HFS MANAGED CARE BILLING AND ENCOUNTER REPORTING GUIDELINES: SUPR
(Substance Use Prevention and Recovery) SERVICES
Updated 4/2020

The purpose of this update is to outline policy and procedure billing changes that will be effective on 7/1/2020 for facilities billing for SUPR services by providers designated to provide SUPR services by HFS and a facility that holds a valid license as a Department of Substance Use Prevention and Recovery provider.

Effective 7/1/2020, HFS and IAMHP have made billing rule updates and changes to account for the 1115 Waiver Pilot programs in effect for SUPR providers as well as 837I billing format changes needed to comply with the HFS encounter claims system.

The below billing guidance will REPLACE the guidance previously set forth in June 2017. Efforts have been made to articulate the upcoming changes in the attached guidance. Please note:

- The 837I billing format changes are highlighted in yellow
- The 1115 Waiver program changes are denoted on each of the tables (Table 3 and Table 4) associated to the appropriate claim type and denoted with a double asterisk **

The billing guidance that is currently in effect until 7/1/2020 can be found in the IAMHP Comprehensive Billing Manual v15: https://iamhp.net/resources/Documents/IAMHP_Billing%20Manual_v15.0.pdf.
Billing Guidance
SUPR (Substance Use Prevention and Recovery)
Effective 7/1/2020

a. Purpose

The purpose of this section is to outline policies and procedures for facilities billing for services for provider designated to provide SUPR services by HFS and a facility that holds a valid license as a Department of Substance Use Prevention and Recovery provider and complies with the requirements stated HFS guidelines.

b. Provider Type

This section applies to providers who are registered with HFS as Provider Type 075- Substance Use Prevention and Recovery provider.

NPIs

SUPR providers are required to register their NPIs as a Provider Type 075- Substance Use Prevention and Recovery provider with HFS.

Appropriate SUPR Categories of Service (COS) for 837P/837I billing are listed below and need to be associated to the NPI in IMPACT.

SUPR services may only be rendered from a site that is certified by the Illinois Department of Human Services (DHS), Division of SUPR (Provider Type 075). The NPI the provider uses to bill MCO Plans must correspond to a SUPR certified site.

Providers offering both substance abuse services and mental health services from the same site may not utilize the same NPI number for billing substance use disorder services and mental health services. Mental health services must be billed under a separate NPI number from the substance use disorder services

Note: Always ensure that if you have multiple NPIs and IMPACT Medicaid IDs that they match on the claim. MCOs will not process the claim if the specific NPI used does not match the corresponding Medicaid ID and IMPACT-registered categories of service, etc.

Categories of Service

Although COS is not directly added to a claim submitted to a MCO, the specialties and subspecialties registered in the HFS Provider IMPACT system are critical to accurate claims payment. If a provider does not have the appropriate specialty or subspecialties registered with HFS, claims will deny. It is suggested providers confirm they have the correct COS on file with HFS by reviewing the Provider Information Sheet provided by HFS.

Provider Type 075 (SUPR):
- 035-Alcohol and Substance Abuse Rehabilitation Services
- 106-Methadone Clinic
c. Coding Requirements

The required SUPR services covered by HFS contracted MCOs are listed in Table 1 below, along with the corresponding ASAM (American Society of Addiction Medicine) level(s) and general billing structure overview:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>ASAM Level(s)</th>
<th>Claim Type</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and Discharge Assessment</td>
<td>All levels</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Psychiatric Evaluation</td>
<td>All levels</td>
<td>837P</td>
<td>Event</td>
</tr>
<tr>
<td>Psychotropic Medication Monitoring</td>
<td>All levels</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT)</td>
<td>All levels</td>
<td>837P</td>
<td>Event</td>
</tr>
<tr>
<td>Individual - Therapy/Counseling, Substance Abuse</td>
<td>Level I</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Group - Therapy/Counseling, Substance Abuse</td>
<td>Level I</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Individual - Intensive Outpatient, Substance Abuse</td>
<td>Level II</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Group - Intensive Outpatient, Substance Abuse</td>
<td>Level II</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Rehabilitation - Adult (age 21+)</td>
<td>Level III.5</td>
<td>837I</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Rehabilitation - Child (age 20 or under)</td>
<td>Level III.5</td>
<td>837I</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Adolescent Residential</td>
<td>Level III.5</td>
<td>837I</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Level III.5</td>
<td>837I</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Withdrawal Management Waiver (Withdrawal Management Waiver)</td>
<td>All levels</td>
<td>837I</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Case Management Waiver SUD (Case Management Waiver)</td>
<td>All levels</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
<tr>
<td>Peer Recovery Support (PRS Waiver)</td>
<td>All levels</td>
<td>837P</td>
<td>1/4 hour</td>
</tr>
</tbody>
</table>

All outpatient SUPR services are to be submitted on an 837P claim listed in Table 1. All inpatient/residential SUPR services are to be submitted on an 837I claim, in line with the Claim Type listed in Table 1.

