Substance Use Disorder Services

This drafted policy is open for a two-week public comment period. This box is not part of the drafted policy language itself, and is intended for use only during the comment period as a means to provide readers with a summarized list of what has been drafted and what is out of scope for this review.

Summary of changes in scope for this review:

- Updated statement of benefits section
- Addressed Mental Health Parity and Addiction Equity Act requirements by allowing limits to be exceeded for adults with prior authorization
- Made Medication Assisted Treatment payable on same day as withdrawal management and treatment services
- Made Vivitrol payable to Chemical Dependency Treatment Facilities
- Made buprenorphine payable to Physician Assistants and Nurse Practitioners as allowed under the Comprehensive Addiction and Recovery Act of 2016
- Updated Prior Authorization forms for Fee for Service Medicaid recipients: Qualified Credentialed Counselor signature now permissible consistently across all forms, and supporting documentation now required with all forms consistently

Out of scope for this review:

- Admission criteria for services as outlined in Texas Department of Insurance regulations (28 TAC, Part 1, Chapter 3, Subchapter HH)
- Licensure requirements for Chemical Dependency Treatment Facilities and Opioid Treatment Programs as outlined in 25 TAC, Part 1, Chapter 448, pertaining to Standards of Care

Note: Once implemented, updated policy language regarding substance use disorder services will be contained in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Behavioral Health and Case Management Services Handbook.

Statement of Benefits

1. Treatment for substance use disorders (SUD) is a benefit of Texas Medicaid for individuals who meet the criteria for a substance-related disorder as outlined in the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM).

2. SUD treatment services are individualized, age-appropriate medical and psychosocial interventions designed to treat an individual’s problematic use of alcohol and/or other drugs, including prescription medication.
3. SUD treatment services may include: withdrawal management services, individual and group SUD counseling in an outpatient setting, residential treatment services, medication assisted treatment, and evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.

4. Services must adhere to current evidence-based industry-standards and guidelines for SUD treatment such as those outlined in the current edition of the American Society of Addiction Medicine's *Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions*, as well as the licensure requirements outlined in Texas Administrative Code Title 25 Chapter 448 pertaining to Standards of Care.

5. SUD treatment services should be integrated or coordinated with treatment for other behavioral health and physical health conditions to the extent permitted by federal and state regulations, including confidentiality and scope of licensure.

6. SUD treatment services must include an individualized treatment plan with clearly defined goals, and indications for discharge, informed by a comprehensive multi-dimensional assessment.

7. The treatment setting and the intensity or level of services will vary depending on the severity of the individual’s SUD and stage of readiness to change. The intensity or level of services refers to number of hours of services per week as well as what types of services the individual receives.

8. SUD treatment services (whether outpatient or residential) may only be delivered in a licensed Chemical Dependency Treatment Facility (CDTF). Medication assisted treatment may also be delivered by appropriately trained physicians, advanced practice registered nurses (APRNs) and Physician Assistants (PAs) in an office setting.

**Early Intervention**

9. Early Intervention services are part of the spectrum of SUD treatment and are a benefit in Texas Medicaid. Early intervention services target individuals who are at risk of developing a substance related problem but may not have a diagnosed SUD. Refer to the *Screening, Brief Intervention, and Referral to Treatment* policy for further information on early intervention services.

**SUD Treatment Services**

**Assessment**

10. Upon admission into a treatment setting, a face-to-face multi-dimensional assessment must be conducted by a qualified credentialed counselor (QCC) or intern as defined in Title 25, Part 1, Chapter 448, Subchapter H, §448.803 to determine a course of treatment that is medically necessary and clinically appropriate.

11. The assessment must be signed off by a QCC.

**Evaluation and Treatment (or Referral) for Co-Occurring Conditions**
12. CDFTs shall facilitate access to physical health, mental health, and ancillary services, if those services are not available through the program, and are necessary to meet treatment goals or client needs.

13. CDTFs shall screen each client for risk for contracting tuberculosis, Hepatitis B and C, HIV antibody and sexually transmitted infections and, as appropriate, provide access to testing and follow up.

14. Testing may be performed on site and billed by the ordering provider if appropriate testing facilities are available that are compliant with the rules and regulations for the Clinical Laboratory Improvement Amendments (CLIA). Providers that do not comply with CLIA are not reimbursed for laboratory services.

