22-A6400. Purpose.

6400.1 This chapter establishes the reimbursement rate for services provided to eligible District residents ages twenty-one (21) and older by Department of Behavioral Health (Department) certified substance use disorder providers, as this term is defined in Chapter 63 (Certification Standards for Substance Use Disorder Treatment and Recovery Providers) of Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations (DCMR).

6400.2 Establishment of these reimbursement rates will allow the Department to reimburse providers using non-Medicaid local funds for services provided in accordance with the Human Care Agreement to those clients who are not eligible for Medicaid funding, and for those services that are not reimbursable by Medicaid. Reimbursement rates using non-Medicaid local funds are equivalent to the reimbursement rates for equivalent services that may be reimbursable by Medicaid.

6400.3 Nothing in this chapter grants to a certified substance use disorder provider the right to reimbursement for costs of substance use disorder services and supports. Eligibility for reimbursement is determined solely by the Human Care Agreement between the Department and the certified substance use disorder provider, and reimbursement is subject to the availability of appropriated funds.

22-A6401. Reimbursement Rate.

6401.1 The Department of Health Care Finance has published rates for Medicaid-funded services under Title 22-A District of Columbia Municipal Regulations (DCMR), Chapter 63. Those rates are contained in the District of Columbia Medicaid fee schedule available online at *www.dc-medicaid.com*. The Department of Behavioral Health ("the Department") shall reimburse providers for Chapter 63 services provided to non-Medicaid beneficiaries at the same rates as contained in the District of Columbia Medicaid fee schedule.

6401.2 Reimbursement for the local-only substance use services provided under Title 22-A DCMR Chapter 63, which include: (a) Multi-systemic Therapy for Transition Age Youth and (b) Environmental Stability, as well as Chapter 63-adjacent (c) Residential Room and Board, are set forth in the table below. The Department shall publish notice of all future updates to these codes and rates through a Public Notice in the D.C. Register and provide for meaningful comment before implementation. The Notice shall describe the type of change, the reason for the change, the effective date of the change, and the new local only reimbursement rate.

SERVICE	CODE	RATE per UNIT	UNIT
Multi-systemic Therapy for Transition Age Youth (TAY) (ACRA) (ages 21 - 24)	H2033HF	63.11	15 min.
Residential Treatment, Room & Board	H0043	101.14	Per diem
Residential Treatment, Room & Board, Woman w/1 child	H0043UN	210.00	Per diem
Residential Treatment, Room & Board, Woman w/2 children	H0043UP	215.00	Per diem
Residential Treatment, Room & Board, Woman w/3 children	H0043UQ	220.00	Per diem
Residential Treatment, Room & Board, Women w/4 or more children	H0043UR	225.00	Per diem
Environmental Stability, Supported Housing, Individual	H0044HF	849.00	Per month
Environmental Stability, Supported Housing, Woman w/children	H0044HFUN	1000.00	Per month

6401.3 Reimbursement for the following tests provided to non-Medicaid clients shall be the rate contained in the District of Columbia Medicaid fee schedule available online at *www.dc-medicaid.com:*

(a) HIV-1 and HIV-2 Single Result Testing (86703);

(b) Urine Pregnancy Test (81025);

(c) Tuberculosis Test, Intradermal (86580);

(d) Hepatitis C Test (86803);

(e) Presumptive Drug Test, Optical Observation (80305);

(f) Presumptive Drug Test, Assisted Direct Optical Observation (80306); and

(g) Presumptive Test by Instrument Chemistry Analyzers (80307).

6401.4 Reimbursement for the following tests provided to non-Medicaid clients shall be the rate contained in the District of Columbia Medicaid fee schedule available online at *www.dc-medicaid.com:*

(a) Definitive Drug Testing 1-7 Drug Classes (G0480); and

(b) Definitive Drug Testing 8-14 Drug Classes (G0481).

6401.5 All future updates to the service codes and rates will be included in the District of Columbia Medicaid fee schedule pursuant to the procedures established in Title *29 DCMR, Section 988*, by providing notice and an opportunity for comment.

22-A6402. Reimbursement Rate for Clients Who are Deaf or Hard-of-Hearing.

6402.1 Reimbursement for the local-only substance use services provided under Title 22-A DCMR Chapter 63, which include: (a) Multi-systemic Therapy for Transition Age Youth and (b) Environmental Stability, as well as Chapter 63-adjacent (c) Residential Room and Board provided to clients who are deaf or hard-of-hearing are set forth in the table below. The Department shall publish all future updates to these codes and rates through a Public Notice in the D.C. Register, which provides an opportunity for meaningful comment. The Notice shall describe the type of change, the reason for the change, the effective date of the change, and the new local only reimbursement rate.

