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**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

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**Related Clinical Coverage Policies**

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

## **1.0 Description of the Procedure, Product, or Service**

Clinically Managed Residential Withdrawal Services is an organized facility-based service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for beneficiaries, who are intoxicated, or experiencing withdrawal. This an American Society of Addiction Medicine (ASAM) Level 3.2-WM service intended for beneficiaries who are not at risk of severe withdrawal syndrome, are free of severe physical and psychiatric complications, where moderate withdrawal symptoms are safely manageable at this level of care.

This service has an emphasis on the utilization of peer and social support to safely assist beneficiaries through withdrawal. All programs must have established clinical protocols developed and supported by a physician who is available 24 hours a day. Support systems must include direct coordination with other levels of care. These services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the transition into ongoing treatment and recovery.

### **1.1 Definitions**

#### **1.1.1 Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR):**

Is defined as a tool utilized to assess an individual's alcohol withdrawal.

## **2.0 Eligibility Requirements**

### **2.1 Provisions**

#### **2.1.1 General**

*(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

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- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

**2.1.2 Specific**

*(The term “Specific” found throughout this policy only applies to this policy)*

**a. Medicaid**

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover Clinically Managed Residential Withdrawal Services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

**b. NCHC**

NCHC shall cover Clinically Managed Residential Withdrawal Services for an eligible beneficiary who is 18 years of age till he or she reaches their 19<sup>th</sup> birthday and meets the criteria in **Section 3.0** of this policy.

Retroactive eligibility does not apply to the NCHC program.

**2.2 Special Provisions**

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

**a. 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 shall be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service

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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:

1. that is unsafe, ineffective, or experimental or investigational.
2. 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.

**b. EPSDT and Prior Approval Requirements**

1. 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.
2. **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/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who is not 18 years of age and does not meet the criteria within **Section 3.0** of this policy.

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**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

**3.2 Specific Criteria Covered**

**3.2.1 Specific criteria covered by both Medicaid and NCHC**

Medicaid and NCHC shall cover Clinically Managed Residential Withdrawal Services when ALL following criteria are met:

- a. The beneficiary has a substance use disorder (SUD) diagnosis as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; and
- b. Meets American Society of Addiction Medicine (ASAM) Level 3.2 -WM Clinically Managed Residential Withdrawal Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013 or any subsequent editions of this reference material.

**3.2.1.1 Admission Criteria**

- a. Due to the nature of this crisis service, a comprehensive clinical assessment (CCA) is not required before admission for Clinically Managed Residential Services.
- b. An initial abbreviated assessment must be completed by clinical staff and protocols must be developed and in place to determine when a physical exam must be conducted by a medical director, physician assistant, or nurse practitioner.
- c. The initial abbreviated assessment shall be used to establish medical necessity for this service and the development of a service plan as a part of the admission process.
- d. The initial assessment must ~~include~~ contain the following documentation in the service record:
  1. the beneficiary's presenting problem;
  2. the beneficiary's needs and strengths;

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3. a provisional or admitting diagnosis when the assessment is completed by an appropriately licensed professional;
4. a physical examination by the medical director, a physician assistant, or nurse practitioner if self-administered withdrawal management medications are to be used;
5. a pertinent social, family, and medical history; and
6. other evaluations or assessments as appropriate.

The medical director, physician assistant, or nurse practitioner can bill an Evaluation and Management (E/M) code separately for the admission assessment and physical exam.

Within 3 calendar days of the admission, a comprehensive clinical assessment shall be completed by a licensed professional to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and be included in the treatment or service plan.

**3.2.1.2 Continued Stay and Discharge Criteria**

The beneficiary meets the criteria for discharge if any ONE of the following applies:

- a. The beneficiary's withdrawal signs and symptoms are sufficiently resolved that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical withdrawal management monitoring;
- b. The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system, as appropriate) indicating a transfer to a more intensive level of withdrawal management services is indicated;
- c. The beneficiary is unable to complete withdrawal management at level 3.2-WM indicating a need for more intensive services; OR
- d. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

**3.2.2 Medicaid Additional Criteria Covered**

None Apply.

