COMPREHENSIVE SUBSTANCE TREATMENT & REHABILITATION/ AMERICAN SOCIETY OF ADDICTION MEDICINE PROGRAM MANUAL

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Introduction

MO HealthNet Division (MHD) provides coverage for Comprehensive Substance Treatment and Rehabilitation (CSTAR), an outpatient substance use disorder (SUD) treatment program. Coverage is targeted to individuals eligible for MHD benefits who are assessed as needing SUD treatment. Services include, but are not limited to assessment, treatment and community support. Services are provided based on a diagnosis from a qualified physician or licensed mental health professional (LMHP). Reimbursement by MHD is limited to qualified MO HealthNet-enrolled CSTAR providers. Additional detail is found in **9 CSR 30-3.032** through **9 CSR 30-3.192**, as well as clinical bulletins or other guidance documents issued by the Department of Mental Health (DMH), Division of Behavioral Health (DBH) **DMH Information for Providers**.

Effective July 1, 2022, CSTAR services were approved by the Centers for Medicare and Medicaid Services (CMS) to be provided in accordance with the American Society of Addiction Medicine (ASAM) Criteria. The following ASAM levels of care are covered under the MO HealthNet program. Service definitions, staffing, assessment, treatment planning, and other requirements for each level of care are included in this manual.

Level of Care	Description
Level 0.5	Early intervention
Level 1	Outpatient services
Level 1	Opioid treatment services (OTP)
Level 1-WM	Ambulatory withdrawal management without extended on-site monitoring
Level 2.1	Intensive outpatient services
Level 2-WM	Ambulatory withdrawal management without extended on-site monitoring
Level 2-WM-EM	Ambulatory withdrawal management with extended on-site monitoring
Level 2.5	Partial hospitalization services
Level 3.1	Clinically managed low intensity residential services
Level 3.2-WM	Clinically managed residential withdrawal management
Level 3.3	Clinically managed population specific high intensity residential services
Level 3.5	Clinically managed high intensity residential services
Level 3.5	Clinically managed high intensity residential services (women and children)
Level 3.7	Medically monitored intensive inpatient services
Level 3.7-WM	Medically monitored inpatient withdrawal management

Section 1: Reimbursement Methodology

1.1 The Basis for Establishing a Rate of Payment

The MO HealthNet Division (MHD) establishes and administers the payment rates for medical services covered by the Missouri Title XIX Program. MHD sets a payment rate to meet the following goals:

- Ensures access to quality medical care for all participants by encouraging an adequate number of providers
- Allows for no adverse impact on private-pay patients
- Assures a reasonable rate to protect the interests of the taxpayers
- Provides incentives that encourage efficiency on the part of medical providers

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover costs. The funding amount from the federal government is based on a percentage of allowable expenditures. The percentage varies from program to program and some services within the same program may have different percentages. Funding from the federal government ranges from 60% to 90%; depending on the service or program. State general revenue appropriated funds make up the balance of allowable expenditures, from 10% to 40%.

Under a **Fee Schedule** each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable rate established. In determining what this rate should be, MHD considers the following information when applicable:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders
- Medicare's allowable reasonable and customary charge payment or cost-related payment
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public.

MHD then determines a maximum allowable rate for the service based upon all applicable information and current appropriated funds.

Total expenditures for MHD must be within the appropriation limits established by the General Assembly. If the expenditures exceed the appropriation limits set and funds are insufficient to pay the total amount, payment for services may be reduced pro rata in proportion to the deficiency.

1.2 Comprehensive Substance Treatment and Rehabilitation Services

Reimbursement for Comprehensive Substance Treatment and Rehabilitation (CSTAR) services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by MHD to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service) or the maximum allowable per unit of service.

1.3 Fee Schedule

The **Fee Schedule** identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The Fee Schedule is updated monthly and is intended as a reference not a guarantee for payment.

The **Fee Schedule** can be searched for a specific procedure code or it can be downloaded. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are not necessarily provider specific.

Section 2: Benefits and Limitations

2.1 Provider Participation

The Department of Mental Health (DMH), through an interagency agreement with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC) Unit, reviews all requests for participation in the Comprehensive Substance Treatment and Rehabilitation/American Society of Addiction Medicine (CSTAR/ASAM) Program and provides validation of the applicant's certification status to MMAC. MMAC, based upon review of the application and certification by DMH, approves or denies the application request.

To participate in the MHD CSTAR/ASAM program, the organization must satisfy the following requirements:

- Be certified as a CSTAR provider by DMH in accordance with **9 CSR 10-7.010** through **9 CSR 10-7.140**, **9 CSR 10-5.190** through **9 CSR 10-5.230**, and **9 CSR 30-3.032** through **9 CSR 30-3.192**, and submit a copy of their current DMH certification with the enrollment forms. In order to receive federal funds and participate in the MHD Program, all providers must comply with all applicable state and federal laws including, but not limited to, civil rights and regulations in the delivery of services. It is the provider's responsibility to review the **civil rights information**.
- Complete necessary provider enrollment documents and agreements required by MMAC. These documents can be requested by e-mailing the **MMAC Provider Enrollment Section**.
- Agree to maintain auditable program records reflecting services provided, individuals' progress in treatment, number of individuals served and related demographic information, and other relevant program records for six (6) years or if a minor, three (3) years after the individual reaches legal age as determined by Missouri law, or longer if specified by a contract with DMH.
- Allow DSS or its authorized representatives (such as MMAC, DMH) to inspect and examine its premises and records related to the provision of services under this program.
- Employ and retain qualified staff to render the services covered through the MHD CSTAR/ASAM Program or any additional federal or state regulations.

Additional information regarding conditions of participation can be found in the **General Sections Manual**.

2.2 Participant Eligibility

The participant must have MHD coverage for each date a service is rendered in order for reimbursement to be made to a provider.

The state-funded Medicaid Eligibility (ME) codes not eligible to receive CSTAR benefits are as follows:

ME Code	Description	ME Code	Description
02	Blind Pension	64	Group Home – Health Initiative Fund (State Placement)
08	Child Welfare Services-Foster Care	65	Group Home – Health Initiative Fund – (Parent/Guardian Placement)
52	Division of Youth Services – General Revenue	82	Missouri Rx (Medicare Part D wrap-around benefits)
57	Child Welfare Services – Foster Care – Adoption Subsidy	0F	Foster Care – IMD Placement
59	Presumptive Eligibility (Non-Subsidized)	5A	Adoption Sub-Guardianship IMD Placement

The ME codes with restricted benefit packages not eligible to receive CSTAR benefits are as follows:

ME Code	Description	ME Code	Description
55	Qualified Medicare Beneficiary (QMB)	82	Missouri Rx (Medicare Part D wrap-around benefits)
58	Presumptive Eligibility (Subsidized)	89	Uninsured Women's Health Services
59	Presumptive Eligibility (Non-Subsidized)	94	Show-Me Healthy Babies – Presumptive Eligibility Income to 300%
80	Extended Women's Health Services		

2.3 Participant Copay

Services of the CSTAR program do not require a copay amount.

2.4 Adequate Documentation

Documents retained by CSTAR providers must include the treatment plan and clinical records. Information must be sufficient to disclose the actual provider of the service, quantity, quality, appropriateness and timeliness of services provided under the agreement.

Time spent documenting service interventions, when it is done collaboratively with the participant during the course of the service activity/intervention is considered billable time. Collaborative documentation occurs when the individual is engaged with the service provider/practitioner and this process is integrated into the service session. It is done collaboratively with the individual and involves sharing the assessment, treatment plan or documentation with the individual as it is being written by the service provider to assure a consistent understanding as to what was accomplished during the service session.

Collaborative documentation is not typing or writing notes throughout a treatment session or taking time at the end of a session to write a note in front of an individual who is waiting to leave and is uninvolved. The individual must be actively involved and engaged in writing the note, including seeing and contributing to the note. Providers utilizing collaborative documentation must implement policies and procedures regarding its use.

For additional information relating to adequate documentation, please reference the **General Sections Manual**.

Documentation Requirements

Reimbursement for each date of service requires the following documentation be present in the individual's medical/clinical record:

- First name, last name and middle initial or date of birth of the MO HealthNet participant.
- MO HealthNet participant's identification number (DSS Departmental Client Number-(DCN))
- An accurate, complete and legible description of each service(s) provided
- Name, title, credential and signature with date of the MHD enrolled provider delivering the service. Services provided by an individual under the direction or supervision of a MHD provider are not reimbursed by MHD. Services provided by a person not enrolled with MHD are not reimbursed by MHD
- Name of the referring entity, when applicable
- Date of service (month/day/year)
- For MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s), the actual begin and end time taken to deliver the service (***Example***, 4:00 p.m. – 4:30 p.m.) must be documented. When billing Medication Services using Current Procedural Terminology (CPT) Evaluation/Management (E/M) procedure codes, clock time is not required unless the provider spends over 50% of the time on counseling and/or care coordination and uses the actual clock time as the key factor to determine which E/M code to bill.
- Setting in which the service was rendered
- Plan of treatment, evaluation(s), test(s), findings, results and prescription(s), as necessary. The individual treatment plan must be approved and signed by a licensed diagnostician.
- Need for the service(s) in relationship to the MO HealthNet participant's treatment plan
- MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes)
- For applicable programs, adequate invoices, trip tickets/reports, activity log sheets

The requirements listed above represent minimal elements for maintaining adequate documentation required by MHD. Additional documentation may be needed to satisfy the requirements of outside reviews or delivery of a specific CSTAR service. If additional documentation is required for a specific service, it will be included with the service description in this manual.

Employee records (excluding health records) and training records of staff shall be maintained in a separate location from the medical/clinical records of individuals receiving services.

2.5 Enrollment and Billing

To be eligible for reimbursement of services delivered, the provider must enroll the individual for CSTAR services by inputting required information into the DMH Customer Information, Management and Outcomes Reporting System (CIMOR).

All billings to the MHD for MHD eligible CSTAR services are electronically submitted to DMH through the CIMOR. Billing information is electronically submitted by DMH to MHD for processing and reimbursement.

2.6 Authorization of Comprehensive Substance Treatment and Rehabilitation Services

All providers of services for which Title XIX Medicaid funding is requested, must receive authorization from DMH to provide CSTAR services. CSTAR services must meet all criteria established in this section to be eligible for reimbursement. Reference the **General Sections Manual** for additional information.

2.7 General Limitations

The following general limitations apply to all MHD services provided through the CSTAR program:

- Must be medically necessary*; and the service must relate to the diagnosis of a SUD, or in the case of withdrawal management services, the diagnosis of alcohol and/or drug intoxication, or withdrawal
- Must be rendered by or under the direction or recommendation of a physician or licensed mental health professional (LMHP) who participates in the development and approval of the treatment plan
- Must be rendered by appropriate and qualified staff as specified in **Section 2.8** and as specified elsewhere in this manual
- Must be reasonable for the treatment of an individual's specific SUD diagnosis
- When applicable, all other payers such as the Veterans Administration and third party insurance, must be billed prior to billing MHD
- CSTAR services are not covered by MHD for individuals who are receiving psychiatric inpatient hospital treatment or who are residents of a MHD participating nursing facility, however, services are covered on the day of admission and the day of discharge from those types of settings
- Services are not covered for individuals who are receiving inpatient hospital treatment for a physical health condition
- Services are not covered for individuals who are incarcerated in a public institution, such as county jail, juvenile detention setting or an institution for mental diseases

*Medically necessary means health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

2.8 Qualified Providers of Comprehensive Substance Treatment and Rehabilitation /American Society of Addiction Medicine Services

The following are qualified providers of CSTAR Services and a description of each.

Adolescent Treatment Team

A physician, registered nurse (RN) or licensed practical nurse (LPN), qualified addiction professional (QAP), qualified mental health professional (QMHP), associate substance use counselor, community support specialist (CSS), group rehabilitation support specialist and treatment technicians.

Advanced Practice Registered Nurse

An RN certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified nurse anesthetist or a certified clinical nurse specialist under Missouri law.

Assistant Physician

An individual licensed under Missouri law who performs tasks that might otherwise be performed by a licensed physician.

Associate Substance Use Counselor

A trainee that meets the requirements set forth by the Missouri Credentialing Board (MCB) or the appropriate board of professional registration within the Department of Insurance, Financial Institutions and Professional Registration.

Associate substance use counselors must be supervised by a QAP who has completed the MCB Clinical Supervision training. Clinical supervision must focus on enhancing the quality of treatment delivered by improving the counseling skills, competencies and effectiveness of persons supervised. All counselor functions performed by an associate substance use counselor are performed pursuant to the supervisor's control, oversight, guidance and full professional responsibility.

Documentation that must be countersigned includes treatment plans, treatment plan updates and discharge summaries.

Certified Family Support Provider

A family member of an individual (17 years of age and younger) who had or currently has a behavioral/emotional disorder or a SUD and has a high school diploma or equivalent certificate, is certified by the MCB and is supervised a QAP or QMHP.

Certified Peer Specialist

An individual who is in recovery from mental illness and/or SUD with at least a high school diploma or equivalent certificate and is certified by the MCB. Certified peer specialists must be supervised by QMHP or QAP.

Community Support Specialist

An individual meeting one (1) of the following qualifications:

- QMHP as defined in this manual
- QAP as defined in this manual
- Bachelor's degree in a human services field from a college or university included in the U.S. Department of Education's database of accredited schools at **http://ope.ed.gov/accreditation**
- Any four (4) year degree and two (2) years of qualifying experience
- Any four (4) year combination of higher education and qualifying experience
- Four (4) years of qualifying experience
- Associate of Applied Science in Behavioral Health Support degree from an approved institution

Qualifying experience must include delivery of services to individuals with mental illness, SUDs or intellectual and/or developmental disabilities (IDD). Experience must include at least one (1) of the following:

- Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus
- Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance use issues while encouraging the use of natural resources
- Supporting individuals in their efforts to find and maintain housing, employment, and/or to function appropriately in family, school and community settings
- Assisting individuals to achieve the goals and objectives on their individual treatment plan

CSSs must complete the necessary orientation and training requirements specified by the DMH and must be supervised by one (1) of the following:

- QAP
- QMHP
- Staff meeting the qualifications of a CSS with at least three (3) years of population- specific experience providing community support services in accordance with the key service functions specified in **9 CSR 30-3.157**.

It is the responsibility of the provider to clearly document how the employee meets qualifications based on the above criteria.

Group Rehabilitation Support Specialist

An individual who:

- Is suited by education, background, knowledge or experience to present the information being discussed
- Demonstrates competency and skill in facilitating group discussion

Group rehabilitation support specialists must be supervised by a QAP or QMHP.

Licensed Mental Health Professional (for Diagnosis)

A licensed mental health professional (LMHP) is one of the following:

- A physician (including psychiatrist) licensed or provisionally licensed under Missouri law to furnish services within their scope of practice
- A psychologist licensed or provisionally licensed under Missouri law to furnish services within their scope of practice
- A resident physician, including resident psychiatrist
- A professional counselor licensed or provisionally licensed under Missouri law to practice counseling
- A clinical social worker licensed or provisionally licensed under Missouri law to practice social work
- A master social worker (LMSW) under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker (LCSW)
- A marital and family therapist licensed or provisionally licensed under Missouri law to provide marriage and family services
- APRN, an RN who is currently recognized by the Board of Nursing as an APRN
- A licensed assistant physician under Missouri state law
- A licensed physician assistant under Missouri state law

These professions are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scope of practice for each. However, individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual level of competence.

Licensed Practical Nurse

A person licensed as an LPN under Missouri law to furnish services within their scope of practice.

Marital and Family Therapist

A person licensed or provisionally licensed under Missouri law to furnish services within their scope of practice.

Certified Medical Assistant

A certified medical assistant (CMA) performs duties under the direction of medical staff related to the health and wellness of individuals who are ill or otherwise require assistance. A CMA must have a high school diploma or equivalent, complete medical assistant training and obtain certification.

Paramedic

A person trained to assist a physician or give first aid or other healthcare in the absence of a physician, within their scope of practice. The individual must be on the National Registry of Emergency Medical Technicians (NREMT) and complete an EMT training program from a state-approved training college or institute. Paramedics may be utilized to provide withdrawal management and residential services.

Physician

A person licensed as a physician under Missouri law to furnish services within their scope of practice.

Physician Assistant

A person who has graduated from a physician assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants to provide health care services delegated by a licensed physician under Missouri law.

Program Director

An individual who oversees all behavioral health treatment services for a program and, at a minimum, possesses a master's degree and has at least three (3) years of full-time experience in the treatment of substance use disorders.

NOTE: Providers may retain non-master's level clinical supervisors and/or program directors who are currently employed in these positions. Should natural attrition occur such that a non-master's level clinical supervisor and/or program director position becomes vacant in the future, providers will be expected to fill the position with a master's level supervisor.

If a program director provides direct services, they must meet the staff qualifications and service delivery requirements specified in this manual.

Psychiatrist

A licensed physician who is a psychiatrist and delivers services within their scope of practice.

Psychologist

A person licensed or provisionally licensed under Missouri law to furnish services within their scope of practice.

Qualified Addiction Professional

One (1) of the following:

- A physician (including psychiatrist) licensed or provisionally licensed under Missouri law

- An individual who meets the applicable training and credentialing required by the MCB for any of the following positions:
    - Certified Alcohol and Drug Counselor (CADC)
    - Certified Reciprocal Alcohol and Drug Counselor (CRADC)
    - Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC)
    - Certified Criminal Justice Addictions Professional (CCJP)
    - Registered Alcohol Drug Counselor-Provisional (RADC-P)
    - Registered Alcohol Drug Counselor (RADC)
    - Co-Occurring Disorder Professional (CCDP)
    - Co-Occurring Disorders Professional Diplomat (CCDP-D)

Qualified Mental Health Professional

Meets one (1) of the following:

- Licensed or provisionally licensed as a physician (including psychiatrist) under Missouri law to furnish services within their scope of practice
- Licensed or provisionally licensed as a psychologist under Missouri law to furnish services within their scope of practice
- Resident physician including resident psychiatrist
- Professional counselor licensed or provisionally licensed under Missouri law to practice counseling
- Clinical social worker with a Master's degree in social work from a college or university listed in the U.S. Department of Education's database of accredited schools **http://ope.ed.gov/accreditation**
- Master's degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, social work, family therapy or related field and has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional
- Occupational therapist certified by the National Board for Certification in Occupational Therapy registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting, or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting, or has one (1) year of experience in a psychiatric setting
- Licensed assistant physician under Missouri law
- Licensed physician assistant under Missouri law
- APRN
- Psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy, board-certified pharmacist (BCPP) through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psychopharmacology residency where the service has been supervised by a board-certified psychiatric pharmacist

- A psychiatric nurse, a registered professional nurse licensed under **Chapter 335, RSMo**, with at least two (2) years of experience in a psychiatric or SUD treatment setting or a Master's Degree in Psychiatric Nursing

Registered Nurse

An individual licensed as an RN under Missouri law to furnish services within their scope of practice.

Resident Physician

A medical school graduate and doctor in training who is taking part in a graduate medical education (GME) program.

Substance Use Recovery Aide

A substance use recovery aide has completed specific training related to withdrawal management and who provides continuous supervision and ensures safety of individuals receiving care. Substance use recovery aides are supervised by nursing staff on duty in the withdrawal management setting.

