



# Alcohol and Substance Abuse Treatment

Policy Number: BH803ASATMCS1224  
Annual Review Date: December 17, 2024  
Interim Review Date: N/A

Table of Contents .....	Page
<a href="#">Introduction &amp; Instructions for Use</a> .....	<a href="#">1</a>
<a href="#">Alcohol and Substance Abuse Treatment</a> .....	<a href="#">2</a>
<a href="#">Coverage, Indications, Limitations and/or Medical Necessity</a> .....	<a href="#">2</a>
<a href="#">Medicare Benefit Policy Manual Partial Hospitalization Services</a> .....	<a href="#">5</a>
<a href="#">References</a> .....	<a href="#">9</a>
<a href="#">Revision History</a> .....	<a href="#">10</a>

## Introduction & Instructions for Use

### Introduction

Medicare Coverage Summaries are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for Medicare behavioral health benefit plans managed by Optum®.

### Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

# Alcohol and Substance Abuse Treatment

This Medicare Coverage Summary is based on the following CMS National Coverage Determinations (NCDs) and is applicable to all states.

- (CMS 130.1) Inpatient Hospital Stays for Treatment of Alcoholism
- (CMS 130.2) Outpatient Hospital Services for Treatment of Alcoholism
- (CMS 130.3) Chemical Aversion Therapy for Treatment of Alcoholism
- (CMS 130.4) Electrical Aversion Therapy for Treatment of Alcoholism
- (CMS 130.5) Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic
- (CMS 130.6) Treatment of Drug Abuse (Chemical Dependency)
- (CMS 130.7) Withdrawal Treatments for Narcotic Addictions

*For Partial Hospitalization for substance related disorders, the Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B, section 70.3 Partial Hospitalization Services is used as it offers sufficient guidance to make medical necessity determinations, see the section, [Partial Hospitalization Services](#).*

*For Intensive Outpatient Services for mental health and substance related disorders, the Medicare Benefit Policy Manual Chapter 6; Hospital Services Covered Under Part B, § 70.4 Intensive Outpatient Services is used as it offers sufficient guidance to make medical necessity determinations, see the [Optum Medicare Coverage Summary - Intensive Outpatient Programs](#).*

*For Opioid Treatment Programs (OTP) Intensive Outpatient Services, the Medicare Benefit Policy Manual, Chapter 17; Opioid Treatment Programs (OTPs), § 20 Definitions is used as it offers sufficient guidance to make medical necessity determinations, see the [Optum Medicare Coverage Summary - Intensive Outpatient Programs](#).*

*Optum utilizes the [Level of Care Utilization System \(LOCUS\) Criteria](#) to supplement the Medicare National Coverage Determination (NCDs 130.1-130.7) for Inpatient Detoxification for members receiving care in freestanding specialty hospitals (psychiatric). Optum utilizes [The ASAM Criteria](#) (see below) to supplement for inpatient services occurring in an acute care general hospital.*

*Optum utilizes [The ASAM Criteria](#) to supplement the Medicare National Coverage Determinations (NCDs 130.1-130.7) for all other Alcohol and Substance Abuse Treatment to ensure consistency in making medical necessity determinations.*

- o Access the ASAM Criteria [here](#)

*Use of The ASAM Criteria and/or LOCUS Criteria to supplement the general provisions outlined under 42 CFR 422.101(b)(6)(i) provides clinical benefits that are highly likely to outweigh any clinical harms from delayed or decreased access to items or services.*

*Specifically, The ASAM Criteria and/or LOCUS Criteria are consulted when the NCDs do not fully address the type of treatment or appropriate treatment setting that will likely lead to improvement of the member's condition. The ASAM Criteria and/or LOCUS Criteria are also consulted due to the comprehensive multi-dimension analysis to determine if comorbid medical, mental health and substance related factors add to the evidence for services not offered in the NCDs.*

## Coverage, Indications, Limitations and/or Medical Necessity

### Indications (CMS 130.1 Inpatient Hospital Stays for Treatment of Alcoholism)

- A. Inpatient Hospital Stay for Alcohol Detoxification
  - o Many hospitals provide detoxification services during the more acute stages of alcoholism or alcohol withdrawal. When the high probability or occurrence of medical complications (e.g., delirium, confusion, trauma, or unconsciousness) during detoxification for acute alcoholism or alcohol withdrawal necessitates the constant availability of physicians and/or complex medical equipment found only in the hospital setting, inpatient hospital care during this period is considered reasonable and necessary and is therefore covered under the program. Generally, detoxification can be accomplished within two to three days with an occasional need for up to five days where the patient's condition

dictates. This limit (five days) may be extended in an individual case where there is a need for a longer period for detoxification for a particular patient.

