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To all beneficiaries enrolled in a Prepaid Inpatient Health Plan (PIHP): for questions about benefits and services available, please contact your PIHP.

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1.0 Description of the Procedure, Product, or Service

Clinically Managed Population Specific High-Intensity Residential Program is a therapeutic rehabilitation service delivered by trained and experienced medical and nursing professionals, and clinical and support staff, for a beneficiary with both substance use disorder (SUD) and traumatic brain injury (TBI). This is an American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.3 service that provides a 24-hour structured recovery environment in combination with high-intensity clinical services to meet the functional and cognitive limitations of a beneficiary to support recovery from substance use disorders. The effects of the substance use disorder combined with the cognitive limitations are such that outpatient or other levels of residential care are not feasible or effective. This treatment service focuses on overcoming a lack of awareness of, or ambivalence about, the effects of addiction as well as preventing relapse, and promoting reintegration into the community.

1.1 Definitions

Traumatic Brain Injury (TBI)

A traumatic brain injury (TBI) is an injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all the following criteria:

a. Involves an open or closed head injury;
b. Resulted from a single event or resulted from a series of events which may include multiple concussions;
c. Occurs with or without a loss of consciousness at the time of injury;
d. Results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem-solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing, and speech; and
e. Does not include brain injuries that are congenital or degenerative.

The ASAM Criteria, Third Edition

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, Third Edition 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*) and shall meet the criteria in **Section 3.0 of this policy**;
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 may 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 may file for reimbursement with Medicaid for these services.

Medicaid shall cover Clinically Managed Population Specific High-Intensity Residential 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 a Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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

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

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

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, intensity, 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 Population Specific High-Intensity Residential Program services when the beneficiary meets the following specific criteria:

a. has a current substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material;
b. meets American Society of Addiction Medicine (ASAM) Level 3.3 Clinically Managed Population Specific High-Intensity Residential Program admission criteria as defined in The ASAM Criteria, Third Edition, 2013;
c. has a documented diagnosis of TBI as defined in Section 1.1 Definitions; and
d. is able to actively engage in treatment services with identified supports in accordance with their Person-Centered Plan.

3.2.2 Medicaid Additional Criteria Covered

None Apply

3.2.3 Admission Criteria

An initial abbreviated assessment must be conducted by a physician as a part of the admission process to establish medical necessity for this service in the development of a Person-Centered Plan (PCP).

The initial abbreviated assessment must contain the following documentation in the service record:

a. the beneficiary's presenting problem;

b. the beneficiary's needs and strengths;

c. a provisional or admitting diagnosis;

d. a physical examination by a physician within 24 hours of admission, including laboratory and toxicology tests;

e. medical records that confirm a TBI diagnosis as defined in **Section 1.1**;

f. a pertinent social, family, and medical history; and

g. other evaluations or assessments as necessary to meet the beneficiary's needs.

If the beneficiary does not have medical records that confirm a diagnosis of TBI, a provider can use the NC TBI Physician Referral Form to confirm a diagnosis of TBI, which can be found at Traumatic Brain Injury | NCDHHS.

Within seven (7) calendar days of the admission, a Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA) must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Information from the initial abbreviated assessment can be utilized as a part of the current CCA or DA. The CCA or DA must contain observational information obtained during the first seven (7) days of treatment in the program. 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.

The CCA or DA process must include the completion of the NC TBI Waiver Risk Support Needs Assessment and the NC TBI Waiver Wellness Assessment, which evaluates for traumatic brain injury, assists in the clinical evaluation of the extent and severity of the brain injury, and identifies rehabilitation goals. The assessments must include information on the specific functional limitations the beneficiary is experiencing.

3.2.4 Continued Stay and Discharge Criteria

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

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

   2. The beneficiary is making progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated;

3. The beneficiary is not making progress, is regressing, or new problems have been identified and the beneficiary has the capacity to resolve the problems; or
4. The beneficiary is actively working towards goals, so continuing at the present level of care is indicated.

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

1. The beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
2. The beneficiary's admitting signs and symptoms have failed to respond to treatment, and have intensified, indicating a transfer to a more intensive level of residential care is indicated;
3. The beneficiary is not making progress, or is regressing, and all realistic treatment options have been exhausted indicating a need for more intensive services; or
4. The beneficiary or their legally responsible person requests discharge from Clinically Managed Population Specific High-Intensity Residential Program.