Withdrawal Management (Outpatient or Residential)

15. Withdrawal management, also known as detoxification, is the medical and behavioral treatment of patients experiencing withdrawal symptoms as a result of ceasing or reducing substance use.

16. Withdrawal management involving opioids, alcohol, sedatives, hypnotics or anxiolytics will vary depending on the severity of the withdrawal symptoms experienced but will typically involve medications to treat symptoms in addition to supportive care, observation and monitoring.

17. Withdrawal management involving stimulants, inhalants and cannabis typically involves supportive care, observation and monitoring, and medications to treat withdrawal symptoms as required.

18. Withdrawal management may be performed in an outpatient setting for patients experiencing mild to moderate withdrawal symptoms which can be safely managed outside of a residential setting.

19. Withdrawal management in a residential setting may be required for patients with heavy use of substances who have withdrawal symptoms that can be potentially life threatening or cause serious physical harm, or disruptive enough to make outpatient treatment unsuitable.

Individual and Group Counseling (Outpatient)

20. Counseling for substance use disorders is designed to assist individuals in developing a better understanding of their SUD, help to establish treatment goals and plan action toward achieving those goals. Counseling may be done individually or in a group setting with multiple members.

21. Outpatient counseling services are appropriate for individuals:
   
   21.1. with less severe disorders,
   21.2. for those who are in early stages of change,
   21.3. as a step down from more intensive services, or
21.4. For those who are stable but for whom ongoing monitoring is appropriate.

**Note:** for individuals unable or unwilling to access SUD treatment services at a CDTF, psychotherapy delivered by a licensed practitioner of the healing arts may be an alternative treatment option to address a client’s SUD.

**Residential Treatment Services**

22. Residential treatment programs provide a structured therapeutic environment where clients reside and deliver comprehensive substance use disorder treatment. The frequency and duration of services should be based on meeting the client’s needs and achieving the client’s treatment goals.

23. Residential services are appropriate for individuals who require a structured therapeutic environment to stabilize SUD symptoms and develop coping and recovery skills.

24. Residential treatment programs may specialize in the unique needs of a specific population such as adolescents, or pregnant or parenting women with children.

25. Residential treatment may be required for individuals with moderate to severe substance use disorder who are experiencing significant functional impairment across one or more life domains and who:

   25.1. have a co-occurring condition that precludes meaningful participation in a less restrictive level of care or,
   25.2. The individual’s living environment jeopardizes their ability to maintain abstinence in an outpatient treatment setting

26. Residential services may only be delivered by a licensed CDTF.

**Medication Assisted Treatment**

27. Medication assisted treatment (MAT) is the use of FDA-approved medications in combination with behavioral treatment to treat substance use disorders, particularly alcohol and opioid use disorders.

28. MAT treatment may begin early on as part of the withdrawal management process to help reduce withdrawal symptoms and address cravings.

29. Duration of MAT is determined on an individual basis based on the person’s unique needs and treatment goals.

30. Determination of which MAT medication to use is also an individualized treatment decision based on provider assessment and the individual’s needs and treatment goals. Providers are encouraged to offer as many treatment options as possible (within the parameters of their licensing and scope of practice) to maximize patient choice and access to care.
31. MAT may be utilized as part of the service array delivered by outpatient or residential treatment services programs at CDTFs.

32. MAT may also be administered in stand-alone provider settings such as opioid treatment programs (also referred to as narcotic treatment programs) or physicians’ and other qualified health care professionals’ offices where behavioral services are not offered. Referral to behavioral services is recommended as a best practice in those circumstances.

33. Opioid treatment programs that administer methadone or buprenorphine for opioid use disorder must comply with additional federal regulations and licensure requirements.

34. CDTFs or physicians, NPs, & PAs may also administer long acting injectable naltrexone (Vivitrol) to treat cravings associated with either opioid use disorder or alcohol use disorder.

35. Physicians, nurse practitioners and physicians assistants who have received a federal waiver to dispense buprenorphine may choose to incorporate this form of MAT into their medical practice while also providing or referring for other types of treatment services (also referred to as the Office-Based Opioid Treatment Model or OBOT).