**3.2.3 NCHC Additional Criteria Covered**

None Apply.

**4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

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**4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

**4.2 Specific Criteria Not Covered**

**4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

Medicaid shall not cover these activities:

- a. Transportation for the beneficiary or family members;
- b. Any habilitation activities;
- c. Time spent attending or participating in recreational activities unless tied to specific planned social skill assistance;
- d. Clinical and administrative supervision of Clinically Managed Residential Withdrawal Services 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 substitute for education personnel;
- h. Interventions not identified on the beneficiary's service plan;
- i. Services provided to children, spouse, parents, or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the service plan; and
- j. Payment for room and board; and
- k. Beneficiaries under the age of 17.

**4.2.2 Medicaid Additional Criteria Not Covered**

None apply.

**4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.

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2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

## **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **5.1 Prior Approval**

Upon admission to Clinically Managed Residential Withdrawal Services a beneficiary is allowed an initial three day (calendar days) pass-through. An authorization from the Prepaid Inpatient Health Plan (PIHP), Prepaid Health Plan (PHP), or utilization management contractor is required after the initial three day (calendar days) pass-through.

### **5.2 Prior Approval Requirements**

#### **5.2.1 General**

The provider(s) shall submit to the PIHP, PHP, or utilization management contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

#### **5.2.2 Specific**

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

##### **5.2.2.1 Initial Authorization**

Services are based upon a finding of medical necessity, must be directly related to the beneficiary’s diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary’s service plan. Medical necessity (10A NCAC 25A .0201) is determined by North Carolina community practice standards, as verified by the PIHP, PHP, or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary’s physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

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To request an initial authorization after the pass-through units have been utilized, the CCA, service order for medical necessity, the service plan, and the required NC Medicaid authorization request form must be submitted to the PIHP, PHP, or utilization management contractor within the first 3 calendar days of service initiation. **Medicaid may cover up to 5 calendar days for the initial authorization period if continued stay criteria is met.**

**5.2.2.2 Reauthorization**

**NC Medicaid may cover an additional 5-day reauthorization if continued stay criteria is met.** Reauthorization shall be submitted before initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the service plan, the authorization request form, and supporting documentation.

**5.3 Additional Limitations or Requirements**

- a. A beneficiary can receive the Clinically Managed Residential Withdrawal Service from only one provider organization during any active authorization period.
- b. Clinically Managed Residential Withdrawal Services cannot be billed on the same day (except day of admission or discharge) as:
  1. Residential levels of care
  2. Other withdrawal management services
  3. Outpatient treatment services
  4. Substance Abuse Intensive Outpatient Program
  5. Substance Abuse Comprehensive Outpatient Treatment
  6. Assertive Community Treatment
  7. Community Support Team
  8. Supported Employment
  9. Psychiatric Rehabilitation
  10. Peer Support Services
  11. Mobile Crisis Management
  12. Partial Hospitalization
  13. Facility Based Crisis (adult)

**5.4 Service Orders**

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by the medical director, a physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for the episode of care. Medical necessity must be revisited, and service must be ordered based on episode of care if multiple episodes of care are required within a twelve (12) month period.

- a. ALL the following apply to a service order:
  1. Backdating of the service order is not allowed;

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2. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
3. A service order must be in place before or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

**5.5 Documentation Requirements**

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid or NCHC, providers must ensure that their documentation is consistent with the requirements contained in this policy. This service requires a shift note to be completed for every eight hours of service provided. Events in a beneficiary's life which require additional activities or interventions shall be documented over and above the minimum frequency requirement. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must include credentials for the staff member who provided the service. The service plan and a documented discharge plan must be discussed with the beneficiary and included in the service record.

**5.5.1 Contents of a Shift Note**

A shift note is required for each beneficiary for each eight hour shift they are enrolled in Clinically Managed Residential Withdrawal Services.