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:

d. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
e. the beneficiary does not meet the criteria listed in **Section 3.0;**
f. the procedure, product, or service duplicates another provider's procedure, product, or service; or
g. 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

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover these activities:

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 assistance;
d. Clinical and administrative supervision of 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 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.

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 Population Specific High-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

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.

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, by 10A NCAC 25A .0201, and as verified by the Prepaid Inpatient Health Plan (PIHP) 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 effective 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.

5.3.2 Initial Authorization

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 or utilization management contractor within the first fourteen (14) calendar days of service initiation.

Concurrent reviews determine the ongoing medical necessity for the service. Providers shall submit an updated PCP and any authorization or reauthorization forms required by the PIHP or utilization management contractor.

5.3.3 Additional Limitations

A beneficiary shall receive the Clinically Managed Residential Withdrawal Management Service from only one provider organization during any active authorization period.

Clinically Managed Population Specific High-Intensity Residential Program services must not be billed on the same day (except day of admission or discharge) as:

a. other residential levels of care;
b. withdrawal management services;
c. outpatient treatment services;
d. Substance Abuse Intensive Outpatient Program (SAIOP);
e. Substance Abuse Comprehensive Outpatient Treatment (SACOT);
f. Assertive Community Treatment (ACT);
g. Community Support Team (CST);
h. Supported Employment;
i. Psychiatric Rehabilitation (PSR);
j. Peer Support Services (PSS);
k. Partial Hospitalization;
l. Facility Based Crisis (adult);
m. TBI State-funded program services.

Outpatient therapy services can be billed separately when the beneficiary is in need of a specialized therapy that cannot be provided by the Clinically Managed Population Specific High-Intensity Residential Program provider, including Dialectical Behavioral Therapy, exposure therapy, and Eye Movement Desensitization and Reprocessing.

5.4 Service Order

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 a physician according to their 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.

ALL of the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
c. A service order must be in place prior to or on the first day that the service is initially provided, to bill 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, providers shall ensure that their documentation is consistent with the requirements contained in this policy. This service requires a shift note to be completed for every shift of service provided. Events in a beneficiary's life which require additional activities or interventions must be documented over and above the minimum frequency requirement.

To bill Medicaid, providers shall ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. Service notes must meet the requirements of the 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 Population Specific High-Intensity Residential Program services must be delivered by providers employed by a substance use provider organization that:

a. meets the provider qualification policies, procedures, and standards established by the 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. within one year of enrollment as a provider with NC Medicaid, achieves national accreditation with at least one of the designated accrediting agencies; 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.

This service must be provided in a facility licensed by the NC Division of Health Service Regulation Mental Health Licensure and Certification Section under 10A NCAC 27G Section .5600 Supervised Living for Individuals of all Disability Groups licensure waiver rules . Refer to Tribal & Urban Indian Health Centers | HRSA when the 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.

6.2 Provider Certifications

Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Medical Director	**Physician** Shall be a licensed physician and in good standing with the NC Medical Board. Shall have at least one year of SUD treatment experience. Shall have experience working with a beneficiary with TBI.	The **Medical Director** is responsible for providing medical services and supervising the nursing staff according to the physician approved policies and protocols of the Clinically Managed Population Specific High-Intensity Residential 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 nursing staff. In addition to the above, the Medical Director is responsible for the following: • Develop policies and procedures for the program, to include secure transportation and storage of any medications administered for Medication Assisted Treatment, in collaboration with the Program Director;