36. Certain MAT medications to treat alcohol and opioid use disorders (such as buprenorphine, Disulfiram, Acamprosate and naltrexone), are available as a pharmacy benefit and may be prescribed to individuals by their physician or other qualified health care professionals. See the Vendor Drug Program Formulary for additional information on covered medications.

37. Prescribing of certain MAT medications may be done via telemedicine so long as all other applicable state and federal laws are followed.

38. A prescription for the opioid antagonist naloxone should be given to all individuals receiving treatment for opioid use disorder and instruction should be provided on how to administer if needed.

39. Urinalysis drug screens ordered by physicians, NPs and APRNs to monitor compliance to MAT may be billed by the individually enrolled physician or other qualified health care professionals.

Prior Authorization Requirements

40. Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature, Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are
acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client’s medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients’ responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

41. To complete the prior authorization process by paper, the provider must fax or mail the completed prior authorization request form to the TMHP prior authorization unit and retain a copy of the signed and dated prior authorization form in the client’s medical record.

42. To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the client’s medical record.

43. All prior authorization requests must be completed and signed by a Qualified Credentialed Counselor (QCC).

44. To facilitate determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including documentation for medical necessity for the services requested. The provider must maintain documentation of medical necessity in the client’s medical record.

45. The requesting provider may be asked for additional information to clarify or complete a request.

46. Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

47. Prior authorization will be considered when requested within three business days after the date of admission.

48. The following services do not require prior authorization:
   
48.1. Assessment
48.2. Outpatient treatment services, unless calendar year hours/units are exceeded.
48.3. Medication assisted treatment (MAT)

49. The following services require prior authorization:
   
49.1. Residential withdrawal management services
49.2. Outpatient withdrawal management services
49.3. Residential treatment services
49.4. Outpatient treatment for clients who exceed the benefit limitation (135 units of group services and 26 hours of individual services per calendar year)

50. Prior authorization for outpatient withdrawal management, residential treatment, or residential withdrawal management services, may be considered when requested within three business days after the date of admission.

51. Prior authorization may be considered for clients enrolled in a Medicaid MCO when admitted to SUD services, and whose eligibility changes to fee-for-service during treatment. Requests must be submitted within three business days after the date that fee-for-service eligibility started.

52. Prior authorization for outpatient treatment service extensions may be considered when requested before the services are delivered.

53. Prior authorization requests for extension of services must be received on or before the last date authorized in the initial request. If the last date falls on a holiday or a weekend, the request for an extension is due by 5 p.m. of the next business day.

54. Authorization will be considered for the least restrictive environment appropriate to the client’s medical needs as determined in the client’s plan of care, based on national standards.

Admission Criteria

55. Admission criteria for residential treatment services, and outpatient or residential withdrawal management (detoxification) services follow the existing licensure requirements and standards at Texas Department of Insurance regulations found at 28 TAC, Part 1, Chapter 3, Subchapter HH.

Admission Criteria for Residential Treatment Services:

56. The diagnosis must meet the criteria for substance use disorder, as detailed in the current edition of the DSM

57. All clients must meet the conditions below in order to receive treatment in a residential treatment service program:

57.1. With regards to medical functioning the following must be present:

57.1.1. Documented medical assessment following admission (except in instances in which the client is being referred from an inpatient service) indicates that the client is medically stable and not in acute withdrawal

57.1.2. The client is not bed-confined or has no medical complications that would hamper participation in the residential service
57.2. With regards to family, social, or academic dysfunction and logistic impairments, at least one of the following must be present:

57.2.1. The client manifests severe social isolation or withdrawal from social contacts

57.2.2. The client lives in an environment (social and interpersonal network) in which treatment is unlikely to succeed (e.g., a chaotic family dominated by interpersonal conflict, which undermines client's efforts to change)

57.2.3. Client’s family and/or significant others are opposed to the client’s treatment efforts and are not willing to participate in the treatment process

57.2.4. Family members and/or significant other(s) living with the client manifest current substance use disorders, and are likely to undermine treatment

57.2.5. Logistic impairments (e.g., distance from treatment facility, mobility limitations, etc.) preclude participation in an outpatient treatment setting

