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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:
8A- Enhanced Mental Health and Substance Abuse Services
8A-1 Assertive Community Treatment (ACT) Program
8A-2 Facility-Based Crisis Service for Children and Adolescents
8A-5 Diagnostic Assessment
8A-6 Community Support Team (CST)
8B Inpatient Behavioral Health Services
8C Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8D-1 Psychiatric Residential Treatment Facilities for Children under the Age of 21
8D-2 Residential Treatment Services
8G Peer Support Services

1.0 Description of the Procedure, Product, or Service

Clinically Managed Residential Services are designed to serve a beneficiary with specific functional limitations due to their substance use disorder (SUD). A beneficiary meeting The American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.5 has significant social and psychological issues complicating their recovery. This service provides a 24-hour structured, safe, and stable living environment. This service helps the beneficiary develop recovery skills to prevent immediate relapse or the continuation of use upon transfer to a less intensive level of care. A beneficiary meeting this level of care may be experiencing justice system involvement, co-occurring mental illness, and impaired functioning. Clinically Managed Residential Services are tailored to meet the beneficiary's level of readiness to change.

The goals of treatment are to promote abstinence from substance use which can consist of the use of medication assisted treatment (MAT) for opioid use disorder or other FDA approved medications for the treatment of substance use disorders. This level of care is intended to affect changes in the beneficiary's lifestyle, attitudes, and values to facilitate healthy reintegration into the community.

This service can be provided to the following beneficiaries:
a. **Attachment B-** Adolescents, Medium-Intensity;
b. **Attachment C-** Adults, High-Intensity; and
c. **Attachment D-** Pregnant and Parenting, High-Intensity

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1.1 Definitions

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.

Medication Assisted Treatment (MAT)

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

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 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.

b. **Populations Served**
Medicaid shall cover Clinically Managed Residential Services for an eligible beneficiary who is either an adolescent aged 12-17 or an adult 18 years of age and older, and who meets the criteria in **Section 3.0** of this policy.

c. **Medicaid for Pregnant Women (MPW)**
An applicant may be approved for MPW 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.

MPW shall cover Clinically Managed 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.

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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.

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3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

Medicaid shall cover Clinically Managed Residential Services when the beneficiary meets the following specific criteria:

a. has a substance use disorder (SUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, or any subsequent editions of this reference material;
b. meets American Society of Addiction Medicine (ASAM) Level 3.5 Clinically Managed Residential Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013; and
c. the beneficiary is:
    1. an adolescent age 12-17;
    2. an adult age 18 and older;
    3. a pregnant beneficiary; or
    4. a parenting beneficiary with a dependent minor child or children in their physical custody.

3.2.2 Medicaid Additional Criteria Covered

Admission Criteria

Clinically Managed Residential Services requires a comprehensive clinical assessment (CCA) or a diagnostic assessment (DA) to be completed within seven days of admission. The assessment must confirm the beneficiary has a SUD diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. The assessment must also confirm that the beneficiary meets ASAM Criteria, Third Edition, Level 3.5. The CCA or DA must be updated as new strengths and barriers are observed in the residential setting.

The beneficiary's Person-Centered Plan (PCP) must document

a. The amount, duration, and intensity of Clinically Managed Residential Treatment Services must be documented in a beneficiary's PCP.
b. Relevant diagnostic information must be obtained and documented in the PCP.

Continued Stay and Discharge Criteria

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

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 level of care to meet additional goals;
    2. The beneficiary is making some progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated; or
    3. The beneficiary is not making progress and is regressing, or new symptoms have been identified and the beneficiary has the capacity to

resolve these symptoms at this level of care. The PCP must be modified to identify more effective interventions; or

4. The beneficiary is actively working towards goals, so continuing at the present level of care is indicated, and the PCP must be modified to identify more effective interventions.

b. The beneficiary meets the criteria for discharge if any one of the following applies:
   1. The beneficiary has achieved goals documented in the PCP, resolved the symptoms(s) that justified admission to the present level of care and a less intensive level of care is indicated;
   2. The beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified. An updated CCA or DA indicates transfer to a different level of care is needed;
   3. The beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions. An updated CCA or DA indicates transfer to a different level of care is needed; or
   4. The beneficiary or person legally responsible for the beneficiary requests a discharge from Clinically Managed Residential Services.