		• Provide supervision to the nursing staff; • Perform a medical history and physical exam upon admission; • Determine diagnosis of substance use disorder per program eligibility requirements; • Monitor the Controlled Substance Reporting System (CSRS); • Ensure there is emergency medical backup and coverage available for consultation 24 hours a day, seven days a week; • Participate in the development of PCPs; • Evaluate, prescribe, and monitor all medications currently being taken by the beneficiary, including coordination with off-site prescribers; • Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects; • Order medically necessary toxicology and laboratory tests; • Coordinate with Care Management or other care coordination to ensure the beneficiary is informed about benefits, community resources, and services; • Coordinate with Care Management or other care coordination to ensure beneficiary is provided linkage and referrals for needed services and supports; • Assess for traumatic brain injury, co-occurring medical and psychiatric disorders; • Make medically necessary referrals and follow up for treatment of co-occurring medical and psychiatric disorders; • Coordinate care with other medical and psychiatric providers.
Nursing Staff	**Registered Nurse (RN), Licensed Practice Nurse (LPN), and Certified Nursing Assistant (CNA)** Shall be registered and in good standing with the NC Board of Nursing.	The **Nursing Staff** shall be responsible for maintaining an adequate level of nursing for the program's dispensing and medical operations under the supervision of the Medical Director. In addition to the above, the Nursing Staff is responsible for the following within their scope of practice: • Conduct a nursing evaluation upon admission, in accordance with their scope of work; • Monitor the Controlled Substance Reporting System (CSRS), when delegated by a physician;

		• Oversee the monitoring of the beneficiary's progress and medication administration; • Assess the beneficiary's progress and any treatment changes on a daily basis; • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the treatment and monitoring of those conditions; • Prepare and dispense medication to the beneficiary and maintain medication inventory records and logs in compliance with state regulations; • Document in the beneficiary's service record all nursing activities performed related to beneficiary care; • Ensure medical orders are being followed and carried out; • Provide psychoeducation, including HIV, AIDS, TB, Hepatitis C, pregnancy, reproductive health, and other health education services; • Coordinate medical treatment and referral for biomedical problems; • Perform auxiliary testing based on medical orders; • Consult with other program medical staff for guidance in medical matters concerning the well-being of the beneficiary; • Participate in staff meetings and treatment team meetings.
Program Director	**Certified Brain Injury Specialist (CBIS) or Certified Brain Injury Specialist Trainer (CBIST)** Shall be certified or obtain the CBIS certification from the Brain Injury Association of America within one year from date of hire.	The **Program Director** shall be responsible for general oversight of the program, to include ensuring adequate staffing is in place, managing admission and discharges, and ensuring the program is adhering to the policy, rules, and statutes. The Program Director is responsible for ensuring there is 24 hours a day, 365 days a year access to on-call staff who can provide immediate support to facility staff supporting a beneficiary experiencing a behavioral crisis, either in person or virtually. In addition to the above, the Program Director is responsible for the following: • Oversee the administrative operation of the Clinically Managed Population Specific High-Intensity Residential program;

		• Coordinate with the Medical Director to develop program policies and procedures, to include secure transportation and storage of any medications administered for Medication Assisted Treatment; • Ensure the physical and environmental layout of the residential program takes into consideration the unique needs of a beneficiary with traumatic brain injury (lighting, volume and noise level, privacy considerations); • Provide programmatic supervision to staff to ensure the delivery of best and ethical practices, especially as it relates to supporting a beneficiary with traumatic brain injury; • Facilitate recurring trainings on best practices when working with a beneficiary with traumatic brain injury; • Coordinate the initial and ongoing assessment activities; • Facilitate 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; • Develop collaborative working relationships with the Care Management, community-based providers, and organizations to facilitate warm handoffs at discharge; • Coordinate with Care Management or other care coordination to ensure the beneficiary is informed about benefits, community resources, and services; • Coordinate with Care Management or other care coordination to ensure beneficiary is provided linkage and referrals for needed services and supports; • Develop and implement supervision plans that meet the requirements of 10A NCAC 27G .0104
Licensed Clinical Staff	**Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)**	The **Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)** is responsible for providing substance use focused and co-occurring assessment services, developing an ASAM Level of Care determination, and providing referral and

	Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	coordination to substance use disorder treatment and recovery resources. The LCAS or LCAS-A shall be available seven days a week for clinical interventions. In addition to the above, the LCAS or LCAS-A is responsible for the following: • Discharge planning must begin upon admission; • Complete a comprehensive clinical assessment and update as needed; • Lead the development of the PCP and ongoing revisions; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals; • Plan and deliver clinical and didactic motivational interventions appropriate to the beneficiary's stage of readiness to change; • Facilitate individual and group therapy sessions; • Provide clinical program supervision to Clinical Staff; • Provide crisis interventions, when clinically necessary; • Engage with family members or significant others and provide education and supports; • Provide support for the coordination and consultation with medical, clinical, familial, and ancillary parties with beneficiary consent; • Ensure linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations; • Coordinate with Care Management or other care coordination to ensure the beneficiary is informed about benefits, community resources, and services; • Coordinate with Care Management or other care coordination to ensure beneficiary is provided linkage and referrals for needed services and supports; • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP; • Maintain accurate service notes and documentation for all interventions provided;

		• Participate in staff meetings and treatment team meetings.
Clinical Staff	**LCAS, LCAS-A, LCSW, LCSWA, LMFT, LMFTA, LCMHC, LMHCA, CADC, CADC-I, CSAC, or CSAC-I** Shall be certified or licensed and in good standing with the NC Addictions Specialist Professional Practice Board, NC Social Work Certification and Licensure Board, NC Board of Licensed Clinical Mental Health Counselors, or NC Marriage and Family Therapy Licensure Board.	The **Licensed Clinical Addictions Specialist (LCAS), Licensed Clinical Addictions Specialist-Associate (LCAS-A), Licensed Clinical Social Worker (LCSW), Licensed Clinical Social Worker Associate (LCSWA), Licensed Marriage and Family Therapist (LMFT), Licensed Marriage and Family Therapist Associate (LMFTA), Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor Intern (CADC-I), Certified Substance Abuse Counselor (CSAC), or Certified Substance Abuse Counselor Intern (CSAC-I)** coordinates with the LCAS or LCAS-A and Program Director to ensure that the beneficiary has access to counseling supports, psychoeducation, and crisis interventions. They play a lead role in case management and coordination of care functions. The Clinical Staff shall be available seven days a week for clinical interventions. In addition to the above, the Clinical Staff is responsible for the following: • Participate in the development, implementation, and ongoing revision of the PCP; • Assist the LCAS or LCAS-A with behavioral and substance use disorder interventions; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals; • Provide crisis interventions, when clinically necessary; • Provide 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; • Support the beneficiary in skill building interventions;

		• 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 and Program Director as outlined in the PCP; • Engage with family members or significant others and provide education and supports; • Inform the beneficiary about benefits, community resources, and services; • Provide linkage and referrals for recovery services and supports; • Coordinate with Care Management or other care coordination to ensure the beneficiary is informed about benefits, community resources, and services; • Coordinate with Care Management or other care coordination to ensure the beneficiary is provided linkage and referrals for needed services and supports; • Advocate for and assist the beneficiary in accessing benefits and services; • Maintain accurate service notes and documentation for all interventions provided; • Participate in staff meetings and treatment team meetings.
Recovery Supports	**Certified Peer Support Specialist (CPSS)** Shall be fully certified as a peer support specialist in NC. Shall have at least one year of experience working with a beneficiary diagnosed with a SUD. Shall have experience working with a beneficiary with traumatic brain injury.	The **Certified Peer Support Specialist (CPSS)** uses their lived experience and recovery to provide support to the beneficiary and share hope as they walk with a beneficiary through the first steps of their recovery journey. The CPSS shall be scheduled and available seven days a week to support recovery-related activities. In addition to the above, the CPSS is also responsible for the following: • Share lived experience to support, encourage and enhance treatment and recovery; • Model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience; • Explore the importance and creation of a recovery and wellness identity; • Promote the opportunity for personal growth by identifying teachable moments for building

		relationship skills to empower the beneficiary and enhance personal responsibility; • 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; • Guide and encourage the beneficiary to take responsibility for and actively participate in their own recovery; • Assist with self-determination and decision-making; • Model recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience; • Teach and promote self-advocacy; • Assist with crisis interventions; • Participate in team meetings and the PCP process.
Medication Assisted Treatment Organizer	At minimum shall be a paraprofessional. Shall have a current NC driver's license.	**The Medication Assisted Treatment (MAT) Organizer** coordinates MAT appointments and facilitates transportation to scheduled MAT appointments for a beneficiary receiving Clinically Managed Population Specific High-Intensity Residential Program services. The MAT Organizer collaborates with the medical staff and Program Director to ensure information regarding MAT is reflected in the beneficiary's PCP and clinical record. In addition to the above, the MAT Organizer is also responsible for the following: • Organize, coordinate, and monitor all MAT and physical health appointments; • Ensure that a beneficiary who is eligible to receive MAT has transportation to and from the MAT administration site, 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; • Coordinate exchange of information between MAT staff to medical and clinical staff;