- o In such cases, however, there should be documentation by a physician which substantiates that a longer period of detoxification was reasonable and necessary. When the detoxification needs of an individual no longer require an inpatient hospital setting, coverage should be denied on the basis that inpatient hospital care is not reasonable and necessary as required by §1862(a)(1) of the Social Security Act (the Act). Following detoxification, a patient may be transferred to an inpatient rehabilitation unit or discharged to a residential treatment program or outpatient treatment setting.
- B. Inpatient Hospital Stay for Alcohol Rehabilitation
  - o Hospitals may also provide structured inpatient alcohol rehabilitation programs to the chronic alcoholic. These programs are composed primarily of coordinated educational and psychotherapeutic services provided on a group basis. Depending on the subject matter, a series of lectures, discussions, films, and group therapy sessions are led by either physicians, psychologists, or alcoholism counselors from the hospital or various outside organizations. In addition, individual psychotherapy, and family counseling (see §70.1) may be provided in selected cases. These programs are conducted under the supervision and direction of a physician. Patients may directly enter an inpatient hospital rehabilitation program after having undergone detoxification in the same hospital or in another hospital or may enter an inpatient hospital rehabilitation program without prior hospitalization for detoxification.
  - o Alcohol rehabilitation can be provided in a variety of settings other than the hospital setting. In order for an inpatient hospital stay for alcohol rehabilitation to be covered under Medicare it must be medically necessary for the care to be provided in the inpatient hospital setting rather than in a less costly facility or on an outpatient basis. Inpatient hospital care for receipt of an alcohol rehabilitation program would generally be medically necessary where either (1) there is documentation by the physician that recent alcohol rehabilitation services in a less intensive setting or on an outpatient basis have proven unsuccessful and, as a consequence, the patient requires the supervision and intensity of services which can only be found in the controlled environment of the hospital, or (2) only the hospital environment can assure the medical management or control of the patient's concomitant conditions during the course of alcohol rehabilitation. (However, a patient's concomitant condition may make the use of certain alcohol treatment modalities medically inappropriate.)
  - o In addition, the "active treatment"<sup>1</sup> criteria (see the Medicare Benefit Policy Manual, Chapter 2, "Inpatient Psychiatric Hospital Services," §20) should be applied to psychiatric care in the general hospital as well as to psychiatric care in a psychiatric hospital. Since alcoholism is classifiable as a psychiatric condition the "active treatment" criteria must also be met in order for alcohol rehabilitation services to be covered under Medicare. (Thus, it is the combined need for "active treatment" and for covered care which can only be provided in the inpatient hospital setting, rather than the fact that rehabilitation immediately follows a period of detoxification which provides the basis for coverage of inpatient hospital alcohol rehabilitation programs.)
  - o Generally, 16-19 days of rehabilitation services are sufficient to bring a patient to a point where care could be continued in other than an inpatient hospital setting. An inpatient hospital stay for alcohol rehabilitation may be extended beyond this limit in an individual case where a longer period of alcohol rehabilitation is medically necessary. In such cases, however, there should be documentation by a physician which substantiates the need for such care. Where the rehabilitation needs of an individual no longer require an inpatient hospital setting, coverage should be denied on the basis that inpatient hospital care is not reasonable and necessary as required by §1862 (a)(1) of the Act.
  - o Subsequent admissions to the inpatient hospital setting for alcohol rehabilitation follow-up, reinforcement, or "recap" treatments are considered to be readmissions (rather than an extension of the original stay) and must meet the requirements of this section for coverage under Medicare. Prior admissions to the inpatient hospital setting - either in the same hospital or in a different hospital - may be an indication that the "active treatment" requirements are not met (i.e., there is no reasonable expectation of improvement) and the stay should not be covered. Accordingly, there should be documentation to establish that "readmission" to the hospital setting for alcohol rehabilitation services can reasonably be expected to result in improvement of the patient's condition. For example, the documentation should indicate what changes in the patient's medical condition, social or emotional status, or treatment plan make improvement likely, or why the patient's initial hospital treatment was not sufficient.
- C. Combined Alcohol Detoxification/Rehabilitation Programs