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 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 Clinically Managed Residential Services staff, which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;

f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified on the beneficiary's 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 Person-Centered Plan; 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 Residential Services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations and Requirements

A beneficiary shall receive Clinically Managed Residential Services from only one provider organization during any active episode of care. Clinically Managed Residential Services must not be provided or billed on the same day (except day of admission or discharge) as:

a. Other residential levels of care;
b. Withdrawal management services;
c. Substance Abuse Intensive Outpatient Program (SAIOP);
d. Substance Abuse Comprehensive Outpatient Treatment (SACOT);
e. Psychosocial Rehabilitation (PSR);
f. Peer Support Services (PSS);
g. Partial Hospitalization;
h. Facility Based Crisis (Adult);
i. Facility Based Crisis (Child and Adolescent);
j. Psychiatric Residential Treatment Facilities for Children under the Age of 21;
k. Assertive Community Treatment (ACT); and
l. Community Support Team (CST).

The case management component of Assertive Community Treatment (ACT) or Community Support Team (CST) may be billed concurrently with Clinically Managed Residential Services, for the first and last 30 days, in accordance with the beneficiary's Person-Centered Plan (PCP).

Outpatient therapy services can be billed separately when the beneficiary needs specialized therapy that cannot be provided by the Clinically Managed Residential Service provider, may include Dialectical Behavioral Therapy (DBT), exposure therapy, and Eye Movement Desensitization and Reprocessing (EMDR).

5.4 Service Order

A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the beneficiary's needs. A signed service order must be completed prior to or on the first day that Clinically Managed Population Specific High Intensity Residential Program Services are provided. The service order must be completed by a physician, physician assistant, nurse practitioner, or licensed psychologist according to their scope of practice. A service order is valid for the episode of care. Medical necessity must be revisited, and service must be ordered based on current episode of care, if multiple episodes of care are required within a twelve (12) consecutive 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.

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 the 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.

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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 using a service note, over and above the minimum frequency requirement.

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. 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) or equivalent federally recognized tribal code or federal regulations.

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 licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Clinically Managed Residential Services must be delivered by a substance use disorder treatment provider 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 or equivalent federally recognized tribal code or federal regulations.

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 or federal Tribal equivalence or allowance.

Population Specific Provider Qualifications and Occupational Licensing Entity Regulations are identified in the population specific attachments.

6.2 Provider Certifications

The Provider Certifications for Clinically Managed Residential Services are identified in the population specific attachments. Refer to the following attachments and sections for population specific provider certifications:

a. **Attachment B -** Adolescent, Section B. Population Specific Provider Requirements;
b. **Attachment C -** Adult, Section B. Population Specific Provider Requirements; and
c. **Attachment D -** Pregnant and Parenting, Section B. Population Specific Provider Requirements.

6.3 Program Requirements

a. Clinically Managed Residential Service provides a structured recovery environment and clinical services to meet the functional limitations of a beneficiary with a substance use disorder. The beneficiary shall be appropriate for one of the following three program types: adolescent, adult, or pregnant or parenting. This service offers support for recovery from substance use disorders. This service is provided by licensed professionals, certified staff, peers, and paraprofessionals. A beneficiary eligible for this service experiences significant impairments from their substance use disorder that make outpatient or relapse prevention strategies not feasible or effective.
b. Protocols must be in place to determine the nature of the interventions that are required. Protocols must contain:
    1. under what conditions physician care is warranted;
    2. when transfer to a medically monitored facility or an acute care hospital is necessary; and
    3. when a beneficiary is medically appropriate to step down to a lower level of care based on the ASAM Criteria, Third Edition, 2013.

c. Providers shall provide notification to the beneficiary's care manager or care coordinator on the first day of admission to the service to coordinate services.
d. Providers shall ensure access to medical care. Medical care may be administered by the provider, or through a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) that details the collaboration with external provider(s).
e. A provider shall ensure access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) covered by the Medicaid formulary for a beneficiary that meets medical necessity for this service. MAT may be administered by the provider, or through a MOA or MOU with another provider that is no further than 60 minutes from the facility.
f. Providers shall ensure access to naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose on site. Providers shall ensure 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.
g. Providers shall ensure access to behavioral health prescriber services. prescriber services may be administered by the provider, or through a MOA or MOU that details the collaboration with external provider(s).