Treatment Technician

An individual suited by education, background or experience who is under the supervision of a QMHP or a QAP, and meets the following minimum requirements:

- Has received training on the topics being presented
- Demonstrates competency and skill in educational techniques

2.9 Comprehensive Substance Treatment and Rehabilitation /American Society of Addiction Medicine Staffing Requirements

All programs must meet the staff requirements specified in this section. Detailed information is located on the Division of Behavioral Health website: **ASAM Minimum Staffing Requirements**.

Telemedicine is considered a face-to-face service. Services in all levels of care may be provided via telemedicine, including individual services within residential levels of care such as medication services, individual counseling, and medication services support.

All staff must be:

- Knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment
- Knowledgeable about the use of naloxone in order to effectively respond to an opioid overdose that may occur in the program
- Competent in recognizing and responding appropriately to the presence of the effects of past and current traumatic experiences in the lives of individuals served

All direct care and non-direct care staff who have contact with individuals served must receive training on trauma-informed care, suicide prevention (such as Zero Suicide), and co-occurring disorders, including prevalence, signs/symptoms, assessment, treatment, and the impact of one's own attitudes/beliefs on the delivery of services.

Staff Categories

Medical Staff

- Physician/Psychiatrist
- Resident Physician/Psychiatrist
- Physician Assistant (PA)
- Assistant Physician (AP)
- Advanced Practice Registered Nurse (APRN)

Nursing Staff

- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Paramedic
- Certified Medical Assistant

Clinical Staff

- Licensed Mental Health Professional (LMHP)
- Qualified Addiction Professional (QAP)
- Qualified Mental Health Professional (QMHP)
- Associate Substance Use Counselor – Missouri Associate Alcohol Drug Counselor I (MAADC I) and Missouri Associate Alcohol Drug Counselor II (MAADC II)

Technical Staff

- Community Support Specialist
- Certified Peer Specialist
- Family Support Provider

Paraprofessional Staff

- Group Rehabilitation Support Specialist
- Treatment Technician
- Substance Use Recovery Aide

Minimum Staffing Patterns

The following minimums are based on application of The ASAM Criteria and must be maintained:

- Group counseling sessions cannot exceed an average of 12 individuals, per calendar month, per facilitator, per group
- Group rehabilitative support sessions cannot exceed an average of 30 individuals during a calendar month, per facilitator, per group. Group averages are calculated per site
- QAPs must perform the majority of individual and group counseling
- Clinical supervisors shall have oversight of no more than 12 professionals

- On-call physicians or medical staff are assumed to be available 24 hours per day, seven (7) days per week, when noted as such. Where on-call coverage is indicated for any position, such coverage can be combined across programs within the same agency
- One full time equivalent (FTE) works 40 hours per week; coverage on a 24 hours seven (7) days basis requires 4.2 FTEs (168 working hours)
- FTE minimums are per site
- Any type of staff listed under the following categories (medical, clinical, technical, nursing and paraprofessional) can be utilized to meet the ASAM functions and service provisions to meet the FTE minimum, unless otherwise noted:
    - **Medical staff:** PA, AP, APRN and resident physician must have a written collaborative practice arrangement with a physician licensed in Missouri and practice within the scope of practice for their specific professional license
    - **Clinical staff:** Agencies must demonstrate a 60/40 staffing pattern of QAP, QMHP, LMHP to associate substance use counselors (MAADC I and MAADC II)
    - **Technical staff:** It is expected that community, peer and family support are available and provided as outlined in individual treatment plans
    - **Nursing staff:** It is expected that all LPNs, paramedics and certified medical assistants are appropriately supervised by an RN or APRN, as required by licensing standards
- All levels of care and programs shall provide services in accordance with The ASAM Criteria, including medical oversight and consultation for the total program size and according to individual treatment plans
- Residential capacity is limited to 16 beds. For residential levels of care, minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, seven (7) days per week (staff shall be dressed and awake) as follows:
    - Up to 16 beds (Minimum of two staff at all times)
    - Nursing staff (RN, LPN or paramedic) (On-site 40 hours per week, per 16 individuals for levels 3.2 WM, 3.3, 3.5 and 3.7)
    - RNs work under the direction and orders of a licensed physician or resident physician, APRN, AP or PA
        1. LPNs, paramedics and certified medical assistants shall be appropriately supervised by an RN or APRN as required by licensing standards.
        2. Orders shall not exceed the nurse or ordering practitioner's scope of practice
    - Up to 16 beds (one (1) certified peer specialist on-site at least 40 hours per week)
    - Certified peer specialists should be on-site while individuals are awake, including presence on evenings and weekends. The required number of certified peers is based on program size

2.10 General Comprehensive Substance Treatment and Rehabilitation Service Delivery Requirements

CSTAR includes an array of person-centered outpatient and residential services consistent with the individual's assessed needs and treatment goals with a rehabilitation and recovery focus, designed to promote skills for coping with and managing substance use. Services are for individuals who have been assessed based on the risk and severity of their substance use and are found to be in need of a particular intensity level of CSTAR services.

All individuals must have a treatment plan which includes services and supports to meet their circumstances and needs. CSTAR services are provided to or directed exclusively toward the treatment of individuals who are eligible for MHD benefits.

Service delivery shall be consistent with the current state of knowledge of SUDs treatment and best practices including, but not limited to:

- Provision of educational information about the progressive nature of SUDs and the disease model, principles and availability of self-help groups, medications for the treatment of SUDs, health and nutrition
- Support of a personal recovery process, recognizing thought distortions and behavior, promoting self-awareness and self-esteem, encouraging personal responsibility and constructively using leisure time
- Skill development such as communication skills, stress reduction and management, coping with trauma, conflict resolution, decision-making, assertiveness training and parenting
- Promotion of positive family relationships and family recovery/resiliency
- Relapse recognition, prevention and recovery

Children under the age of 21 may receive services without limitation, based on medical necessity, in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements included in **Section 1905(r) of the Social Security Act**.

An objective of the CSTAR program is to provide services that align with the National Outcome Measures (NOMs) established by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NOMs have been defined to embody meaningful, real-life outcomes for individuals who are striving to attain and sustain recovery, build resilience, and work, learn, live and participate fully in their communities. The NOMs' domains and associated outcome measures include:

- Reduced Morbidity: Abstinence from alcohol and drug use, including decreased use of substances of misuse
- Employment/Education: Increased/retained employment or return to/stay in school
- Crime and Criminal Justice: Decreased criminal justice involvement, incarcerations, alcohol-related car crashes and injuries, alcohol and drug-related crime
- Stability in Housing: Increased stability in housing
- Social Connectedness: Increased social supports/social connectedness (i.e., personal and social resources and strengths including the availability and use of family, social, peer, and other natural supports)

- Retention: Increased retention in substance use treatment and access to evidence-based programs/strategies

Priority for admission to CSTAR shall be given to:

- Women who are pregnant and use intravenous (IV) drugs shall receive immediate admission
- Women who are pregnant or postpartum, up to one (1) year after delivery
- Individuals who use IV drugs
- Women who have children and are at risk of losing custody or are attempting to regain custody
- Individuals who test positive for the human immunodeficiency virus (HIV)
- Individuals determined to be high risk and are referred for treatment by Department of Corrections' institutions and the Division of Probation and Parole via the designated referral form and protocol, as well as individuals referred from federal correctional institutions. High Risk referrals shall be assessed and admitted within five (5) working days of initial contact or scheduled release date, including weekends and holidays.
- Individuals who are applying for or receiving Temporary Assistance for Needy Families (TANF) and are referred for treatment by staff of DSS, Family Support Division, via the designated electronic referral process and protocol

CSTAR services do not include, and Federal Financial Participation (FFP) is not available, for the following:

- Room and board
- Educational, vocational and job training services
- Recreational and social activities
- Services that are covered elsewhere in the state Medicaid plan

Eligibility for Services

Services shall be provided in accordance with general eligibility criteria including a diagnosis of a SUD (not including tobacco use disorder) as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) of the American Psychiatric Association, and the results of a multidimensional assessment utilizing The ASAM Criteria which substantiates the individual's placement in the appropriate ASAM level of care.

The information obtained through the assessment process helps establish issues that are of the highest severity and highest priority to the individual in order to determine the intensity of services that should be provided. Individuals may require weekly, daily or hourly services which may require residential support.

Services shall be developmentally appropriate and responsive to each individual's social/cultural situation and any linguistic/communication needs.

Coordination of care is demonstrated when services and supports are being provided by multiple agencies or programs.

To the fullest extent possible, individuals are responsible for action steps to achieve their goals. Services and supports provided by staff should be readily available to help individuals achieve their goals and objectives.

Individuals eligible for services as part of the **SUD Disease Management (DM)** project are not required to have one of the specific diagnoses listed in **Section 4 of the CSTAR Program Manual**.

Individuals shall not be denied services solely because of a return to substance use or withdrawal from treatment against advice during a previous treatment occurrence.

Services for Family Members/Natural Supports

Services shall be available to family members/natural supports of individuals participating in SUD treatment and rehabilitation. Available services shall include:

- Family therapy
- Family conference
- Collateral dependent counseling (individual and group)

Family members/natural supports should be informed of available services and supports.

Services provided to collateral dependents also enrolled in the CSTAR program should be billed to the dependent's DCN, with the exception of Family Therapy for collateral dependents enrolled in Women and Children's Level 3.5, in which case the service is billed under the mother's DCN with the UK modifier.

Group services may include family members/natural supports and the primary individual engaged in treatment when indicated by the goals, content and methods of the group.

The following applies to services involving family members/natural supports:

- Family/family members/natural supports are defined as persons who comprise a household or are otherwise related by marriage or ancestry to the individual served, or an individual's chosen family which may include unrelated loved ones with whom the individual develops a significant personal bond, who are affected by the behavioral health disorder of the individual served
- Family members/natural supports must be determined to be clinically appropriate to participate in treatment as a collateral dependent with a member of a family system
- Services shall not conflict with the primary individual's treatment goals

Services for Women and Their Children

Women and Children's CSTAR programs provide SUD treatment solely to women and their children. Services may be offered with or without residential support in accordance with eligibility criteria specified in this manual.

Treatment occurs in the context of a family systems model. The program shall address therapeutic issues relevant to women and address their specific needs. Programs shall also provide therapeutic activities designed for the benefit of children who accompany their mothers in treatment.

Therapeutic issues relevant to women shall include, but are not limited to:

- Parenting and child development
- Life skills
- Family programs
- Facilitation of supervised parent-child bonding
- Educational remediation and support
- Employment readiness services
- Co-occurring disorder services, including access to psychological and pharmacological treatments for mental health disorders
- Linkages with legal and child welfare systems, including reunification with children if applicable
- Education and linkage to eating disorder and nutrition services
- Housing support efforts and referrals
- Medication services, including access to approved medication to treat SUDs for women who are pregnant or breastfeeding
- Recovery support and community support services that address long-term recovery needs such as domestic violence services, career counseling, legal services and transportation services

Therapeutic issues relevant to children shall include age-appropriate activities, training and guidance to meet the following goals:

- Build self-esteem and self-awareness
- Learn to identify and express feelings
- Learn healthy social engagement, peer relationships, social pressure skills and teamwork
- Develop decision-making skills
- Understand SUDs and its effects on the family
- Learn self-management (impulse control, stress management) and goal setting
- Learn safety practices such as personal space, boundaries and personal safety
- Address developmental needs
- Learn and practice nonviolent ways to resolve conflict
- Provide education on preventing alcohol, tobacco and other drug use

Services for Adolescents

Specialized CSTAR services are available to individuals between the ages of nine (9) and 17. Services in residential levels of care are available for individuals between the ages of 12 and 17. Exceptions to the age criteria may be authorized through the DMH clinical review process.

The following principles and philosophies shall be reflected in services directed to adolescents:

- Adolescents are effectively treated in therapeutic environments that are programmatically and physically separate from treatment services for adults.
- Services shall maintain individuals in the family and community setting, when clinically appropriate.

- Services shall involve parents/guardians and other family members/natural supports in the treatment and recovery process, when clinically appropriate. If the caregiver(s) are not available, program staff shall assist in developing alternate social and family/natural supports systems for the adolescent.
- Services to family members/natural supports shall be directed toward understanding and supporting the adolescent's recovery/resiliency, identifying and intervening with any behavioral health needs of their caregiver(s), improving parenting and communication skills within the family or with other caregivers/natural supports and facilitating improved family function.
- A cooperative team approach shall be utilized in order to provide a consistent therapeutic environment.
- Effective treatment for SUDs in adolescents requires identifying and treating other co-occurring conditions they may have.
- Services shall be coordinated with the juvenile justice system, children's services and other community agencies to ensure the needs of individuals are met.
- Staff shall possess the knowledge and expertise to engage adolescents with histories of trauma, recognize the presence of trauma symptoms, understand the role of trauma in the lives of adolescents and conduct themselves in ways that are not re-traumatizing to those being served.
- Issues such as violence, child abuse and risk of suicide shall be identified and addressed.
- Communicable disease counseling and testing for sexually transmitted infections, such as HIV and hepatitis B and C, are important aspects of adolescent treatment (refer to **9 CSR 30-3.110(C)** for service delivery requirements). Testing may be waived if parent/guardian consent is not obtained and is documented, as applicable to the individual served.

Service delivery shall address recovery/resiliency skill development including, but not limited to:

- Substance use prevention and education
- Assertiveness training
- Conflict resolution skills
- Emotional regulation
- Social network development
- Leisure time management
- Problem-solving skills
- Adolescent development
- Sexual health
- Trauma

For adolescents enrolled in ASAM Level 1, Level 2.1, or Level 2.5, certain CSTAR services may be provided within the school setting. An agreement for the provision of such services must be arranged by the CSTAR provider and their local school district.

CSTAR services delivered in the school setting are limited to three (3) hours/12 units per week total.

CSTAR services that may be delivered in school settings are limited to the following:

- Comprehensive Assessment (H0001)
- Community Support (H2015)
- Individual Counseling (H0004, H0004 HH and H0004 UK)
- Group Counseling (H0005 UK)
- Group Rehabilitative Support (H0025 and H0025 ST)
- HIV Pre-Test and Post-Test Counseling (H0047 and H0047 TS)
- Medication Services Support – RN (T1002), LPN (T1003)
- Family Therapy/Conference (T1006 and T1006 52)

2.11 Covered Services

CSTAR services must be billed using the appropriate modifiers listed below. Refer to Section 5 for a concise list of procedure codes and the corresponding modifiers.

Modifiers

Modifier	Description
52	Reduced services
HF	Substance Abuse Program
HH	Integrated Mental Health/Substance Abuse Program
HI	Integrated Mental Health & Intellectual Disability/Developmental Disabilities Program
HP	Doctoral Level
ST	Related to trauma or injury
TG	Complex/High Tech Level of Care
TS	Follow-up Service
UK	Services provided on behalf of the individual to someone other than the individual served (collateral relationship)

Outcome Measures and Instruments

CSTAR providers are required to measure outcomes for individuals served and shall collect data related to their outcomes. In order to promote consistency and the wider applicability of outcome data, DMH may require the use of designated outcome measures and instruments. The required use of particular measures or instruments is only applicable to services funded by DMH.

Transportation

Transportation may be provided or arranged by the CSTAR Program, except for the following services as listed below, to promote participation in treatment and rehabilitation services and to access other recovery resources and supports in the community.

Non-emergency medical transportation (NEMT) is available for individuals eligible for MO HealthNet benefits for the following services:

- Intake Assessment
- Assessment Update
- Adolescent Global Assessment of Individual Needs (GAIN)
- Medication Services (delivered by a physician (including psychiatrist), resident physician (including psychiatrist), physician assistant, assistant physician or APRN)

See the **NEMT Manual** for additional information.

Drug Screening Tests

Qualitative (presumptive) and semi-quantitative drug screening tests are covered by MHD. MHD only covers quantitative (definitive) or "confirmative" tests (i.e., procedure codes from the Therapeutic Drug Assay or Chemistry sections of the CPT book), if there is a positive screen for the drug class to be quantified and if the physician has documented the medical necessity in the patient medical record.

Urine drug screening must be medically necessary. When a provider conducts a drug test that needs to be sent to an external lab, the provider bills directly to MHD for individuals enrolled in MO HealthNet.

All ASAM team-based rates (intensive outpatient and residential levels of care) include other service-related costs which reflect consideration for provider expenses such as latex gloves, drug testing supplies (e.g., dipsticks, panels, etc.), tuberculosis testing and other supply items.

If a provider conducts drug testing that needs to be sent to an external lab, the lab will bill the separate drug lab code for that instance. NOTE: The provider's collection and supply costs in this instance are considered in the team-based outpatient and residential rates.

Please reference the **Physician's Manual** for more information on drug screenings.

2.12 Comprehensive Substance Treatment and Rehabilitation Covered Services

CSTAR services defined in this section are covered for individuals who are eligible for MO HealthNet benefits, when medically necessary and the diagnosis is related to a SUD (not including tobacco use disorder).

Screening and Eligibility Determination

A screening must be conducted as specified in **DBH Core Rules**, **9 CSR 10-7.030(1)**.

Each individual determined eligible and admitted to a CSTAR program (or a parent/guardian) must provide informed, written consent to treatment. A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained in the individual record. Consent to treat shall be updated annually, including the date of consent and signature of the individual served or a parent/guardian, and be maintained in the individual record.

Treatment, transfer, transition and discharge planning begins at the point of admission for all ASAM levels of care.

Eligibility determination may be completed to expedite the admission process. Eligibility determination requires placement in a level of care with inclusion of The ASAM Criteria and confirmation of an eligible diagnosis with verification by a LMHP (see **Section 2.8** of this manual) prior to delivering CSTAR services. The eligibility determination must be documented in accordance with DMH regulations, unless otherwise directed by DMH. This documentation must include, but is not limited to:

- Presenting problem and referral source
- Brief history of previous SUD/psychiatric treatment, including type of admission
- Current medications
- Current substance use supporting the diagnosis
- Current mental health symptoms
- Current medical conditions
- Diagnoses, including substance use and mental disorders, medical conditions and notation for psychosocial and contextual factors
- Functional assessment using a DMH-approved instrument, if required
- Identification of urgent needs including suicide risk, personal safety and risk to others
- Initial treatment recommendations
- Initial treatment goals to meet immediate needs within the first 45 days of services
- Signature, date, title and credential of service provider determining eligibility

Qualified Providers of Eligibility Determination

Eligibility determination shall be completed by one of the following:

- A LMHP (see **Section 2.8** of this manual) conducts a diagnostic assessment, including dated signature; or
- A QAP or QMHP (see **Section 2.8** of this manual) assists in obtaining information from the individual to complete the eligibility determination with finalization by an LMHP for completion of the diagnosis and clinical summary, including dated signature

The date of the LMHP's signature is the date eligibility has been determined.

Eligibility Determination Limitations

The unit of service is 45 minutes.

Procedure Code for Eligibility Determination

PROCEDURE CODE	DESCRIPTION
H0002	Behavioral Health Assessment/Eligibility Determination

Comprehensive Assessment

The comprehensive assessment is an evaluation of an individual's physical, mental and emotional health, including issues related to substance use, along with their ability to function within a community in order to determine service needs and formulate recommendations for treatment. Components include:

- Risk assessment to determine emergency, urgent and/or routine need for services
- Presenting problem, brief history, current medications, current medical conditions and current symptoms as obtained from the individual
- Formulation of a diagnosis by a LMHP
- Development of a treatment plan

The ASAM Criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all levels of care.

