CMS National Coverage Determination (NCD) for Hospital –Based Outpatient Treatment of Drug Abuse (Chemical Dependency)
130.6
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf

Item/Service Description

The Centers for Medicare & Medicaid Services 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.

Indications and Limitations of Coverage

Accordingly, 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/B Medicare Administrative Contractors (MACs) based on accepted medical practice with the advice of their medical consultant. (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.)

Cross Reference

Also see the Medicare Benefit Policy Manual, Chapter 6 §20, and Chapter 16 §90.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
All of the following are required: 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	**All of the following are required:** 1. Member continues to meet all admission criteria 2. Evidence suggests that the defined problems are likely to respond to current treatment plan.	**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

16, "General Exclusions from Coverage," §90 below.) 3. 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.) **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);	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. 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	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. 5. Patient's individual treatment plan and goals have been met.

• Dental services (§140); • 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).*		