A shift note must document ALL following elements:

- a. Beneficiary name;
- b. Medicaid identification number;
- c. Date of service;
- d. Type of contact face-to-face, phone call, collateral
- e. Purpose of the contact
- f. Description of the provider's interventions.
- g. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- h. Shift/ coverage hours (Third Shift: 11:30 pm- 7:30 am)
- i. Assessment of the effectiveness of the interventions and the beneficiary's progress towards meeting the beneficiary's goals; and
- j. Date and signatures and credentials or job title of staff providing the service.

**5.5.2 Contents of A Service Note**

- a. A full service note for each contact or intervention provided due to a life event in a beneficiary's life that required additional activities or interventions for each service, written and signed by the person who provided the service is required. A service note must document ALL following elements:
  1. Beneficiary name;
  2. Medicaid identification number;
  3. Date of service;

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4. Type of contact;
  5. Place of service;
  6. Purpose of contact;
  7. Implementation of the treatment plan;
  8. Details of beneficiary's response to treatment plan;
  9. Description of the provider's interventions;
  10. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
  11. Duration of service, amount of time spent performing the intervention;
  12. Assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
  13. Date and signatures and credentials or job title of staff providing the service.
- b. Detoxification rating scale tables Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been developed in coordination with the beneficiary and is also documented before discharge.

## **6.0 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:

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

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

Clinically Managed Residential Withdrawal Services must be delivered by providers employed by substance use provider organizations that:

- a. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
- b. meet the requirements of 10A NCAC 27G;
- c. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
- d. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and
- e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

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This facility must be licensed under 10A NCAC 27G Section .3200 Social Setting Detoxification for Substance Abuse rules unless provided by a IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a.

NC Division of Health Service Regulation  
Mental Health Licensure and Certification Section  
Refer to <https://info.ncdhhs.gov/dhsr/mhls/mhpage.html>