The six dimensions are listed below:

- **Dimension 1**: Acute intoxication and/or withdrawal potential (exploring an individual's past and current experiences of substance use and withdrawal)
- **Dimension 2**: Biomedical conditions/complications (exploring an individual's health history and current physical condition)
- **Dimension 3**: Emotional, behavioral or cognitive conditions and complications (exploring an individual's thoughts, emotions and mental health issues)
- **Dimension 4**: Readiness to change (exploring an individual's readiness and interest in changing)
- **Dimension 5**: Relapse, continued use or continued problem potential (exploring an individual's unique relationship with relapse or continued use or problems)
- **Dimension 6**: Recovery/living environment (exploring an individual's recovery or living situation, and the surrounding people, places and things)

Documentation for Comprehensive Assessment

Documentation must include the risk ratings across all six dimensions in The ASAM Criteria to determine the appropriate level of care, as well as the following:

- Basic information (demographics, age, language spoken)
- Presenting concerns from the perspective of the individual, including reason for referral/referral source, what occurred to cause them to seek services
- Risk assessment for determining emergent, urgent or routine need for services (suicide, safety and risk to others)
- Trauma history (experienced and/or witnessed abuse, neglect, violence or sexual assault)
- Substance use treatment history and current use including alcohol, tobacco and/or other drugs. For children/youth prenatal exposure to alcohol, tobacco or other substances
- Mental status
- Mental health treatment history
- Medication information including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications

- Physical health summary (health screen, current primary care, vision and dentist, date of last examinations, current medical concerns, body mass index, tobacco use status and exercise level). Immunizations for children/youth and medical concerns expressed by family members that may impact the child/youth.
- Assessed needs based on functioning (challenges, problems in daily living, barriers and obstacles)
- Risk-taking behaviors including child/youth risk behaviors
- Living situation including living accommodations (where and with whom), financial situation, guardianship, need for assistive technology and parental/guardian custodial status for children/youth
- Family, including cultural identity and current and past family life experiences, for family functioning/dynamics, relationships and current issues/concerns impacting children/youth
- Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech, hearing and language, emotional, behavioral and intellectual functioning and self-care abilities
- Spiritual beliefs/religious orientation
- Sexuality, including current sexual activity, safe sex practices and sexual orientation
- Need for and availability of social, community and natural supports/resources such as friends, pets, meaningful activities, leisure/ recreation interests, self-help groups, resources from other agencies and interactions with peers including children/youth and family
- Legal involvement history
- Legal status such as guardianship, representative payee, conservatorship and probation/parole
- Education, including intellectual functioning, literacy level, learning impairments, attendance and achievement
- Employment, including current work status, work history, interest in working and work skills
- Status as a current or former member of the U.S. Armed Forces
- Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders and psychological/social adjustment to disabilities and/or disorders
- Diagnosis(es)
- Individual's expression of service preferences
- Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities and barriers
- Signature, date, title and credential of staff completing the assessment

Comprehensive Assessment Using the Addiction Severity Index – Multimedia Version or Behavioral Health Index – Multimedia Version

For adult programs, the service provider may administer the ASI-MV® or BHI-MV® instrument as a component of the comprehensive assessment.

Qualified Providers of the Comprehensive Assessment

If a diagnosis is rendered through eligibility determination, other trained staff may gather assessment data from the individual with finalization by a QAP or QMHP (see **Section 2.8** of this manual), including development of treatment recommendations and dated signature.

If a diagnosis is rendered during completion of the comprehensive assessment, finalization by an LMHP (see **Section 2.8** of this manual) is required for completion of the diagnosis and clinical summary, including dated signature.

Comprehensive Assessment Service Limitations

Requirements for completion of the comprehensive assessment:

- Completed on the date of admission or within seven (7) days of the date of CSTAR eligibility determination for individuals admitted to a residential level of care
- Completed on the date of admission or within 30 days of the date of eligibility determination for individuals admitted to an outpatient level of care
- If an individual completes treatment or leaves treatment and subsequently is readmitted to the same provider, that provider may bill for a new comprehensive assessment if it has been more than six (6) months since the last comprehensive assessment was completed. If the individual is readmitted to the same provider within six (6) months, the provider may update the existing assessment and bill one (1) unit of assessment and diagnostic update.
- If an individual completes treatment or leaves treatment and subsequently is readmitted to a different provider, the admitting provider may bill for a new comprehensive assessment, unless the individual was also at this same provider within the prior six (6)-month period.
- Comprehensive assessments shall only be billed for the individual being admitted to the CSTAR Program.

Procedure Codes for Comprehensive Assessment

PROCEDURE CODE	DESCRIPTION
Non-Licensed Staff	
H0001	Comprehensive (Intake) Assessment
H0001 UK	Intake Assessment, Collateral Relationship
Licensed Staff	
90791	Psychiatric Diagnostic Evaluation w/o Medical Services
90792	Psychiatric Diagnostic Evaluation w/Medical
90792 HP	Psychiatric Diagnostic Evaluation w/Medical Services, Physician

90792 UK	Psychiatric Diagnostic Evaluation w/Medical Services, Collateral Relationship, Non-Physician (physician assistant, assistant physician, resident physician, APRN)
90792 UK HP	Psychiatric Diagnostic Evaluation w/Medical Services, Collateral Relationship, Physician

NOTE: Services, Non-Physician (physician assistant, assistant physician, resident physician, APRN) may be billed in addition to H0001 or 90791 if the service occurs on a different date than the assessment. If the evaluation occurs on the same date as either of the allowed assessment completion codes (H0001, 90791), ONLY 90792 may be billed.

Assessment Updates

Assessment updates shall be completed as clinically indicated by the treatment team and as specified in The ASAM Criteria to facilitate transition between levels and placement in the appropriate level of care. At a minimum, reassessment in outpatient levels of care shall take place every 12 months.

Documentation for assessment updates shall include:

- A narrative summary of the individual's risks within each of the six (6) dimensions
- The recommended level of care
- Any recommended changes to the treatment plan based on the reassessment

Reassessment should not be conducted when an individual is intoxicated or experiencing withdrawal symptoms.

Qualified Providers of Assessment Updates

A QAP or QMHP (see **Section 2.8** of this manual) must review and interpret the assessment information, conduct an interview with the individual and update treatment recommendations. A new diagnostic evaluation must be rendered by an LMHP.

Procedure Codes for Assessment Updates

PROCEDURE CODE	DESCRIPTION
Non-Licensed Staff	
H0001 52	Assessment and Diagnostic Update
H0001 52 UK	Assessment and Diagnostic Update, Collateral Relationship
Licensed Staff	
90791 52	Psychiatric Diagnostic Evaluation without Medical Services, Non-Physician (physician assistant, assistant physician, resident physician, APRN) reduced services

90791 52 UK	Psychiatric Diagnostic Evaluation without Medical Services, Collateral Relationship, Non-Physician (physician assistant, assistant physician, resident physician, APRN) reduced services
90792 52	Psychiatric Diagnostic Evaluation with Medical Services, Non-Physician (physician assistant, assistant physician, resident physician, APRN) reduced services
90792 52 HP	Psychiatric Diagnostic Evaluation with Medical Services, Physician (reduced services)
90792 52 UK HP*	Psychiatric Diagnostic Evaluation with Medical Services, Collateral Relationship, Physician (reduced services)

*The procedure code and modifier combination will be used internally at DMH for tracking.

Treatment Plan

A treatment plan must be developed for each individual admitted to CSTAR within 45 days of the date of admission with completion of a comprehensive assessment or completion of an eligibility determination with requirements met.

The individual (and parent/guardian, as applicable and appropriate) shall directly participate in the development of the treatment plan which shall reflect their unique needs and goals. Documentation for completion of the initial treatment plan must include, at a minimum:

- Identifying information
- Goals as expressed by the person served and family members/natural supports, (as appropriate) that are measurable, achievable, time-specific with start date, strength/skill based and include supports/resources needed to meet goals and potential barriers to achieving goals
- Specific treatment objectives that include a start date, are understandable to the individual served and sufficiently specific to assess progress, responsive to the disability or concern and reflective of age, development, culture and ethnicity
- Specific interventions and services including action steps, modalities and services to be utilized, duration and frequency of interventions, who is responsible for the intervention and action steps of the individual served and family members/natural supports, as appropriate
- Identification of other agency/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CSTAR Program to be addressed through referral/services with another organization
- Transfer, treatment and discharge planning beginning at the point of admission which includes but is not limited to criteria for service conclusion, how the individual served and/or parent/guardian and treatment team know treatment goals have been accomplished

- Signature, date, title and credentials of the QAP or QMHP completing the treatment plan with finalization by an LMHP. The LMHP's signature certifies that treatment is needed and services are appropriate as described in the treatment plan and does not recertify the diagnosis. The individual must also sign the treatment plan unless there is a current signed consent to treatment included in the individual record.

Treatment Plan Reviews/Updates

Treatment plans shall be updated each time an individual is reassessed as specified under Assessment Updates prior in this section of this manual.

At a minimum, treatment plans shall be reviewed and updated every 90 days to determine the individual's continued need for services and progress achieved during the past 90 days. A functional assessment may be utilized as the quarterly treatment plan review/update. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

Treatment plans shall be updated collaboratively with the individual and/or parent/guardian and reflect the individual's current strengths, needs, abilities and preferences in the goals and objectives that have been established or continued based on the review. Updates must be documented in the individual record by one of the following:

- A progress note which specifies updates made to the treatment plan
- A treatment plan review conducted quarterly
- An updated functional assessment score with a brief narrative

Signature, date, title and credentials of team/staff who participated in the review must be included on the treatment plan update. The individual served shall also sign the plan unless there is a current signed consent to treatment included in the individual record. The signature of an LMHP is not required on treatment plan reviews/updates.

2.13 Comprehensive Substance Treatment and Rehabilitation/American Society of Addiction Medicine Outpatient Levels of Care

Level 0.5 Early Intervention

Services are designed to address problems or risk factors related to substance use and to help individuals recognize the harmful consequences of high-risk substance use.

Length of service varies according to the following:

- Individual's ability to comprehend the information provided and use that information to make behavior changes and avoid problems related to substance use
- Appearance of new problems that require treatment at another level of care

Admission Guidelines for Level 0.5 Early Intervention Services

Individuals who are appropriate for Level 0.5 services evidences problems and risk factors that appear to be related to a SUD. However, the individual may not meet the diagnostic criteria for a

SUD as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), or there is currently insufficient information to perform a diagnostic assessment.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal or the individual's withdrawal can be safely managed in an outpatient setting
- Biomedical conditions and complications: None or very stable, any biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment
- Emotional, behavioral or cognitive conditions and complications: None or very stable or receiving concurrent mental health monitoring. Adolescents are not at risk of harm and experiencing minimal current difficulties with activities of daily living, but there is significant risk of deterioration.
- Readiness to change: Individual is open to recovery or willing to explore their SUD and/or mental health condition and is at least contemplating change. The individual may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change.
- Relapse, continued use or continued problem potential: Individual is able to achieve or maintain non-use of alcohol and/or other drugs and pursue related recovery or motivational goals with minimal support
- Recovery environment: Family and environment can support recovery with limited assistance or the individual has the skills to cope. Adolescents' risk of initiation of or progression in substance use and/or high-risk behaviors is increased by substance use or values about use. High-risk behaviors of family, peers or others in the adolescent's social support system.

Qualified Providers of Level 0.5 Early Intervention

Individualized outpatient services are provided by staff as specified in **Section 2.14** of this manual.

Interventions for Level 0.5 Early Intervention

Level 0.5 includes Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. SBIRT is designed to intervene early with individuals to identify those who do have a SUD and need to be referred to treatment.

Screening and Assessment for Level 0.5 Early Intervention

To rule in or rule out substance-related disorders and sufficient assessment of the dimensional risk and severity of need is performed prior to services and may continue throughout the process of delivering services.

Documentation Requirements for Level 0.5 Early Intervention

Refer to **Section 2.4** of this manual for documentation requirements applicable to all service delivery and to **Section 2.14** for documentation requirements specific to CSTAR outpatient services.

Procedure Codes for Level 0.5 Early Intervention

PROCEDURE CODE	DESCRIPTION
99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
99409	Alcohol and/or substance abuse structured screening and brief

Level 1 Outpatient Services

Level 1 outpatient services are professionally directed assessment, diagnosis, treatment and recovery services provided in an organized outpatient treatment setting.

Services shall include, but are not limited to the following:

- Individual counseling
- Group counseling
- Family therapy
- Peer and family support
- Group rehabilitative support
- Medication services and supports
- Crisis intervention
- Community support

For individuals with mental health conditions, issues of psychotropic medications, mental health treatment and their relationship to substance use shall be addressed, as needed.

Services shall vary in level of intensity based on individual needs and shall be fewer than nine (9) contact hours per week for adults age 18 and older, and fewer than six (6) contact hours per week for adolescents age nine (9) through 18.

The duration of treatment shall vary based on the severity of the individual's illness and their response to treatment.

Admission Guidelines for Level 1 Outpatient Services

Individuals appropriately placed in Level 1 are assessed as meeting the diagnostic criteria for a SUD as defined in the DSM-5-TR, as well as the dimensional criteria for admission.

If the individual's presenting substance use history is inadequate to substantiate a diagnosis, the probability of such diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian or natural supports, when there is valid authorization to obtain this information.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal or the individual's withdrawal can be safely managed in an outpatient setting
- Biomedical conditions and complications: Any biomedical conditions and problems, if any, are sufficiently stable to permit participation in outpatient treatment
- Emotional, behavioral or cognitive conditions and complications: None, or very stable or receiving concurrent mental health monitoring. Adolescents are not at risk of harm and experiencing minimal current difficulties with activities of daily living, but there is significant risk of deterioration.
- Readiness to change: Individual is open to recovery or willing to explore their SUD and/or mental health condition and is at least contemplating change. The individual may require monitoring and motivating strategies to engage in treatment and to progress through the stages of change.
- Relapse, continued use or continued problem potential: Individual is able to achieve or maintain non-use of alcohol and/or other drugs and pursue related recovery or motivational goals with minimal support
- Recovery environment: Family and environment can support recovery with limited assistance or the individual has the skills to cope

Additional admission guidelines for level 1 outpatient services are:

- Initial point of entry/reentry: Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between programs and/or treatment levels, relapse assessment and assignment to level of care
- Early intervention for those who have been identified as having a SUD and are referred for services designed to prevent progression of disease
- Continuing care following a more intensive level of care
- Any combination of the above

Qualified Providers for Level 1 Outpatient Services

Individualized services are provided by staff as specified in **Section 2.14** of this manual.

Adolescent program staff should be knowledgeable about adolescent development and experienced in working with and engaging adolescents.

Interventions for Level 1 Outpatient Services

For individuals with mental health conditions, issues of psychotropic medications, mental health treatment and their relationship to substance use should be addressed, as needed.

Assessment/Treatment Plan Review for Level 1 Outpatient Services

Refer to the assessment and treatment plan requirements in **Sections 2.12** of this manual.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Documentation Requirements for Level 1 Outpatient Services

Refer to **Section 2.4** of this manual for documentation requirements applicable to all service delivery, and to **Section 2.14** for documentation requirements specific to CSTAR outpatient services.

Procedure Codes for Level 1 Outpatient Services

Procedure codes are located in **Section 2.14** of this manual.

Level 1 Opioid Treatment Program

Opioid treatment programs (OTP) offer community-based outpatient treatment for individuals diagnosed with an opioid use disorder. OTPs administer medications approved by the Food and Drug Administration (FDA) to treat opioid use disorder and alleviate the adverse medical, psychological and physical side effects of opioid dependence. Medications are provided in conjunction with highly structured psychosocial programming that addresses major lifestyle, attitudinal and behavioral issues that could undermine an individual's recovery-oriented goals.

OTPs must comply with the federal opioid treatment regulations set forth under **42 CFR 8.12** and DMH regulation **9 CSR 30-3.132**. These regulations require that programs provide medical and counseling services, drug testing and other interventions for individuals admitted to treatment.

Admission Guidelines for Level 1 Opioid Treatment Program

Individuals placed in Level 1 OTP care, are assessed as meeting the diagnostic criteria for severe opioid use disorder as defined in the DSM-5-TR, aside from those exceptions listed in **42 CFR 8.12**. If the individual's drug use history is inadequate to substantiate a diagnosis, the probability of such diagnosis may be determined from information submitted by other healthcare professionals and programs and collateral parties such as family members, legal guardian or natural supports, when there is valid authorization to obtain this information.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: Meets diagnostic criteria for an opioid use disorder
- Biomedical conditions and complications: Meets biomedical criteria for opioid use disorder and may have a concurrent biomedical illness that can be treated on an outpatient basis
- Emotional, behavioral or cognitive conditions and complications: None or stable or receiving concurrent mental health monitoring and/or treatment
- Readiness to change: Requires a structured therapeutic and pharmacotherapy program to promote treatment progress and recovery

- Relapse, continued use or continued problem potential: High risk of return to use of opioids or continued use without opioid pharmacotherapy, close outpatient monitoring and structured support
- Recovery environment: Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate primary or social support system, but has demonstrated motivation and willingness to obtain such a support system

Qualified Providers of Level 1 Opioid Treatment Program

Refer to DMH regulation for OTP, **9 CSR 30-3.132**.

Interventions for Level 1 Opioid Treatment Program

Interventions include, but are not limited to:

- Nursing assessment at time of admission that is reviewed by a physician to determine the need for opioid treatment services, eligibility and appropriate level of care placement for admission and referral
- A fully documented physical examination by a program physician or an AP, PA, APRN or resident physician working under the supervision of the program physician. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission.
- A pregnancy test for women, as deemed clinically appropriate
- Referral and assistance, as needed, for the individual to gain access to other needed medical, SUD and/or mental health services

Assessment/Treatment Plan Review for Level 1 Opioid Treatment Program

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Documentation Requirements for Level 1 Opioid Treatment Program

Refer to **Section 2.4** of this manual for documentation requirements applicable to all service delivery, and to **Section 2.14** for documentation requirements specific to CSTAR outpatient services.

Procedure Code for Level 1 Opioid Treatment Program

PROCEDURE CODE	DESCRIPTION
H0020	Methadone dosing

NOTE: Level 1 OTP may overlap with any additional ASAM level of care.

2.14 Comprehensive Substance Treatment and Rehabilitation Outpatient Services

CSTAR services described in this section are available to individuals assigned to **ASAM Level 1 Outpatient Services** specified in **Sections 2.13** of this manual. Services provided shall be based on individualized treatment plans.

2.14 A Community Support

Community support is a comprehensive service designed to reduce the individual's disability resulting from mental illness, emotional disorders and/or SUDs, restore functional skills of daily living, build natural supports and solution-oriented interventions intended to achieve the recovery identified in the goals and/or objectives as set forth in the individualized treatment plan.

This service may be provided to the individual's family members/natural supports when such services are for the direct benefit of the individual, in accordance with their needs and goals identified in the individual treatment plan and for assisting in the individual's recovery. Most contact occurs in community locations where the individual lives, works, attends school and/or socializes. Community support services must be provided in accordance with **9 CSR 30-3.157**.

Qualified Providers of Community Support Services

Community support must be provided by a CSS as defined in this manual.

