HCPCS Code H0018 and H0019 Short-term and Long-term Residential Treatment (per diem)

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Background

HCPCS codes H0018 and H0019 are used to bill behavioral health; short-term and long-term residential services without room and board. These codes represent “Medically Monitored Intensive Inpatient” residential substance use disorder services.

- H0018 behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem.
    - Only reimbursable as a SUD treatment service
    - Used for days 1–30
- H0019 behavioral health, long term, residential services (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
    - Reimbursable as a SUD treatment service or a psychiatric residential treatment service (PRTS)
    - used from day 31 onward

The rule is part of Chapter 309, Division 18 of the Oregon Administrative Rules, specifically targeting residential SUD treatment programs.

Scope

Only Medicaid-enrolled, Oregon-certified SUD residential treatment providers delivering ASAM Level 3.1, 3.3, 3.5, or 3.7 may bill H0018. Psychiatric residential treatment services (PRTS) may be reported with H0019. No other behavioral health provider types—including community mental health clinics, therapists, counselors, or peer support specialists—are authorized to bill H0018 or H0019 in Oregon.

SUD Residential ASAM Levels of Care

ASAM levels of care are a standardized continuum developed by the American Society of Addiction Medicine (ASAM) to match individuals with substance use disorders and co-occurring conditions to the least intensive, yet medically appropriate, level of treatment based on their clinical needs. The levels range from early intervention and outpatient services to residential treatment and medically managed inpatient care. Level 3.1-3.7 is the focus of this guide for residential SUD services.

3.1: Clinically managed low-intensity residential: 24-hour residential support with low-intensity clinical services to focus on recovery and life skills.

3.3: Clinically managed population-specific high-intensity residential: Treatment for individuals with significant cognitive, behavioral, or emotional challenges.

3.5: Clinically managed high-intensity residential: 24-hour residential treatment with intensive clinical services for individuals needing a structured recovery environment.

3.7: Medically monitored intensive inpatient: 24-hour medically monitored treatment with physician supervision for significant withdrawal, medical, or psychiatric needs. (OAR 309-018-0184)

Policy

Billing units and daily limits

1 unit = 1 day of service

Only one unit may be billed for each date of service that the patient is treated at the service center.

All services performed by the staff of the treatment center are considered inclusive to this daily rate. All services performed on the same day by any staff member of the treatment center cannot be billed separately.

Per OAR 410-172-0620, and 309-019-0320, as applicable, all behavioral health services must be documented in a way that supports the extent of services billed. Documentation must be clear, detailed, and complete enough for internal and external review. It must also meet the professional standards applicable to the provider's discipline.

Discharge and transfer days: Per OAR 410-172-0730 (Payment Limitations for Behavioral Health Services), OHA does not reimburse for the day of transfer or discharge; residential per diem authorizations are approved only through the last full 24-hour period.

Prior authorization: Per CareOregon's Behavioral Health Utilization Management procedures, prior authorization is required for SUD Residential Treatment (ASAM 3.1–3.7). Standard determinations are issued within 7 calendar days of the request; expedited requests are decided within 72 hours.

Timely filing: Per OAR 410-141-3565 and CareOregon's Behavioral Health Provider Manual, initial claims must be submitted within 120 calendar days of the date of service; corrected claims or appeals must be submitted within 365 days of the original adjudication date.

Documentation requirements

Each date of services billed using code H0018 and H0019 must include at a minimum:

Date of Service: Clear record of each day billed.

Provider Credentials & Identification: Name, credentials, and signature (or electronic equivalent) of the clinician delivering services.

- Length and Duration: Hours or units of service per day as applicable.
- Detailed Clinical Notes: Daily progress notes describing therapeutic activities, interventions, and participant responses.
- Diagnosis Codes: Primary and secondary ICD-10 codes supporting medical necessity.
- Narrative Service Description: Explanation of the type, intensity, and rationale for services provided.
- Service Plan & Goals: Individualized treatment/treatment plan outlining objectives, interventions, and expected outcomes, inclusive of addressable behavioral health needs.
- Transition Planning: Documentation of discharge readiness and planning or transition to the next level of care.
- Authorization Documents: Current authorization or referral number for each episode or level-of-care change, including day 31 transition from H0018 to H0019.
- Compliance & Medical Necessity: Clear evidence that clinical documentation meets Oregon's medical necessity criteria defined by ASAM and adherence to applicable administrative rules (e.g., SERI guidelines for residential care).

Modifiers commonly used with H0018 and H0019

A billing modifier is a two-character code (letters, numbers, or a combination) added to a medical billing code to provide additional information about the service or procedure performed and may impact the payment for services. CareOregon requires one of the following modifiers to ensure correct reimbursement:

- HB-Services Provided in a Licensed Adult Substance Use Disorder (SUD) Treatment Program
- UA-Services Provided in a Licensed Adolescent Alcohol and Drug Treatment Program
- U1-Specialty SUD Residential Program as defined by OHA

In addition to required modifiers above, the following can be used to identify ICD or CLSS services:

- TN- Culturally and Linguistically Specific Services (CLSS) For Rural Providers - provider must be certified as rural by the OHA to receive 27% of the fee-for-service (FFS) rate listed on the behavioral health fee schedule.
- U2-ICD SUD Residential Program-provider must be enrolled with an ICD specialty of 007 or 009 and must be contracted for ICD services to be reimbursed for an increased percentage.
- U9-CLSS For Non-Rural Providers-- provider must be certified by OHA to reimburse at 22% of the FFS rate listed in the behavioral health fee schedule.

Best practices

- ✓ Verify insurance eligibility before service
- ✓ Stay updated with OHA and CCO billing policies
- ✓ Conduct internal audits to ensure compliance

References

Oregon Health Authority, Health Systems Division. (2024, April 22). New customary charge for ASAM Level 3.7 R services. https://www.oregon.gov/oha/HSD/OHP/Announcements/3.7R-LOC-Rate0424.pdf

Oregon Health Authority. (2024). Oregon Administrative Rules, 309-018-0108: Licensing standards. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299460

Oregon Health Authority. (2025). Oregon Administrative Rules, 309-018-0125: Specific staff qualifications and competencies. Oregon Secretary of State. https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-018-0125

Oregon Health Authority. (2024). Oregon Administrative Rules, 309-018-0130: Documentation, training, and supervision. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299463

Oregon Health Authority. (2017). Oregon Administrative Rules, 309-019-0320: Documentation requirements. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=44031

Oregon Health Authority. (2015). Oregon Administrative Rules, 410-172-0620: Documentation standards. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=88302

Oregon Health Authority. (2024). Oregon Administrative Rules, 309-018-0184: SUD residential ASAM level of care 3.7. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299473

Oregon Health Authority. (2024). Oregon Administrative Rules, 410-120-1280: Billing. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=319141

Oregon Health Authority. (2024). Oregon Administrative Rules, 410-172-0705: Residential rate standardization. Oregon Secretary of State. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=329249

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