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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:
CCP 8B, ASAM Level 4, Medically Managed Intensive Inpatient Services
CCP 8B, ASAM Level 4WM, Medically Managed Intensive Inpatient Withdrawal Management

1.0 Description of the Procedure, Product, or Service

Clinically Managed Low-Intensity Residential Services, American Society of Addiction Medicine (ASAM) Level 3.1 is provided in a 24-hour, seven (7) day a week community based residential setting. This structured and supportive setting provides clinical and recovery services to treat a beneficiary experiencing functional limitations due to their substance use disorder (SUD). Functional limitations include problems in the application of recovery skills, self-efficacy, and lack of connection to the community systems of work, education, or family life. The beneficiary has the opportunity to develop and practice interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and family settings, and experience employment or academic pursuits. Clinical and recovery services are characterized by individual, group, and family therapy, medication management, and psychoeducation.

1.1 Definitions

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

1. Acute Intoxication and Withdrawal Potential;
2. Biomedical Conditions and Complications;
3. Emotional, Behavioral, or Cognitive Conditions and Complications;
4. Readiness to Change;
5. Relapse, Continued Use, or Continued Problem Potential; and
6. Recovery and Living Environment.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid 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.

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 can become retroactively eligible for Medicaid while receiving covered services.

A retroactively eligible beneficiary is 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 can file for reimbursement with Medicaid for these services.

b. Populations Served

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

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 must 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:

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/

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 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 Medicaid

Medicaid shall cover Clinically Managed Low-Intensity Residential Treatment services when the beneficiary meets the following specific criteria:

a. The beneficiary is diagnosed with a substance use disorder (SUD) 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. The beneficiary meets the American Society of Addiction Medicine (ASAM Criteria) Third Edition, 2013 or any subsequent editions of this reference manual for ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment services level of care.

3.2.2 Admission Criteria

Clinically Managed Low-Intensity Residential Treatment services requires a comprehensive clinical assessment (CCA) or a diagnostic assessment (DA) to be completed prior to admission that confirms the beneficiary has a SUD diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria and meets ASAM level 3.1. The assessment must be updated as new strengths and barriers are observed in the residential setting. Relevant diagnostic information must be obtained and documented in the Person-Centered Plan (PCP).

A service order for Clinically Managed Low-Intensity Residential Services 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 Clinically Managed Low-Intensity Residential Treatment services are provided.

The amount, duration, and frequency of Clinically Managed Low-Intensity Residential Treatment services must be documented in a beneficiary's PCP.

3.2.3 Continued Stay Criteria

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

a. The beneficiary has achieved initial PCP goals and requires this service in order to meet additional goals;

b. The beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible or can be achieved; or

c. The beneficiary is not making progress or regressing. The PCP must be modified to identify more effective interventions.

3.2.4 Discharge Criteria

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

a. The beneficiary has achieved goals articulated in the PCP, thus resolving the symptoms(s) that justified admission to the present level of care; and continuing the chronic disease management of the beneficiary's condition at a less intensive level of care is indicated;

b. The beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified despite amendments to the PCP, and an updated CCA or DA indicates transfer to a different level of care is needed;

c. The beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions that limit the ability to alleviate the beneficiary's symptom(s), and an updated CCA or DA indicates transfer to a different level of care is needed; or

d. The beneficiary or their legally responsible person requests a discharge from Clinically Managed Low-Intensity Residential Services.

3.2.5 Medicaid 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.

4.1 General Criteria Not Covered

Medicaid 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 Medicaid

Medicaid shall not cover the following:

a. Transportation for the beneficiary or family members;
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 Clinically Managed Low-Intensity Residential Treatment 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;
h. Interventions not identified on the beneficiary's PCP;
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 PCP; and
j. Payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

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

Medicaid shall not require prior approval for Clinically Managed Low-Intensity Residential Treatment services upon admission through the first 14 calendar days of services.

5.2 Prior Approval Requirements

5.2.1 General

None apply.

5.2.2 Specific

None apply.

5.3 Utilization Management and Additional Limitations or Requirements

5.3.1 Utilization Management

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. All utilization review activity shall be documented in the service record and maintained by the program.

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 PCP. Medical necessity is determined by North Carolina community practice standards, according to 10A NCAC 25A .0201, as verified by the Prepaid Inpatient Health Plan (PIHP), Prepaid Health Plan (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 mode, 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.

To request an initial authorization, the CCA or DA, service order for medical necessity, the PCP, and the required NC Medicaid authorization request form must be submitted to the PIHP, PHP, or utilization management contractor within the first 14 calendar days of service initiation.

