break in stay that is greater than 24 hours between a same level-of-care admission or 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 the date of admission, beginning with the third admission in a calendar year and will accumulate as separate events.

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

III. 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 medical records must show evidence of medical necessity of services and follow Ohio Administrative Code guidelines.
C. The residential program has a written Affiliation Agreement, so members are connected and ensured access to outpatient care in a timely manner upon discharge. The residential program has policies and procedures in place to monitor its affiliations.

IV. Medical Necessity Criteria

CareSource follows The American Society of Addiction Medicine (ASAM) Criteria® as required by the Ohio Department of Medicaid.

V. Billing

A. Residential level of care admission:
    1. One admission is considered one length of stay (LOS).
    2. Any stay under 30 consecutive days counts as a full 30-day admission.
    3. Service gaps in excess of 24 hours are considered a termination of one admission.
    4. 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.
    5. 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. Brief leave of absences include but are not limited to the following:
        - Family visits
        - Religious services
        - Same day health services
        - Social support group attendance

B. The benefit follows the member, not the provider's tax identification number.

C. CareSource only processes claims from the following:
   1. Provider type 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 a member receives services from more than one provider, claims are paid to providers who submit first, regardless of date of service.

F. SUD residential is paid per diem. Per diem does not include room and board costs and/or 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 a 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 behavioral health 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 Behavioral Health Ohio fee schedule for appropriate codes.

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
	09/16/2020	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.
	12/28/2020	Revised I. C. D. and E. Provided clarification of policy per ODM – D. 1. C, D, and E; and D. IV. A.
	11/30/2021	Removed codes from policy, updated definitions.
Date Effective	06/01/2022	
Date Archived	05/31/2023	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. Centers for Medicare and Medicaid Services, Inpatient Psychiatric Facility PPS (2021, December 1). Retrieved December 28, 2021 from www.cms.gov.
2. Ohio Administrative Code, 5160-27-01, Eligible provider for behavioral health services. (2021, July 9). Retrieved November 30, 2021 from www.codes.ohio.gov.
3. Ohio Administrative Code, 5160-27-02, Coverage and limitations of behavioral health services. (2021, July 9). Retrieved November 30, 2021 from www.codes.ohio.gov.
4. Ohio Administrative Code, 5160-27-09, Substance use disorder treatment services. (2021, August 5). Retrieved November 30, 2021 from www.codes.ohio.gov.
5. Ohio Department of Medicaid. Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual. (2021, March 18). Retrieved November 30, 2021 from www.bh.medicaid.ohio.gov.
6. Substance Abuse and Mental Health Services Administration, Medication Assisted Treatment (2021, December 16). Retrieved December 28, 2021 from www.samhsa.gov.
7. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, Third Edition.