CMS National Coverage Determination (NCD) of Alcohol and Drug Abuse in a Freestanding Clinic
130.5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Indications and Limitations of Coverage

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 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. Of course, the services also must 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

Cross Reference

See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 §30, Medicare Claims Processing Manual, Chapter 12 §10, and Medicare Benefit Policy Manual, Chapter 15 §60.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following must be met: 1. Member's clinical presentation does not require the availability and intensity of services found only in an inpatient hospital setting. 2. Services must be reasonable and necessary for treatment of the individual's condition. (See the Medicare BPM, Chapter 16, "General Exclusions from Coverage," §90 below.)	**All of the following must be met:** 1. Member continues to meet all admission criteria 2. Evidence suggests that the defined problems are likely to respond to current treatment plan. 3. Patient progress is monitored regularly and the treatment plan modified if patient is not making substantial progress toward a set of clearly defined and measurable goals.	**Any of the following must be met:** 1. Patient no longer meets admission criteria and/or meets criteria for another LOC, either more or less intensive 2. Patient or parent/guardian withdraws consent for treatment and patient does not meet criteria for involuntary/ mandated treatment. 3. Active Treatment is no longer occurring 4. Patient is not making progress toward goals, nor is there expectation of any progress.

3. Services are provided directly by a physician or under the direct supervision of a physician **Exclusions:** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services, when the following conditions exist: • Not reasonable and necessary (§20); • No legal obligation to pay for or provide (§40); • Paid for by a governmental entity (§50); Not provided within United States (§60); • Resulting from war (§70); • Personal comfort (§80); • Routine services and appliances (§90); • Custodial care (§110); • Cosmetic surgery (§120); • Charges by immediate relatives or members of household (§130) 4. Dental services (§140);	4. Goals for treatment are specific and targeted to patient's clinical issues though It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients	5. Patient's individual treatment plan and goals have been met.

• Paid or expected to be paid under workers' compensation (§150); • Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (§170); • Services Related to and Required as a Result of Services Which are not Covered Under Medicare (§180); • *Excluded investigational devices (See Chapter 14).*		