Clinical Policy: Substance Abuse Intensive Outpatient Program SAIOP)

Reference Number: WNC.CP.285 Coding Implications
Last Review Date: 01/2026 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Substance Abuse Intensive Outpatient Program (SAIOP) provides a structured program of skilled treatment services for adults or adolescents with a primary substance use disorder (SUD) diagnosis. SAIOP is an American Society of Addiction Medicine (ASAM), Third Edition, Level 2.1 service that provides nine to nineteen (9-19) hours of skilled treatment services per week for adults, and six to nineteen (6-19) hours of skilled treatment services per week for adolescents. SAIOP treatment services include individual, group, and family counseling, medication management through consultation and referral, educational groups, and service coordination activities provided in amounts, frequencies, and intensities appropriate to the objectives of the member's Person-Centered Plan (PCP). SAIOP treatment services can be delivered during the day, weekend, or evening.

Definitions

I. The ASAM Criteria, Third Edition

The American Society of Addiction Medicine (ASAM) Criteria is a comprehensive set of treatment standards for addictive, substance-related, and co-occurring conditions. The ASAM Criteria, Third Edition, uses six dimensions to create a holistic, biopsychosocial assessment to be used for service planning and treatment. The six dimensions are:

- **A.** Acute Intoxication and Withdrawal Potential;
- **B.** Biomedical Conditions and Complications;
- **C.** Emotional, Behavioral, or Cognitive Conditions and Complications;
- **D.** Readiness to Change;
- **E.** Relapse, Continued Use, or Continued Problem Potential; and
- **F.** Recovery and Living Environment.

II. Medication Assisted Treatment (MAT)

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), Medication Assisted Treatment (MAT) is "the use of medications, in combination with counseling and behavioral therapies, to provide a 'whole patient' approach to the treatment of substance use disorders. Medications used are approved by the Food and Drug Administration (FDA), and are clinically driven and tailored to meet each member's needs."

III. Telehealth

Per Clinical Coverage Policy WNC.CP.193 *Telehealth, Virtual Communications and Remote Patient Monitoring,* "Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations."

Policy/Criteria[1]

I. Telehealth

- **A.** Services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in Clinical Coverage Policy 1-H, *Telehealth, Virtual Communications and Remote Patient Monitoring*, at NCDHHS Medicaid Clinical Coverage Policies /.
- **B.** The determination to provide services via telehealth must be for the benefit of the member with a signed attestation of member choice.
- **C.** A provider shall consider and document the member's behavioral, physical, and cognitive abilities to participate in services provided via telehealth. Documentation must include the individual's SUD treatment and recovery needs, including appropriateness of their recovery environment for telehealth services.
- **D.** A member is not required to seek services through telehealth and shall have access to in person services.
- **E.** Services must be available in person at least five (5) days per week.
- **F.** All services that are provided via telehealth must be billed with the appropriate modifier, and documentation should include provision via telehealth

II. WellCare of North Carolina® shall cover SAIOP services when a member meets the following specific criteria:

- **A.** Has a current substance use disorder (SUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference manual; and
- **B.** Meets the American Society of Addiction Medicine (ASAM) Level 2.1 Substance Abuse Intensive Outpatient Program (SAIOP) admission criteria as defined in the ASAM Criteria Third Edition, 2013.

III. Admission Criteria

- **A.** A comprehensive clinical assessment (CCA) or Diagnostic Assessment (DA) must be completed by a licensed professional to determine an ASAM level of care for admission and discharge planning. The CCA or DA, which demonstrates medical necessity, must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA or DA. Relevant diagnostic information must be obtained and documented in the member's Person-Centered Plan (PCP). The assessment and PCP must be updated as changes, new strengths and barriers are observed during the treatment process.

B. A service order for SAIOP must be completed by a physician, , physician assistant, nurse practitioner or licensed psychologist, according to their scope of practice prior to or on the day that SAIOP services are provided. Refer to Background I.C. for Service Order requirements.