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h. Providers shall have clinicians and professional staff who are available 24 hours a day. Providers shall have the ability to screen a potential beneficiary seven days a week. Providers shall be staffed to complete CCAs or DAs and accept medically necessary admissions a minimum of five days a week.
i. Providers shall have policies and procedures that address:
    1. admission expectations;
    2. how the screening, intake and admission process are handled; and
    3. staffing expectations to consist of back-up and consultation coverage.
j. This service must be in operation 24 hours a day, seven days a week. Clinical staff (Certified Clinical Supervisor, Clinical Supervisor Intern, Licensed Clinical Addictions Specialist, Licensed Clinical Addictions Specialist-Associate, Licensed Clinical Social Worker, Licensed Clinical Social Worker Associate, Licensed Clinical Mental Health Counselor, Licensed Clinical Mental Health Counselor Associate, Licensed Marriage and Family Therapist, Licensed Marriage and Family Therapist Associate, Certified Substance Abuse Counselor, Certified Substance Abuse Counselor Intern, Certified Alcohol and Drug Counselor, or Certified Alcohol, Drug Counselor Intern, and Registrant) shall be available seven days a week for clinical interventions. Clinical interventions must be provided a minimum of 20 hours per week for each beneficiary.
k. Additional program components and training requirements are identified in the population specific attachments.
l. Provider shall identify and implement evidence-based practices for the program to address the population to be served.

Components of this service include the following:

1. A CCA or DA completed within seven (7) days of admission;
2. Interdisciplinary assessments and treatment designed to develop and apply recovery skills;
3. A PCP, documenting problem identification in the ASAM Criteria, Third Edition dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
4. A daily program schedule that consists of clinical services, individual, group and family therapy, case management, peer supports, and other recovery supports. Interventions can focus on improving the beneficiary's ability to structure and organize their tasks of daily living and recovery, develop and practice prosocial behaviors, stabilize and maintain the stability of the beneficiary's addiction symptoms, and help the beneficiary develop and apply recovery skills;
5. Counseling and clinical monitoring to assist the beneficiary with successful initial involvement or reinvolvement in regular, productive daily activities;
6. Trauma informed practices and interventions tailored to the specific population being served;
7. Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the beneficiary's PCP;
8. A range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and

management, addiction pharmacotherapy, educational skill building groups, and occupational or recreational activities;
9. A range of evidence-based practices and therapies for a beneficiary with co-occurring substance use and mental health disorders;
10. Motivational enhancement and engagement strategies appropriate to the beneficiary's stage of readiness and desire to change;
11. Counseling and clinical interventions to facilitate teaching the beneficiary skills needed for successful reintegration into family and community living;
12. Reproductive planning and health education, including referral to external partners to access necessary services and supports;
13. Regular monitoring of the beneficiary's adherence in taking any prescribed and over the counter medications;
14. Daily assessment of progress and any treatment changes;
15. 24-hour access to emergency medical consultation services;
16. Behavioral health crisis interventions, when clinically appropriate;
17. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
18. Arrange for the involvement of family members or significant others to provide education on and engagement in the treatment process, with informed consent;
19. Direct coordination with other levels of care, including specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
20. Direct coordination with the justice system and the Department of Social Services, when the beneficiary has current involvement with either of these systems;
21. Affiliation with other ASAM levels of care, behavioral health providers, and care management for linkage and referrals for counseling, as well as medical, psychiatric, and continuing care; and
22. Discharge and transfer planning beginning at admission.

Note: Additional population specific required components are identified in the population specific appendix.

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). 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:

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	

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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)

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-CM 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.