		• Document MAT information in the beneficiary's clinical chart.
Support Staff	**Paraprofessionals, Associate Professionals (AP), or Qualified Professionals (QP)** Shall have at least one year of experience working with an adult diagnosed with a SUD or an adult with a traumatic brain injury.	**Support Staff** are responsible for tasks that ensure the beneficiary is 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 the provision of recovery oriented interventions. In addition to the above, Support Staff are responsible for the following: • Use psychoeducation strategies and recovery interventions to support a beneficiary with SUD; • Take, record, and report out vital signs as ordered by medical staff; • 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; • Communicate effectively with the beneficiary, staff, and others; • Learn and apply recovery-oriented practices and person- centered approaches; • Participate in team meetings and provide input into the PCP.

A minimum of two (2) staff shall be on-site at all times. At least one of the two (2) on-site staff shall be a RN or a LPN. Supervision of the LPN and CNA shall be conducted by a RN or physician, and the supervisor shall be either on-site or continually available, with the ability to be physically on-site in a timely manner to address beneficiary care. Programs shall develop and adhere to staffing ratio policies that consider the number of adults currently residing in the program and their level of acuity, to ensure health, safety, and the availability of clinical supports.

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.

Note: Per 25 USC 1621t "Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State 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

a. Protocols, developed and supported by a Medical Director knowledgeable in addiction medicine and a Program Director that is CBIS certified 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.

b. Clinically Managed Population Specific High-Intensity Residential Program providers shall be staffed to screen and accept admissions a minimum of eight (8) hours a day, five (5) days a week. The Clinically Managed Population Specific High-Intensity Residential Medical Director and Program Director shall develop agency specific policies and procedures that address admission expectations, how the intake process is handled, and staffing expectations to consist of back-up and consultation coverage.

c. Clinically Managed Population Specific High-Intensity Residential Program providers shall ensure that all programs have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses. Programs shall develop policies that detail the use, storage and education provided to staff regarding naloxone.

d. The facility shall operate 24 hours a day, seven days a week. The facility shall have a physician available to provide consultation 24 hours a day, according to treatment and transfer practice protocols and guidelines. This service must be available for admission five days per week. Program medical staff as well as staff trained to deliver crisis behavioral interventions shall be available to provide 24-hour access to emergency consultation services.

e. Required components of this service contain all of the following:

   1. An initial abbreviated assessment consisting of an addiction focused history and physical examination completed at admission by the Medical Director along with the completion of a traumatic brain injury assessment;
   2. A CCA or DA within seven (7) calendar days of admission;
   3. Person-Centered Plan completed within 30 calendar days, which contains the problem identification in ASAM dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
   4. Daily clinical services to improve the beneficiary's ability to structure and organize the tasks of daily living and recovery, to include personal responsibility, personal appearance, punctuality, and family services;
   5. Planned clinical program activities designed to stabilize and maintain the stability of addiction symptoms, such as relapse prevention, interpersonal and social relationships, daily living skill building, and the development of a social network supportive of recovery;
   6. A range of cognitive, behavioral, and other therapies administered individually and in family and group settings. Therapies must be delivered in a manner that is slowly paced, concrete, and repetitive;
   7. Providers shall ensure access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) for a beneficiary who meets 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;