Appropriate SUPR Taxonomy Codes are listed below and should follow the guides as specified in this guidance for billing purposes by Claim Type tables listed in this guide:

- Provider Type 075 (SUPR):
  - 324500000X-Substance Abuse Disorder Rehab Facility-Institutional Billing
  - 3245S0500X-Substance Abuse Disorder Treatment (Children)-Institutional Billing
  - 261QR0405X-Rehabilitation, Substance Abuse-Professional Billing
  - 276400000X-Rehabilitation, Substance Use Disorder Unit-Professional Billing
  - 261QM2800X-Methadone-Assigns COS 106-Professional Billing

**Diagnosis Codes**

A primary diagnosis code is required on all SUPR claims. Acceptable primary diagnosis codes for SUPR claims are listed below in Table 2.

<table>
<thead>
<tr>
<th>ICD10 (services rendered on or after October 1, 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10-F19.99</td>
</tr>
</tbody>
</table>
Professional Claims (837P)

The following billing codes (Table 3) will be accepted for all outpatient SUPR services:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Unit</th>
<th>Place of Service</th>
<th>Approval for member to participate from HFS?</th>
<th>Taxonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and Discharge Assessment</td>
<td>H0002</td>
<td>1/4 hour</td>
<td>03, 21, 22, 55, 57, 99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Evaluation</td>
<td>90791</td>
<td>Event</td>
<td>03, 21, 22, 55, 57, 99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Psychotropic Medication Monitoring</td>
<td>H2010</td>
<td>1/4 hour</td>
<td>03, 21, 22, 55, 57, 99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Individual - Therapy/Counseling, Substance Abuse</td>
<td>H0004</td>
<td>1/4 hour</td>
<td>03, 22, 57,99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Group - Therapy/Counseling, Substance Abuse</td>
<td>H0005</td>
<td>1/4 hour</td>
<td>03, 22, 57,99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Individual - Intensive Outpatient, Substance Abuse</td>
<td>H0004</td>
<td>TF</td>
<td>1/4 hour</td>
<td>03, 22, 57,99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
</tr>
<tr>
<td>Group - Intensive Outpatient, Substance Abuse</td>
<td>H0005</td>
<td>TF</td>
<td>1/4 hour</td>
<td>03, 22, 57,99</td>
<td>N/A</td>
<td>261QR0405X or 275400000X</td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT) Methodone Treatment*</td>
<td>H0020</td>
<td>Event</td>
<td>11, 55</td>
<td>N/A</td>
<td>261QM2800X</td>
<td></td>
</tr>
<tr>
<td>Case Management Waiver SUD (Case Management Waiver)**(age 21 +)</td>
<td>H0006</td>
<td>1/4 hour</td>
<td>11, 55, 99</td>
<td>OBRA code = RC</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Case Management Waiver SUD (Case Management Waiver)**(age 20 &amp; under)</td>
<td>H0006</td>
<td>HA</td>
<td>1/4 hour</td>
<td>11, 55, 99</td>
<td>OBRA code = RC</td>
<td>261QR0405X or 275400000X</td>
</tr>
<tr>
<td>Peer Recovery Support (PRS Waiver)**(age 21 +)</td>
<td>H2014</td>
<td>1/4 hour</td>
<td>11, 55, 99</td>
<td>OBRA code = RD</td>
<td>261QR0405X or 275400000X</td>
<td></td>
</tr>
<tr>
<td>Peer Recovery Support (PRS Waiver)**(age 20 &amp; under)</td>
<td>H2014</td>
<td>HA</td>
<td>1/4 hour</td>
<td>11, 55, 99</td>
<td>OBRA code = RD</td>
<td>261QR0405X or 275400000X</td>
</tr>
</tbody>
</table>

* Provider must be approved by DHS to provide MAT services
** Refer to 1115 Waiver Rules

Additional professional claims (837P) claim submission requirements:

1) MAT services are reimbursed on an event-based basis, with a maximum of one unit per every seven (7) calendar days.
2) MAT services must be submitted on a unique claim.
3) H2010 – Psychotropic Medication Monitoring
   This code should not be used for the management of methadone or any other MAT service. This code is meant to manage the use of medications for those patients who have a co-occurring mental health diagnosis and need medication to help with their condition. Methadone is not considered a psychotropic medication. Only physicians can bill for psychotropic medication monitoring. This is typically not needed every day.
4) The 2010AA billing loop of the 837 must contain the taxonomy code for the SUPR facility.
Institutional Claims (837I)

The following billing codes (Table 4) will be accepted for all institutional/residential SUPR services:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Approval for member to participate from HFS?</th>
<th>Taxonomy</th>
<th>Type of Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation - Adult (age 21+)</td>
<td>944 or 945</td>
<td>H0047</td>
<td>N/A</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE: This program expanded to additional populations on Medicaid effective 1/1/2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation - Child (age 20 or under)</td>
<td>944 or 945</td>
<td>H0047</td>
<td>HA</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE: This program expanded to additional populations on Medicaid effective 1/1/2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Residential</td>
<td>944 or 945</td>
<td>H2036</td>
<td>N/A</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>944 or 945</td>
<td>H0010</td>
<td>N/A</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Management Waiver**(age 21+)**</td>
<td>944 or 945</td>
<td>H0012</td>
<td>OBRA code = RB</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Management Waiver <strong>(age 20 or under)</strong></td>
<td>944 or 945</td>
<td>H0012</td>
<td>OBRA code = RB</td>
<td>324500000X or 324550000X</td>
<td>06X, 089X</td>
<td></td>
</tr>
<tr>
<td><strong>Refer to 1115 Waiver Rules</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional institutional claims (837I) claim submission requirements:

- SUPR residential/institutional services are to be billed as one global rate on a single 837I claim- domiciliary (room and board costs) and treatment costs should not be split nor, should they be billed to the MCOs separately.
- SUPR providers are asked to comply with HFS Billing Guidance as documented in the IAMHP Comprehensive Billing Manual for inpatient hospital providers when submitting bill type 837I claims. This methodology is based on treating 944 and 945 as accommodation revenue codes vs. treatment days as previously indicated to providers in June 2017.
  - Revenue code 944 and 945 are considered ‘accommodation’ revenue codes in this instance per HFS.
  - The units will be defined as UNITS (UN) only, not DAYS (DA) in the 837I transaction.
  - Should be reported on one single line at the (2400 Loop, LX1, SV2, DTP segments). Examples are later in this document.
  - This change is mandated by HFS and is effective with claims received as 7/1/2020.
- Admission Date (FL 12) is the date the patient was admitted to the facility or indicates the start of care date. It must be reported on the claim regardless of whether it is an initial, interim, or final bill. On an Interim Continuing (FL 4 Type of Bill = XX3) or Interim Final (FL 4 Type of Bill = XX4), the Admission Date must be prior to the statement covers “From” date. For additional guidance refer to Inpatient Hospital Coding Guidance in this manual <hyperlink> to the Statement and Admission Dates.
- SUPR services are to be billed with statement from and statement through dates and ONE applicable line level dates of service for services (LX*1).
  - Example = when billing H0047 should include statement from and through dates and service line detail of when the services were received. Example:

```
LX*1
SV2*0945*HC>H0047*20169*UN*26
DTP*472*RD8*20190401-20190427
```
Units must be defined as **units (UN)**, not days (DA), at the line level

- The month statement from date and the month of statement through date must be the same month. For additional guidance refer to Inpatient Hospital Coding Guidance in this manual <hyperlink> to the Statement and Admission Dates. See the interim claim rules and Value Code 80 rules below.

- Field 14- Type of Admission or Visit (2300 Loop CL1 Segment -CL1-01 Admission Type) must be present on the claim for SUPR providers and must be equal to 1 - 5. HFS only accept codes 1 – 5. The CMS value of 9 for ‘Information Not Available’ is not accepted by HFS.
- If a member is being dually treated for both alcohol and substance abuse, the primary admitting diagnosis should be utilized to determine the appropriate revenue code (944 or 945) for the claim.
- POA (Present on Admission) is **NOT** required for 837I SUPR claims.
- A Value Code of 80 is required on all 837I claims and should be reported as the total days of the accommodation revenue code (944 or 945).