57.3. With regards to emotional/behavioral status, the client must meet all three of the following criteria:

57.3.1. Client is coherent, rational, and oriented for treatment

57.3.2. Mental state of the client does not preclude the client’s ability to comprehend and understand the materials presented and participate in rehabilitation/treatment process

57.3.3. There is documentation in the medical record that with continued treatment the client will be able to improve and/or internalize the client’s motivation toward recovery within the recommended length of stay time frames (e.g., becoming less defensive, verbalizing, and working on alcohol and/or drug related issues). Interventions, treatment goals, and/ or contracts are in place to help the client deal with or confront the blocks to treatment (e.g., family intervention, employee counseling confrontation)

57.4. With regards to the recent chemical substance use the client must meet at least one of the following criteria:

57.4.1. The client’s chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so (as long as chemical substances are available)

57.4.2. Virtually all of the client’s daily activities revolve around obtaining, using, or recuperating from the effects of chemical substances and the client requires a secured environment to control the client’s access to chemical substances
58. Adolescents who are 13 through 17 years of age must meet all above admission criteria as well as the following conditions in order to receive treatment in an adolescent residential treatment service program:

58.1. With regards to maturation level the adolescent client must meet both of the following criteria:

58.1.1. The adolescent is assessed as manifesting physical maturation at least in middle adolescent range (i.e., post pubescent; not growth retarded)

58.1.2. The history of the adolescent reflects cognitive development of at least 11 years of age.

58.2. With regards to developmental status the adolescent client must display one of the following:

58.2.1. Documented history of inability to function within the expected age norms despite normal cognitive and physical maturation (e.g., refusal to interact with family members, overt prostitution, felony, or other criminal charges)

58.2.2. A recent history of moderate to severe conduct disorder, as defined in the DSM, or impulsive disregard for social norms and rights of others

58.2.3. Documented difficulty in meeting developmental expectations in a major area of functioning (e.g., social, academic, or psychosexual) to an extent that interferes with the capacity to remain behaviorally stable

Continued Stay Criteria for Residential Treatment

59. One of the following conditions must be present for continued stay in a residential treatment program:

59.1. Chemical dependency rehabilitation/treatment complication:

59.1.1. The client recognizes or identifies with the severity of the alcohol and/or drug problem, but demonstrates minimal insight into the client’s defeating the use of alcohol/drugs. However, documentation in the medical record indicates that the client is progressing in treatment

59.1.2. The client identifies with the severity of their alcohol and/or drug problem and manifests insight into their personal relationship with mood-altering chemicals, yet does not demonstrate behaviors indicating the development of problem solving skills necessary to cope with the problem

59.1.3. The client would predictably relapse if moved to a lesser level of care

59.2. Psychiatric or medical complications:
59.2.1. Documentation in the medical record indicates an intervening medical or psychiatric event, which was serious enough to interrupt rehabilitation/treatment, but the client is again progressing in treatment.

59.2.2. Documentation in the medical record indicates that the client is being held pending an immediate transfer to a psychiatric, acute medical service, or inpatient withdrawal management alcohol/drug service.

59.3. Withdrawal management services:

59.3.1. Withdrawal management services may be authorized for up to 21 days. The level of service and number of days authorized will be based on the substance(s) of abuse, level of intoxication and withdrawal potential, and the client’s medical needs.

Admission criteria for residential withdrawal management (detoxification) services:

60. An individual is considered eligible for admission to a residential withdrawal management service when they have two previous unsuccessful individual treatment episodes of outpatient withdrawal management or meets the criteria for the definition of substance use with withdrawal or intoxication, as detailed in the most current edition of the DSM.

60.1. With regards to other factors for admission to residential withdrawal management the client must meet at least one of the following criteria:

60.1.1. Impaired neurological functions as evidenced by:

60.1.2. Extreme depression (e.g., suicidal)

60.1.3. Altered mental state with or without delirium as manifested by disorientation to self, alcoholic hallucinosis, toxic psychosis, altered level of consciousness, as manifested by clinically significant obtundation, stupor, or coma.

60.1.4. History of recent seizures or past history of seizures on withdrawal.

60.1.5. The presence of any presumed new asymmetric and/or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb incoordination).

