REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

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.

A. Subject

Residential Treatment Services - Substance Use Disorder (SUD)

B. Background

Substance Use Disorder (SUD) treatment is dependent on the needs of the member with the type, length, and intensity of treatment determined by the severity of the SUD, 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.

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intensive inpatient levels of care, are considered transitional with the goal of returning the member to the community with a less restrictive level of care. 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 level of care criteria as a basis for the provision of SUD benefits to deliver services for the full continuum of care, which also ensures 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 that guide services. Treatment of substance use disorders is dependent on an SUD diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).

C. Definitions

x American Society of Addiction Medicine (ASAM) ±

The REIMBURSEMENT Policy Statement detailed above has r

period of 38 days. After day 30, the facility is required to obtain a PA for days 31 through 38.

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

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, the step-up or step-down is counted as a single event.
   2. 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, G H S H Q G L Q J R Q W K H P H P E H U ¶ V X W L C 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. Prior authorization is required for a same level of care 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 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 a PA for any reason, the transition admission will require that a PA be obtained by the receiving facility from the date of admission.
   2. Same level of care 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 level of care 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 PA 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 to the member at the site in order to bill per diem.
   B. Medical records must show evidence of medical necessity of services and follow OAC guidelines.
   C. Programs must have written Affiliation Agreements monitored by program

The REIMBURSEMENT Policy Statement detailed above has received due considerati

2. Select BH 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