---

<sup>1</sup> Per the Medicare Benefit Policy Manual, Chapter 2, Section 30.2.2.1, for services to be designated as active treatment, they must be: 1) provided under an individualized treatment or diagnostic plan (2) reasonably expected to improve the patient's condition or for the purpose of diagnosis; and (3) supervised and evaluated by a physician.

- o Medicare Administrative Contractors (MACs) should apply the guidelines in A. and B. above to both phases of a combined inpatient hospital alcohol detoxification/rehabilitation program. Not all patients who require the inpatient hospital setting for detoxification also need the inpatient hospital setting for rehabilitation. (See §130.1 for coverage of outpatient hospital alcohol rehabilitation services.) Where the inpatient hospital setting is medically necessary for both alcohol detoxification and rehabilitation, generally a 3-week period is reasonable and necessary to bring the patient to the point where care can be continued in other than an inpatient hospital setting.
- o Decisions regarding reasonableness and necessity of treatment, the need for an inpatient hospital level of care, and length of treatment should be made by A/MACs based on accepted medical practice with the advice of their medical consultant<sup>2</sup>. (In hospitals under PSRO review, PSRO determinations of medical necessity of services and appropriateness of the level of care at which services are provided are binding on A/MACs for purposes of adjudicating claims for payment.)

### Indications (CMS 130.2 Outpatient Hospital Services for Treatment of Alcoholism)

- Coverage of outpatient hospital services for treatment of alcoholism is available for both diagnostic and therapeutic services furnished for the treatment of alcoholism by the hospital to outpatients subject to the same rules applicable to hospital outpatient services in general. While there is no coverage for day hospitalization programs, per se, individual services which meet the requirements in the Medicare Benefit Policy Manual, Chapter 6, §20 may be covered. Meals, transportation and recreational and social activities do not fall within the scope of covered outpatient hospital services under Medicare.
- All services must be reasonable and necessary for diagnosis and treatment of the patient's condition Medicare Benefit Policy Manual, Chapter 6, §20. Thus, educational services and family counseling would only be covered where they are directly related to treatment of the patient's condition. The frequency of treatment and period of time over which it occurs must also be reasonable and necessary.

### Indications (CMS 130.3 Chemical Aversion Therapy for Treatment of Alcoholism)

- Available evidence indicates that chemical aversion therapy may be an effective component of certain alcoholism treatment programs, particularly as part of multi-modality treatment programs which include other behavioral techniques and therapies, such as psychotherapy. Based on this evidence chemical aversion therapy is covered under Medicare. However, since chemical aversion therapy is a demanding therapy which may not be appropriate for all Medicare beneficiaries needing treatment for alcoholism, a physician should certify to the appropriateness of chemical aversion therapy in the individual case. Therefore, if chemical aversion therapy for treatment of alcoholism is determined to be reasonable and necessary for an individual patient, it is covered under Medicare.
- When it is medically necessary for a patient to receive chemical aversion therapy as a hospital inpatient, coverage for care in that setting is available (See §130.1 regarding coverage of multi-modality treatment programs). Follow-up treatments for chemical aversion therapy can generally be provided on an outpatient basis. Thus, where a patient is admitted as an inpatient for receipt of chemical aversion therapy, there must be documentation by the physician of the need in the individual case for the inpatient hospital admission.
- Decisions regarding reasonableness and necessity of treatment, the need for an inpatient hospital level of care, and length of treatment should be made by A/MACs based on accepted medical practice with the advice of their medical consultant<sup>3</sup>. (In hospitals under Quality Improvement Organization (QIO) review, QIO determinations of medical necessity of services and appropriateness of the level of care at which services are provided are binding on A/MACs for purposes of adjudicating claims for payment).