60.1.6. Unstable vital signs combined with a history of past acute withdrawal syndromes, that are interpreted by a physician to be indication of acute alcohol/drug withdrawal.
60.1.7. Evidence of coexisting serious injury or systemic illness, newly discovered or progressive

60.1.8. Clinical condition (e.g., agitation, intoxication, or confusion) that prevents satisfactory assessment of the above conditions, indicating placement in residential withdrawal management service may be justified

60.1.9. Neuropsychiatric changes of a severity and nature that place the client at imminent risk of harming self or others (e.g., pathological intoxication or alcohol idiosyncratic intoxication, etc.)

60.1.10. Serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains arrhythmia, or hypotension

60.2. With regards to medical complications the individual must present a documented condition or disorder, which in combination with alcohol and/or drug use, presents a determined health risk (e.g., gastrointestinal bleeding; gastritis; anemia, severe; diabetes mellitus, uncontrolled; hepatitis; malnutrition; cardiac disease, hypertension, etc.).

60.3. With regards to major psychiatric illness the individual must meet at least one of the following conditions:

60.3.1. Documented DSM condition or disorder, which, in combination with alcohol and/or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the individual

60.3.2. Severe neurological and psychological symptoms: (e.g., anguish; mood fluctuations; overreactions to stress, lowered stress tolerance; impaired ability to concentrate; limited attention span; high level of distractibility; extreme negative emotions; extreme anxiety)

60.3.3. Danger to others and/or homicidal

60.3.4. Uncontrolled behavior endangering self or others, or documented neuropsychiatric changes of a severity and nature that place the individual at imminent risk of harming self or others

60.3.5. Mental confusion and/or fluctuating orientation

Continued Stay Criteria for Residential Withdrawal Management (Detoxification) Services

61. Eligibility for continued stay for residential withdrawal management services is based on the client meeting at least one of the criteria for chemical substance withdrawal, major medical complications, and major psychiatric complications.
62. With regards to chemical substance withdrawal complication the client must exhibit one of the following:

62.1. Incomplete medically stable withdrawal from alcohol/drugs, as evidenced by documentation of:
   62.1.1. Unstable vital signs
   62.1.2. Continued disorientation
   62.1.3. Abnormal laboratory findings related to chemical dependency
   62.1.4. Continued cognitive deficit related to withdrawal with the deficit affecting the client’s ability to recognize alcohol/drug use as a problem; or
   62.1.5. Laboratory finding, which, in the judgment of a physician, indicates that a drug has not sufficiently cleared the client’s system

62.2. With regards to major medical complications:
   62.2.1. Documentation in the medical record must indicate that a medical condition or disorder (e.g., diabetes mellitus, uncontrolled) continues to present a health risk and is actively being treated.

62.3. With regards to major psychiatric complication the following must be present:
   62.3.1. Documentation in the medical record that a psychiatric condition or disorder, which in combination with alcohol/drug use, continues to present a major health risk, is actively being treated
   62.3.2. Documentation in the medical record that severe neurological and/or psychological symptoms have not been satisfactorily reduced but are actively being treated

Admission Criteria for Outpatient Withdrawal Management (Detoxification) Services

63. An individual is considered eligible for treatment in an outpatient withdrawal management service when the individual’s diagnosis meets the criteria for the definition of substance use disorder, as detailed in the most current edition of the DSM.

63.1. The client meets all of the following conditions:
   63.1.1. Chemical substance withdrawal
   63.1.2. The individual is expected to have a stable withdrawal from alcohol/drugs
63.2. With regards to medical functioning the client must meet all the following criteria:

63.2.1. No history of recent seizures or past history of seizures on withdrawal

63.2.2. Lacks clinical evidence of altered mental state as manifested by disorientation to self, alcoholic hallucinations, toxic psychosis, or altered level of consciousness (clinical significant obtundation, stupor, or coma)

63.2.3. The symptoms are due to withdrawal and not due to a general medical condition. Absence of any presumed new asymmetric and/or focal findings (i.e., limb weakness, clonus, spasticity, unequal pupils, facial asymmetry, eye ocular movement paresis, papilledema, or localized cerebellar dysfunction, as reflected in asymmetrical limb coordination)

63.2.4. The client must have vital signs interpreted by a physician to be stable, without a previous history of complications from acute chemical substance withdrawal, and judged to be free of a physician-determined health risk

63.2.5. The client has no evidence of a coexisting serious injury or systemic illness, newly discovered or progressive in nature

63.2.6. Absence of serious disulfiram-alcohol (Antabuse) reaction with hypothermia, chest pains, arrhythmia, or hypotension

63.2.7. The client’s clinical condition allows for a comprehensive and satisfactory assessment

63.3. With regards to family, social, academic dysfunction the client must meet at least one of the following criteria:

63.3.1. The client’s social system and significant others are supportive of recovery to the extent that the client can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the client’s substance use disorder.