Community Support Service Limitations

Community Support service limitations:

- The maximum billable for any one (1) individual per day is 24 units. Additional units may be authorized through DMH clinical review.
- Community support may be delivered on behalf of children/youth who are considered collateral dependents of women enrolled in a Women and Children's CSTAR program and should be billed using the UK modifier.
- The CSTAR provider shall ensure that an adequate number of qualified staff are available to provide community support services and functions
- Caseload size may vary according to the acuity, symptom complexity and needs of individuals. An individual or the parent/guardian has the right to request an independent review by the CSTAR Program director if they believe individual needs are not being met. If the CSTAR director deems it necessary, caseload size or other changes may be implemented. The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by individuals. The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

Documentation for Community Support Services

Refer to **Section 2.4** of this manual for documentation requirements applicable to all service delivery, and to **Section 2.14** for documentation requirements specific to CSTAR outpatient services.

Written documentation must be maintained in the individual's clinical record for each community support session, service or activity. Additional documentation must include:

- Phone contacts
- Pertinent/significant information reported by family members/natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in their life

Procedure Codes for Community Support

PROCEDURE CODE	DESCRIPTION
H2015	Community Support
H2015 UK	Community Support, Collateral Relationship

2.14 B Individual Counseling

Individual counseling is a structured and goal-oriented therapeutic interaction to resolve issues related to the use of alcohol and/or other drugs that interfere with the individual's functioning. This includes evidence-based interventions such as motivational interviewing, cognitive behavioral therapy and trauma-specific services.

Specialized individual counseling includes trauma and co-occurring disorders counseling.

Examples of evidence-based practices that may be utilized include, but are not limited to:

- Motivational Interviewing (MI), a goal-oriented, person-centered counseling style for eliciting behavioral change by helping individuals to explore and resolve ambivalence. This approach upholds four principals which are: expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance and supporting self-efficacy.
- Cognitive Behavioral Therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, SUDs, marital problems, eating disorders and severe mental illness. CBT usually involves efforts to change thinking patterns.

Key Service Functions of Individual Counseling

Key service functions of individual counseling may include, but are not limited to:

- Exploration of an identified problem and its impact on individual functioning
- Examination of attitudes, feelings and behaviors that promote recovery and improved functioning
- Identification and consideration of alternatives and structured problem-solving
- Discussion of skills to aid in making positive decisions

- Application of information presented in the program to the individual's life situations to promote recovery and improved functioning
- Discussion of harm reduction strategies to reduce substance use, lower health risk complications, such as hepatitis C, and reduce overdose deaths

Qualified Providers of Individual Counseling

Individual counseling must be provided by a QAP or an associate substance use counselor who holds an appropriate credential through the Missouri Credentialing Board.

A majority of the program's staff who provide individual and group counseling must be QAPs.

Individual Counseling/Trauma

Trauma individual counseling is provided to the individual in accordance with their treatment plan to resolve issues related to psychological trauma in the context of a SUD. Personal safety and empowerment of the individual must be addressed.

Qualified Providers of Individual Counseling/Trauma

This service shall be provided by a licensed/provisionally LMHP as defined in this manual. Qualified staff must have specialized trauma training and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.

Individual Counseling/Co-Occurring Disorder Services

Co-occurring disorder counseling services is a structured and goal-oriented therapeutic interaction between an individual and their counselor designed to identify and resolve issues related to substance use and co-occurring mental illness.

Qualified Providers of Individual Counseling/Co-Occurring Disorders

Co-occurring disorders counseling service is provided by a person licensed/provisionally licensed by the Missouri Division of Professional Registration as a mental health professional who is practicing within their current competence or a person certified by the MCB as a professional working in co-occurring disorders who is practicing within their current competence.

Individual Counseling Service Limitations

Services must be billed in 15 minute increments.

Procedure Codes for Individual Counseling, Individual Counseling/Trauma, and Individual Counseling/Co-Occurring Disorders

PROCEDURE CODE	DESCRIPTION
Non-Licensed Staff	
H0004	Individual Counseling (Associate Substance Use Counselor, QAP)
H0004 HH	Individual Counseling, Co-Occurring Disorders (QAP)

H0004 UK	Individual Counseling, Collateral Relationship (QAP)
H0004 UK HH	Individual Counseling, Collateral Relationship, Co- Occurring (QAP)
H0004 ST	Individual Counseling (Trauma)(QAP)
Licensed staff	
90832	Psychotherapy, 30 minutes (LMHP)
90832 HH	Psychotherapy, 30 minutes (Co-Occurring) (LMHP)
90832 ST	Psychotherapy, 30 minutes (Trauma) (LMHP)
90832 UK	Psychotherapy, Collateral Relationship, 30 minutes (LMHP)
90832 UK HH	Psychotherapy, Collateral Relationship, 30 minutes (Co-Occurring)(LMHP)
90832 UK ST	Psychotherapy, Collateral Relationship, 30 minutes (Trauma)(LMHP)
90834	Psychotherapy, 45 minutes (LMHP)
90834 HH	Psychotherapy, 45 minutes (Co-Occurring) (LMHP)
90834 ST	Psychotherapy, 45 minutes (Trauma) (LMHP)
90834 UK	Psychotherapy, Collateral Relationship, 45 minutes (LMHP)
90834 UK HH	Psychotherapy, Collateral Relationship, 45 minutes (Co-Occurring)(LMHP)
90834 UK ST	Psychotherapy, Collateral Relationship, 45 minutes (Trauma)(LMHP)
90837	Psychotherapy, 60 minutes (LMHP)
90837 HH	Psychotherapy, 60 minutes (Co-Occurring) (LMHP)
90837 ST	Psychotherapy, 60 minutes (Trauma) (LMHP)
90837 UK HH	Psychotherapy, Collateral Relationship, 60 minutes (Co-Occurring)(LMHP)
90837 UK ST	Psychotherapy, Collateral Relationship, 60 minutes (Trauma)(LMHP)
90839	Psychotherapy for crisis, first 60 minutes (LMHP)
90839 HH	Psychotherapy for crisis, first 60 minutes (Co-Occurring) (LMHP)
90839 ST	Psychotherapy for crisis, first 60 minutes (Trauma) (LMHP)
90839 UK	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (LMHP)
90839 UK HH	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (Co-Occurring)(LMHP)
90839 UK ST	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (Trauma)(LMHP)

2.14 C Group Counseling Services

Group counseling is a goal-oriented therapeutic interaction between a counselor and two (2) or more individuals based on needs and goals specified in individual treatment plans. Services shall be designed to promote individual functioning and recovery through personal disclosure and interpersonal interaction among group members. This service can include trauma-related symptoms, co-occurring behavioral health disorders and SUDs.

Evidence-based practices such as MI and CBT may be utilized by appropriately trained staff.

Key Service Functions of Group Counseling

Key service functions of group counseling include, but are not limited to:

- Facilitate individual disclosure of substance use-related issues which permits generalization of the issues to the larger group
- Promote recognition of thought distortions and behaviors and teaching strategies that support non-use of alcohol and/or other drugs that interfere with the individual's functioning
- Prepare individuals to cope with physical, cognitive and emotional symptoms of craving alcohol and/or other drugs
- Encourage and model productive and positive interpersonal communication
- Develop motivation and action by group members through peer influence, structured confrontation and constructive feedback
- Discuss harm reduction strategies to reduce substance use, lower health risk complications, such as hepatitis C and reduce overdose deaths

Qualified Providers of Group Counseling Services

Group counseling services must be provided by a QAP or an associate substance use counselor who holds an appropriate credential through MCB.

Documentation Requirements for Group Counseling Services

For each group session, a group log or documentation in the individual record (paper or electronic) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of group, each individual's in and out time and the signature, date, and title/credential of the staff member providing the service. Signature stamps shall not be used.

Group Counseling Service Limitations

The unit of service is 15 minute increments.

Group averages are calculated per site. The usual and customary group size is 12 individuals. The size of group counseling sessions cannot exceed an average of 12 individuals, per calendar month, per facilitator, per group.

Procedure Codes for Group Counseling

PROCEDURE CODE	DESCRIPTION
Non-licensed staff	
H0005	Group Counseling (Associate Substance Use Counselor, QAP)
H0005 HH	Group Counseling (Co-Occurring)(QAP)
H0005 ST	Group Counseling (Trauma)(QAP)
H0005 UK	Group Counseling, Collateral Relationship

H0005 UK HH	Group Counseling, Collateral Relationship (Co Occurring)(QAP)
H0005 UK ST	Group Counseling, Collateral Relationship (Trauma)(QAP)
Licensed Staff	
90853	Group Psychotherapy
90853 HH	Group Psychotherapy (Co-Occurring)
90853 ST	Group Psychotherapy (Trauma)
90853 UK	Group Psychotherapy, Collateral Relationship
90853 UK HH	Group Psychotherapy, Collateral Relationship (Co-Occurring)
90853 UK ST	Group Psychotherapy, Collateral Relationship (Trauma)

2.14 D Group Rehabilitative Support

Group rehabilitative support consists of facilitated group discussions, based on individual needs and treatment plan goals, designed to promote an understanding of the relevance of the nature, course and treatment of SUDs, to assist individuals in understanding their recovery needs and how they can restore functionality.

Key Service Functions of Group Rehabilitative Support

Key service functions of group rehabilitative support may include, but are not limited to:

- Classroom style didactic lecture to present information about a topic and its relationship to substance use
- Presentation of audio-visual materials that are educational in nature with required follow-up discussion and are relevant to individuals' needs and treatment plan goals. Instructional aids shall be incorporated to enhance understanding and promote discussion and interaction among individuals. Aids may include, but are not limited to, videos or other electronic media, worksheets and informational handouts and shall not comprise more than 20% of group rehabilitative support sessions.
- Promotion of discussion and questions about the topic presented to the individuals in attendance
- Generalization of the information and demonstration of its relevance to recovery and enhanced functioning

Programs must have a schedule and curriculum for delivery of group rehabilitative support that address topics and material relevant to the individuals served. Individuals should only attend groups with topics that are relevant to their needs based on the assessment and interventions recommended in their treatment plan.

Qualified Providers of Group Rehabilitative Support

Group rehabilitative support shall be provided by a group rehabilitation support specialist who is present throughout the session and:

- Is suited by education, background, knowledge or experience to present the information being discussed
- Demonstrates competency and skill in facilitating group discussions

Documentation Requirements for Group Rehabilitative Support

A group log or documentation in the individual record (paper or electronic format) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual's in and out time and the signature, date and title of the staff member providing the service. Signature stamps shall not be used.

A separate record for a family member is not required if group rehabilitative support is the only service provided by a program that is funded by/contracted with DMH. Documentation of group rehabilitative support sessions and the participating family member(s) shall be maintained.

Group Rehabilitative Support Limitations

- Unit of service is 15 minute increments
- Group size of rehabilitative support cannot exceed an average of 30 individuals during a calendar month, per facilitator, per group. Group averages are calculated per site.

Group Rehabilitative Support/Trauma

Group rehabilitative support service consists of the presentation of recovery and trauma-related information and its application to individuals, along with group discussion in accordance with individualized treatment plans. Groups must be gender-specific.

Qualified Providers of Group Rehabilitative Support/Trauma

Trauma group rehabilitative support must be provided by a group rehabilitation support specialist with specialized training in trauma and substance use.

Documentation Requirements for Group Rehabilitative Support/Trauma

A group log or documentation in the individual record (paper or electronic format) shall be maintained for each session documenting the type of service, summary of the service, date, actual beginning and ending time of the group, each individual's in and out time and the signature, date, and title of the staff member providing the service. Signature stamps shall not be used.

Group Rehabilitative Support/Trauma Limitations

Group size shall not exceed an average of 30 individuals during a calendar month, per facilitator, per group. Group averages are calculated per site.

Procedure Codes for Group Rehabilitative Support and Group Rehabilitative Support/Trauma

PROCEDURE CODE	DESCRIPTION
H0025	Group Rehabilitative Support
H0025 HH	Group Rehabilitative Support (Co-Occurring)
H0025 ST	Group Rehabilitative Support (Trauma)

H0025 UK	Group Rehabilitative Support (Collateral Relationship)
H0025 UK HH	Group Rehabilitative Support (Collateral Relationship-Co-Occurring)
H0025 UK ST	Group Rehabilitative Support (Collateral Relationship-Trauma)

2.14 E Family Therapy

Family therapy service consists of counseling or family-based therapeutic interventions such as role playing, psychoeducational discussions for the primary individual and/or one or more family members/natural supports. It is designed to address and resolve patterns of dysfunctional communication and interactions that have become engrained over time, particularly as it relates to the impact of substance use. It is delivered by specialized staff in accordance with the primary individual's treatment plan. One or more family members/natural supports must be present. Services can be offered to members of a single family, or members of multiple families dealing with similar issues.

Services to the individual's family members/natural supports is for the direct benefit of the individual, in accordance with their needs and treatment goals identified in the treatment plan and for the purpose of assisting in the individual's recovery.

Key Service Functions of Family Therapy

Key service functions of family therapy include, but are not limited to:

- Utilizing generally accepted principles of family therapy to influence family interaction patterns
- Examining family interaction styles, confronting patterns of dysfunctional behavior and strengthening communication patterns that promote healthy family function
- Facilitating family participation in family self-help recovery groups
- Developing and applying skills and strategies for improvement in family functioning
- Promoting healthy family interactions independent of formal helping systems

Qualified Providers of Family Therapy

Family therapy shall be provided by a LMHP or licensed marital and family therapist (LMFT) or a QAP (within their current competence) and receives close supervision from an LMHP or LMFT.

Family Therapy Limitations

Family therapy service limitations:

- In any calendar month, for 50% of an individual's family therapy, the primary individual must be present, in addition to one (1) or more family members/natural supports. Family members below the age of five (5) can be counted as one of the required family members when the child is shown as having the requisite social and verbal skills to participate in and benefit from the service.
- Unit of service is in 15 minute increments of direct contact with an individual by a qualified provider

- With the exception of Women and Children's Level 3.5, family therapy provided to collateral dependents also enrolled in the CSTAR program should be billed to the dependent's DCN

Documentation for Family Therapy

The service episode note documenting family therapy must clearly state the relationship of the family members/natural supports to the individual receiving MHD CSTAR services.

2.14 F Family Conference

Family conference is a substance use intervention that enlists the support of the individual's family members, natural supports and referral sources by meeting with them about the individual's treatment plan, transfer and/or transition plan and discharge plan. The service must include the individual served and be for their direct benefit in accordance with the needs and goals identified in their treatment plan and for assisting in their recovery.

Key Service Functions of Family Conference

Key service functions include, but are not limited to:

- Communicating about issues in the individual's home that are barriers to achieving treatment plan goals
- Identifying relapse triggers and establishing a continuing recovery/relapse prevention plan
- Participating in transition and/or transfer planning and discharge planning conferences
- Assessing the need for family therapy or other referrals to support the family system

Family conference does not replace family therapy, which continues to be a more specialized clinical service delivered by qualified staff as specified in **Section 2.14** in this manual.

Qualified Providers of Family Conference

Family conference is provided by a QAP or an associate substance use counselor.

Family Conference Service Limitations

Family conference service limitations:

- Unit of service is 15 minute increments
- Service is limited to a maximum of eight (8) units per week, per individual
- Services provided to collateral dependents also enrolled in the CSTAR program should be billed to the dependent's DCN

Additional units may be authorized through the DBH clinical review process.

Procedure Codes for Family Therapy and Family Conference

PROCEDURE CODE	DESCRIPTION
Non-Licensed Staff	
T1006	Family Therapy (Office) Individual
T1006 52	Family Conference

T1006 UK	Family Conference, Collateral Relationship
Licensed Staff	
90846	Family Psychotherapy, 50 minutes (without patient)
90846 HH	Family Psychotherapy, 50 minutes (without patient) (Co-Occurring)
90846 ST	Family Psychotherapy, 50 minutes (without patient) (Trauma)
90847	Family Psychotherapy, 50 minutes (with patient present)
90847 HH	Family Psychotherapy, 50 minutes (with patient) (Co-Occurring)
90847 ST	Family Psychotherapy, 50 minutes (with patient) (Trauma)

2.14 G Collateral Dependent Counseling

Collateral dependent counseling is the planned, goal-oriented therapeutic interaction with an individual or group of individuals, to address dysfunctional behaviors and life patterns associated with being a family member/natural support of an individual who has a SUD and is currently participating in treatment.

Key Service Functions of Collateral Dependent Counseling

Key service functions of collateral dependent counseling include, but are not limited to:

- Exploration of SUDs and its impact on the family member's functioning
- Development of coping skills and personal responsibility for changing one's own dysfunctional patterns in relationships
- Examination of attitudes, feelings and long-term consequences of living with a person with a SUD
- Identification and consideration of alternatives and structured problem-solving
- Productive and functional decision-making
- Development of motivation and action by group members through peer support, structured confrontation and constructive feedback

Qualified Providers of Collateral Dependent Counseling

Collateral dependent counseling shall be provided by a LMFT, LMHP or a QAP practicing within their current competence.

Collateral Dependent Counseling Limitations

Collateral dependent counseling limitations:

- Unit of service is 15 minute increments
- For women and children's CSTAR programs, wherein the screening of dependent children is required, individual collateral dependent counseling may be billed to conduct the screening and subsequent assessment activities
- With the exception of Women and Children's Level 3.5, services provided to collateral dependents also enrolled in the CSTAR program are billed to the dependent's DCN
- This service is only provided to an individual who is a member of the primary individual's family when such services are for the direct benefit of the individual, in accordance with

needs and goals identified in the treatment plan and for assisting in the individual's recovery
- The primary individual is not present in collateral dependent counseling sessions
- Collateral dependent counseling may be provided to children five (5) years of age and younger only when the child is shown to have the requisite social and verbal skills to participate in and benefit from the service
- The size of group collateral dependent counseling sessions that include only family members shall not exceed an average of 12 individuals per calendar month, per facilitator, per group

Procedure Codes for Collateral Dependent Counseling

PROCEDURE CODE	DESCRIPTION
H0004 UK	Individual Counseling, Collateral Relationship (QAP)
H0004 UK HH	Individual Counseling, Collateral Relationship (Co-occurring) (QAP)
H0004 ST UK	Individual Counseling, Collateral Relationship (Trauma)(QAP)
H0005 UK	Group Counseling, Collateral Relationship (QAP)
H0005 UK HH	Group Counseling, Collateral Relationship (Co-occurring) (QAP)

2.14 H Medication Services

A medication service consists of a goal-oriented interaction to assess the appropriateness of medications in an individual's treatment, periodic evaluation/reevaluation of the efficacy of any prescribed medications and ongoing management of a medication regimen within the context of the individual's treatment plan.

Key Service Functions of Medication Services

Key service functions of medication services include, but are not limited to:
- Assessment of the individual's presenting condition
- Mental status exam
- Review of symptoms and screening for medication side effects
- Review of functioning
- Assessment of the individual's ability to self-administer medications
- Education regarding the effects of medication and its relationship to the individual's SUD and/or mental illness
- Prescription of medications, when indicated

Qualified Providers of Medication Services

Medication services shall be provided by a licensed physician (including psychiatrist) or non-physician (includes resident physician, physician assistant, assistant physician or APRN) who is in a collaborative practice arrangement with a licensed physician.

Procedure Codes for Medication Services

Refer to **Section 5** of the CSTAR Manual for a complete listing of medication services procedure codes. Use the appropriate E/M code based upon the complexity of the visit and documentation must support the level chosen.

2.14 I Medication Services Support

Medication support service consists of medical and other consultative services for the purpose of monitoring and managing an individual's health needs while taking medications.