C. The amount, duration, frequency, and intensity of SAIOP services must be documented in a member's PCP. Services must not be offered less frequently than the structured program set forth in the **Description** of this policy.

IV. Continued Stay Criteria

Each of the six dimensions of the ASAM criteria must be reviewed and documented in the member's service record to document the determination for continued stay, discharge, or transfer to another level of care.

A. The member meets the criteria for continued stay at the present level of care if any **ONE** of the following applies:

1. The member has achieved initial PCP goals and requires this present level of care in order to meet additional goals;
2. The member is making some progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated;
3. The member is not making progress, is regressing, or new symptoms have been identified and the member has the capacity to resolve these problems; **or**
4. The member is actively working towards goals so continuation at the present level of care is indicated, and the PCP must be modified to identify more effective interventions.

V. Discharge Criteria

B. The member shall meet the criteria for discharge if any **ONE** of the following applies:

1. Substance Use Disorder (SUD) signs and symptoms are resolved such that the member can participate in self-directed recovery or ongoing treatment without the need for SAIOP services.
2. The signs and symptoms of SUD have failed to responding to treatment, and have intensified, indicating a transfer to a more intensive level of SUD treatment services is indicated; or
3. The member or their legally responsible person for the member requests a discharge from the service.

Note: *Each of the six dimensions of the ASAM criteria must be reviewed and documented in the member's service record to document the determination for continued stay, discharge, or transfer to another level of care.*

VI. WellCare of North Carolina® shall **NOT** cover these activities:

A. Transportation for the member or member's family is not billable under this policy. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina's Non-Emergency Medical Transportation benefit. See related policy, Non-Emergency Medical Transportation: WNC.CP.262, available at WellCare NC Clinical Coverage Guidelines WNC.CP.262 NEMT for prior

authorization information. Information for WellCare of North Carolina members is available at WellCare NC Medicaid Transportation Services.

B. Any habilitation activities;
C. Time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill building or therapy;
D. Clinical and administrative supervision of SAIOP staff, which is covered as an indirect cost and part of the rate;
E. Covered services that have not been rendered;
F. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
G. Services provided to teach academic subjects or as a substitutes for education personnel;
H. Interventions not identified on the member's PCP;
I. Services provided to children, spouse, parents, or siblings of the member under treatment or others in the member's life to address problems not directly related to the member's needs and not listed on the PCP; and
J. Payment for room and board.

Background[1]

I. Requirements for and Limitations on Coverage

A. Additional Limitations or Requirements

1. A member can receive SAIOP services from only one provider organization during an episode of care. A member may receive Peer Support Services in the same episode of care as SAIOP, but must be billed during distinct hours separate from the hours of the SACOT programming.
2. SAIOP must not be provided and billed during the same episode of care (except on the day of admission or discharge) as:
   a. Substance Abuse Comprehensive Outpatient Services (SACOT)
   b. Individual, family, or group therapy for treatment of substance use disorder (Please see WNC.CP117 *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers* for exclusions related to psychotherapy and SACOT).
   c. Clinically Managed Residential Withdrawal Management (ASAM Criteria, Level 3.2 WM)
   d. Medically Monitored Inpatient Withdrawal Management (ASAM Criteria, Level 3.7 WM)
   e. Clinically Managed Population-Specific High-Intensity Residential Programs (ASAM Criteria, Level 3.3)
   f. Clinically Managed Residential Services (ASAM Criteria, Level 3.5)
   g. Medically Monitored Intensive Inpatient Services (ASAM Criteria, Level 3.7);
   h. Psychiatric residential treatment facilities
   i. Partial Hospitalization (PH).

B. Service Order

A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the member's needs. A signed service order must be completed by a physician, physician assistant, nurse practitioner, or licensed psychologist per their scope of practice. A service order is valid for twelve (12) months. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

1. **ALL the following apply to a service order:**
   a. Backdating of the service order is not allowed;
   b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; **AND**
   c. A service order must be in place prior to or on the first day that the service is initially provided to bill WellCare of North Carolina® for the service. Even if the member is retroactively eligible for WellCare of North Carolina® the provider shall not bill WellCare of North Carolina® without a valid service order.