### Indications (CMS 130.4 Electrical Aversion Therapy for Treatment of Alcoholism)

- Electrical aversion therapy has not been shown to be safe and effective and therefore is excluded from coverage.

<sup>2</sup> See the Medicare Coverage Summary, Psychiatric Inpatient Hospitalization for guidance

<sup>3</sup> See the Medicare Coverage Summary, Psychiatric Inpatient Hospitalization for guidance

## Indications (CMS 130.5 Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic)

- Coverage is available for alcoholism or drug abuse treatment services (such as drug therapy, psychotherapy, and patient education) that are provided incident to a physician's<sup>4</sup> professional service in a freestanding clinic to patients who, for example, have been discharged from an inpatient hospital stay for the treatment of alcoholism or drug abuse or to individuals who are not in the acute stages of alcoholism or drug abuse but require treatment. The coverage available for these services is subject to the same rules generally applicable to the coverage of clinic services. Services must also be reasonable and necessary for the diagnosis or treatment of the individual's alcoholism or drug abuse. The Part B psychiatric limitation would apply to alcoholism or drug abuse treatment services furnished by physicians to individuals who are not hospital inpatients.

## Indications (CMS 130.6 Treatment of Drug Abuse (Chemical Dependency))

- CMS recognizes that there are similarities between the approach to treatment of drug abuse and alcohol detoxification and rehabilitation. However, the intensity and duration of treatment for drug abuse may vary (depending on the particular substance(s) of abuse, duration of use, and the patient's medical and emotional condition) from the duration of treatment or intensity needed to treat alcoholism.
- When it is medically necessary for a patient to receive detoxification and/or rehabilitation for drug substance abuse as a hospital inpatient, coverage for care in that setting is available. Coverage is also available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. (See the Medicare Benefit Policy Manual (BPM), Chapter 6, "Hospital Services Covered Under Part B," §§20.) The services must also be reasonable and necessary for treatment of the individual's condition. (See the Medicare BPM, Chapter 16, "General Exclusions from Coverage," §90.)
- Decisions regarding reasonableness and necessity of treatment, the need for an inpatient hospital level of care, and length of treatment should be made by A/MACs based on accepted medical practice with the advice of their medical consultant<sup>5</sup>. (In hospitals under Quality Improvement Organization (QIO) review, QIO determinations of medical necessity of services and appropriateness of the level of care at which services are provided are binding on A/B MACs for purposes of adjudicating claims for payment.)

## Indications (CMS 130.7 Withdrawal Treatments for Narcotic Addictions)

- Withdrawal is an accepted treatment for narcotic addiction and payment can be made for these services if they are provided by the physician directly or under the physician's personal supervision and if they are reasonable and necessary. In reviewing claims, reasonableness and necessity are determined with the aid of the B/Medicare Administrative Contractor's medical staff.
- Drugs that the physician provides in connection with this treatment are also covered if they cannot be self-administered and meet all other statutory requirements.

# Medicare Benefit Policy Manual Partial Hospitalization Services

## [Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B, section 70.3 Partial Hospitalization Services:](#)

- Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.
  - o Program Criteria

<sup>4</sup> Per the Medicare Benefit Policy Manual, Chapter 15, Section 60, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist) authorized by the Act to receive payment for services incident to his or her own services.

<sup>5</sup> See the Medicare Coverage Summaries, Psychiatric Inpatient Hospitalization, Psychiatric Partial Hospitalization, and Outpatient Psychiatric and Psychological Services for guidance.

