REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Residential Treatment Services - Substance Use Disorder-OH MCD-PY-0137	09/01/2025
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

Residential Treatment Services - Substance Use Disorder (SUD)

B. Background

Substance Use Disorder (SUD) treatment is dependent on member needs with the type, length and intensity of treatment determined by the severity of the diagnosis, types of substances used, support systems available, prior life experiences, and behavioral, physical, gender, cultural, cognitive and/or social factors. Additional factors include the availability of treatment in the community and coverage for the cost of care.

The American Society of Addiction Medicine's (ASAM) levels 3 and 4, or residential and intensive inpatient levels of care (LOC), are considered transitional with the goal of returning the member to the community with a less restrictive LOC. Level 3 services include residential and/or inpatient services that are clinically managed or medically monitored. Level 4 services include medically managed, intensive inpatient services.

Providers use the ASAM criteria as the basis to deliver services for the full continuum of care, ensuring that care is delivered consistently with industry-standard criteria. ASAM also provides key benchmarks from nationally adopted standards of care and guidelines involving evidence-based treatment measures to guide services. Treatment of substance use disorders is dependent on a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

CareSource follows the Ohio Dept of Medicaid's (ODM) policies and procedures and the Ohio Revised and Administrative Codes (ORC and OAC, respectively).

C. Definitions

- **ASAM's Residential Levels of Care (LOC):**
  - 3.1 – Clinically managed, low-intensity residential program
  - 3.3 – Clinically managed, high-intensity, population specific
  - 3.5 – Clinically managed, high-intensity residential program for adults and/or medium intensity for adolescents
  - 3.7 – Medically monitored, intensive inpatient for adults and/or high-intensity for adolescents
- **Clinically Managed Services** – Services directed by nonphysician addiction specialists appropriate for members with emotional, behavioral, cognitive, readiness to change, relapse, or recovery environment concerns. Intoxication, withdrawal, and biomedical concerns, if present, are safely manageable, particularly under Level 3.1, 3.3, and 3.5 residential programs.
- **Inpatient Services** – Behavioral health (BH) services provided during an inpatient admission or confinement for acute inpatient services in a hospital or treatment setting on a 24-hour basis under the direct care of a physician, including psychiatric hospitalization, inpatient detoxification, and emergency evaluation and stabilization.

- **Medically Managed Services** – Services involving 24-hour nursing and daily medical care by an appropriately trained and licensed physician providing diagnostic and treatment services directly, managing the provision of those services, or both, particularly under Level 4 programs.
- **Medically Monitored Services** – Services provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, or other health and technical personnel under the direction of a licensed physician through a mix of direct patient contact, review of records, team meetings, 24-hour coverage by a physician and nursing staff and a quality assurance program, particularly under Level 3.7 inpatient programs.
- **Medication Assisted Treatment (MAT)** – The use of Food and Drug Administration (FDA)-approved medications in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of SUD.
- **Per Diem** – An allowance/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 LOC** – Services for BH that can include individual, family and group therapy, nursing services, medication assisted treatment, detoxification (ambulatory or subacute), and pharmacological therapy in a congregate living community with 24-hour support.

D. Policy

I. A residential program is staffed 24 hours a day and follows ASAM's LOC criteria and OAC 5122-29-09.

II. A review of medical necessity is required for the following:

A. For the 1st and 2nd admissions per calendar year, a review is only required for admission exceeding 30 consecutive days.
   - For example, a member goes into treatment the 1st time in a calendar year for 10 days. No review is required. The same member goes into treatment for a 2nd admission during the same calendar year for 38 days. After day 30, the facility is required to obtain an authorization for days 31 through 38.

B. For any stay or admission exceeding 2 admissions per calendar year, a review is required from the 1st day of admission.
   - The same member above admits for treatment for a 3rd time during the same calendar year. A review for this admission is required, starting day 1.

C. Changes in LOC
   1. When step-up or step-down occurs between 2 SUD residential LOC codes within the same residential provider agency and there is consecutive billing, the step-up or step-down is counted as a single event.
   2. When step-up or step-down occurs between 2 SUD residential LOC codes and billing is not consecutive, the events will be considered separate events. Reviews of medical necessity may be required, depending on the member's utilization in that calendar year.
      a. If step-up or step-down occurs during the 1st 30 days of the 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 length of stay (LOS) 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. A review of medical necessity is required for a same LOC admission or transfer between 2 SUD residential facilities (national provider identifiers (NPI) and/or tax identification numbers [TIN]) when the total number of days at that LOC exceeds 30 calendar days and there is not a break in stay that is greater than 24-hours between admissions indicating 2 separate events. If the admission already required a review or authorization for any reason, the transition admission will require that a review be obtained by the receiving facility from the date of admission.
2. Same LOC admissions or transfers between 2 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.
3. If there is a break in stay that is greater than 24 hours between a same LOC admission or transfer between 2 SUD residential facilities (NPIs and/or TINs), the admission to the receiving facility is considered a separate event and is subject to a review from the date of admission, beginning with the 3rd admission in a calendar year and will accumulate as separate events.