HCPCS Code(s)	Billing Unit
H0012 HD- Pregnant and Parenting	1 Unit = 1 Day
H0012 HB- Adult	1 Unit = 1 Day
H0012 HA- Adolescent	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.

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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/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/
Physician and other professional time not included in the daily rate are billed separately.

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

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

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Attachment B: Clinically Managed Medium-Intensity Residential Service - Adolescent

A. Adolescent Population Specific Service Definition and Required Components

This level of care is for an adolescent beneficiary who is aged 12 to 17 and experiencing impaired functioning across a broad range of psychosocial domains. These impairments can manifest as:

1. disruptive behaviors;
2. delinquency;
3. juvenile justice involvement;
4. educational difficulties;
5. family conflicts;
6. developmental immaturity; and
7. impaired psychological functioning.

This level of care frequently works with adolescents who are impulsive, displaying severe conduct problems, and struggling with interpersonal relationships, hostility, and aggression.

Clinically Managed Medium-Intensity Residential Service - Adolescent programs operate under protocols for the management of medical or behavioral health emergencies. Programs are staffed by clinicians and professional staff who have training and experience working with an adolescent diagnosed with substance use disorder and co-occurring mental health conditions. Clinicians and professional staff shall be available 24 hours a day. This service must have:

1. the availability of specialized medical consultation;
2. the ability to arrange for medical procedures, including indicated laboratory and toxicology testing;
3. the ability to arrange for medical and psychiatric treatment through consultation;
4. the ability to refer to off-site, concurrent treatment services or transfer to another level of care; and
5. direct affiliations with other levels of care to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

Programs are expected to coordinate with other agencies and entities involved in the beneficiary's care such as social services, local school districts, juvenile justice, and medical providers.

B. Population Specific Provider Requirements

In addition to the provider and program requirements identified above, Clinically Managed Medium-Intensity Residential Service - Adolescent providers shall be expected to provide or directly link to educational services that are:

1. provided according to local regulations;
2. designed to maintain the educational and intellectual development of the beneficiary and,
3. when indicated, provide opportunities to remedy deficits in the educational level of a beneficiary who has fallen behind because of their involvement with alcohol and other substances.

If the program is coordinating with a local school district for educational supports, this must be documented in a MOU or MOA.

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Clinically Managed Medium-Intensity Residential Service - Adolescent providers shall coordinate with local Department of Social Services (DSS) offices when working with an adolescent beneficiary who has DSS involvement. Adolescent providers shall coordinate with Department of Juvenile Justice and Delinquency Prevention (DJJDP) when working with an adolescent who has DJJDP involvement.

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. Facilities must be licensed under an approved rule waiver, if applicable.

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.

C. Population Specific Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Program Director	**Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS), or Clinical Supervisor Intern (CSI)** Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board. Shall have experience working with adolescents.	The **Program Director** is responsible for clinical and general oversight of the program, to include development of clinical policies, procedures, and operations. The program director shall oversee and manage admissions and discharges and provide direct clinical services. The Program Director will identify, develop and lead quality improvement projects, and monitor and evaluate services provided by the team to determine effectiveness of program activities. The Program Director develops supervision plans and provides staff and clinical program supervision to ensure the program is adhering to the policy, rule, and statutes. The Program Director or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically, for consultation with the Program Manager, clinical staff, and support staff.
Program Manager	**Qualified Professional in Substance Abuse (QP)** in accordance with 10A NCAC 27G .0104 or equivalent federally	The **Program Manager** is responsible for the general oversight of the program, as delegated by the Program Director to include administrative oversight and management of staff. The Program Manager manages admissions, discharges, transitions of care and ensures the program is