Key Service Functions of Medication Services Support

Key service functions include, but are not limited to:

- Evaluating individuals' physical condition and need for withdrawal management
- Recording initial medical histories and vital signs
- Monitoring health status during withdrawal management
- Monitoring general health needs and meeting with individuals about medical concerns
- Educating individuals about disease prevention, risk reduction and reproductive health
- Triaging medical conditions that occur during treatment and managing medical emergencies such as accidental injuries and drug reactions
- Conferring with healthcare providers and coordinating medical services from other providers, as needed
- Arranging or monitoring special dietary needs for medical conditions
- Reviewing medication requirements and the benefits of taking prescribed medications as prescribed with individuals served
- Consulting with medication prescribers or pharmacy staff to confirm medications prescribed
- Consulting with individuals on use of over-the-counter medications and monitoring their use
- Administering therapeutic injections of medication (subcutaneous or intramuscular)
- Monitoring lab levels and providing feedback to individuals served, as well as consulting with healthcare providers and treatment team members
- Coordinating individuals' medication needs with pharmacies, family members/natural supports and prescription/drug assistance programs
- Monitoring medication side-effects, including the use of standardized evaluations
- Monitoring medication orders from healthcare providers for treatment modifications and educating individuals, as necessary

Qualified Providers of Medication Services Support

Services must be provided by an APRN, RN or LPN.

Medication Services Support Limitations

Medication Services Support limitations:

- Unit of service is 15 minute increments
- Services may be provided to collateral dependents also enrolled in the CSTAR program and are billed to the dependent's DCN

Procedure Codes for Medication Services Support

PROCEDURE CODE	DESCRIPTION
T1002	Medication Services Support (APRN/RN)
T1003	Medication Services Support (LPN)

2.14 J Peer and Family Support

Peer and family support services are coordinated within the context of a comprehensive, individualized treatment plan that includes specific individualized goals. Peer and family support services are person-centered and promote individual ownership of the treatment plan.

These services may be provided to the individual's family members/natural supports when such services are for the direct benefit of the individual being served, in accordance with the needs and goals identified in their treatment plan and for assisting in the individual's recovery.

Key Service Functions for Peer and Family Support

Key components for peer and family support include:

- Person-centered planning to promote the development of self-advocacy
- Empowering the individual to take a proactive role in the developing, updating and implementing their individualized treatment plan
- Crisis support
- Assisting the individual and family members in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the treatment plan so the individual remains in the least restrictive settings; achieves recovery and resiliency goals, self-advocates for quality physical and behavioral health and medical services in the community
- Assisting individuals/families in identifying strengths and personal/family resources to aid recovery/promote resilience and recognize their capacity for recovery/resilience. Serving as an advocate, mentor or facilitator for the resolution of issues and skills necessary to enhance and improve the health of a child/youth with substance use or co-occurring disorders.
- Providing information and support to parents/caregivers of children with emotional disorders so they have a better understanding of the individual's needs, the importance of their voice in the development and implementation of the individualized treatment plan, the roles of the various service providers and the importance of the "team" approach and assisting in the exploration of options to be considered as part of treatment

Qualified Providers of Peer and Family Support

Peer support services are provided by a certified peer specialists who may participate in staff meetings/discussions related to service delivery, but cannot be solely assigned to an individual receiving treatment services.

Family support services are provided by a certified family support provider.

Peer and family support providers must be supervised by a QAP or QMHP.

Peer and Family Support Limitations

The unit of service for peer support is 15 minute increments.

Family support is limited to eight (8) hours (32 units per day) and 24 hours (96 units per month), per individual. Family support can be billed for transportation to and from an appropriate service activity. Family support cannot be billed if the only service being provided is transportation.

Procedure Codes for Peer and Family Support

PROCEDURE CODE	DESCRIPTION
H0038	Peer Support
H0038 UK	Peer Support Services - Collateral Relationship
H0038 HA	Family Support

Documentation Requirements for Peer and Family Support

Refer to **Section 2.4** of this manual for general documentation requirements and to **Section 2.14** for documentation requirements specific to CSTAR outpatient services.

2.14 K Communicable Disease Counseling

Communicable disease counseling assists individuals in understanding how to reduce the behaviors that interfere with their ability to lead healthy, safe lives and to restore them to their best possible functional level. Communicable disease counseling topics can include, but are not limited to, HIV, hepatitis, sexually transmitted infections (STI), tuberculosis (TB) status and/or disclosure of substance use to family members/natural supports, addressing stigma in accessing services, maximizing healthcare service interactions, reducing substance use and avoiding overdose and addressing anxiety, anger and depressive episodes.

The provider shall have a working relationship with a local health department, physician or other qualified healthcare professional to provide individuals with necessary testing for HIV, TB, STIs and hepatitis.

Prior to an individual being tested for HIV, counseling must be provided by staff who are knowledgeable about communicable diseases including HIV, TB, and STIs through training and/or previous employment experience. Post-test counseling may be provided for those testing positive for either HIV or TB. Staff providing these services shall be competent to therapeutically assist individuals to understand and appropriately respond to test results.

HIV Pre-Test Counseling

Individuals with an SUD diagnosis may receive counseling for the purpose of assessing their risk of exposure to HIV. Included in the HIV pre-test are an HIV risk assessment interview, HIV pre-test counseling session and appropriate documentation of the pre-test counseling session.

HIV Post-Test Counseling

Individuals with an SUD diagnosis who test positive for HIV may receive counseling following the test. This service includes HIV post-test counseling and the appropriate documentation and medical, social and psychological referrals, as needed or requested by the individual.

TB Post-Test Counseling

Individuals testing positive for TB may receive a counseling session that includes the test results and documentation. If appropriate, referrals may be made to local TB clinics.

Qualified Providers of Communicable Disease Counseling

Communicable disease counseling service must be provided by an LMHP, QAP or associate substance use counselor knowledgeable about communicable diseases including HIV, TB, hepatitis and STIs through training and/or previous employment experience.

Knowledge shall include, but is not limited to, awareness of risks, disease management/treatment and resources for care, confidentiality requirements and therapeutically assisting individuals in understanding and appropriately responding to test results.

LMHPs, QAPs and associate substance use counselors providing post-test counseling for HIV or TB must also be knowledgeable about services and care coordination available through the Department of Health and Senior Services (DHSS).

Pre- and Post-Test Counseling Limitations

Pre- and post-test counseling limitations:

- Services are limited to one (1) 15 minute unit each per episode of care
- HIV pre-test counseling and TB/HIV post-test counseling must be used with one of the following diagnosis codes: Z20.1 or Z20.6

NOTE: TB testing materials are included in the rate.

Procedure Codes for Communicable Disease Counseling

PROCEDURE CODE	DESCRIPTION
H0047	HIV Pre-Test Counseling
H0047 TS	TB Post-Test Counseling
H0047 TS	HIV Post-Test Counseling

2.14 L Crisis Intervention

Crisis intervention is designed to interrupt and/or ameliorate a substance use crisis experience. The goal of crisis intervention is symptom reduction, stabilization and restoration to a previous level of functioning.

Key service functions include, but are not limited to:

- Preliminary assessment of risk, mental status and medical stability
- Stabilization of immediate crisis
- Determination of the need for further evaluation and/or substance use services
- Linkage to needed additional treatment services

Qualified Providers of Crisis Intervention

Services must be provided by an LMHP, QMHP, QAP or CSS with population-specific experience providing community support services in accordance with the key service functions for community support services.

Procedure Code for Crisis Intervention

PROCEDURE CODE	DESCRIPTION
H0007	Crisis Intervention

2.15 American Society of Addiction Medicine Team-Based Services

ASAM team-based services are described in this section. If a minimum number of hours of service is specified for a particular level of care, that amount of service must be provided on a daily basis in order to bill the team based-rate, as supported by The ASAM Criteria and individual treatment plans. If a program does not provide the minimum number of hours specified, it is at risk of recoupment of funds by DMH or other authorized representative(s.)

No more than one (1) per diem treatment rate may be billed per day for team-based services (intensive outpatient and residential levels of care), with the exception of Level 1-WM and Level 2-WM (see the following sections.)

NOTE: Level 1-WM and Level 2-WM can be offered in conjunction with other outpatient levels of care (ASAM Levels 1, 2.1 and 2.5). If additional services are needed in Level 1-WM, the individual should receive those services in the appropriate level of care. Refer to the billing guidance on the DBH website: **ASAM Billing Overlap Guidance**.

2.15 A Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring

Organized outpatient services are delivered by trained clinicians who provide medically supervised evaluation, withdrawal management and referral services according to a predetermined schedule. Services are provided in regularly scheduled sessions under a defined set of policies and procedures or medical protocols.

Services shall include, but are not limited to:

- Assessment
- Medication or non-medication methods of withdrawal management
- Non-pharmacological clinical support
- Involvement of family members/natural supports in the withdrawal management process
- Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal
- Referral for counseling and involvement in community recovery support groups and arrangements for counseling, medical, psychiatric and continuing care

The individual continues in Level 1-WM until:

- Withdrawal signs and symptoms are sufficiently resolved such that they can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring
- Their signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management service is indicated
- They are unable to complete withdrawal management at Level 1-WM despite an adequate trial, for ***example***, they are experiencing intense craving and evidence insufficient coping skills to prevent continued use concurrent with the withdrawal management medication, indicating a need for more intensive services

Admission Guidelines for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Individuals shall meet the diagnostic criteria for a substance withdrawal disorder and the ASAM dimensional criteria for admission to this level of care.

For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

Staff Requirements for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to the following sections of this manual for a complete description of qualified providers and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Interventions include, but are not limited to:

- A medical history and physical examination by a physician, AP, PA, resident physician or APRN during the treatment episode or within 24 hours of admission, whichever occurs sooner
    - A physical examination performed by an AP, PA, resident physician or APRN shall be dated and countersigned by a physician during the treatment episode or within 72 hours, whichever occurs sooner, signifying their review of and concurrence with the findings
- Daily assessment of progress during withdrawal management and any treatment changes, or less frequent if the severity of withdrawal is sufficiently mild or stable
- Transfer, treatment and discharge planning, beginning at the point of admission
- Referral and assistance for the individual to gain access to other needed SUD and/or mental health services

Assessment/Treatment Plan Review for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to **Section 2.12** of this manual for general requirements.

It is recommended that the individual treatment plan, including problem identification in Dimensions two (2) through six (6), be completed with goals and measurable treatment objectives and activities designed to meet those objectives as they apply to the management of the withdrawal syndrome.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Individuals shall receive a minimum of 30 minutes of service(s) per day.

NOTE: This level of care may be offered in conjunction with other outpatient levels of care (ASAM Levels 1, 2.1 and 2.5) with the expectation that if additional services are needed, the individual receives them in the appropriate level of care. Refer to the billing guidance on the DBH website: **ASAM Billing Overlap Guidance**.

Documentation Requirements for Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to **Sections 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 1-WM - Ambulatory Withdrawal Management without Extended On-Site Monitoring

PROCEDURE CODE	DESCRIPTION
H0014	ASAM 1 WM: Ambulatory Withdrawal Management

2.15 B Level 2-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring

Organized outpatient services are provided by trained clinicians to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate their entry into ongoing treatment and recovery.

Services shall include, but are not limited to:

- Assessment
- Medication or non-medication methods of withdrawal management
- Non-pharmacological clinical support
- Involvement of family members/natural supports in the withdrawal management process
- Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal
- Referral for counseling and involvement in community recovery support groups and arrangements for counseling, medical, psychiatric and continuing care

The individual continues in Level 2-WM until:

- Withdrawal signs and symptoms are sufficiently resolved such that they can be safely managed in a less intensive level of care.
- Their signs and symptoms of withdrawal have failed to respond to treatment and have intensified (based on a standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated.
- They are unable to complete withdrawal management at Level 2-WM despite an adequate trial, for ***example***, they are experiencing intense craving and have insufficient coping skills to prevent continued alcohol or other drug use, indicating a need for more intensive services

Admission Guidelines for Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Individuals shall meet the diagnostic criteria for substance withdrawal disorder and the ASAM dimensional criteria for admission.

For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

Qualified Providers Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Staff

- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Interventions include, but are not limited to:

- A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within 24 hours of admission, whichever occurs sooner
    - A physical examination performed by an AP, PA, resident physician or APRN shall be dated and countersigned by a physician during the treatment episode or within 72 hours, whichever occurs sooner, signifying their review of and concurrence with the findings
- Daily assessment of progress during withdrawal management and any treatment changes
- Transfer, treatment and discharge planning, beginning at the point of admission
- Referral and assistance for the individual to gain access to other needed SUD and/or mental health services

Assessment/Treatment Plan Review for Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to **Section 2.12** of this manual for general requirements.

It is recommended that the individual treatment plan, including problem identification in Dimensions two (2) through six (6), be completed with goals and measurable treatment objectives and activities designed to meet those objectives as they apply to the management of the withdrawal syndrome.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Individuals shall receive a minimum of one (1).25 hours of service(s) per day in order to bill the team-based rate.

NOTE: This level of care can be offered in conjunction with other outpatient levels of care (ASAM Levels 1, 2.1 and 2.5) with the expectation that if additional services are needed, the individual receives them in the appropriate level of care. Refer to the billing guidance on the DBH website: **ASAM Billing Overlap Guidance**.

Documentation Requirements for Level 2-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all services provided.

Procedure Code for Level 2-WM - Ambulatory Withdrawal Management without Extended On-Site Monitoring

PROCEDURE CODE	DESCRIPTION
H0012	ASAM 2 WM: Team-Based Ambulatory Withdrawal Management

2.15 C Level 2-WM-EM: Ambulatory Withdrawal Management with Extended On-Site Monitoring

Organized outpatient services are provided by trained clinicians who provide medically supervised evaluation, withdrawal management and referral services. Services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery.

Services shall include, but are not limited to:

- Assessment
- Medication or non-medication methods of withdrawal management
- Non-pharmacological clinical support
- Involvement of family members/natural supports in the withdrawal management process
- Physician and/or nurse monitoring, assessment and management of signs and symptoms of intoxication and withdrawal

Services shall include up to 23 hours of continuous observation, monitoring and support in a supervised environment for the individual to achieve initial recovery from the effects of alcohol and/or other drugs and to be appropriately transitioned to the most appropriate level of care to continue the recovery process.

Individuals must be discharged within 23 hours of admission.

Programs shall operate 24 hours per day, seven (7) days per week. Staff must be dressed and awake. Twenty-four (24) hour access to emergency medical consultation services must be available, as needed.

The individual continues in Level 2-WM-EM until:

- Withdrawal signs and symptoms are sufficiently resolved that the individual can be safely managed in a less intensive level of care
- The individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (based on a standardized scoring system) such that transfer to a more intensive level of withdrawal management service is indicated
- The individual is unable to complete withdrawal management at Level 2-WM despite an adequate trial, for ***example***, they are experiencing intense craving and have insufficient coping skills to prevent continued alcohol or other drug use, indicating a need for more intensive services

Admission Guidelines for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Individuals shall meet the diagnostic criteria for substance withdrawal disorder and the ASAM dimensional criteria for admission.

For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

Qualified Providers Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Interventions include, but are not limited to:

- A medical history and physical examination by a physician, AP, PA, resident physician, or APRN during the treatment episode or within 24 hours of admission, whichever occurs sooner
    - A physical examination not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within 72 hours, whichever occurs sooner, signifying their review of and concurrence with the findings
- Daily assessment of progress during withdrawal management and any treatment changes
- Transfer, continuing recovery and discharge planning beginning at the point of admission
- Conducting or arranging for appropriate laboratory and toxicology tests which can be point-of-care testing, as medically necessary
- Referral and assistance for the individual to gain access to other needed SUD and/or mental health services

Assessment/Treatment Plan Review for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Refer to **Section 2.12** of this manual for general requirements.

It is recommended that the individual treatment plan, including problem identification in Dimensions two (2) through six (6), be completed with goals and measurable treatment objectives and activities designed to meet those objectives as they apply to the management of the withdrawal syndrome.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Individuals shall receive a minimum of two (2) hours of service(s) per day in order to bill the team-based rate.

This level of care can be offered in conjunction with other outpatient levels of care (levels 1, 2.1, and 2.5) with the expectation that if additional services are needed, the individual receives them in the appropriate level of care.

Documentation Requirements for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all services provided.

Procedure Code for Level 2-WM-EM Ambulatory Withdrawal Management with Extended On-Site Monitoring

PROCEDURE CODE	DESCRIPTION
H0012 TG	ASAM 2 WM: Detoxification (Team Based Ambulatory detoxification) – 23-Hour Extended Monitoring

2.15 D Level 2.1: Intensive Outpatient Treatment

Intensive Outpatient Treatment (IOP) level of care includes professionally directed assessment, diagnosis, treatment and recovery services provided in an organized, non-residential treatment setting.

Services include, but are not limited to:

- Psychiatric, medical and laboratory services, as needed
- Comprehensive bio-psychosocial assessments and individualized treatment, allowing for a valid assessment of dependency
- Frequent monitoring/management of the individual's medical and emotional concerns in order to avoid hospitalization
- Individual counseling, group counseling, family therapy, peer and family support, crisis intervention and community support
- Monitoring of substance use, medication services, medication services support, medical and psychiatric examinations, crisis intervention and orientation to community-based support groups

Services shall also include monitoring of substance use and orientation and referral to community-based support groups. Timely access to additional support systems and services including medical, psychological and toxicology shall be available through consultation or referral.

Services shall vary in level of intensity and must include nine (9) or more contact hours per week for adults, age 18 years and older, not to exceed 19 hours per week. Services for adolescent's age nine (9) through 17 shall include six (6) or more contact hours per week, not to exceed 19 hours per week.

The duration of treatment shall vary based on the severity of the individual's illness and their response to treatment.

Admission Guidelines for Level 2.1 Intensive Outpatient Treatment

Adults appropriately placed in a Level 2.1 program are assessed as meeting the diagnostic criteria for a SUD as well as the ASAM dimensional criteria for admission.

If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian or natural supports.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal or the individual's withdrawal needs can be safely managed in an intensive outpatient setting. The adolescent who is appropriately placed in this level of care is likely to attend, engage and participate in treatment as evidenced by being able to tolerate mild subacute withdrawal symptoms, has made a commitment to sustain treatment and follow treatment recommendations, and has external supports to promote engagement in treatment.
- Biomedical conditions and complications: None or sufficiently stable to permit participation in outpatient treatment.
- Emotional, behavioral or cognitive conditions and complications: None to moderate. If present, the individual must receive appropriate co-occurring disorder services depending on their level of function, stability and degree of impairment in this dimension.
- Readiness to change: Requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level of care were unsuccessful. Adolescents admitted to this level of care may be only passively involved in treatment or demonstrate variable adherence with attendance at outpatient treatment sessions or self-help groups.
- Relapse, continued use or continued problem potential: Experiencing an intensification of symptoms of the substance-related disorder and level of functioning is deteriorating despite modification of the treatment plan. Alternatively, there is a high likelihood of relapse, continued use or continued problems without close monitoring and support several

times a week as indicated by the individual's lack of awareness of relapse triggers, difficulty in coping or in postponing immediate gratification, or ambivalence toward treatment.

- Recovery environment: Insufficiently supportive environment and the individual lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment. Alternatively, the individual lacks social contacts, has unsupportive social contacts that jeopardize recovery, or has few friends or peers who do not use alcohol or other drugs.

Qualified Providers of Level 2.1 Intensive Outpatient Treatment

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**.