- PHPs work best as part of a community continuum of mental health services (including SUD services) which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. Program objectives should focus on ensuring important community ties and closely resemble the real-life experiences of the patients served. PHPs may be covered under Medicare when they are provided by a hospital outpatient department or a Medicare-certified CMHC.
- Partial hospitalization is active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient and includes a multidisciplinary team approach to patient care under the direction of a physician. The program reflects a high degree of structure and scheduling. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.
- A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of services which make up active treatment in a PHP.
- o Patient Eligibility Criteria
  - Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization, including the need for a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder (including SUD) which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, PHP patients must be able to participate in the active treatment process cognitively and emotionally and be capable of tolerating the intensity of a PHP program.
  - Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. Where partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense level of care, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification must address the continuing serious nature of the patients' psychiatric condition requiring active treatment in a PHP.
  - Discharge planning from a PHP may reflect the types of best practices recognized by professional and advocacy organizations that ensure coordination of needed services and follow-up care. These activities include linkages with community resources, supports, and providers in order to promote a patient's return to a higher level of functioning in the least restrictive environment.
- o Covered Services
  - Items and services that can be included as part of the structured, multimodal active treatment program include:
    - Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, mental health counselors, marriage and family therapists, clinical nurse specialists, certified alcohol and drug counselors);
    - Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physician's treatment plan for the individual;
    - Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients (including patients with SUD. These include principal illness navigation services provided by auxiliary staff, including peer support specialist;
    - Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);
    - Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
    - Family counseling services for which the primary purpose is the treatment of the patient's condition. These include services for caregivers;

- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition. These services include caregiver training services furnished for the benefit of the patient; and
- Medically necessary diagnostic services related to mental health treatment (including SUD).
- Partial hospitalization services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. It is not enough that a patient qualify under the benefit category requirements in or of §1835(a)(2)(F) unless the patient also has the need for the active treatment provided by the program of services defined in §1861(ff). It is the need for at least 20 hours per week of intensive, active treatment of the patient's condition to maintain a functional level and to prevent relapse or hospitalization, that qualifies the patient to receive the services identified in §1861(ff).
- o Reasonable and Necessary Services
  - This program of services provides for the diagnosis and active, intensive treatment of the individual's serious psychiatric condition (including SUD) and, in combination, are reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. A particular individual covered service (described above) as intervention, expected to maintain or improve the individual's condition and prevent relapse, may also be included within the plan of care, but the overall intent of the partial program admission is to treat the serious presenting psychiatric symptoms (including SUD). Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g., intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.
  - Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, must have an adequate support system to sustain/maintain themselves outside the PHP and must not be an imminent danger to themselves or others. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5, of the version of the International Classification of Diseases (ICD) applicable to the service date, which severely interferes with multiple areas of daily life. Examples include eating disorders, mood disorders, psychotic disorders, and substance use disorders. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition.
  - For patients who do not meet this degree of severity of illness, and for whom partial hospitalization services are not necessary for the treatment of a psychiatric condition (including SUD), professional services billed to Medicare Part B (e.g., services of psychiatrists and psychologists) may be medically necessary, even though partial hospitalization services are not.
  - Patients in PHP may be discharged by either stepping up to an inpatient level of care which would be required for patients needing 24-hour supervision, or stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes, and the patient no longer requires structured, intensive, multimodal treatment.
- o Reasons for Denial
  - Benefit category denials made under §1861(ff) or §1835(a)(2)(F) are not appealable by the provider and the limitation on liability provision does not apply (HCFA Ruling 97-1). Examples of benefit category based in §1861(ff) or §1835(a)(2)(F) of the Act, for partial hospitalization services generally include the following:
    - Day care programs, which provide primarily social, recreational, or diversionary activities, custodial or respite care;
    - Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill; or
    - Patients who are otherwise psychiatrically stable or require medication management only.
  - Coverage denials made under §1861(ff) of the Act are not appealable by the provider and the Limitation on Liability provision does not apply (HCFA Ruling 97-1). The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Social Security Act:
    - Services to hospital inpatients;
    - Meals, self-administered medications, transportation; and
    - Vocational training.