**6.2 Provider Certifications**

<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
<b>Medical Director (MD)</b>	A minimum 0.25 FTE Medical Director	Must be licensed physician and in good standing with the NC Medical Board and have at least one year of SUD treatment experience	<p>The <b>medical director</b> is responsible for providing medical services and supervising physician extender staff according to the physician approved policies and protocols of the Clinically Managed Residential Withdrawal program. The medical director shall be available for emergency medical consultation services 24 hours a day, 365 days a year, either for direct consultation or for consultation with the physician extender.</p> <p>Responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Perform a medical history and physical exam upon admission;</li> <li>• Determine diagnosis of substance use disorder per program eligibility requirements;</li> <li>• Responsible for monitoring the Controlled Substance Reporting System (CSRS);</li> <li>• Ensuring there is emergency medical backup and coverage available for consultation 24 hours a day, seven days a week</li> <li>• Contribute to service plan development;</li> <li>• Evaluate medication or non-medication methods of withdrawal management;</li> <li>• Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions</li> <li>• Evaluate, prescribe and/or monitor all</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>medications currently being taken by the beneficiary including coordination with other prescribers;</p> <ul style="list-style-type: none"> <li>• Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;</li> <li>• Order medications as medically appropriate;</li> <li>• Order medically necessary toxicology and laboratory tests;</li> <li>• Provide case consultation with interdisciplinary treatment team;</li> <li>• Assess for co-occurring medical and psychiatric disorders;</li> <li>• Make appropriate referrals and follow up for treatment of co-occurring medical and psychiatric disorders; and</li> <li>• Coordinate care with other medical and psychiatric providers.</li> </ul>
<b>Physician Extender</b>	A minimum 0.5 FTE Physician Assistant (PA) or Nurse Practitioner (NP)	Must be licensed physician assistant or nurse practitioner and in good standing with the NC Medical Board or NC Nursing Board and have at least one year of SUD treatment experience	<p>The <b>physician extender</b> is responsible for providing medical services according to the physician approved policies and protocols of the Clinically Managed Residential Withdrawal program. The physician extender shall be available for emergency medical consultation services 24 hours a day, 365 days a year.</p> <p>Responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Perform a medical history and physical exam upon admission;</li> <li>• Determine diagnosis of substance use disorder per program eligibility requirements;</li> <li>• Responsible for monitoring the Controlled Substance Reporting System (CSRS);</li> <li>• Providing emergency medical back up and coverage available for consultation 24 hours a day, seven days a week, as directed by the Medical Director</li> <li>• Contribute to service plan development;</li> <li>• Evaluate medication or non-medication</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>methods of withdrawal management;</p> <ul style="list-style-type: none"> <li>• Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions</li> <li>• Evaluate, prescribe and/or monitor all medications currently being taken by the beneficiary including coordination with other prescribers;</li> <li>• Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;</li> <li>• Order medications as medically appropriate;</li> <li>• Order medically necessary toxicology and laboratory tests;</li> <li>• Provide case consultation with interdisciplinary treatment team;</li> <li>• Assess for co-occurring medical and psychiatric disorders;</li> <li>• Make appropriate referrals and follow up for treatment of co-occurring medical and psychiatric disorders; and</li> <li>• Coordinate care with other medical and psychiatric providers.</li> </ul>
<b>Program Manager</b>	1.0 FTE, full-time dedicated Qualified Professional	Must have a minimum of 2 years of experience working with adults with SUD	<p>The <b>Program Manager</b> shall be responsible for general oversight of the program, to include ensuring staffing is in place, managing admission and discharges, and ensuring the program is adhering to the policy, the rules and statues.</p> <p>Program Manager responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Overseeing the administrative operation of the withdrawal program</li> <li>• Providing programmatic supervision to staff to assure the delivery of best and ethical practices</li> <li>• Coordinates the initial and ongoing assessment activities</li> <li>• Modeling behaviors through service provision for the purpose of staff</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>supervision</p> <ul style="list-style-type: none"> <li>• Facilitates any recurring program meetings</li> <li>• Monitors and evaluates the services, interventions, and activities provided by the team</li> <li>• Assist with crisis interventions</li> <li>• Participating in service and discharge planning meetings</li> <li>• Facilitating transition to the next level of care and community-based resources</li> <li>• Working with beneficiary’s natural supports</li> <li>• Developing collaborative working relationships with community-based providers and organizations to facilitate warm handoffs at discharge</li> <li>• Developing and implementing supervision plans that meet the requirements of 10A NCAC 27G .0104</li> </ul>
<b>Clinical Staff</b>	0.25 FTE LCAS or LCAS-A	Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board	<p>The <b>Licensed Clinical Addiction Specialist or Licensed Clinical Addiction Specialist-Associate</b> is responsible for providing substance use focused and co-occurring assessment services, development of an ASAM Level of Care determination and provide referral and coordination to appropriate substance use disorder treatment and recovery resources</p> <p>LCAS or LCAS-A responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Discharge planning shall begin upon admission;</li> <li>• Participating in the development of an individualized service plan and ongoing revisions</li> <li>• Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals;</li> <li>• Provide clinical supervision to CADCs</li> <li>• Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>treatment and monitoring of those conditions</p> <ul style="list-style-type: none"> <li>• Provides crisis interventions, when clinically appropriate;</li> <li>• Engage with family members or individuals identified by the beneficiary as being important to their care and recovery in the withdrawal management process, as appropriate;</li> <li>• Provides education to family members or individuals identified by the beneficiary as being important to their care and recovery regarding withdrawal management process, as appropriate;</li> <li>• Provides support with the coordination and consultation with medical, clinical, familial, and ancillary relevant parties with beneficiary consent;</li> <li>• Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations;</li> <li>• Informs the beneficiary about benefits, community resources, and services;</li> <li>• Monitors and documents the status of the beneficiary’s progress and the effectiveness of the strategies and interventions outlined in the service plan;</li> <li>• Maintains accurate service notes and documentation for all interventions provided; and</li> <li>• Participates in staff meetings and treatment team meetings.</li> </ul>
<b>Certified Alcohol and Drug Counselor (CADC)</b>	1.5 FTE CADC	Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board	The <b>Certified Alcohol and Drug Counselor (CADC)</b> coordinates with the LCAS or LCAS-A and Program manager to ensure that beneficiaries have access to counseling supports, psychoeducation, and crisis interventions when needed. They play a lead role in case management and coordination of care functions.