SERVICE	CODE	RATE per UNIT	UNIT
Multi-systemic Therapy for Transition Age Youth (TAY) (ACRA) (ages 21 - 24)	H2033HFHK	77.52	15 min.
Residential Treatment, Room & Board	H0043HK	98.42	Per diem
Residential Treatment, Room & Board, Woman w/1 child	H0043UNHK	283.50	Per diem
Residential Treatment, Room & Board, Woman w/2 children	H0043UPHK	290.25	Per diem
Residential Treatment, Room & Board, Woman w/3 children	H0043UQHK	297.00	Per diem
Residential Treatment, Room & Board - Women w/4 or more children	H0043URHK	303.75	Per diem
Environmental Stability, Supported Housing, Individual	H0044HFHK	849.00	Per month
Environmental Stability, Supported Housing, Woman w/children	H0044HFUNHK	1000.00	Per month

22-A6403. Additional Reimbursement Requirements

6403.1 The following provisions apply to the reimbursement of substance user disorder (SUD) providers billing the Department or the Department of Health Care Finance pursuant to this chapter, except where otherwise noted.

6403.2 Reimbursement for Short-term MMIWM services shall not exceed five (5) days unless a longer stay is authorized by the Department.

6403.3 H0010 or H0010HK shall be billed for locally-funded clients in MMIWM. Residential treatment room and board (H0043 and H0043HK) is not a separate service for these clients and shall not be billed in addition to MMIWM.

6403.4 H0010U1 or H0010U1HK shall be billed for Medicaid clients in MMIWM. Residential treatment room and board (H0043 and H0043HK) shall be billed separately for these clients in order to be reimbursed.

6403.5 Reimbursement will not be provided for the following services for clients in MMIWM:

(a) Medication Management;

(b) Clinical Care Coordination;

(c) Medication Assisted Treatment;

(d) Drug Screening; and

(e) Crisis Intervention.

6403.6 The Department shall reimburse an SUD provider for a maximum of one (1) Initial Diagnostic Assessment per client within a thirty (30)-day period.

6403.7 The Department shall reimburse an SUD provider for a maximum of one (1) Comprehensive Diagnostic Assessment per client per level of care (LOC).

6403.8 The Department shall reimburse an SUD provider for a maximum of two (2) Ongoing Diagnostic Assessments per client per sixty (60) days.

6403.9 Comprehensive Diagnostic Assessment and Ongoing Diagnostic Assessment shall not be billed on the same day.

6403.10 Clinical Care Coordination shall not be billed in conjunction with staff's clinical supervision or at the same time as any Diagnostic Assessment service.

6403.11 The following reimbursement limits shall apply, per LOC, to Crisis Intervention:

(a) Level 1: Eighty (80) units;

(b) Level Opioid Treatment Program ("OTP"): One hundred and forty-four (144) units;

(c) Level 2: One hundred and twenty (120) units; and

(d) Level 3: One hundred and sixty (160) units.

6403.12 The following reimbursement limits shall apply, per LOC, to SUD Counseling/Therapy. The Department may approve additional units with justification.

(a) Level 1: Thirty-two (32) units per week;

(b) Level 2: Eighty (80) units per week; and

(c) Level 3: One hundred (100) units per week.

6403.13 No more than ninety-six (96) units of Medication Management shall be billed per LOC. Medication Management shall not be billed for observing the self-administration of medication.

6403.14 The following provisions apply to reimbursement for all medications dispensed in OTPs:

(a) Medication shall be billed on a per-dose basis; and

(b) A single fifteen (15)-minute administration session may be billed when an individual is receiving take-home doses.

6403.15 The following provisions further apply to reimbursement of methadone administered in OTPs:

(a) A client can be dispensed a maximum of one dose per day;

(b) An initial and second authorization can be authorized for a maximum of ninety (90) days each; subsequent authorizations cannot exceed one hundred and eighty (180) days each; and

(c) Prior authorization from the Department is required for reimbursement of more than two- hundred and fifty (250) units of medication in one calendar year. The maximum quantity of medication and administration services over a twelve (12)-month period is three hundred and sixty-five (365) units.

6403.16 All claims seeking Medicaid or local only reimbursement under this Chapter shall include the active National Provider Identification (NPI) numbers for the certified provider and the rendering provider. The rendering provider is the staff member who provided the service.