Ohio Administrative Code

Rule 5160-27-09 Substance use disorder treatment services.

Effective: January 1, 2018

(A) For the purpose of medicaid reimbursement, substance use disorder treatment services shall be defined by and shall be provided according to the American society of addiction medicine also known as the ASAM treatment criteria for addictive, substance related and co-occurring conditions for admission, continued stay, discharge, or referral to each level of care (LOC).

(B) Medicaid will reimburse for the services provided under the following ASAM levels of care:

(1) LOC 1: outpatient services. LOC 1 services are designed to treat the recipients level of clinical severity and function. These services may be delivered in a variety of settings. Addiction, mental health, or general health care treatment personnel provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Service provision is limited to less than nine hours per week for adults and less than six hours per week for adolescents.

(2) LOC 2: intensive outpatient/partial hospitalization including LOC 2 withdrawal management (WM). LOC 2 services are capable of meeting the complex needs of people with addiction and co-occurring conditions. They can be rendered during the day, before or after work or school, in the evening, and/or on weekends.

(3) LOC 3: residential services/inpatient services including LOC 3 WM. These services are co-occurring capable, co-occurring enhanced, and complexity capable in nature and provided by addiction treatment, mental health and general medical personnel in a twenty four hour treatment setting. Services are provided in Ohio department of mental health and addiction services certified permanent facilities which are staffed twenty four hours a day. The following services are included in the residential treatment service and will not be reimbursed separately:

(a) Ongoing assessments and diagnostic evaluations.

(b) Crisis intervention.

(c) Individual, group, family psychotherapy and counseling.

(d) Case management.

(e) Substance use disorder peer recovery services.

(f) Urine drug screens.

(g) Medical services.

(4) The following services are considered non-covered for individuals in residential treatment:

(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.

(C) Individuals in residential treatment may receive medically necessary services from practitioners who are not affiliated with the residential treatment program. Examples include, but are not limited to, psychiatry, medication assisted treatment, or other medical treatment that is outside the scope of the residential level of care as defined by the American society of addiction medicine. Medicaid will reimburse providers of these services outside the per diem rate paid to residential treatment programs. All treatment services, regardless of whether they are rendered by the residential

treatment program or unaffiliated billing practitioners or agencies must be documented in the clients treatment plan maintained by the residential treatment provider.

(D) The entity providing a residential service must ensure that the medicaid recipient has access to the appropriate practitioner for receipt of clinical services as stated in the ASAM treatment criteria.

(E) Eligible practitioners of substance use disorder treatment services must meet all applicable requirements stated in rule 5160-27-01 of the Administrative Code. Qualified mental health specialists are not eligible to be a residential treatment team practitioner.

(F) Limitations.

(1) Residential levels of care are mutually exclusive, therefore a patient can only receive services through one level of care at a time.

(2) Prior authorization is required for LOC 2.5 (partial hospitalization) which requires a minimum of twenty hours of services per week. If, after the first four consecutive weeks of treatment, the amount of services provided is less than twenty hours, the prior authorization will be rescinded but services may still be reimbursed at a lower level of care not to exceed 19.9 hours per week.

(3) Prior authorization is required for LOC 3 residential treatment according to the following:

(a) Up to thirty consecutive days without prior authorization per medicaid enrollee for the first and second admission in a calendar year. If the stay continues beyond the thirty days of the first or second stay, prior authorization is required to support the medical necessity of the continued stay. If medical necessity is not substantiated and approved by the ODM designated entity, only the initial thirty consecutive days will be reimbursed.

(b) Third and subsequent admissions during the same calendar year must be prior authorized from the first day of admission.

(G) The patients medical record must substantiate the medical necessity of services performed. Providers shall adhere to documentation requirements set forth in rules 5160-1-27 and 5160-8-05 of

the Administrative Code.