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>CADC responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Facilitate the initial development, implementation, and ongoing revision of the service plan</li> <li>• Assists the LCAS or LCAS-A with behavioral and substance use disorder interventions</li> <li>• Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals;</li> <li>• Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions</li> <li>• Provides crisis interventions, when clinically appropriate;</li> <li>• Provides psychoeducation as indicated in the person-centered service plan</li> <li>• Monitors and documents the status of the beneficiary’s progress and the effectiveness of the strategies and interventions outlined in the service plan;</li> <li>• Provides substance use, health, and community services education;</li> <li>• Assists with the development or relapse prevention and disease management strategies</li> <li>• Communicates the beneficiary’s progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and Program Manager as outlined in the person-centered service plan</li> <li>• Engage with family members or individuals identified by the beneficiary as being important to their care and recovery in the withdrawal management process, as appropriate;</li> <li>• Provides education to family members</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>or individuals identified by the beneficiary as being important to their care and recovery regarding withdrawal management process, as appropriate;</p> <ul style="list-style-type: none"> <li>• Informs the beneficiary about benefits, community resources, and services;</li> <li>• Assist in accessing transportation services;</li> <li>• Provides appropriate linkage and referrals for recovery services and supports;</li> <li>• Advocates for and assists the beneficiary in accessing benefits and services;</li> <li>• Maintains accurate service notes and documentation for all interventions provided; and</li> <li>• Participates in staff meetings and treatment team meetings.</li> <li>• Ability to take, record and report out vital signs as ordered by medical staff</li> </ul>
<p><b>NC Certified Peer Support Specialist (CPSS)</b></p>	<p>2.0 FTE NC CPSS</p>	<p>Must have at least 1-year experience working with beneficiaries with SUD and be fully certified as a peer support specialist in NC</p>	<p>The <b>NC Certified Peer Support Specialist (CPSS)</b> uses their lived experience and recovery to provide support to beneficiaries and share hope as they walk with a beneficiary through the first steps of their recovery journey.</p> <p>CPSS responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Ability to share lived experience to support, encourage and enhance a beneficiary’s treatment and recovery</li> <li>• Ability to model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for beneficiaries served</li> <li>• Ability to explore with a beneficiary served the importance and creation of a recovery and wellness identity</li> <li>• Ability to promote a beneficiary’s</li> </ul>

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<b>Staffing Requirements Position</b>	<b>FTEs</b>	<b>Minimum Requirements</b>	<b>Responsibilities</b>
			<p>opportunity for personal growth by identifying teachable moments for building relationship skills to empower the beneficiary and enhance personal responsibility</p> <ul style="list-style-type: none"> <li>• Ability to model and share examples of healthy social interactions and facilitate familiarity with, and connection to, the local community, including mutual aid groups and self-help resources</li> <li>• Guides and encourages beneficiaries to take responsibility for and actively participate in their own recovery</li> <li>• Assists the beneficiary with self-determination and decision-making</li> <li>• Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience</li> <li>• Teaches and promotes self-advocacy to the beneficiary</li> <li>• Assists with crisis interventions</li> <li>• Participates in team meetings and provides input into the person-centered service planning process</li> <li>• Ability to take, record and report out vital signs as ordered by medical staff</li> </ul>
<b>Paraprofessional Staff</b>	5.0 FTE	Must have 1-year experience working with adults with SUD	<p><b>Paraprofessional staff</b> are responsible for tasks that ensure beneficiaries are medically able to receive support at this level of care. They work closely with medical staff to ensure monitoring is completed and recorded, and with clinical staff to support in the provision of recovery- oriented interventions.</p> <p>Paraprofessional responsibilities also include the following:</p> <ul style="list-style-type: none"> <li>• Use psychoeducation strategies and recovery interventions to support beneficiaries with SUD</li> <li>• Ability to take, record and report out</li> </ul>

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Staffing Requirements Position	FTEs	Minimum Requirements	Responsibilities
			vital signs as ordered by medical staff <ul style="list-style-type: none"> <li>• Ability to communicate observations and recommendations effectively in written and verbal form</li> <li>• Assist with crisis interventions</li> <li>• Ability to follow the service plan and/or clinical orders</li> <li>• Ability to work independently and as a member of a team</li> <li>• Ability to communicate effectively with beneficiaries, staff, and others</li> <li>• Ability to learn and apply recovery-oriented practices and person-centered approaches when working with beneficiaries</li> <li>• Participate in team meetings and provide input into the service planning process</li> </ul>

**Note:** To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment will be effective the date the related rule Change for 10A NCAC 27G is finalized.