C. Documentation Requirements:

The service record documents the nature and course of a member's progress in treatment. To bill WellCare of North Carolina®, a provider shall ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by WellCare of North Carolina®. Service notes must meet the requirements of the DHHS Records Management and Documentation Manual.

D. Provider Eligibility, Provider Qualifications and Occupational Licensing Entity Regulations, Provider Certifications, Staffing Requirements, Program Requirements, and Staff Training Requirements:

Please refer to North Carolina Medicaid State Policy Site for Substance Abuse Intensive Outpatient Treatment (SAIOP) Clinical Coverage Policy No: 8A-12 at NCDHHS Medicaid Clinical Coverage Policies.

E. Program Requirements

1. SAIOP must be available in person at least five days per week, with no more than two consecutive days without services available to achieve nine to nineteen (9-19) hours of services per week for adults and six to nineteen (6-19) hours of services per week for adolescents. SAIOP shall schedule a minimum of three (3) service days per week for each member with a minimum of three (3) hours per service day for adults, and a minimum of two (2) hours per service day for adolescents.
2. SAIOP program components include:
   a. Individual counseling, therapy, and support;
   b. Group counseling, therapy, and support;
   c. Family counseling and support, which involves family members, guardians, or significant other(s) in the assessment, treatment, and continuing care of the member, with informed consent;
   d. Coordination and referral for ancillary services;
   e. Biomedical testing to evaluate recent drug use (such as urine drug screens);

f. Education on relapse prevention and development of support systems in treatment;
g. Education on life skills and crisis contingency planning;
h. Education on physical health management;
i. Reproductive planning and health education;
j. A planned format of therapies, delivered on an individual and group basis and adapted to the member 's developmental stage and comprehension level; and
k. Service coordination activities.

3. SAIOP shall support a member who is prescribed or would benefit from medications, including Medication Assisted Treatment (MAT), to address their substance use or mental health diagnosis. Coordination of care with a prescribing physician is required.
4. A SAIOP provider shall ensure that all staff have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses. SAIOP shall develop policies that detail the use, storage and education provided to staff regarding naloxone.
5. A comprehensive clinical assessment (CCA), diagnostic assessment (DA), or reassessment must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Relevant diagnostic information must be obtained in the assessment or reassessment and documented in the member's PCP. CCA, DA, toxicology testing, peer support services, and psychiatric and medical services can be billed separate from SAIOP.

Urine toxicology testing should only be done when medically necessary, as defined in WNC.CP253-*Drug Testing for Opioid Treatment and Controlled Substance Monitoring.*

F. Expected Outcomes:

The expected clinical outcomes for SAIOP are specific to recommendations resulting from clinical assessments and meeting the identified goals in the member's PCP. Expected outcomes are as follows:

1. Reduction or elimination of substance use and substance use disorder symptoms;
2. Sustained improvement in health and psychosocial functioning;
3. Reduction in involvement in the justice system;
4. Reduction of risk of relapse, continued problems, or continued use;
5. Reintegration of the individual into the community;
6. Linkage to other necessary treatment services concurrently and upon discharge;
7. Identification and linkage to community-based resources to address unmet social determinants of health and;
8. Increase in the identification and use of healthy coping skills.

Note: Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with federal laws and regulations. All providers shall be in compliance with 42 CFR Part 2- Confidentiality of Substance Use Disorder Patient Records.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description	Billing Unit
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	1 unit = 1 event per day (minimum of 3 hours)

SAIOP service is billed with a minimum of three (3) hours per day as an event..

Telehealth Claims: Modifier GT must be appended to the HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/2026	01/2026

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 8A-12 Substance Abuse Intensive Outpatient Treatment (SAIOP). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2026. Accessed January 1, 2026.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.