8. Providers shall ensure access to a Level I or Level II trauma hospital no further than 45 minutes from the facility that meets the requirements of 10A NCAC 13P .0901 Level I Trauma Center Criteria or 10A NCAC 13P .0901 Level II Trauma Center Criteria (ncdhhs.gov);
9. Referrals to vendors that provide cognitive rehabilitation services when those services are clinically necessary;
10. Counseling and clinical monitoring to assist with successful initial involvement or reinvolvement in regular, productive daily activities;
11. Regular monitoring of the beneficiary's prescribed or over the counter medications or supplement adherence;
12. Daily scheduled professional addiction and mental health treatment services;
13. Clinical and didactic motivational interventions appropriate to the stage of readiness to change;
14. Daily assessment of progress and any treatment changes;
15. Monitoring of the health of the beneficiary, such as the beneficiary's general condition and vital signs (pulse rate, blood pressure and temperature);
16. Provide 24-hour access to emergency medical consultation services;
17. Provide behavioral health crisis interventions, when clinically necessary;
18. Arrange for laboratory and toxicology tests, which can be point-of-care testing;
19. Urine screens to shape behavior and reinforce treatment gains, when clinically necessary;
20. Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
21. Health education services, including reproductive health education;
22. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
23. Arrange for the involvement of family members or significant others, with informed consent;
24. Direct coordination with other levels of care, such as specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
25. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals for counseling, medical, psychiatric, and continuing care;
26. Linkage and coordination with Care Management or other case management services; and
27. Discharge and transfer planning beginning at admission.

6.4 Staff Training Requirements

Time Frame	Training Required	Who
Prior to Service Delivery	▪ Crisis Response, including supporting individuals with brain injury experiencing crisis * ▪ Opioid Antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Harm Reduction ▪ Clinically Managed Population Specific High-Intensity Residential Program Definition Required Components	All Staff
	▪ Medication Administration	Physician, Program Director, Clinical Staff
Within **90 calendar days** of hire to provide service	▪ Substance Use and Traumatic Brain Injury Training ▪ Behavioral and cognitive challenges associated with traumatic brain injury	All Staff
	▪ ASAM Criteria	Physician, Program Director, Clinical Staff, CPSS, Support Staff
	▪ 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.)	Program Director, Clinical Staff, Support Staff
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing	Program Director, Clinical Staff
	▪ Trauma informed care* ▪ Co-occurring conditions*	Program Director, Clinical Staff, CPSS, Support Staff
Annually	▪ Crisis Response Training**,** including supporting individuals with brain injury experiencing crisis* ▪ Continuing education in evidence-based and promising treatment practices which must include crisis response training, cultural competency, substance use disorder and traumatic brain injury, and brain injury intervention strategies*	All Staff

Time Frame	Training Required	Who
	▪ Working with a beneficiary with TBI	

The initial training requirements may be waived by the hiring agency if the staff can produce documentation certifying that training appropriate for the population being served was completed no more than 48 months before the hire date.

Staff hired prior to the effective date of this policy shall complete the required training identified in the above Staff Training Requirements chart. Training must be completed within one (1) year of the original effective date of this policy. **Refer to Section 8.0** of this policy.

*Training must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical professionals. Some 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), National Association of Social Work (NASW), and Motivational Interviewing Network of Trainers (MINT). Documentation of training activities must be maintained by the program.

6.5 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 PCP. Expected outcomes as follows:

a. Sustained improvement in health and psychosocial functioning;
b. Development of compensatory strategies to increase the beneficiary's level of independence, self-sufficiency, and independent activities of daily living;
c. A reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors;
d. Increased use of peer support services to facilitate recovery and link the beneficiary to community-based peer support and mutual aid groups;
e. Linkage to treatment and other supportive services post discharge;
f. Increased links to community-based resources to address unmet needs; and
g. 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
   a. 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). All providers shall be in compliance with 42 CFR Part 2-Confidentiality of Substance Use Disorder Patient Records. 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: 07/01/2024

History:

Date	Section or Subsection Amended	Change
07/01/24	All Sections and Attachment(s)	

DRAFT

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)

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.

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.

CPT Code(s)	Billing Unit
H0047	1 Unit = 1 Day

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.

F. Place of Service

Services are provided in a licensed residential facility as identified in **Section 6.0**.

G. Co-payments

For Medicaid refer to Medicaid 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/

Evaluation and Management CPT codes, specifically with an addiction focused history and biopsychosocial screening assessments, the comprehensive clinical assessment, physical exam, laboratory and toxicology tests, and medical evaluation and consultation can be billed separate from the Clinically Managed Population Specific High-Intensity Residential Program.

Note: North Carolina Medicaid shall not reimburse for conversion therapy.