- Reasonable and necessary denials based on §1862(a)(1)(A) are appealable and the Limitation on Liability provision does apply. The following examples represent reasonable and necessary denials for partial hospitalization services and coverage is excluded under §1862(a)(1)(A) of the Social Security Act:
  - Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of a PHP; or
  - Treatment of chronic conditions without acute exacerbation of symptoms that place the individual at risk of relapse or hospitalization.
- o Documentation Requirements and Physician Supervision
  - Initial Psychiatric Evaluation/Certification–Upon admission, a certification by the physician must be made that the patient admitted to the PHP would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided and that the patient requires at least 20 hours of service per week. The certification should identify the diagnosis and clinical need for the partial hospitalization. Partial hospitalization services must be furnished under an individualized written plan of care, established by the physician, which includes the active treatment provided through the combination of structured, intensive services identified in §1861 that are reasonable and necessary to treat the presentation of serious psychiatric symptoms (including SUD) and to prevent relapse or hospitalization.
  - Physician Recertification Requirements:
    - Signature – The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient’s response to treatment.
    - Timing – The first recertification is required as of the 18th calendar day following admission to the PHP. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.
    - Content – The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the PHP and describe the following:
      - The patient’s response to the therapeutic interventions provided by the PHP;
      - The patient’s psychiatric symptoms (including SUD) that continue to place the patient at risk of hospitalization; and
      - Treatment goals for coordination of services to facilitate discharge from the PHP.
  - Treatment Plan: Partial hospitalization is active treatment pursuant to an individualized treatment plan, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the patient, and includes a multidisciplinary team approach to patient care. The treatment goals described in the treatment plan should directly address the presenting symptoms and are the basis for evaluating the patient’s response to treatment. Treatment goals should be designed to measure the patient’s response to active treatment. The plan should document ongoing efforts to restore the individual patient to a higher level of functioning that would permit discharge from the program or reflect the continued need for the intensity of the active therapy to maintain the individual’s condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms (including SUD) placing the patient at risk, do not qualify as partial hospitalization services.
  - Progress Notes: Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that shows that services were provided and to determine the amounts due. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient’s response to the therapeutic intervention and its relation to the goals indicated in the treatment plan.

## Clinical Best Practices

This Medicare Coverage Summary is based on NCDs that do not provide guidance regarding clinical best practices. See the following Medicare Coverage Summaries:

- Outpatient Psychiatric and Psychological Services
- Psychiatric Inpatient Hospitalization

## References

- American Association of Community Psychiatry (AACP). (2020). Level of Care Utilization System for Psychiatric and Addiction Services. AACP website: <https://www.communitypsychiatry.org/locus>.
- American Society of Addiction Medicine (ASAM). (2024). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions*, (Fourth ed.). ASAM website: <https://www.asam.org/asam-criteria/about-the-asam-criteria/evidence-base>.
- Angarita, G.A., Reif, S., Pirard, S., Lee, S., Sharon, E., & Gastfriend, D.R. (2007). No-Show for treatment in substance abuse patients with comorbid symptomatology: Validity results from a controlled trial of the ASAM patient placement criteria. *Journal of Addiction Medicine*, 1(2), 79-87.
- Baker, S.L. & Gastfriend, D.R. (2003). Reliability of multidimensional substance abuse treatment matching: Implementing the ASAM Patient Placement Criteria. *Journal of Addictive Diseases*, 22 Suppl 1, 45-60.
- Deck, D., Gabriel, R., Knudsen, J., & Grams, G. (2003). Impact of patient placement criteria on substance abuse treatment under the Oregon health plan. *Journal of Addictive Diseases*, 22 Suppl 1, 27-44.
- Kosanke, N., Magura, S., Staines, G., Foote, J., & DeLuca, A. (2002). Feasibility of matching alcohol patients to ASAM levels of care. *The American Journal on Addictions*, 11(2), 124-134.
- Magura, S., Staines, G., Kosanke, N., Rosenblum, A., Foote, J., DeLuca, A., & Bali, P. (2003). Predictive validity of the ASAM patient placement criteria for naturalistically matched vs. mismatched alcoholism patients. *The American Journal on Addictions*, 12(5), 386-397.
- Magura, S., Fong, C., Staines, G.L., Cleland, C., Foote, J., Rosenblum, A., Kosanke, N., & DeLuca, A. (2005). The combined effects of treatment intensity, self-help groups and patient attributes on drinking outcomes. *Journal of Psychoactive Drugs*, 37(1), 85-92.
- McKay, J.R., Cacciola, J.S., McLellan, A.T., Alterman, A.I., & Wirtz, P.W. (1997). An initial evaluation of the psychosocial dimensions of the American Society of Addiction Medicine criteria for inpatient versus intensive outpatient substance abuse rehabilitation. *Journal of Studies on Alcohol*, 58(3), 239-252.
- Scott, C.K. & Foss, M.A. (2002). Impact of centralized intake on drug and alcohol treatment placement decisions. *Journal of Psychoactive Drugs*, 34(1), 7-15.
- Sharon, E., Krebs, C., Turner, W., Desai, N., Binus, G., Penk, W., & Gastfriend, D.R. (2003). Predictive validity of the ASAM patient placement criteria for hospital utilization. *Journal of Addictive Diseases*, 22 Suppl 1, 79-93.
- Staines, G., Kosanke, N., Magura, S., Bali, P., Foote, J., & Deluca, A. (2003). Convergent validity of the ASAM patient placement criteria using a standardized computer algorithm. *Journal of Addictive Diseases*, 22 Suppl 1, 61-77.
- Stallvik, M. & Nordahl, H.M. (2014). Convergent validity of the ASAM criteria in co-occurring disorders. *Journal of Dual Diagnosis*, 10(2), 68-78.
- Stallvik, M. & Gastfriend, D.R. (2014). Predictive and convergent validity of the ASAM criteria software in Norway. *Addiction Research & Theory*, 22(6), 515-523.
- Stallvik, M., Gastfriend, D.R., & Nordahl, H.M. (2015). Matching patients with substance use disorder to optimal level of care with the ASAM criteria software. *Journal of Substance Use*, 20(6), 389-398.