**6.3 Program Requirements**

- a. Clinically Managed Residential Withdrawal Service is an organized facility-based service that is provided by trained clinicians who provide clinically supervised evaluations, by certified staff and paraprofessionals that provide withdrawal management, referral services, and has the ability to refer for medical evaluation if clinically indicated. A beneficiary eligible for this service experiences intoxication and withdrawal signs and the symptoms are sufficiently severe which require 24-hour structure and support, but do not require extensive medical or nursing care. This service is designed explicitly to safely assist beneficiaries through withdrawal without the need for ready on-site access to medical personnel.
- b. Protocols, developed and supported by a medical director knowledgeable in addiction medicine, must be in place to determine the nature of the medical interventions that may be required. Protocols must include under what conditions physician care is warranted and when transfer to a medically monitored facility or an acute care hospital is necessary.
- c. Clinically Managed Residential Withdrawal Service providers must have staff to screen and accept admissions at a minimum of twelve (12) hours a day, seven (7) days a week. At least five (5) of these twelve hours must occur during second shift.

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The Clinically Managed Residential Withdrawal Services Medical Director shall develop agency specific policies and procedures that address admission expectations, how the intake process shall be handled, and staffing expectations to include back-up and consultation coverage.

- d. Clinically Managed Residential Withdrawal Service providers shall provide access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) for beneficiaries that meet medical necessity for that service. MAT may be provided on-site by the provider or through a memorandum of agreement (MOA) or memorandum of understanding (MOU) with an off-site provider that is no further than 60 minutes from the facility.
- e. Required components of this service include the following:
  1. A comprehensive clinical assessment within 3 calendar days of admission;
  2. An initial assessment at admission
  3. A physical examination, to be completed by a medical director, physician assistant, or nurse practitioner, when clinically indicated;
  4. Individualized service plan, including problem identification in ASAM dimensions 2 through 6, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
  5. Daily assessment of progress during withdrawal management and any treatment changes;
  6. Provide monitoring of the beneficiary, to include the beneficiary's general condition and vital signs (pulse rate, blood pressure and temperature) based on documented severity of signs and symptoms of withdrawal;
  7. Provide 24-hour access to emergency medical consultation services;
  8. Provide behavioral health crisis interventions, when clinically appropriate;
  9. Ability to arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing;
  10. Staff supervision of self-administered medications for the management of withdrawal, as needed;
  11. Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
  12. Health education services;
  13. Provide clinical services, including individual and group counseling, to enhance the beneficiary's understanding of addiction, the completion of the withdrawal management process, and referral to an level of care for continuing treatment;
  14. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
  15. Arranges involvement of family members or others to provide education on and engagement in the withdrawal management process, as and with informed consent;
  16. Ability to assist in accessing transportation services for beneficiaries who lack safe transportation;
  17. Direct coordination with other levels of care, including specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;

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- 18. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals for counseling, medical, psychiatric, and continuing care; and
  - 19. Discharge and transfer planning beginning at admission.
- f. Evaluation and Management CPT codes, specifically with an addiction focused history and biopsychosocial screening assessments, the comprehensive clinical assessment, physical exam, laboratory tests and toxicology tests, and medical evaluation and consultation can be billed separate from the Clinically Managed Residential Withdrawal Service.
- g. This facility must be in operation 24 hours a day, seven (7) days a week, 365 days a year. The facility must have a physician available to provide medical evaluations and consultation 24 hours a day, in accordance with treatment and transfer practice protocols and guidelines. The physician shall have the availability to schedule and provide medical evaluations per policy requirements. This service must be available for admission seven (7) days per week. Program medical staff must be available to provide 24-hour access for emergency medical consultation services. Staffing ratios cannot exceed one direct care staff to nine beneficiaries. The Medical Director, physician extender, LCAS, and LCAS-A positions cannot count towards the staff to beneficiary ratio.