Concurrent reviews determine the ongoing medical necessity for the service. To request reauthorization, the PCP and the required NC Medicaid authorization form must be submitted to the PIHP, PHP, or utilization management contractor prior to initial or concurrent authorization expiring.

5.3.2 Additional Billing Limitations

Clinically Managed Low-Intensity Residential Treatment services cannot be provided and billed during the same authorization as:

a. Clinically managed residential services
b. Clinically managed residential withdrawal management
c. Medically monitored inpatient withdrawal management
d. Clinically managed population-specific high-intensity residential programs
e. Clinically managed high-intensity residential services
f. Medically monitored intensive inpatient services
g. Substance Abuse Comprehensive Outpatient Treatment (SACOT)

5.4 Service Orders

A service order is 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, according to their cope of practice. A service order is 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) consecutive month period.

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;
c. A service order must be in place prior to 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 shall not bill Medicaid without a valid service order; and
d. Service orders are valid for one (1) calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP service order.

If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in a beneficiary's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation must reflect why a verbal service order was

obtained in lieu of a written service order. The appropriate professional must countersign the service order with a dated signature within seventy-two (72) hours of the date of the verbal service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must 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 Medicaid. Service notes must meet the requirements of the Department of Health and Human Services DHHS Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (C)(4).

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 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 Low-Intensity Residential Treatment services must be delivered by a provider employed by an organization that:

a. Meets the provider qualification policies, procedures, and standards established by NC Medicaid;
b. Meets the requirements of 10A NCAC 27G Rules for Mental Health Developmental Disabilities, and Substance Abuse Facilities and Services;
c. Demonstrates that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
d. Achieves national accreditation with at least one of the designated accrediting agencies within one year of enrollment as a provider with NC Medicaid; and
e. Becomes 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.

The facility shall be licensed under 10A NCAC 27G .5600 rules unless service is provided by an Indian Health Service (IHS) or 638 contract or compact operated by a Federally Recognized Tribe as allowed in 25 USC Ch. 18: INDIAN HEALTH CARE §1621t. Licensing and §1647a. Nondiscrimination under Federal health care programs in qualifications for reimbursement services. Refer to Tribal & Urban Indian Health Centers | HRSA.

Providers and Organizations that provide Clinically Managed Low-Intensity Residential must provide crisis response 24-hours-a-day, seven (7)-days-a-week to a beneficiary who is receiving Clinically Managed Low-Intensity Residential services.

6.2 Provider Certifications

Staffing Requirements

Required Position/Role	Minimum Qualifications	Responsibilities
Program Manager	**Non-Licensed Qualified Professional** **AND** Must have at least 1-year experience working with beneficiaries with SUD.	The **Program Manager** is responsible for general oversight of the program, to include ensuring adequate staffing is in place, managing admissions and discharges, and ensuring the program is adhering to the policy, rules, and statues. The Program Manager is responsible for ensuring there is 24/7 access to an on-call staff that can provide immediate support to facility staff supporting beneficiaries experiencing a behavioral crisis, either directly or for telephonic or telehealth back up. In addition to the above, the Program Manager is responsible for the following: • Oversee the administrative operation of the Clinically Managed Low-Intensity Residential Treatment services program; • Develop program policies and procedures, to include secure transportation and storage of any medications administered for Medication Assisted Treatment; • Provide programmatic supervision to staff to assure the delivery of best and ethical practices; • Facilitate or coordinate recurring trainings on best practices for staff; • Coordinate the initial and ongoing assessment activities; • Facilitate any recurring program meetings; • Monitor and evaluate the services, interventions, and activities provided by the team; • Assist with crisis interventions; • Participate in service and discharge planning meetings; • Facilitate transition to the next level of care and community-based resources; • Work with natural supports including to engage with family members or significant others and provide education and supports, as requested by the beneficiary;

		• Develop collaborative working relationships with care management providers, community-based providers, and organizations to facilitate discharge; • Develop and implement supervision plans that meet the requirements of 10A NCAC 27G .0104 for Associate Professionals (AP) and paraprofessionals.
Licensed Clinical Staff	**LCAS or LCAS-A** **AND** Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board	The **Licensed Clinical Addiction Specialist (LCAS) or Licensed Clinical Addiction Specialist-Associate (LCAS-A)** is responsible for providing substance use focused and co-occurring assessment services, development of an ASAM Level of Care determination, provide substance use disorder treatment services or referral and coordination to appropriate substance use disorder treatment and recovery resources. In addition to the above, the LCAS or LCAS-A is responsible for the following: • Discharge planning must begin upon admission; • Lead in the development of an individualized PCP and ongoing revisions; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP goals; • Facilitate individual, group and family therapy sessions; • Provide clinical supervision to Certified Alcohol and Drug Counselor (CADC); • Facilitate service coordination to address the needs of the beneficiary; • Monitor signs and symptoms of substance use, intoxication, and withdrawal, as well as the appropriate treatment and monitoring of those conditions; • Provide crisis interventions, when clinically appropriate; • Engage with family members or significant others and provide education regarding SUD treatment and the recovery process and supports, as appropriate; • Provide coordination and consultation with medical, clinical, familial, and ancillary relevant parties with beneficiary consent; • Assess and determine clinically appropriate services that support recovery; • Maintain accurate service notes and documentation for all interventions provided;