- For Bill Frequency Code (2300 CLM Segment) that represent an Admit through Discharge Claim
  i. (Type of Bill = XX1) Admit Through Discharge or Interim-Last Claim (Type of Bill XX4) (FL 4 Type of Bill on paper claims):
  ii. Admit through Discharge Claim = (Date of Service (DOS) Thru Date minus DOS from Date)
  iii. Do not calculate the day of discharge in total days of the stay.
  iv. On the service lines level (2400 SV2 and DTP), Units reported with the 944 or 945 revenue codes must be equal to total number of covered units with RD8 qualifier in the 837I (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD)

  SV2*0944* HC>H0047*9645*UN*5
  DTP*472*RD8*20190701-20190706

**Example 1:**

**Incorrect Billing**

CLM*TMGMH19146000H000000*3735***89>A>1***C*Y*Y~—— Bill Frequency 1
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190503~ Statement From – Statement To
DTP*435*DT*201904291300~
CL1*3*9*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>>Y~
HI*ABJ>F1120~
HI*ABF>F1220>>>>>>>Y*ABF>F1420>>>>>>>>Y*ABF>F329>>>>>>>>Y~
**HI*BE>80>>5** ~ Provider billed 5 -Incorrect number, should be 4 -as last day (discharge date) is not counted since bill frequency is 1
NM1*71*1*CCCCCAR*SANDEEP****XX*1124999999~
LX*1~
SV2*0944*HC>H0047*2988*UN*5~ Units are incorrect
DTP*472*RD8*20190429-20190503~
REF*6R*1~

**Correct Billing**

CLM*TMGMH19146000H000000*3735***89>A>1***C*Y*Y~—— Bill Frequency 1
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190503~ Statement From – Statement To
DTP*435*DT*201904291300~
CL1*3*9*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>>Y~
HI*ABJ>F1120~

Value Code 80 Examples following HFS rules for ‘Hospitals’ with Bill Frequency = 1
Interim Claims

Claims for inpatient services rendered and paid by the per diem reimbursement methodology **cannot be split unless** the stay exceeds 30 days or unless the patient is transferred to another facility or category of service.

- **If billing on an interim basis**, it must be billed monthly with month statement from date and the month statement through date. For additional guidance refer to Inpatient Hospital Coding Guidance in this manual <hyperlink> to the Interim Claims.
- Patient status 30 must be billed for interim claims
- Type of Bill = XX2 or Interim- First Claim = (DOS Thru Date minus DOS from Date) + 1
- Type of Bill = XX3 or Interim- Continuing Claim = (DOS Thru Date minus DOS from Date) + 1
- On interim claims, it is allowable to include day of discharge in covered non-covered day calculations.
Providers who are eligible to bill in an interim fashion should note the following:

- Services billed should be in one-month increments
  - Example 1: 3/1/19-3/31/19
  - Example 2: with an admit date of 2/6/19
    - 2/6/19-2/28/19

**Example 3: Interim First Claim or Interim Continuing Claims**

- **892/893 Bill Type- MUST BE BILLED IN 30 DAY INCREMENTS PER HFS**
- The statement from and statement through plus 1 is the value code 80 calculation

Incorrect Example:

CLM*TMGMH19146000H000000*3735***89>A>2**C*Y*Y~
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190603~ Statement From – Statement To – Incorrect for interim claim – must be full month
DTP*435*DT*201904291300~
CL1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>>>Y~
HI*ABF>F1120~
HI*ABF>F1220>>>>>>>>Y*ABF>F1420>>>>>>>>Y*ABF>F329>>>>>>>>Y~
**HI**BE>80>>>5~ CLAIM WILL BE DENIED 1) NOT A FULL MONTH NOT ALLOWED ANY LONGER and 2) not a 1-line claim
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*DB*20190429~
REF*6R*1~
LX*2~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*DB*20190430~
REF*6R*2~
LX*3~
Each individual date of service is no longer allowed
SV2*0944*HC>H0047*747*UN*1~
DTP*472*DB*20190501~
REF*6R*3~
LX*4~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*DB*20190502~
REF*6R*4~
LX*5~
SV2*0944*HC>H0047*747*UN*1~
DTP*472*DB*20190503~
REF*6R*5~