**6.4 Staff Training Requirements**

<b>Time Frame</b>	<b>Training Required</b>	<b>Who</b>	<b>Total Minimum Hours Required</b>
Within <b>30 calendar days</b> of hire to provide service	<ul style="list-style-type: none"> <li>▪ 2 hours Clinically Managed Residential Withdrawal Service Definition Required Components</li> <li>▪ 3 hours of Crisis Response</li> </ul>	All Staff	5 hours
	<ul style="list-style-type: none"> <li>▪ 6 hours Medically supervised withdrawal management including assessing and managing intoxication and withdrawal states</li> <li>▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management</li> </ul>	MD, PA, NP	8 hours
	<ul style="list-style-type: none"> <li>▪ 6 hours Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, Treatment and Monitoring of the Condition and Facilitation into Ongoing Care</li> <li>▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management</li> </ul>	Program Manager, LCAS/LCAS-A, CADC, CPSS and Paraprofessionals	8 hours
	<ul style="list-style-type: none"> <li>▪ 6 hours of ASAM Criteria Training</li> </ul>	MD, PA, NP, Program Manager,	6 hours

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<b>Time Frame</b>	<b>Training Required</b>	<b>Who</b>	<b>Total Minimum Hours Required</b>
		LCAS/LCAS-A, CADC, CPSS	
	<ul style="list-style-type: none"> <li>▪ 3 hours Measuring Vital Signs (to include how to effectively and accurately obtain, record, and report the vital signs of temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, and pain.)</li> <li>▪ 2 hours Medication Administration training</li> </ul>	Program Manager, CADC, CPSS, Paraprofessionals	5 hours
Within <b>90 calendar days</b> of hire to provide this service	▪ 6 hours of Introductory Motivational Interviewing* (MI)	Program Manager, LCAS/LCAS-A, CADC	6 hours
	<ul style="list-style-type: none"> <li>▪ 2 hours Trauma informed care</li> <li>▪ 2 hours Co-occurring conditions</li> </ul>	Program Manager, LCAS/LCAS-A, CADC, CPSS, Paraprofessionals	4 hours
<b>Annually</b>	<ul style="list-style-type: none"> <li>▪ 3 hours of Crisis Response Training</li> <li>▪ 10 hours of continuing education in evidence-based treatment practices</li> </ul>	All Staff	13 hours

The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training for the population being served was completed no more than 24-months before hire date.

\*Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer. If a staff person is a MINT trainer, they are not required to have this training. Documentation of training activities shall be maintained by the program.

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**Expected Outcomes**

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments, medical evaluation and meeting the identified goals in the beneficiary's service plan. Expected outcomes as follows:

- a. Reduction or elimination of withdrawal signs and symptomatology
- b. Increased use of peer support services to support withdrawal management, facilitate recovery and link beneficiaries to community-based peer support and mutual aid groups
- c. Linkage to treatment services post discharge
- d. Increased links to community-based resources to address unmet social determinants of health
- e. Reduction or elimination of psychiatric symptoms, if applicable

**7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

**7.1 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). Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with Federal law and regulations.

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**8.0 Policy Implementation and History**

**Original Effective Date:** Month Day, Year

**History:**

<b>Date</b>	<b>Section or Subsection Amended</b>	<b>Change</b>
	All Sections and Attachment(s)	Clinically Managed Residential Withdrawal

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**Attachment A: Claims-Related Information**

Provider(s) shall comply with the, *NCTracks 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 and NCHC. Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

**A. Claim Type**

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.

**B. 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.

ICD-10-CM Code(s)

ICD-10-PCS Code(s)

**C. 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.

HCPCS Code(s)
H0011

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**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.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

PHPs, PIHPs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. PHPs and PIHPs shall assess network providers' adherence to service guidelines to assure quality services for beneficiaries.

**F. Place of Service**

This is a facility-based service.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>