Staff providing services for adolescents should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Staff who assess and treat adolescents should be able to recognize the need for specialty evaluation and treatment for intoxication or withdrawal and able to arrange for such evaluation or treatment in a timely manner.

Interventions for Level 2.1 Intensive Outpatient Treatment

Interventions include, but are not limited to:

- Monitoring including biomarkers and/or toxicology testing, as medically necessary
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Documented referral to more or less intensive services

Assessment/Treatment Plan Review for Level 2.1 Intensive Outpatient Treatment

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 2.1 Intensive Outpatient Treatment

Individuals shall receive a minimum of one (1) point five (5) hours of service(s) per day in order to bill the team-based rate. The week starts on the individual's date of admission.

Documentation Requirements for Level 2.1 Intensive Outpatient Treatment

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 2.1 Intensive Outpatient Services

Level 2.1 IOP procedure code is shown in the chart below.

PROCEDURE CODE	DESCRIPTION
H0015	ASAM 2.1: Intensive Outpatient (IOP)

2.15 E Level 2.5: Partial Hospitalization Services

Partial hospitalization is a planned format of services that are delivered on an individual and group basis to meet individual needs.

Services shall include, but are not limited to:

- Psychiatric, medical and laboratory services, as needed
- Comprehensive bio-psychosocial assessments and individualized treatment, allowing for a valid assessment of dependency
- Frequent monitoring/management of the individual's medical and emotional concerns in order to avoid hospitalization
- Individual counseling, group counseling, family therapy, peer and family support, crisis intervention and community support
- Monitoring of substance use, medication services, medication services support, medical and psychiatric examinations, crisis intervention and orientation to community-based support groups

Level 2.5 provides 20 or more hours of clinically intensive programming per week, based on individual treatment plans.

Admission Guidelines for Level 2.5 Partial Hospitalization Services

Individuals must meet diagnostic criteria for a SUD as well as the ASAM dimensional criteria for admission.

If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian or natural supports.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: No signs or symptoms of withdrawal or the individual's withdrawal needs can be safely managed in a partial hospital setting
- Biomedical conditions and complications: None, or not sufficient to interfere with treatment but are severe enough to distract from recovery efforts and require medical monitoring and/or medical management
- Emotional, behavioral or cognitive conditions and complications: None to moderate. If present, the individual must receive appropriate co-occurring disorder services depending on their level of function, stability and degree of impairment in this dimension.

- Readiness to change: Individual requires structured therapy and a programmatic milieu to promote treatment progress and recovery because motivational interventions at another level were unsuccessful
- Relapse, continued use or continued problem potential: Individual is experiencing an intensification of symptoms related to their SUD and their level of functioning is deteriorating despite modification of the treatment plan and active participation in a Level 1 or Level 2.1 program
- Recovery environment: Insufficiently supportive environment and the individual lacks the resources or skills necessary to maintain an adequate level of functioning without services in a partial hospitalization program. Alternatively, family members and/or other natural supports who live with the individual are not supportive of their recovery goals or are passively opposed to their treatment.

Qualified Providers of Level 2.5 Partial Hospitalization Services

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Adolescent program staff should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Clinical staff who assess and treat adolescents should be able to recognize the need for specialty evaluation and treatment for intoxication or withdrawal and be able to arrange for such evaluation or treatment in a timely manner.

Interventions for Level 2.5 Partial Hospitalization Services

Interventions include, but are not limited to:

- A physical examination, based on the individual's medical condition. Such determinations are made according to established protocols, which include reliance on the individual's personal healthcare provider, when possible. They are based on the staff's capabilities and the severity of the individual's symptoms and are approved by a physician.
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan

Assessment/Treatment Plan Review for Level 2.5 Partial Hospitalization Services

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 2.5 Partial Hospitalization Services

Individuals shall receive a minimum of two (2) point four (4) hours of service(s) per day in order to bill the team-based rate. The week starts on the individual's date of admission.

Documentation Requirements for Level 2.5 Partial Hospitalization Services

Refer to **Section 2.14** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 2.5 Partial Hospitalization Services

Level 2.5 Partial Hospitalization (PHP) service procedure code is shown in the chart below.

PROCEDURE CODE	DESCRIPTION
H0015 TG	ASAM 2.5: Partial Hospitalization (PHP)

2.15 F Level 3.1: Clinically Managed Low-Intensity Residential Services (Adolescent and Adult Criteria)

Level 3.1 programs provide a structured recovery environment which allows sufficient stability to prevent or minimize relapse or continued use and continued problem potential for individuals served.

Treatment services are focused on improving the individual's readiness to change and/or functioning and coping skills. Services shall include, but are not limited to:

- Individual counseling
- Group counseling
- Group rehabilitative support
- Family therapy
- Medication services.
- Medication services support
- Community support

The target length of stay is one (1) to three (3) months based on individual needs.

Programs must be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Admission Guidelines for Level 3.1 Clinically Managed Low-Intensity Residential Services

Individuals must meet diagnostic criteria for a substance use disorder as well as the ASAM dimensional criteria for admission.

If the individual's presenting substance use history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information appropriately submitted or obtained from collateral parties such as family members, legal guardian or natural supports.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: None, or minimal/stable withdrawal risk and can be safely managed in this level of care. The adolescent's status in this dimension

is characterized by problems with intoxication or withdrawal (if any) that are being managed through concurrent placement at another level of care for withdrawal management (typically Level 1, 2.1, or 2.5).

- Biomedical conditions and complications: Biomedical problems, if any, are stable and do not require medical or nurse monitoring and the individual is capable of self-administering any prescribed medications. The adolescent's status in this dimension is characterized by a biomedical condition that distracts from recovery efforts and requires limited residential supervision to ensure adequate treatment and provide support to overcome the distraction, or continued substance use would place them at risk of serious damage to their physical health.
- Emotional, behavioral or cognitive conditions and complications: Minimal problems in this area. The individual's mental status is assessed as sufficiently stable to allow them to participate in therapeutic interventions provided at this level of care and to benefit from treatment. The adolescent's status in this dimension is characterized by at least one (1) of the following:
    - Risk of dangerous consequences because of the lack of a stable environment
    - Emotional, behavioral or cognitive problems result in moderate impairment in social functioning
    - Moderate impairment in their ability to manage the activities of daily living
    - History and present situation suggests an emotional, behavioral or cognitive condition would become unstable without 24 hours supervision
    - Emotional, behavioral or cognitive condition suggests the need for low-intensity and/or longer term reinforcement and practice of recovery skills in a controlled environment
- Readiness to change: Open to recovery, but in need of a structured, therapeutic environment to promote treatment progress and recovery due to impaired ability to make behavior changes without the support of a structured environment.
- Relapse, continued use or continued problem potential: Understands the risk of relapse, but lacks relapse prevention skills or requires a structured environment to continue to apply recovery and coping skills. The adolescent is at high risk of substance use or deteriorated mental functioning with dangerous emotional, behavioral or cognitive consequences in the absence of 24 hour structured support.
- Recovery environment: Able to cope for limited periods of time outside of the 24 hour structure, but the environment jeopardizes recovery. The adolescent's home environment is too chaotic or ineffective to support or sustain treatment goals such that recovery is assessed as unachievable without residential support.

Qualified Providers of Level 3.1 Clinically Managed Low-Intensity Residential Services

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers

- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Staff in adolescent programs should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Experience in adolescent medicine is ideal.

Interventions for Level 3.1 Clinically Managed Low-Intensity Residential Services

Interventions include, but are not limited to:

- Tuberculosis screening and testing, provided directly or by referral. Pre- and post-test counseling shall be provided, as needed
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Documented physical examination one (1) month prior to admission or a physical exam completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination
- Referral and assistance, as needed, for the individual to gain access to other needed SUD or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders, as appropriate and for the continuation of appropriate treatment
- Specific and documented plans for community reintegration and transition to less intensive levels of residential and treatment support, including the aftercare to which the individual is being discharged

Assessment/Treatment Plan Review for Level 3.1 Clinically Managed Low-Intensity Residential Services

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment, and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.1 Clinically Managed Low-Intensity Residential Services

Individuals shall participate in at least five (5) hours of services per week. The week starts on the individual's date of admission. Mutual/self-help meetings shall not be included in five (5) hours of treatment per week.

Documentation Requirements for Level 3.1 Clinically Managed Low-Intensity Residential Services

Refer to **Sections 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.1 Clinically Managed Low-Intensity Residential Services

PROCEDURE CODE	DESCRIPTION
H2036 HF	ASAM 3.1: Clinically Managed Low Intensity Residential Services

2.15 G Level 3.2-WM: Clinically Managed Residential Withdrawal Management

Services are provided in an organized, residential, non-medical setting and are delivered by appropriately trained staff who provide safe, 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal.

Programs may be staffed to supervise self-administered medications for management of withdrawal symptoms. All programs shall have established clinical protocols to identify individuals in need of medical services beyond the program's capacity and to arrange for transfer to an appropriate healthcare facility.

Services shall include, but are not limited to:

- Individual counseling
- Group counseling
- Group rehabilitation support
- Peer and family support
- Community support
- Medical and medication services support

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Target length of stay is one (1) to three (3) days.

Admission Guidelines for Level 3.2-WM Clinically Managed Residential Withdrawal Management

Individuals admitted to this level of care are experiencing signs and symptoms of withdrawal or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition and/or emotional, behavioral or cognitive conditions) that withdrawal is imminent. The individual is assessed as not being at risk of severe withdrawal and moderate withdrawal is safely manageable at this level of service.

- In addition, the individual may be assessed as not requiring medication to assist in managing withdrawal symptoms, but requires this level of service to complete withdrawal management and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting one (1) of the following criteria:
    - The individual's recovery environment is not supportive of withdrawal management and entry into treatment, and they do not have sufficient coping skills to safely manage issues in the recovery environment

- The individual has a recent history of withdrawal management at less intensive levels of service that is marked by inability to complete withdrawal management or to enter into continuing SUD treatment and continues to have insufficient skills to complete withdrawal management
- The individual recently demonstrated an inability to complete withdrawal management at a less intensive level of service, as evidenced by continued use of non-prescribed drugs or other substances

Qualified Providers of Level 3.2-WM Clinically Managed Residential Withdrawal Management

Refer to the following sections of this manual for a complete description of qualified providers and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 3.2 Clinically Managed Residential Withdrawal Management

Interventions include, but are not limited to:

- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- During the treatment episode or within 24 hours of admission, whichever occurs sooner, a medical history and physical examination, by a physician, AP, PA, resident physician or APRN
    - A physical examination that is not performed by a physician shall be dated and countersigned by a physician during the treatment episode or within 72 hours, whichever occurs sooner, signifying their review of and concurrence with the findings
- A comprehensive nursing assessment at admission which includes a substance use history and assessment recommendations that are reviewed with a physician
- Documented referral and assistance for the individual to gain access to other needed SUD and/or mental health services

Assessment/Treatment Plan Review for Level 3.2-WM Clinically Managed Residential Withdrawal Management

Refer to **Section 2.12** of this manual for general requirements.

For individuals new to the program, it is recommended that an assessment be completed within 24 hours of admission which substantiates appropriate level of care placement.

It is recommended that the individual treatment plan be completed within 24 hours which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan should be developed in collaboration with the individual.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.2-WM Clinically Managed Residential Withdrawal Management

Target length of stay is one (1) to three (3) days. The week starts on the individual's date of admission. Services must be available 7 days per week.

Documentation Requirements for Level 3.2-WM Clinically Managed Residential Withdrawal Management

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.2-WM Clinically Managed Residential Withdrawal Management

PROCEDURE CODE	DESCRIPTION
H0010	ASAM 3.2 WM: Clinically Managed Residential Withdrawal Management

2.15 H Level 3.3: Clinically Managed, Population-Specific High Intensity Residential Services (Adult Criteria)

Programs provide a structured recovery environment in combination with high-intensity clinical services to meet the individual's functional limitations and to support recovery from substance-related disorders.

Individuals shall receive a minimum of 20 hours of services per week. The week starts on the individual's date of admission.

At least 10 of the 20 hours of services shall include a combination of individual counseling, group counseling, group rehabilitative support, family therapy, peer and family support, community support, medication services and medication services support.

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Length of stay is based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services/Adults

Individuals admitted to this level of care must meet diagnostic criteria for a moderate or severe SUD as well as the ASAM dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined

from information submitted by collateral parties such as family members/natural supports and legal guardians.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: None, or minimal risk of withdrawal or withdrawal needs can be safely managed at this level
- Biomedical conditions and complications: None or stable. Any biomedical problems do not require medical or nurse monitoring and the individual is capable of self-administering any prescribed medications.
- Emotional, behavioral or cognitive conditions and complications: Individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment
- Readiness to change: Due to the intensity and chronicity of the SUD or the individual's cognitive limitations, they have little awareness of the need for continuing care, or the existence of their substance use or mental health problem and need for treatment, therefore, has limited readiness to change
- Relapse, continued use or continued problem potential: Individual has limited awareness of relapse triggers and is in imminent danger of relapse or continued substance use. The individual requires relapse prevention activities that are delivered at a slower pace, more concretely and more repetitively within a 24 hour structured environment.
- Recovery environment: Environment interferes with recovery and is characterized by moderately high risk of initiation or repetition of physical, sexual or emotional abuse, or substance use is so prevalent the individual is unable to cope outside of a 24 hour supervised setting

Qualified Providers of Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services/Adults

Refer to the following sections of this manual for a complete description of qualified providers and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services/Adults

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre-and post-test counseling shall be provided, as needed
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual's treatment plan

- Comprehensive nursing assessment completed within 72 hours of admission, with consultation with a physician when necessary
- A documented physical examination one (1) month prior to admission or a physical exam completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination.
- Referral and assistance, as needed, for the individual to gain access to other needed SUD and/or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment

Assessment/Treatment Plan Review for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment, and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services

Individuals shall receive a minimum of 20 hours of services per week. The week starts on the individual's date of admission.

Documentation Requirements for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services

Refer to **Section 2.4** of this manual for documentation requirements applicable to all levels of care.

Procedure Code for Level 3.3 Clinically Managed, Population-Specific High Intensity Residential Services

PROCEDURE CODE	DESCRIPTION
H2036 HI	ASAM 3.3: Clinically Managed, High Intensity Residential Population Specific

2.15 I Level 3.5: Clinically Managed High-Intensity Residential Services (Adult Criteria)

Programs are designed to serve individuals who, because of specific functional limitations, need a safe and stable environment in order to develop and/or demonstrate sufficient recovery skills so they do not immediately relapse or continue to use in an imminently dangerous manner upon transfer to a less intensive level of care. Individual needs are of such severity that treatment cannot be safely provided in a less intensive level of care.

Individuals shall receive at least 20 hours per week of a combination of clinical and recovery services. The week starts on the individual's date of admission.

At least 10 of the 20 hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services and/or medication services support.

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Length of stay is based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

Individuals admitted to this level of care meet the diagnostic criteria for SUD of moderate to high severity, as well as the dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (e.g., family members/natural supports, and legal guardians.)

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: None or withdrawal symptoms can be safely managed at this level
- Biomedical conditions and complications: None or stable and the individual can self-administer any prescribed medication or if their condition is severe enough to distract from treatment and recovery, the individual can receive medical monitoring within the program or through another provider
- Emotional, behavioral or cognitive conditions and complications: Individual's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment. Despite the individual's best efforts, they are unable to control their use of alcohol and/or other drugs, and their level of dysfunction is so severe they would not be successful in a less structured level of care.
- Readiness to change: Individual has marked difficulty with or opposition to treatment, with dangerous consequences and has limited insight and awareness of the need for continuing care or the existence of their substance use or mental health problem and need for treatment, thereby has limited readiness to change
- Relapse, continued use or continued problem potential: The individual is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued

use, with limited ability to initiate or sustain ongoing recovery in a less structured environment

- Recovery environment: Individual lives in an environment with moderately high risk of neglect, initiation or repetition of physical, sexual or emotional abuse or is in a culture highly invested in substance use. The individual lacks skills to cope with challenges to recovery outside of a highly structured 24-hour setting.

Qualified Providers of Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**

Interventions for Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Comprehensive nursing assessment completed within 72 hours of admission, with consultation with a physician when necessary
- A documented physical examination one (1) month prior to admission or a physical exam completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination.
- Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable
- Referral and assistance as needed for the individual to gain access to other needed SUD and/or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment
- Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged

Assessment/Treatment Plan Review for Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment, and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

- Individuals shall receive a combination of at least 20 hours of clinical and recovery services per week. The week starts on the individual's date of admission
- At least 10 of the 20 hours must include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services and/or medication services support
- Therapy must be available seven (7) days per week.

If a program does not provide the minimum number of hours specified in the individual's treatment plan, and as supported by the ASAM admission criteria, the program is at risk of recoupment of funds.

Documentation Requirements for Level 3.5 Clinically Managed High-Intensity Residential Services/Adults

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.5 Clinically Managed High-Intensity Residential Services (Adults)

PROCEDURE CODE	DESCRIPTION
H2036	ASAM 3.5: Clinically Managed High-Intensity Residential

2.15 J Level 3.5: Clinically Managed Medium-Intensity Residential Services (Adolescent Criteria)

Level 3.5 is a residential program offering a 24-hour supportive treatment environment. Adolescents placed in this level of care typically have impaired functioning across a broad range of psychosocial domains. These impairments may be expressed as disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situations, developmental immaturity and psychological problems. Programs shall comply with **9 CSR 30-3.192**.

Individuals shall receive a combination of at least 20 hours of clinical and recovery services per week. The week starts of the individual's date of admission.

At least 10 of the 20 hours must include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, medication services and/or medication services support.

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Length of stay is based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

Adolescents admitted to this level of care meet diagnostic criteria for a SUD of moderate to high severity, as well as the ASAM dimensional criteria for admission. If the adolescent's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by family members/natural supports and legal guardians.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: At risk of or experiencing acute or subacute intoxication or withdrawal, with mild to moderate symptoms. Needs secure placement and increased treatment intensity to support engagement in treatment, ability to tolerate withdrawal and prevention of immediate continued use. Alternatively, the adolescent has a history of unsuccessful treatment at the same or a less intensive level of care.
- Biomedical conditions and complications: Biomedical conditions distract from recovery efforts and require residential supervision (that is unavailable in a less intensive level of care) to ensure adequate treatment or the adolescent requires medium-intensity residential treatment to provide support to overcome the distraction. Continued substance use would place the adolescent at risk of serious damage to their physical health because of a biomedical condition (such as pregnancy or HIV) or an imminently dangerous pattern of high-risk use.
- Emotional, behavioral or cognitive conditions and complications: Adolescent is at moderate but stable risk of imminent harm to self or others and needs medium intensity, 24-hour monitoring and/or treatment for protection and safety, however, does not require access to medical or nursing services. Their recovery efforts are negatively impacted by their emotional, behavioral or cognitive problems in significant and distracting ways.
- Readiness to change: Due to the intensity and chronicity of their SUD and/or mental health problems, the adolescent has limited insight into and little awareness of the need for continuing care or the existence of their SUD or mental health issues and has limited readiness to change. The individual has marked difficulty in understanding the relationship between their SUD, mental health, or life problems and their impaired coping skills and level of functioning, often blaming others for their problems.
- Relapse, continued use or continued problem potential: Adolescent does not recognize relapse trigger and lacks insight into the benefits of continuing care and is therefore not

committed to treatment. Their continued use of substances poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support.