		• Participate in staff meetings and treatment team meetings.
Certified Clinical Staff (maybe substituted with LCAS/LCAS-A at the discretion of the provider)	**CADC, CSAC, CSAC-I, CADC-I** **AND** Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board	The **Certified Alcohol and Drug Counselor (CADC), Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Counselor Intern (CSAC-I) and Certified Alcohol and Drug Counselor (CADC-I)** coordinates with the LCAS or LCAS-A and Program Manager to ensure that beneficiaries have access to counseling supports. In addition to the above, the CADC, CSAC, CSAC-I, or CADC-I is responsible for the following: • Participate in the initial development, implementation, and ongoing revision of the PCP; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals; • Monitor signs and symptoms of substance use, intoxication, and withdrawal as well as the appropriate treatment and monitoring of those conditions; • Provide crisis interventions, when clinically appropriate; • Facilitate individual, group, and family counseling sessions; • Work with natural supports. Engage with family members or significant others and provide education and supports, as requested by the beneficiary; • Provides psychoeducation as indicated in the PCP • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP; • Provide substance use, health, and community services education; • Assist with the development of relapse prevention and disease management strategies; • Communicate the beneficiary's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A as outlined in the PCP; • Coordination with Care Management to ensure that beneficiary is informed about benefits, community resources, and services; • Coordination with Care Management to ensure beneficiary is provided appropriate linkage and referrals for needed services and supports;

		• Coordinates with Medication for Opioid Use Disorder providers; • Participate in staff meetings and treatment team meetings.
Support Staff	**Support Staff can be paraprofessionals, associate professionals (AP) or qualified professionals (QP)** **AND** Must have 1-year experience working with beneficiaries with SUD	**Support staff** are responsible for tasks that ensure a beneficiary has 24 hour a day, seven (7) day a week access to supports to meet their behavioral health and physical needs. They work closely with clinical staff to support and monitor the acquisition of new skills, ensure basic daily needs and activities of daily living are completed and recorded, and support in the recovery oriented interventions. Support Staff may coordinate with beneficiary's primary physician when needed. In addition to the above, the Support Staff are responsible for the following: • Use psychoeducation strategies and recovery interventions to support a beneficiary with SUD; • Communicate observations and recommendations effectively in written and verbal form; • Assist in skill building interventions; • Assist with crisis interventions; • Follow the PCP and clinical orders; • Work independently and as a member of a team; • Communicate effectively with beneficiaries, staff, and others; • Learn and apply recovery-oriented practices and person-centered approaches; • Participate in team meetings and provide input into the PCP.
Medication Assisted Treatment Coordinator	At minimum Paraprofessional **AND** Must have valid current NC driver's license	**The Medication Assisted Treatment (MAT) Coordinator** coordinates MAT appointments and facilitates transportation to scheduled MAT appointments for a beneficiary receiving Clinically Managed Low-Intensity Residential Treatment. The MAT Organizer also provides support coordinating physical health and specialist appointments to ensure that a beneficiary is able to access needed physical health care services without disrupting treatment. The MAT Organizer collaborates with the medical staff and program manager to ensure information regarding MAT is reflected in the beneficiary's PCP and clinical record. In addition to the above, the MAT Coordinator is responsible for the following:

		• Organize, coordinate, and monitor all MAT appointments; • Organize, coordinate, and monitor all physical health and specialist appointments; • Ensure that a beneficiary eligible to receive MAT has transportation to and from the MAT administration site, which includes direct facilitation of transportation; • Ensure that a beneficiary has transportation to and from physical health and specialist appointments, which includes direct facilitation of transportation; • Ensure safe and secure transportation of any prescribed medications from the MAT provider to the residential program; • Complete progress notes on a beneficiary who receives MAT coordination support, to include detailing the secure custody procedures that were followed; • Complete progress notes on a beneficiary who receives physical health and specialist appointment coordination support, to include the date and time of appointments, provider contact information that the beneficiary went to, and ensuring release of information forms are completed and filed; • Coordinate exchange of information between MAT staff to Clinically Managed Low-Intensity Residential Treatment staff as needed; • Document MAT information in the beneficiary's clinical record.