Turner, W.M., Turner, K.H., Reif, S., Gutowski, W.E., & Gastfriend, D.R. (1999). Feasibility of multidimensional substance abuse treatment matching: Automating the ASAM patient placement criteria. *Drug And Alcohol Dependence*, 55(2019), 35-43.

Westermeyer, J. & Lee, K. (2013). Residential placement for veterans with addiction: American Society of Addiction Medicine criteria vs. a veteran's homeless program. *The Journal of Nervous and Mental Disease*, 201(7), 567-571.

Witbrodt, J., Bond, J., Kaskutas, L.A., Weisner, C., Jaeger, G., Pating, D., & Moore, C. (2007). Day hospital and residential addiction treatment: Randomized and nonrandomized managed care clients. *Journal of Consulting and Clinical Psychology*, 75(6), 947-959.

Centers for Medicare and Medicaid Services, Benefit Policy Manual, 2023. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Chemical Aversion Therapy for Treatment of Alcoholism, 130.3. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Electrical Aversion Therapy for Treatment of Alcoholism, 130.4. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Inpatient Hospital Stays for Treatment of Alcoholism, 130.1. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Outpatient Hospital Services for Treatment of Alcoholism, 130.2. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic, 130.5. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Treatment of Drug Abuse (Chemical Dependency), 130.6. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determination, Withdrawal Treatments for Narcotic Addictions, 130.7. CMS website: [www.cms.gov](http://www.cms.gov).

Centers for Medicare and Medicaid Services, National Coverage Determinations Manual, Chapter 1, Part 2, 2021. CMS website: [www.cms.gov](http://www.cms.gov).

## Revision History

Date	Summary of Changes
June 21, 2021	Annual Review
November 16, 2021	Annual Review Added Medicare Benefit Policy Manual information. Added clarification language regarding applicable NCD use.
July 19, 2022	Annual Review
October 17, 2023	Annual Review
December 12, 2023	Interim Update: Added ASAM information per CMS Final Rule 2024 requirements; updated References section.
February 20, 2024	Interim Update: Updates by CMS to the Medicare Benefit Policy Manual, Partial Hospitalization.

Date	Summary of Changes
04/30/2024	Added information and links to the new Optum Medicare Coverage Summary – Intensive Outpatient Programs.
12/17/2024	Annual Review: Added LOCUS information as applicable.