- Recovery environment: Living and social environments have a high risk of neglect or initiation or repetition of physical, sexual or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential treatment.

Qualified Providers of Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers; and
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements.**

Interventions for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Comprehensive nursing assessment completed within 72 hours of admission, with consultation with a physician when necessary
- A documented physical examination one month prior to admission or a physical examination completed no later than five days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination.
- Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable
- Referral and assistance, as needed, for the individual to gain access to other needed medical, SUD and/or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment
- Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged
- Educational services shall be provided in accordance with state regulations, including opportunities to address deficits in the education level of adolescents who have fallen behind because of their involvement with alcohol and or other drugs

Assessment/Treatment Plan Review for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

- Individuals shall receive a combination of at least 20 hours of clinical and recovery services per week. The week starts on the individual's date of admission.
- At least 10 of the 20 hours must include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services and/or medication services support
- Therapy must be available seven (7) days per week

If a program does not provide the minimum number of hours specified in the individual's treatment plan, and as supported by the ASAM admission criteria, the program is at risk of recoupment of funds.

Documentation Requirements for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.5 Clinically Managed Medium-Intensity Residential Services/Adolescents

PROCEDURE CODE	DESCRIPTION
H2036	ASAM 3.5: Clinically Managed Medium-Intensity Residential

2.15 K Level 3.5 PPW: Clinically Managed High-Intensity Residential Services (Women and Children)

Programs provide a 24-hour supportive treatment environment, specializing in services for women who are pregnant, postpartum and/or have children. Programs must arrange for gender-specific SUD treatment and other therapeutic interventions for women, and comply with child supervision and other requirements specified in **9 CSR 30-3.190**.

Individuals shall receive a combination of at least 20 hours of clinical and recovery services per week. The week starts on the individual's date of admission.

At least 10 of the 20 hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services, and/or medication services support.

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Length of stay is based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

The individual who is appropriately placed in this level of care meets the diagnostic criteria for a substance use disorder of moderate to high severity, as well as the ASAM dimensional criteria for admission. If the individual's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (e.g., family members, legal guardians, and significant others).

Priority for admission shall be given to women who are pregnant, postpartum, or have children in their physical care and custody.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: None or withdrawal symptoms can be safely managed at this level
- Biomedical conditions and complications: None or stable and the individual can self-administer any prescribed medication, or if the condition is severe enough to distract from treatment and recovery, the individual can receive medical monitoring within the program or through another provider
- Emotional, behavioral, or cognitive conditions and complications: Mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit them to participate in the therapeutic interventions provided at this level of care and to benefit from treatment
- Readiness to change: Significant difficulty with treatment, with negative consequences, and may have significant limitations in the areas of readiness to change. Recovery may be perceived as providing a lesser return for the effort.
- Relapse, continued use or continued problem potential: Needs skills to prevent continued use and may have relapse, continued use or continued problem potential
- Recovery environment: Individual lives in an environment with moderately high risk of neglect, initiation or repetition of physical, sexual or emotional abuse, or is in a culture highly invested in substance use. The individual lacks skills to cope with challenges to

recovery outside of a highly structured 24 hour setting. These social influences may represent a sense of hopelessness or an acceptance of deviance as normative.

Qualified Providers of Level 3.5 PPW Clinically Managed High-Intensity Residential Services (Women and Children)

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**.

Interventions for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling shall be provided, as needed.
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Comprehensive nursing assessment completed within 72 hours of admission, with consultation with a physician when necessary
- A documented physical examination one month prior to admission or a physical exam completed no later than five (5) days after admission. Any individual receiving uninterrupted treatment or care shall require only the documentation of the initial physical examination.
- Children accompanying their mother to services shall receive a screening by a QMHP/QAP to determine the appropriateness and need for services.
    - If services are determined to be a need for the child(ren), a licensed diagnostician shall complete an assessment with diagnosis
- Referral and assistance as needed for the individual to gain access to other needed SUD and/or mental health services
- Orientation to and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment
- Documented plans for community reintegration and transition to less intensive levels of residential and treatment support and services, including the aftercare to which the individual is being discharged

Assessment/Treatment Plan Review for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

Refer to **Section 2.12** of this manual for general requirements.

Modification to the treatment plan based on review of any positive drug screen(s) with the individual served, as applicable.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

- Individuals shall receive a combination of at least 20 hours of clinical and recovery services per week. The week starts on the individual's date of admission.
- At least 10 of the 20 hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services and/or medication services support
- Therapy must be available seven (7) days per week

If a program does not provide the minimum number of hours specified in the individual's treatment plan, and as supported by the ASAM admission criteria, the program is at risk of recoupment of funds.

Documentation Requirements for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

Refer to **Section 2.4** of this manual for documentation requirements applicable to all levels of care.

Procedure Code for Level 3.5 PPW Clinically Managed High-Intensity Residential Services/Women and Children

PROCEDURE CODE	DESCRIPTION
H2036	ASAM 3.5: Clinically Managed High-Intensity Residential

2.15 L Level 3.7: Medically Monitored Intensive Inpatient Services (Adult Criteria)

Programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and SUD treatment in a residential setting. Individuals in this level of care may have co-occurring substance use and mental health disorders that need to be stabilized.

The target population includes individuals with a high risk of withdrawal symptoms and moderate co-occurring psychiatric and/or medical problems that are of sufficient severity to require 24-hour treatment.

Individuals shall receive 30 hours of structured treatment per week. The week starts on the individual's date of admission.

At least ten 10 of the 30 hours shall include a combination of individual counseling, group counseling, group rehabilitative support, family therapy, peer and family support, crisis intervention, community support, medication services and/or medication services support.

Programs shall be staffed 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available seven (7) days per week.

Length of stay shall be based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

Individuals admitted to this level of care must meet diagnostic criteria for a moderate or severe substance use disorder, as well as the ASAM dimensional criteria for admission. If the individual's presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by family members/natural supports and legal guardians.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute intoxication and/or withdrawal potential: High risk of withdrawal symptoms that can be managed in a Level 3.7 program
- Biomedical conditions and complications: Moderate to severe conditions which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital
- Emotional, behavioral or cognitive conditions and complications: Moderate to severe conditions and complications (such as diagnosable co-morbid mental disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for ***example***, anxiety/hypomanic or depression and/or cognitive symptoms) and may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan or hallucinations and delusions without acute risk to self or others. Psychiatric symptoms are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.
- Readiness to change: Individual is unable to acknowledge the relationship between the SUD and mental health and/or medical issues or is in need of intensive motivating strategies, activities and processes available only in a (24-hour structured medically monitored setting (but not medically managed)
- Relapse, continued use or continued problem potential: Individual is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of 24-hour monitoring and structured support
- Recovery environment: Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use

so prevalent that the individual is assessed as unable to achieve or maintain recovery at a less intensive level of care

Qualified Providers of Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**.

Interventions for Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed.
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- Nursing assessment at time of admission by an RN (or APRN, physician, resident physician, AP, PA in the absence of an RN)
- A physician or AP, PA, APRN or resident physician is available to assess the individual within 24 hours of admission or a review and update by a physician within 24 hours of admission of the record of a physical examination conducted no more than seven (7) days prior to admission. A physician is available to assess the individual thereafter as medically necessary.
- Additional medical specialty consultation, psychological, laboratory and toxicology services, are available onsite, through consultation, or referral
- Referral and assistance as needed for the individual to gain access to other needed SUD and/or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment

Assessment/Treatment Plan Review for Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

Refer to **Section 2.12** of this manual for general requirements.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.7 Medically Monitored Intensive Inpatient Services (Adults)

- Individuals shall receive at least 30 hours of structured treatment per week. The week starts on the individual's date of admission.

- At least 10 of the 30 hours shall include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services and/or medication services support
- Therapy must be available seven (7) days per week

If a program does not provide the minimum number of hours specified in the individual's treatment plan, and as supported by the ASAM admission criteria, the program is at risk of recoupment of funds.

Documentation Requirements for Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.7 Medically Monitored Intensive Inpatient Services/Adults

PROCEDURE CODE	DESCRIPTION
H2036 TG	ASAM 3.7: Medically Monitored Intensive Inpatient

2.15 M Level 3.7: Medically Monitored Intensive Inpatient Services (Adolescent Criteria)

Programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and SUD treatment. For adolescents, this level of treatment is often necessary to orient the individual to the structure of daily life. Services must be provided in accordance with **9 CSR 30-3.192**.

Individuals shall receive at least 30 hours of structured treatment per week. The week starts on the individual's date of admission.

At least 10 of the 30 hours must include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, crisis intervention, community support, medication services and/or medication services support.

Length of stay shall be based on the individual's severity of illness, level of function and progress in treatment.

Admission Guidelines for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

Adolescents admitted to this level of care meet the diagnostic criteria for a moderate or severe SUD, as well as the ASAM dimensional criteria for admission. If the adolescent's presenting history is conflicting or inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information provided by collateral parties such as parent/guardian, family members or other natural supports.

The information below is not a comprehensive list of placement criteria for this level of care. All components of The ASAM Criteria must be considered when determining level of care for individuals served. This is not a clinical document.

- Acute Intoxication and/or withdrawal potential: Experiencing or at risk of acute or subacute intoxication or withdrawal with moderate to severe signs and symptoms. The individual needs 24-hour treatment services, including the availability of active medical and nurse monitoring to manage withdrawal, support engagement in treatment, and prevent immediate continued use.
- Biomedical conditions and complications: Significant risk of serious damage to physical health or concomitant biomedical conditions or a biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital
- Emotional, behavioral or cognitive conditions and complications: Moderate and possibly unpredictable risk of imminent harm to self or others and needs 24-hour monitoring and/or treatment in a high-intensity programmatic environment for safety
- Readiness to change: Despite experiencing serious consequences or effects of the SUD and/or behavioral health problem, does not accept or relate the disorder to the severity of the presenting problem. The individual is in need of intensive monitoring strategies, activities and processes available in a 24-hour setting
- Relapse, continued use or continued problem potential: Experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of the substance use or mental disorder such as poor impulse control or drug-seeking behavior
- Recovery environment: Living in an environment in which supports that might otherwise have enabled treatment at a less intensive level of care are unavailable or the family is unable to sustain treatment attendance at a less intensive level of care

Qualified Providers of Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**.

Staff should be knowledgeable about adolescent development and experienced in engaging and working with this population.

Interventions for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

Interventions include, but are not limited to:

- Tuberculosis screening and testing provided directly or by referral. Pre- and post-test counseling are provided as needed.
- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan

- Nursing assessment at the time of admission by an RN (or APRN, physician, resident physician, AP, PA in the absence of an RN)
- A physician or NP, PA, APRN or resident physician is available to assess the individual within 24 hours of admission or a review and update by a physician within 24 hours of admission of the record of a physical examination conducted no more than seven (7) days prior to admission. A physician is available to assess the individual thereafter as medically necessary.
- Additional medical specialty consultation, psychological, laboratory and toxicology services, are available onsite, through consultation, or referral
- Referral and assistance, as needed, for the individual to gain access to other needed SUD and/or mental health services
- Orientation and facilitated connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders, as appropriate, and for the continuation of appropriate treatment
- Educational services provided in accordance with state regulations, including opportunities to address deficits in the educational level of adolescents who have fallen behind because of their involvement with alcohol and/or other drugs

Assessment/Treatment Plan Review for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

Refer to **Section 2.12** of this manual for general requirements.

Elements of the assessment and treatment plan review in this level of care for adolescents should also include:

- An initial withdrawal assessment within 24 hours of admission, or earlier if clinically warranted
- Daily nursing withdrawal monitoring assessments and continuous availability of nursing evaluation
- Daily availability of medical evaluation, with continuous on-call coverage

Transfer, treatment, and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

- Individuals shall receive at least 30 hours of structured treatment per week. The week starts on the individual's date of admission.
- At least 10 of the 30 hours must include a combination of individual counseling, group counseling and rehabilitative support, family therapy, peer and family support, community support, crisis intervention, medication services, and/or medication services support
- Therapy must be available seven (7) days per week

If a program does not provide the minimum number of hours specified in the individual's treatment plan, and as supported by the ASAM admission criteria, the program is at risk of recoupment of funds.

Documentation Requirements for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.7 Medically Monitored Intensive Inpatient Services/Adolescents

PROCEDURE CODE	DESCRIPTION
H2036 TG	ASAM 3.7: Medically Monitored Intensive Inpatient

2.15 N Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management (Adult Criteria)

Medically monitored inpatient services shall be provided by medical and nursing professionals who provide medically-supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

Twenty-four (24) hour observation, monitoring and treatment shall be provided by an interdisciplinary team of trained staff.

Individuals remain in this level of care until withdrawal signs and symptoms are sufficiently resolved such that they can be safely managed at a less intensive level of care, or their signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on a standardized scoring system.)

Services shall include assessment, individual and group counseling, group rehabilitative support, peer/family support, community support, medication services, crisis intervention and medication services support.

Admissions shall be accepted 24 hours per day, seven (7) days per week. Staff shall be dressed and awake. Services shall be available 7 days per week.

Admission Guidelines for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

Individuals who are appropriately placed in any level of withdrawal management (1-WM through 3.7-WM) meet the diagnostic criteria for substance withdrawal disorder, as well as the ASAM dimensional criteria for admission.

For individuals whose presenting alcohol or other substance use history is inadequate to substantiate such a diagnosis, information provided by collateral parties (such as family members/natural

supports or a legal guardian) can indicate a high probability of such a diagnosis, subject to confirmation by further evaluation.

Qualified Providers of Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

Refer to the following sections of this manual for a complete description of staff qualifications and minimum staff requirements:

- **Section 2.8** – Qualified Providers
- **Section 2.9** – General Staff Requirements **ASAM Minimum Staffing Requirements**.

Interventions for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

- Random drug screening, as medically necessary, to reinforce treatment gains, as appropriate to the individual treatment plan
- A comprehensive nursing assessment at admission which includes a substance use history and assessment recommendations that are reviewed with a physician
- A physician (or AP/PA/APRN/resident physician) assesses the individual in person, including telehealth with video and audio capabilities, within 24 hours of admission or a review and update by a physician within 24 hours of admission of the record of a physical examination be conducted no more than seven (7) days prior to admission. A physician is available to assess the individual thereafter as medically necessary.
- Daily assessment of the individual's progress through withdrawal management and any treatment changes
- Referral and assistance for the individual to gain access to other needed SUD and/or mental health services

Assessment/Treatment Plan Review for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

Refer to **Section 2.12** of this manual for general requirements.

For individuals new to the program, ASAM recommends an assessment be completed within 24 hours of admission which substantiates appropriate level of care placement.

ASAM recommends an individual treatment plan be developed within 24 hours of admission which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. The plan should be developed in collaboration with the individual.

ASAM recommends a treatment plan be developed within three (3) days, if the individual continues receiving services.

Transfer, treatment and discharge planning begins at admission and is documented as such in the individual's record.

Limitations for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

The following applies to residential services:

- Therapy must be available seven (7) days per week
- The week starts on the individual's date of admission

Documentation Requirements for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

Refer to **Section 2.4** of this manual for documentation requirements which are applicable to all levels of care.

Procedure Code for Level 3.7-WM Medically Monitored Inpatient Withdrawal Management/Adults

PROCEDURE CODE	DESCRIPTION
H0011	ASAM 3.7 WM: Medically Monitored Inpatient Withdrawal Management

2.16 Criteria for Discharge, Transfer and Continuation of Services

All decisions about when to transition individuals to other services, continue services and discharge from services are based on the progress of the individual. The ASAM Criteria does not support treatment with dates of "graduation" or "completion" that are assigned before the individual actually begins treatment. The length of treatment depends on the progress made by the individual, with clearly defined and agreed-upon goals and outcomes, rather than the result of a program's preset structure.

2.17 Non-Covered Services

Laboratory Services

Laboratory services are not covered by MHD through the CSTAR Program. Laboratory services may be reimbursable to other appropriate MHD enrolled provider types subject to program limitations.

Prescriptions

Prescription drugs are not covered through the CSTAR Program. Refer to the **Pharmacy Manual**.

2.18 MO HealthNet Managed Health Care Program

CSTAR services are not included as a plan benefit for the MO HealthNet Managed Health Care Program.

2.19 Administrative Lock-In

Some MO HealthNet participants are restricted or "locked in" to specific authorized MHD providers of certain services to aid the participant in proper utilization of the MO HealthNet Program. Refer to

the General Sections Manual for additional information about the program and information on identifying lock-in participants.

2.20 State Funded Assistance Participants

CSTAR services are not reimbursable by MHD for participants under state funded categories of assistance. These participants may have their needs met if they receive services from a provider who has a purchase of service CSTAR contract administered by the DMH, DBH. For further information for a listing of state-funded ME codes, see the General Sections Manual.

2.21 Quality Assurance

All CSTAR providers are monitored to assure compliance and quality of care by the DMH.

2.22 Definitions

The following definitions apply to this program:

Collateral contact

A source of information regarding an individual's health, safety, functional needs or effectiveness of the individual's plan for services. Communication with a collateral contact may be made in-person, audio-only or by telemedicine.

Examples of collateral contacts that can be utilized to promote the recovery of an individual in services include, but are not limited to:

- Family members
- Therapeutic providers from other agencies providing services
- Pediatricians, family doctors, clinics, medical care specialists other health care providers
- Pharmacy staff
- Legal agency affiliates (such as probation or parole officers)
- Education facilities
- Legal guardians

Non-Physician

Assistant physician, physician assistant, resident physician or APRN.

Section 3-Billing Instructions

3.1 Electronic Claim Submission

For all Comprehensive Substance Treatment and Rehabilitation (CSTAR) services, the provider submits all billing to the Missouri Department of Mental Health (DMH) through the web based Customer Information Management Outcomes and Reporting system (CIMOR). The DMH in turn submits eligible claims to the MO HealthNet Division (MHD.) This includes all adjustments.

DMH submits services for the provider electronically using the most current required X12N version.

Providers may submit services electronically to CIMOR via a HIPAA 837 or through keying services directly online to CIMOR. Providers who wish to submit services electronically should refer to the "HIPAA 837 Companion Guide", the "835 Companion Guide", "Batch Test Steps and Checklist", and the "Batch Submission Contacts List" available at the **DMH website**. Providers submitting CSTAR services electronically to CIMOR will receive a Remittance Advice (RA) from DMH.

Medicaid eligibility and claims submitted to MHD may be viewed in CIMOR. Providers may also use **eMOMED** to view eligibility. Refer to the **General Sections Manual** for additional information on eMOMED.

3.2 Resubmission of Claims

Providers may view their claims in CIMOR or may use the RA if services were submitted to CIMOR electronically on a HIPAA 837.

Services that resulted in zero payment on a claim can be resubmitted if the claim denied due to a correctable error. The error that caused the claim to deny should be corrected before resubmitting it to MHD through CIMOR. The provider may use the Replace button on the service in CIMOR to resubmit a claim to MHD.

3.3 Inquiries

Providers may inquire about CSTAR services by requesting email support through the Division of Behavioral Health (DBH) Support Center. Email support is available after a successful login to the **DMH Portal Site** and selecting DBH Support Center on the subject line.

3.4 Comprehensive Substance Treatment and Rehabilitation Invoices

DMH generates CSTAR invoices through CIMOR. CSTAR Medicaid invoices are generated after the remittance advice (835) is received from MHD. CIMOR invoices are available to providers, and can be viewed on-line or printed.