**Correct example would result in 3 claims:**

**Claim 1**

CLM*TMGMH19146000H000000*3735***89>A>2**C*Y*Y~
DTP*096*TM*0100~
DTP*434*RD8*20190429-20190430~ Statement From – Statement To – Full Month
DTP*435*DT*201904291300~
CL1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>>>>>>>>Y~
HI*ABF>F1120~
HI*ABF>F1220>>>>>>>>Y*ABF>F1420>>>>>>>>Y*ABF>F329>>>>>>>>Y~
**HI**BE>80>>>2~
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
Second claim created for the May portion of the stay:

CLM*TMGMH19146000H000000*3735***89>A>3***C*Y*Y*----- Bill Frequency 3
DTP*096*TM*0100~
DTP*434*RD8*20190501-20190531 ~ Statement From – Statement To – Full Month
DTP*435*DT*201904291300~
CL1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>YYYYY>Y~
HI*ABJ>F1120~
HI*ABF>F1220>YYYYY>ABF>F1420>YYYYY>ABF>F329>YYYYY~
HI*BE>80>>31~
NM1*71*1*GR*SANP****XX*112409999~
LX*1~
SV2*0944*HC>H0047*23157*UN*31~
DTP*472*RD8*20190501-20190531~
REF*6R*1~

Final Interim claim for the June services of the stay when member discharged:

CLM*TMGMH19146000H000000*3735***89>A>4***C*Y*Y*----- Bill Frequency 4 Interim Final
DTP*096*TM*0100~
DTP*434*RD8*20190501-20190603 ~ Statement From – Statement To – Till Discharge date of 6/3/2019
DTP*435*DT*201904291300~
CL1*3*5*01~
K3*D820190526D820190610~
HI*ABK>F1120>YYYYY>Y~
HI*ABJ>F1120~
HI*ABF>F1220>YYYYY>ABF>F1420>YYYYY>ABF>F329>YYYYY~
HI*BE>80>>2~
NM1*71*1*GR*SANP****XX*112409999~ Only get 2 units as discharge date is not billable in this scenario
LX*1~
SV2*0944*HC>H0047*1494*UN*2~
DTP*472*RD8*20190601-20190603~
REF*6R*1~

Admission/Discharge

- Admission-A clinical process that occurs after a member has completed an assessment, received a recommendation for placement into a level of care and has been accepted for such treatment. Covered services provided to patients whose assessment does not result in a substance use disorder diagnosis cannot be billed.
- Discharge-Discharge occurs when the member’s treatment is terminated either by completion or by some other action initiated by the member and/or organization.

Billing Linked to Level of Care

Billing to a Manage Care Organization should match the Level of Care for the member. Outpatient Care (Level 1 or Level 2) cannot be billed on the same day as Residential Care (Level 3).

Admission and discharge assessment, psychiatric evaluations, and medication monitoring may be billed on the same day for any patient in any Level of Care in accordance with stated eligibility or exceptions

- Level 3-Patient Day: No more than one patient day shall be reimbursed for any participant in a 24-hour period.
- Day of Discharge or Transfer-Level III: The day of discharge is not allowable for level 3 services.
Illinois has outlined an ambitious strategy to improve behavioral health outcomes working with CMS for ‘waiver’ of federal Medicaid requirements so State government can pilot or demonstrate projects. The purpose of these demonstrations is to evaluate policy approaches such as providing services not typically covered by Medicaid or creating innovative service delivery systems that improve care, increase efficiency, and reduce costs. Examples of State Plan Amendments (SPAs) or pilots that have been pursued by the state are:

- Medication-assisted treatment (MAT) [approved]
- Residential/Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot- Effective 1/1/2019 which increased the members eligible for this program as well as facilities that qualify as an Institution from Mental Diseases (IMD).
- Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD) Pilot – Effective 2/1/2019 the state will cover clinically managed withdrawal management services.
- SUD Case Management Pilot – Effective 2/1/2019 – the state will cover SUD case management services that assist the member to access needed medical, social, educational, and other services.
- Peer Recovery Support Services Pilot- Effective 2/1/2019- this state will cover peer recovery support services delivered by individuals in recovery from a substance use disorder (peer recovery coach) who is supervised to provide counseling support to help prevent relapse and promote recovery.

HFS provides MCOs with a weekly file (referred to as the ‘Weekly OBRA File’) that contains the list of approved members who are eligible for the following pilots:

- Clinically Managed Residential Withdrawal Management for individuals with Substance Use Disorder (SUD)
- SUD Case Management Pilot
- Peer Recovery Support Services Pilot

Additionally, HFS provides MCOs with a listing of facilities that are approved to perform these services. A facility must be approved by HFS to perform the services referenced in this billing guideline.