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

Note: According to 25 U.S.C. 1621t, licensed health professionals employed by a tribal health program are exempt, if licensed in any state, from the licensing requirements of the State (North Carolina) in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

6.3 Program Requirements

Clinically Managed Low-Intensity Residential Treatment services are provided in a 24-hour licensed facility in accordance with 10A NCAC 27G .5600. Clinically Managed Low-Intensity Residential Treatment must provide a minimum of at least five (5) hours of

clinically directed program activities per week. The beneficiary receiving this service can attend work, school, and substance use or behavioral health treatment services.

Clinically Managed Low-Intensity Residential Treatment programs must support a beneficiary who is prescribed medications to address their substance use or mental health diagnosis. Coordination of care with prescribing physician is required.

Providers shall provide access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) covered by the Medicaid formulary for a beneficiary that meet medical necessity for that service. MAT may be provided on-site by the provider(s) or through a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) with an off-site provider(s) that is no further than 60 minutes from the facility.

Clinically Managed Low-Intensity Residential Treatment providers shall ensure that all programs have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses. Clinically Managed Low-Intensity Residential Treatment programs must develop policies that detail the use, storage and education provided to staff regarding naloxone.

A comprehensive clinical assessment (CCA) 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 and documented in the beneficiary's PCP.

Required components of Clinically Managed Low-Intensity Residential Treatment include the following:

a. A Person-centered Plan, which identifies problems, needs, strengths, skills, and priority formulation of short-term goals and preferences and activities designed to achieve those goals;
b. Telephone or in-person consultation with a physician and emergency services, available 24 hours a day, seven (7) days a week;
c. Direct affiliation with other ASAM levels of care, or close coordination through referral to more and less intensive levels of care and other services (such as intensive outpatient treatment, vocational assessment and placement, literacy training and adult education);
d. Ability to arrange for needed procedures (including indicated lab and toxicology tests) as appropriate to the severity and urgency of the beneficiary's condition;
e. Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications;

6.3.1 Staff Training Requirements

Time Frame	Training Required	Who
Upon Hire, Prior to First Day Worked	▪ Crisis Response ▪ Opioid Antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Harm Reduction ▪ Clinically Managed Low-Intensity Residential Service Definition Required Components	All Staff
Within **30 calendar days** of hire to provide service	▪ ASAM Criteria ▪ PCP Instructional Elements ▪ Designated therapies, practices or modalities used in Clinically Managed Low-Intensity Residential Service ▪ Trauma informed care* ▪ Co-occurring conditions*	All Staff
Within **90 calendar days** of hire to provide this service	▪ Motivational Interviewing* ▪ Additional designated therapies, practices, or models specific to the population(s) served in Clinically Managed Low-Intensity Residential Services	All Staff
Annually	▪ Continuing education in evidence-based treatment practices including crisis response and cultural competency training*	All Staff

The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training was completed no more than 48-months prior to hire date.

* Training must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical professionals. Some examples of approved programs include North Carolina Addictions Specialist Professional Practice Board (NCASPPB), National Association for Addiction Professionals (NAADAC), National Board for Certified Counselors (NBCC) Approved Continuing Education Provider (ACEP), and National Association of Social Work (NASW), and Motivational Interviewing Network of Trainers (MINT).

Documentation of staff training activities must be maintained by the program.

6.3.2 Expected Outcomes

The expected clinical outcomes for Clinically Managed Low-Intensity Residential Service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the beneficiary's PCP. Expected outcomes are as follows:

a. Reduction or elimination of substance use and substance use disorder symptoms;
b. Sustained improvement in health and psychosocial functioning;
c. Reduction of risk of relapse, continued problems, or continued use;
d. Eventual reintegration of the individual into the community;
e. Linkage to other necessary treatment services concurrently and upon discharge;
f. Identification and linkage to community-based resources to address unmet social determinants of health;
g. Increase in the identification and use of healthy coping skills.

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.

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
12/01/2023	All Sections and Attachment(s)	Initial implementation of stand-alone Clinically Managed Low-Intensity Residential Treatment services policy.

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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. 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)
H2034

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 Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations.

Clinically Managed Low-Intensity Residential Treatment service is billed as a daily unit.

F. Place of Service

This is a facility-based service.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

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

Outpatient therapy services can be billed separately when the beneficiary needs specialized therapy that cannot be provided by the Clinically Managed Low-Intensity Residential Treatment services provider (Dialectical Behavioral Therapy, exposure therapy, Eye Movement Desensitization and Reprocessing).

CCA, needed toxicology testing, and psychiatric and medical services are be billed separately from Clinically Managed Low-Intensity Residential Treatment service.