63.3.2. The client’s family and/or significant others are willing to participate in the outpatient withdrawal management program

63.3.3. The client may or may not have a primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system and/or to become involved in a self-help fellowship

63.3.4. The client does not live in an environment where licit or illicit mood altering substances are being used (an individual living in
an environment where licit or illicit mood altering substances are being used may not be a candidate for this level of care)

63.4. With regards to emotional/behavioral status the client must meet all of the following criteria:

63.4.1. Client is coherent, rational, and oriented for treatment

63.4.2. Mental state of the client does not preclude the client’s ability to comprehend and understand the materials presented, and participate in the outpatient withdrawal management process

63.4.3. There is documentation in the medical record that the client expresses an interest to work toward outpatient withdrawal management treatment goals

63.4.4. Client has no neuropsychiatric condition that places them at imminent risk of harming self or others (e.g., pathological intoxication, alcohol idiosyncratic intoxication)

63.4.5. Client has no neurological, psychological, or uncontrolled behavior that places the individual at imminent risk of harming self or others (depression, anguish, mood fluctuations, overreactions to stress, lower stress tolerance, impaired ability to concentrate, limited attention span, high level of distractibility, negative emotions, or anxiety)

63.4.6. Client has no documented psychiatric condition or disorder, which in combination with alcohol and/or drug use, compounds a pre-existing or concurrent emotional or behavioral disorder and presents a major risk to the client

63.4.7. The client has no mental confusion and/or fluctuating orientation

63.5. With regards to recent chemical substance use: the client must meet the criteria in at least one of the following conditions:

63.5.1. The client’s chemical substance use is excessive, and the client has attempted to reduce or control it, but has been unable to do so (as long as chemical substances are available)

63.5.2. The client is motivated to stop using alcohol/drugs, and is in need of a supportive structured treatment program to facilitate withdrawal from chemical substances

_Outpatient Withdrawal Management (Detoxification) Services Extensions:_

64. A client is considered eligible for continued stay in the outpatient withdrawal management treatment service when the client meets at least one of the conditions:
64.1. With regards to chemical substance withdrawal complications the client must meet one of the following conditions:

- 64.1.1. Client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by psychological and physical cravings
- 64.1.2. Client, while physically abstinent from chemical substance use, is exhibiting incomplete stable withdrawal from alcohol/drugs, as evidenced by significant drug levels

64.2. With regards to psychiatric or medical complications the client must meet the following conditions:

- 64.2.1. Documentation in the medical record indicates an intervening medical or psychiatric event, which was serious enough to interrupt outpatient withdrawal management services, but the client is again progressing in treatment

65. Prior authorization for outpatient treatment services beyond the annual limitation of 135 hours of group services and 26 hours of individual services per calendar year, may be considered with documentation of the supporting medical necessity for continued treatment services

66. Requests must be submitted prior to providing the extended services. The documentation must include the following information:

- 66.1. The client is meeting treatment goals
- 66.2. The client demonstrates insight and understanding into relationship with mood altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationship without the use of mood-altering chemicals
- 66.3. The client is physically abstinent from chemical substance use, but remains mentally preoccupied with such use to the extent that the client is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the client will effectively address these issues
- 66.4. Documentation may be considered that other psychiatric or medical complications exists that affect the client’s treatment, but the client continues to show treatment progress and there is evidence to support the benefits of continued treatment

**Documentation Requirements**

67. In addition to documentation requirements outlined in the “Prior Authorization Requirements” section of this policy, the following requirements apply:

- 67.1. All services outlined in this policy are subject to retrospective review to ensure that the documentation in the client’s medical record supports the medical necessity of the service(s) provided

**Reimbursement/Billing Guidelines**
The following procedure codes may be reimbursed for Substance Use Disorder services:

**Table A: Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0001</td>
<td>Comprehensive assessment</td>
<td>Once per episode of care</td>
</tr>
<tr>
<td>H0016, H0050, S9445</td>
<td>Outpatient Withdrawal Management (detoxification)</td>
<td>Up to 21 days per episode of care</td>
</tr>
<tr>
<td>H0012, H0031, T1007, S9445</td>
<td>Residential Withdrawal Management (detoxification)</td>
<td>Up to 21 days per episode of care</td>
</tr>
<tr>
<td>H0004</td>
<td>Individual counseling, per 15 minutes</td>
<td>104 units per calendar year</td>
</tr>
<tr>
<td>H0005</td>
<td>Group counseling by a clinician</td>
<td>135 units per calendar year</td>
</tr>
<tr>
<td>H2035</td>
<td>Residential treatment services</td>
<td>Up to 35 days per episode of care</td>
</tr>
<tr>
<td>H0047</td>
<td>Room and board</td>
<td>For adults only</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone administration and/or service (provision of the drug by a licensed program)</td>
<td>Medication Assisted Treatment (methadone). Must be submitted with a modifier (UA or U1)</td>
</tr>
<tr>
<td>H2010</td>
<td>Comprehensive medication services</td>
<td>Medication Assisted Treatment (oral buprenorphine). Must be submitted with a modifier (UA or U1)</td>
</tr>
<tr>
<td>J0570</td>
<td>Buprenorphine implant</td>
<td>Medication Assisted Treatment. Ordering physician/PA/APRN must be separately enrolled in Medicaid even when CDTF is the billing provider</td>
</tr>
<tr>
<td>J2315</td>
<td>Vivitrol</td>
<td>Medication Assisted Treatment. Ordering physician/PA/APRN must be separately enrolled in Medicaid even when CDTF is the billing provider</td>
</tr>
</tbody>
</table>
Q9991 Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg Medication Assisted Treatment. Ordering physician/PA/APRN must be separately enrolled in Medicaid even when CDTF is the billing provider.

Q9992 Injection, buprenorphine extended-release (sublocade), greater than 100 mg Medication Assisted Treatment. Ordering physician/PA/APRN must be separately enrolled in Medicaid even when CDTF is the billing provider.

Table B: Modifiers for Medication Assisted Treatment (H0020 and H2010)

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Use for</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA</td>
<td>Face to face administration of MAT</td>
</tr>
<tr>
<td>U1</td>
<td>Take home doses of MAT</td>
</tr>
</tbody>
</table>

69. Reimbursement for procedure codes H0004 and H0005 is limited to the following diagnosis codes:

Table C: Diagnosis Codes – Individual and Group Counseling services

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>F1010 F1011 F10120 F10121 F10129 F1014 F10150 F10151</td>
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<tr>
<td>F10159 F10180 F10181 F10182 F10188 F1019 F1020 F1021</td>
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<td>F10220 F10221 F10229 F10230 F10231 F10232 F10239 F1024</td>
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<td>F10250 F10251 F10259 F1026 F1027 F10280 F10281 F10282</td>
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<td>F10288 F1029 F10920 F10921 F10929 F1094 F10950 F10951</td>
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<tr>
<td>F10959 F1096 F1097 F10980 F10981 F10982 F10988 F1099</td>
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<td>F1110 F1111 F11120 F11121 F11122 F11129 F1114 F11150</td>
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<td>F11151 F11159 F11181 F11182 F11188 F1119 F1120 F1121</td>
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<td>F11982 F11988 F1199 F1210 F1211 F12120 F12121 F12122</td>
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<td>Diagnosis Codes</td>
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<td>F16959</td>
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</tbody>
</table>
70. A comprehensive assessment (H0001) is limited to once per day, any provider. An assessment is also limited to once per episode of care and should be performed at the start of each new episode of care.

71. Outpatient treatment is limited to 26 hours of individual counseling (H0004) and 135 units of group counseling (H0005) per calendar year, any provider. Providers may submit requests for individuals requiring additional services via the Outpatient Substance Use Disorder Counseling Extension request form.

72. Group counseling sessions are limited to 16 individuals total per session.

73. Outpatient treatment (procedure codes 9-H0004 and 9-H0005) will be denied if billed on the same date of service as residential withdrawal management or residential treatment services, any provider.