III. Documentation
A. At least 1 documented face-to-face interaction must be performed by a clinical treatment team provider at the site in order to bill per diem.
B. Medical records must substantiate the medical necessity of services and follow OAC guidelines for documentation in OAC 5160-1-27 and 5160-8-05.
C. Programs must have written Affiliation Agreements monitored by program policies and procedures to ensure member access to outpatient care in a timely manner upon discharge.

IV. Billing
A. Residential LOC admission
1. One admission is considered 1 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 1 admission.
4. Leaving the facility associated with significant changes in health status, such as leaving against medical advice, step-ups (including acute medical admissions) or step-downs in LOC, and/or incarceration are considered a termination of 1 admission.
5. Brief leave of absences (24 hours or less except in rare instances), when supported by the member’s individualized treatment plan, should be documented in the member’s treatment plan.
B. The benefit follows the member not the provider’s TIN.
C. CareSource processes claims from the following:

1. provider type 95 – OhioMHAS certified/licensed treatment program
2. provider specialty 954 – OhioMHAS certified/licensed SUD residential facility
3. place of service code 55 – residential substance abuse treatment facility

D. Claims billed out of sequence from date of service may cause inappropriate denials for no prior authorization or review of medical necessity.
E. Claims are paid as received. If a member receives services from more than 1 provider, claims are paid to providers who submit 1st, regardless of date of service.
F. SUD residential is paid per diem, which 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
H. A member can only receive services through 1 LOC at a time.
   1. CareSource considers the following services non-billable when a member is in residential LOC:
      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. Select services, including MAT and psychiatry for example, provided to a member by practitioners not affiliated with the residential treatment program (based on billing group TIN) are considered by CareSource 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.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers. Refer to the BH Ohio fee schedule for codes. Code inclusion in this policy does not imply any right to reimbursement or guarantee claim(s) payment. Additional provisions for services compliant with ASAM's LOC criteria can be found in the OAC, including programs for individuals under age 18, SUD case management, and crisis services.

F. Related Policies/Rules

Medical Necessity Determinations
Behavioral Health Documentation Standards

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

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2017	
Date Revised	05/15/2019	Updated definitions, medical necessary criteria, and billing.
	09/16/2020	Updated definitions. Added note under D.I. Added D.I.C.;D.1.IV. A.5, IV.B. Added related policy.
	12/28/2020	Revised D.IV.H.2 & I.C.D. & E. Provided clarification per ODM – D. 1. C, D, and E; and D. IV. A.
	11/30/2021	Removed codes from policy, updated definitions.
	01/18/2023	Annual review. Updated background. Added definitions.
	01/31/2024	Annual review. Updated D.I.A. Deleted Sections D.II and V., 8 on VI.G. Updated F and H. Approved at Committee.
	06/04/2025	Annual review. Updated reference list. Approved at Committee.
Date Effective	09/01/2025	
Date Archived		

H. References

1. American Society of Addiction Medicine*. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, *4th Ed.* Hazelton Betty Ford Foundation; 2023.
2. Coverage and Limitations of Behavioral Health Services, OHIO ADMIN. CODE 5160-27-02 (2022).
3. Eligible Provider for Behavioral Health Services, OHIO ADMIN. CODE 5160-27-01 (2023).
4. Eligible Providers and Supervisors, OHIO ADMIN. CODE 5122-29-30 (2022).
5. *Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual*. Ohio Dept of Medicaid; 2023. Accessed May 8, 2025. www.medicaid.ohio.gov
6. Residential and Withdrawal Management Substance Use Disorder Services, OHIO ADMIN. CODE 5122-29-09 (2023).
7. Statutes, regulations, and guidelines. Substance Abuse and Mental Health Services Administration. Accessed May 8, 2025. www.samhsa.gov
8. Substance Use Disorder Qualified Residential Treatment Program (QRTP) for Youth, OHIO ADMIN. CODE 5122-29-09.1 (2022).
9. Substance Use Disorder Treatment Services, OHIO ADMIN. CODE 5160-27-09 (2021).

Approved by Ohio Dept of Medicaid 06/10/2025