3.5 Payments

After MHD payments are generated, DMH accounting will generate invoice payments through CIMOR.

3.6 Insurance Coverage Codes

While providers are verifying the participant's eligibility, they can obtain the Third Party Liability (TPL) information in CIMOR. Eligibility may be verified by accessing **eMOMED** or by calling the Interactive Voice Response (IVR) system at (573) 751-2896. Reference the **General Sections Manual**, for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by CIMOR, the IVR or **eMOMED**. It is the provider's responsibility to obtain from

the participant the name and address of the insurance company, the policy number and the type of coverage. Reference the **General Sections Manual** for more information.

3.7 Comprehensive Substance Treatment and Rehabilitation Rebill Instructions

If a service on a claim was incorrect because the service was billed with incorrect information, (e.g., units are too high) for instance, the provider should use the Replace button on the claim to adjust the service in CIMOR and the claim will be resubmitted by DMH.

If a health insurance payment is received after the invoice has been paid, the amount collected must be credited back through CIMOR. The provider should make the adjustment in CIMOR and the claim will be resubmitted by the DMH.

3.8 Special Billing Issues

For other special billing issues concerning CSTAR services, request support through the DBH Support Center. Email support is available after a successful login to the **DMH Portal Site** and selecting DBH Support Center on the subject line.

Units of Service Provided Over Daily Limit

CIMOR uses business rules to hold services to maximum limits where applicable. If providers wish to exceed service limits, providers must submit an Individualized Package request for the participant, with adequate clinical justification, and await approval from DMH Utilization Review staff before limits can be exceeded.

Participant Direct Pay Portion

When a participant, as a result of the Standard Means Test (SMT) must pay an amount for the CSTAR services provided, the provider must add the monthly SMT amount to CIMOR. CIMOR will deduct the SMT amounts from invoice payments.

Section 4-Diagnosis Codes

4.1 General Information

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

NOTE: Providers should use the available Diagnostic and Statistical Manual of Mental Disorders Fifth (5) Edition Text Revision (DSM-5-TR) diagnoses when admitting a Comprehensive Substance Treatment and Rehabilitation (CSTAR) participant in the Department of Mental Health's (DMH) Customer Information Management Outcomes and Reporting (CIMOR) system. CSTAR claims are submitted electronically to MHD from the CIMOR system. The DSM-5-TR code description is mapped to the appropriate ICD-10 code in CIMOR, and the International Classification of Diseases (ICD-10) code is submitted on the electronic HIPAA 837 from DMH.

4.2 Diagnosis Code Listing

The following chart contains the DSM-5-TR diagnoses and the corresponding ICD-10 Clinical Modification (CM) codes.

Admission to Comprehensive Substance Treatment and Rehabilitation Services

ICD-10 Code	ICD-10 Description	DSM 5 Description
F10.10	Alcohol abuse, uncomplicated	Alcohol use disorder, Mild
F10.11	Alcohol abuse, in remission	Alcohol use disorder, Mild, in early or sustained remission
F10.20	Alcohol dependence, uncomplicated	Alcohol use disorder Moderate **/** Alcohol use disorder Severe
F10.21	Alcohol dependence, in remission	Alcohol use disorder Moderate, in early or sustained remission **/** Alcohol use disorder, Severe, in early or sustained remission
F10.13	Alcohol abuse, with withdrawal	
F10.130	Alcohol abuse with withdrawal, uncomplicated	
F10.131	Alcohol abuse with withdrawal delirium	
F10.132	Alcohol abuse with withdrawal with perceptual disturbance	
F10.139	Alcohol abuse with withdrawal, unspecified	
F10.93	Alcohol use, unspecified with withdrawal	
F10.930	Alcohol use, unspecified with withdrawal, uncomplicated	
F10.931	Alcohol use, unspecified with withdrawal delirium	
F10.932	Alcohol use, unspecified with withdrawal with perceptual disturbance	
F10.939	Alcohol use, unspecified with withdrawal, unspecified	
F11.10	Opioid abuse, uncomplicated	Opioid use disorder, Mild
F11.11	Opioid abuse, in remission	Opioid use disorder, Mild, in early or sustained remission
F11.13	Opioid abuse with withdrawal	
F11.20	Opioid dependence, uncomplicated	Opioid use disorder, Moderate **/** Opioid use disorder, Severe

F11.21	Opioid dependence, in remission	Opioid use disorder, Moderate, in early or sustained remission **/** Opioid use disorder, Severe, in early or sustained remission
F12.10	Cannabis abuse, uncomplicated	Cannabis use disorder, Mild
F12.11	Cannabis abuse, in remission	Cannabis use disorder, Mild, in early or sustained remission
F12.13	Cannabis abuse with withdrawal	
F12.20	Cannabis dependence, uncomplicated	Cannabis use disorder, Moderate **/** Cannabis use disorder, Severe
F12.21	Cannabis dependence, in remission	Cannabis use disorder, Moderate, in early or sustained remission **/** Cannabis use disorder, Severe, in early or sustained remission
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder	Unspecified cannabis-related disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated	Sedative, hypnotic, or anxiolytic use disorder, Mild
F13.11	Sedative, hypnotic, or anxiolytic abuse, in remission	Sedative, hypnotic, or anxiolytic use disorder, Mild, in early or sustained remission
F13.13	Sedative, hypnotic, or anxiolytic abuse, with withdrawal	
F13.130	Sedative, hypnotic, or anxiolytic abuse with withdrawal, uncomplicated	
F13.131	Sedative, hypnotic, or anxiolytic abuse with withdrawal delirium	
F13.132	Sedative, hypnotic, or anxiolytic abuse with withdrawal with perceptual disturbance	
F13.139	Sedative, hypnotic, or anxiolytic abuse with withdrawal, unspecified	
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated	Sedative, hypnotic, or anxiolytic use disorder, Moderate **/** Sedative, hypnotic, or anxiolytic use disorder, Severe
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission	Sedative, hypnotic, or anxiolytic use disorder, Moderate, in early or sustained remission **/** Sedative, hypnotic, or anxiolytic use disorder, Severe, in early or sustained remission
F14.10	Cocaine abuse, uncomplicated	Cocaine use disorder, Mild
F14.11	Cocaine abuse, in remission	Cocaine use disorder, Mild, in early or sustained remission
F14.13	Cocaine abuse, unspecified with withdrawal	

F14.20	Cocaine dependence, uncomplicated	Cocaine use disorder, Moderate **/** Cocaine use disorder, Severe
F14.21	Cocaine dependence, in remission	Cocaine use disorder, Moderate, in early or sustained remission **/** Cocaine use disorder, Severe, in early or sustained remission
F14.93	Cocaine use, unspecified with withdrawal	
F15.10	Other stimulant abuse, uncomplicated	Amphetamine-type substance use disorder, Mild
F15.11	Other stimulant abuse, in remission	Amphetamine-type substance use disorder, Mild, in early or sustained remission **/** Other or unspecified stimulant use disorder, Mild, in early or sustained remission
F15.13	Other stimulant abuse with withdrawal	
F15.20	Other stimulant dependence, uncomplicated	Amphetamine-type substance use disorder, Moderate **/** Amphetamine-type substance use disorder, Severe
F15.21	Other stimulant dependence, in remission	Amphetamine-type substance use disorder, Moderate, in early or sustained remission **/** Amphetamine-type substance use disorder, Severe, in early or sustained remission
		Other or unspecified stimulant use disorder, Moderate, in early or sustained remission **/** Other or unspecified stimulant use disorder, Severe, in early or sustained remission
F15.259	Other stimulant dependence, with stimulant-induced psychotic disorder unspecified	Amphetamine-type substance use disorder, Moderate **/** Amphetamine-type substance use disorder, Severe
F16.10	Hallucinogen abuse, uncomplicated	Other hallucinogen use disorder, Mild **/** Phencyclidine use disorder, Mild
F16.11	Hallucinogen abuse, in remission	Other hallucinogen use disorder, Mild, in early or sustained remission **/** Phencyclidine use disorder, Mild, in early or sustained remission
F16.20	Hallucinogen dependence, uncomplicated	Other hallucinogen use disorder, Moderate **/** Other hallucinogen use disorder, Severe
		Phencyclidine use disorder, Moderate **/** Phencyclidine use disorder, Severe
F16.21	Hallucinogen dependence, in remission	Other hallucinogen use disorder, Moderate, in early or sustained remission **/** Other hallucinogen use disorder, Severe, in early or sustained remission

		Phencyclidine use disorder, Moderate, in early or sustained remission **/** Phencyclidine use disorder, Severe, in early or sustained remission
F18.10	Inhalant abuse, uncomplicated	Inhalant use disorder, Mild
F18.11	Inhalant abuse, in remission	Inhalant use disorder, Mild, in early or sustained remission
F18.20	Inhalant dependence, uncomplicated	Inhalant use disorder, Moderate **/** Inhalant use disorder, Severe
F18.21	Inhalant dependence, in remission	Inhalant use disorder, Moderate, in early or sustained remission **/** Inhalant use disorder, Severe, in early or sustained remission
F19.10	Other psychoactive substance abuse, uncomplicated	Other (or unknown) substance use disorder, Mild
F19.11	Other psychoactive substance abuse, in remission	Other (or unknown) substance use disorder, Mild, in early or sustained remission
F19.13	Other psychoactive substance abuse with withdrawal	
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated	
F19.131	Other psychoactive substance abuse with withdrawal delirium	
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance	
F19.139	Other psychoactive substance abuse with withdrawal, unspecified	
F19.20	Other psychoactive substance dependence, uncomplicated	Other (or unknown) substance use disorder, Moderate **/** Other (or unknown) substance use disorder, Severe
F19.21	Other psychoactive substance dependence, in remission	Other (or unknown) substance use disorder, Moderate, in early or sustained remission **/** Other (or unknown) substance use disorder, Severe, in early or sustained remission

Collateral Dependent

The following diagnosis code qualifies a family member for CSTAR collateral dependent services.

ICD-10 Code	ICD-10 Description	DSM 5 Description
Z63.9	Problem related to primary support group, unspecified	None available

Section 5-Procedure Codes

Procedure codes used by the MO HealthNet Division (MHD) are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into three (3) subsystems, referred to as Level I, Level II and Level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes. Level III codes have been developed by Medicaid State agencies for use in specific programs.

5.1 Procedure Codes for Level 0.5: (Early Intervention)

Procedure Code	Description
99408	Alcohol and/or Substance Abuse Structured Screening and Brief Interventions Services, 15-30 minutes
99409	Alcohol and/or Substance Abuse Structured Screening and Brief Interventions Services, greater than 30 minutes

5.2 Procedure Codes for Level 1: (Outpatient Services)

Procedure Code	Description
H0001	Intake Assessment
H0001 52	Assessment and Diagnostic Update
H0001 UK	Assessment, Collateral Relationship
H0001 52 UK	Assessment and Diagnostic Update, Collateral Relationship
H0004	Individual Counseling
H0004 HH	Co-Occurring Disorders Individual Counseling
H0004 ST	Individual Counseling (Trauma)(QAP)
H0004 UK	Co-Occurring Disorders Individual Counseling
H0004 UK HH	Individual Counseling, Collateral Relationship (Co-Occurring)(QAP)
H0004 UK ST	Individual Counseling, Collateral Relationship (Trauma)(QAP)
H0005	Group Counseling (QAP)
H0005 HH	Group Counseling (Co-Occurring)(QAP)
H0005 ST	Group Counseling (Trauma)(QAP)
H0005 UK	Group Collateral Dependent Counseling
H0005 UK HH	Group Counseling, Collateral Relationship (Co-Occurring)(QAP)
H0005 UK ST	Group Counseling, Collateral Relationship (Trauma)(QAP)
H0007	Crisis Intervention
H0014	ASAM 1 WM: Detoxification (Ambulatory Detoxification)
H0020	Opioid (Methadone Dosing)
H0025	Group Rehabilitative Support
H0025 HH	Group Rehabilitative Support (Co-Occurring)
H0025 ST	Trauma Group Rehabilitative Support
H0025 UK	Group Counseling, Collateral Relationship

H0025 UK HH	Group Counseling, Collateral Relationship (Co-Occurring)(QAP)
H0025 UK ST	Group Counseling, Collateral Relationship (Trauma)(QAP)
H0038	Peer Support
H0038 HA	Family Support
H0038 UK	Peer Support, Collateral Relationship
H0047*	HIV Pre-Test Counseling
H0047 TS*	HIV Post-Test Counseling
H0047 TS*	TB Post-Test Counseling
H2015	Community Support
H2015 UK	Community Support, Collateral Relationship
T1002	Medication Services Support (RN)
T1003	Medication Services Support (LPN)
T1006	Family Therapy, Office
T1006 52	Family Therapy, Office
T1006 UK	Family Conference, Collateral Relationship
90791	Psychiatric Diagnostic Evaluation without Medical Services
90791 52	Psychiatric Diagnostic Evaluation without Medical Services, Non-Physician (reduced services)
90791 52 UK	Psychiatric Diagnostic Evaluation without Medical Services, Collateral Relationship, Non-Physician (reduced services)
90791 UK	Psychiatric Diagnostic Evaluation without Medical Services, Collateral Relationship
90792	Psychiatric Diagnostic Evaluation with Medical Services, Non-Physician
90792 HP	Psychiatric Diagnostic Evaluation with Medical Services, Physician
90792 UK	Psychiatric Diagnostic Evaluation with Medical Services, Collateral Relationship, Non-Physician
90792 UK HP	Psychiatric Diagnostic Evaluation with Medical Services, Collateral Relationship, Physician
90792 52	Psychiatric Diagnostic Evaluation with Medical Services, Non-Physician (reduced services)
90792 52 HP	Psychiatric Diagnostic Evaluation with Medical Services, Physician (reduced services)
90792 52 UK	Psychiatric Diagnostic Evaluation with Medical Services, Collateral Relationship, Non-Physician (reduced services)
90792 52 UK HP**	Psychiatric Diagnostic Evaluation with Medical Services, Collateral Relationship, Physician (reduced services)
90832	Psychiatric Diagnostic Evaluation, APN, Telemedicine
90832 HH	Psychotherapy, 30 minutes (Co-Occurring) (LMHP)
90832 ST	Psychotherapy, 30 minutes (Trauma) (LMHP)
90832 UK	Psychotherapy, Collateral Relationship, 30 minutes (LMHP)
90832 UK HH	Psychotherapy, Collateral Relationship, 30 minutes (Co-Occurring)(LMHP)
90832 UK ST	Psychotherapy, Collateral Relationship, 30 minutes (Trauma)(LMHP)
90834	Psychotherapy, 45 minutes (LMHP)

90834 HH	Psychotherapy, 45 minutes (Co-Occurring) (LMHP)
90834 ST	Psychotherapy, 45 minutes (Trauma) (LMHP)
90834 UK	Psychotherapy, Collateral Relationship, 45 minutes (LMHP)
90834 UK HH	Psychotherapy, Collateral Relationship, 45 minutes (Co-Occurring)(LMHP)
90834 UK ST	Psychotherapy, Collateral Relationship, 45 minutes (Trauma)(LMHP)
90837	Psychotherapy, 60 minutes (LMHP)
90837 HH	Psychotherapy, 60 minutes (Co-Occurring) (LMHP)
90837 ST	Psychotherapy, 60 minutes (Trauma) (LMHP)
90837 UK	Psychotherapy, Collateral Relationship, 60 minutes (LMHP)
90837 UK HH	Psychotherapy, Collateral Relationship, 60 minutes (Co-Occurring)(LMHP)
90837 UK ST	Psychotherapy, Collateral Relationship, 60 minutes (Trauma)(LMHP)
90839	Psychotherapy for crisis, first 60 minutes (LMHP)
90839 HH	Psychotherapy for crisis, first 60 minutes (Co-Occurring) (LMHP)
90839 ST	Psychotherapy for crisis, first 60 minutes (Trauma) (LMHP)
90839 UK	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (LMHP)
90839 UK HH	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (Co-Occurring)(LMHP)
90839 UK ST	Psychotherapy for crisis, Collateral Relationship, first 60 minutes (Trauma)(LMHP)
90846	Family Psychotherapy, 50 minutes (without patient)
90846 HH	Family Psychotherapy, 50 minutes (without patient) (Co-Occurring)
90846 ST	Family Psychotherapy, 50 minutes (without patient) (Trauma)
90847	Family Psychotherapy, 50 minutes (with patient present)
90847 HH	Family Psychotherapy, 50 minutes (with patient) (Co-Occurring)
90847 ST	Family Psychotherapy, 50 minutes (with patient) (Trauma)
90853	Group Psychotherapy
90853 HH	Group Psychotherapy (Co-Occurring)
90853 ST	Group Psychotherapy (Trauma)
90853 UK	Group Psychotherapy, Collateral Relationship
90853 UK HH	Group Psychotherapy, Collateral Relationship (Co-Occurring)
90853 UK ST	Group Psychotherapy, Collateral Relationship (Trauma)
99202	Evaluation/Management, Non-Physician, new patient
99202 HP	Evaluation/Management, Physician, new patient
99203	Evaluation/Management, Non-Physician, new patient
99203 HP	Evaluation/Management, Physician, new patient
99204	Evaluation/Management, Non-Physician, new patient
99204 HP	Evaluation/Management, Physician, new patient
99205	Evaluation/Management, Non-Physician, new patient
99205 HP	Evaluation/Management, Physician, new patient
99212	Evaluation/Management, Non-Physician, established patient

99212 HP	Evaluation/Management, Physician, established patient
99213	Evaluation/Management, Non-Physician, established patient
99213 HP	Evaluation/Management, Physician, established patient
99214	Evaluation/Management, Non-Physician, established patient
99214 HP	Evaluation/Management, Physician, established patient
99215	Evaluation/Management, Non-Physician, established patient
99215 HP	Evaluation/Management, Physician, established patient

*HIV pre-test counseling (code H0047) and HIV and TB post-test counseling (code H0047 TS) must be used with one of the following diagnosis codes: Z20.1 or Z20.6, in order to allow the claim to pay.

** The procedure code and modifier combination will be used internally at DMH for tracking.

5.3 Procedure Codes for Level 2: (Team-Based)

Procedure Code	Description
H0015	ASAM 2.1: Intensive Outpatient Services
H0015 TG	ASAM 2.5: Partial Hospitalization Services
H0012	ASAM 2-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring
H0012 TG	ASAM 2-WM-EM: Ambulatory Withdrawal Management with Extended On-Site Monitoring

5.4 Procedure Codes for Level 3: (Does not Include Room and Board)

Procedure Code	Description
H2036 HF	ASAM 3.1: Clinically Managed Low-Intensity Residential Services
H0010	ASAM 3.2-WM: Clinically Managed Residential Withdrawal Management
H2036 HI	ASAM 3.3: Clinically Managed, Population-Specific High Intensity Residential Services
H2036	ASAM 3.5: Clinically Managed High-Intensity Residential Services
H2036 TG	ASAM 3.7: Medically Monitored Intensive Inpatient
H0011	ASAM 3.7-WM: Medically Monitored Inpatient Withdrawal Management

5.5 Place of Service Codes

Places of service (POS) for CSTAR include:

02 – Telemedicine

03 – School (Adolescent CSTAR Outpatient Rehabilitation only, with limitations)

11 – Office

12 – Home

15 – Mobile Unit

99 – Other Unlisted Facility

Note: When an individual receives a combination of team-based services from multiple locations on the same day, the service location should be indicated as 99 (Other Unlisted Facility).