74. Outpatient withdrawal management may be reimbursed on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the client’s treatment plan.

75. Residential withdrawal management and treatment services are considered outpatient services for the purposes of reimbursement and should be billed accordingly.
76. Residential withdrawal management services (procedure codes 1-H0031, 1-T1007, 1-H0012, and 1-S9445) are limited to once per day, any provider.

77. Residential withdrawal management services (procedure codes 1-H0031, 1-T1007, 1-H0047, or 1-S9445) will be denied if billed without procedure code 1-H0012 on the same day, same provider.

78. Room and board (procedure code 1-H0047) for residential withdrawal management and treatment services is limited to once per date of service, any provider. Procedure code 1-H0047 is reimbursed for clients who are 21 years of age and older as an access based fee, and as an informational detail for clients who are 20 years of age or younger.

79. Procedure code 1-H0047 will be denied if billed without procedure code 1-H0012 or 1-H2036 on the same day, same provider.

80. Residential treatment services (procedure code 1-H2036) are limited to one per day, any provider.

81. Each episode of residential treatment is limited to 35 days. Individuals may receive up to 2 episodes per rolling 6 month period and up to 4 episodes per rolling 12 month period. Providers may submit authorization requests for individuals who require additional episodes within the 6 or 12 month time frame utilizing the Residential Substance Use Disorder Treatment Request form.

82. Outpatient withdrawal management services (procedure codes 1-H0016, 9-H0050, and 1-S9445) are limited to once per day, any provider.

83. Outpatient withdrawal management services may be reimbursed on the same date of service as outpatient SUD treatment (H0004 and H0005) by the same or different provider when medically necessary and identified in the client’s treatment plan.

84. Outpatient withdrawal management services are limited to once per day, any provider.

85. Outpatient withdrawal management will be denied if billed without procedure code 1-H0016 on the same day, same provider.

86. Outpatient and residential withdrawal management services are limited to 21 days per episode of care. Providers may submit requests for services using the Outpatient Withdrawal Management Authorization Request form or the Residential Withdrawal Management Authorization Request form.

87. Medication assisted treatment (H0020, H2010, J0570, J3215, Q9991, Q9992) is separately payable from withdrawal management and treatment services in either outpatient or residential settings.
88. Claims billed for MAT must include the client's substance use disorder diagnosis.

89. MAT billed using either procedure code 1-H0020 or 1-H2010 is limited to once per date of service, any provider, except for unsupervised take home (U1 modifier), and is reimbursed at a fixed daily rate.

90. MAT administration (procedure code 1-H0020 or 1-H2010) for opioid use disorder must be submitted with the following modifiers:
   
   90.1. When MAT is administered with supervision in a facility the provider must submit claims using the UA modifier to indicate the facility administered doses
   
   90.2. When MAT is administered without supervision as a take home dose the provider must submit claims using the U1 modifier to indicate take home doses

91. MAT administration (procedure code 1-H0020 or 1-H2010) with modifier U1 for unsupervised take home doses must be submitted on the same claim, by the same provider, and with the same date of service as MAT administration (procedure code 1-H0020 or 1-H2010) with modifier UA for supervised facility doses or the take home doses will be denied.

92. MAT administration (procedure code 1-H0020 or 1-H2010) submitted without a modifier will be denied.

93. Reimbursement for procedure codes 1-H0020/U1 and 1-H2010/U1 is limited to a quantity of 30 per 30 days, any provider.

94. Medical services may be reimbursed separately using the appropriate evaluation and management procedure codes.

95. Inpatient hospital-based withdrawal management is reimbursed by the reimbursement methodology specific to the inpatient hospital. Separate reimbursement may be provided for physician services performed during an inpatient stay.

**Exclusions**

96. SUD treatment services for tobacco use disorder as the primary diagnosis are not a covered benefit, although a comprehensive SUD treatment approach should address tobacco use if reducing or eliminating this substance is part of the patient’s treatment goal.

**Note:** Tobacco cessation counseling is a covered benefit for pregnant women. Further information can be found in the Obstetric Services Policy.

97. SUD treatment services may not be delivered via telemedicine or telehealth, with the exception of prescribing MAT medications via telemedicine.