



REIMBURSEMENT POLICY STATEMENT

Ohio Medicaid

Policy Name & Number	Date Effective
Residential Treatment Services - Substance Use Disorder-OH MCD-PY-0137	10/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject**Residential Treatment Services - Substance Use Disorder (SUD)****B. Background**

Substance Use Disorder (SUD) treatment is tailored to member needs with type, duration and intensity determined by the diagnosis severity, substances used, support systems, prior experiences, and behavioral, physical, gender, cultural, cognitive and social factors, as well as treatment availability and coverage.

The American Society of Addiction Medicine (ASAM) levels 3 and 4, or residential and intensive inpatient levels of care (LOC), serve as transitional stages aiming to return members to less restrictive community-based care. Level 3 includes clinically managed or medically monitored services, while level 4 involves medically managed, intensive inpatient care.

Providers follow ASAM criteria to ensure consistent, evidence-based service delivery across the continuum of care, ensuring that care is delivered consistently with industry-standard criteria. SUD treatment 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 Levels 3.1, 3.3, and 3.5.
- **Inpatient Services** – Behavioral health (BH) services 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 under the direction of a licensed physician through direct patient contact, review of records, team

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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** – A 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 prior authorization (PA) is required after the 30th consecutive day.
 - A member admits for 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 third and subsequent admissions during the same calendar year, a PA 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 PA for this admission is required at day 1.
- III. Changes in LOC and transfers
 - A. Changes between 2 SUD residential LOC codes within the same provider agency
 1. When there is consecutive billing, the step-up or step-down is counted as a single event.
 2. When billing is not consecutive, the events will be considered separate events. Reviews of medical necessity may be required depending on utilization in that calendar year. See II.A.B.
 - B. SUD residential transfers between 2 facilities (national provider identifiers [NPI] and/or tax identification numbers [TIN])
 1. A medical necessity review is required for a same-LOC admission or transfer when the total stay exceeds 30 calendar days without a break of more than 24 hours between admissions. If a PA was already required for any reason, the receiving facility must obtain a PA effective on the date of admission.
 2. Same LOC admissions or transfers without breaks in stay greater than 24 hours are not considered and will not accumulate as separate events.
 3. If there is a break in stay greater than 24 hours between a same LOC admission or transfer, the admission to the receiving facility is considered a separate event and

is subject to PA from the date of admission, beginning with the 3rd admission in a calendar year. The admission will accumulate as a separate event.

IV. 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 maintain written Affiliation Agreements, supported by program policies and procedures, to ensure timely member access to outpatient care upon discharge.

V. Billing

- A. Residential LOC admission
 - 1. One admission is considered 1 length of stay.
 - 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 due to significant changes in health status (eg, leaving against medical advice, step-ups, acute medical admissions, step-downs in LOC, incarceration) are considered a termination of admission.
 - 5. Brief absences of 24 hours or less, except in rare cases, must be documented in the member's record and supported by the individualized 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 PA or review of medical necessity.
- E. Claims are paid as received. If services are received from more than 1 provider, claims are paid to providers submitting the first claim, regardless of date of service.
- F. SUD residential is paid per diem, which excludes room and board.
- G. The following services are included in the residential treatment service and will not be reimbursed separately:
 - 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. point of care urine drug screens
 - 7. medical services
- H. A member can only receive services through 1 LOC at a time.
 - 1. The following are non-billable when a member is in a residential LOC:
 - a. therapeutic behavioral services
 - b. psychosocial rehabilitation
 - c. community psychiatric supportive treatment

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- d. mental health day treatment
- e. assertive community treatment
- f. intensive home-based treatment
- g. laboratory/definitive urine drug screens at an outside, independent laboratory
2. Members in residential treatment may receive medically necessary services from practitioners not affiliated with the residential program (eg, psychiatry, MAT, other medical treatment) that are outside the scope of the residential LOC as defined by ASAM when the service is documented in the treatment plan maintained by the residential provider.

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 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 Service Record Documentation Standards

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.
	06/03/2026	Annual review. Updated D.V.G.6. & added D.V.H.1.g. Updated reference list. Approved at Committee.
Date Effective	10/01/2026	
Date Archived		

H. References

1. American Society of Addiction Medicine. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Ed.* Hazelton Betty Ford Foundation; 2013.

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2. Coverage and Limitations of Behavioral Health Services, OHIO ADMIN. CODE 5160-27-02 (2024).
3. Eligible Provider for Behavioral Health Services, OHIO ADMIN. CODE 5160-27-01 (2024).
4. Eligible Providers and Supervisors, OHIO ADMIN. CODE 5122-29-30 (2024).
5. *Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual*. Ohio Dept of Medicaid; 2023. Accessed May 26, 2026. 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 26, 2026. 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 07/14/2026

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