	recognized tribal code or federal regulation(s). Shall have experience working with adolescents.	adhering to the policy, rule and statutes. They shall organize and oversee daily activities and maintain programmatic standards of satisfaction, quality and performance. The Program Manager or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically for emergency program oversight. All responsibilities of the Program Manager must be covered by the Program Director when a Program Manager is not available or not staffed.
Licensed Clinical Staff	The Licensed Clinical Staff shall meet one of the following: Be a LCAS or LCAS-A with a valid licensed from the NC Addictions Specialist Professional Practice Board; Be a LCSW or LCSWA with a valid license from the NC Social Work Certification and Licensure Board; Be a LCMHC or LCMHCA with a valid license from the NC Board of Licensed Clinical Mental Health Counselors; Be a LMFT or LMFTA with a valid license from the NC Marriage and Family Therapy Licensure Board. AND Shall have experience working with adolescents.	The **Licensed Clinical Staff** provides substance use focused and co-occurring assessment and treatment services, develops an ASAM Level of Care determination, and provides direct clinical services and provide referral and coordination for SUD to treatment and recovery resources. The Licensed Clinical Staff shall provide after-hours phone consultation to on-site staff, and coordinate with the Program Director regarding clinical situations.

Certified Clinical Staff	**Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor Intern (CADC-I), or Registrant (Alcohol and Drug Counselor)*** Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board. Shall have at least one year of experience working with adolescents. *A Registrant shall: • meet the requirements for a Paraprofessional, Associate Professional (AP), or Qualified Professional (QP); and • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of the effective date of this policy (**Refer to Section 8.0**); or • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of hire.	The **CADC, CADC-I, and Registrant*** coordinates with the Licensed Clinical Staff and Program Manager to ensure that a beneficiary has access to counseling supports, psychoeducation, and crisis interventions. The Certified Clinical Staff play a lead role in case management and coordination of care functions and shall assist in developing relapse prevention and disease management strategies. Licensed clinical staff shall fulfill these responsibilities if CADCs are not included in the staffing for this program. All responsibilities of the Certified Clinical Staff must be covered by a Licensed Clinical Staff when Certified Clinical Staff are not available or not staffed.

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Recovery Supports	**Certified Peer Support Specialist (CPSS)** Shall be certified as a peer support specialist in NC. Shall have similar lived experience as the population being served.	The **Certified Peer Support Specialist (CPSS)** provides services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. The CPSS shall be scheduled and available seven days a week to support recovery-related activities.
Recovery Supports	**Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC)** Shall be licensed with the NC Board of Recreational Therapy Licensure. Shall have experience working with a beneficiary with SUD. OR Shall have experience working with adolescents. Note: Federally recognized tribal and Indian Health Service providers may engage a Cultural Coordinator or Cultural Advisor in lieu of the Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC).	The **Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC)** uses recreation, art, or music to support a beneficiary as they foster healthy ways to manage their symptoms and begin to experience recovery from substance use disorder. The LRT, AT-R or MT-BC helps the beneficiary develop positive social and communication skills and explore new recovery-oriented leisure activities that address the beneficiary's emotional, recreational, and sensory needs. In addition to the above, the Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), and Music Therapist-Board Certified (MT-BC) are responsible for the following: • Use assessments to determine the beneficiary's needs that can be addressed through leisure and creative expressive arts; • Establish treatment goals specific to their certification or licensure that support the beneficiary in their recovery journey; • Facilitate individual and group sessions, using interventions and supportive techniques to restore, remediate, or rehabilitate physical, cognitive, emotional, or social functioning to improve independence in life activities within their scope of practice; • Complete routine evaluation of beneficiary progress and satisfaction, to include the need to modify or discontinue specific interventions, to ensure the beneficiary is able to achieve their functional outcome goals;

		• Identify goals to include in the discharge planning process, to identify aftercare services based on the individual's needs; • Communicate with community programs to ensure the beneficiary is linked to community resources and supports to reintegrate into the community after discharge; • Provide reproductive planning and health education, and refer to external partners, as necessary; and • Participate in team meetings and provide input into the PCP.
Support Staff	**Paraprofessional, Associate Professional (AP), or Qualified Professional (QP) in Substance Abuse** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s).	**Support Staff** are responsible for tasks that ensure the beneficiary has 24 hour a day, seven day a week access to supports to meet their behavioral health and physical needs. Support Staff 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 met, ensure monitoring is completed and recorded, and support in the provision of recovery-oriented interventions.
Health Services Coordinator	At minimum, shall be a Paraprofessional and have a current NC driver's license.	The Health Services **Coordinator** organizes and coordinates MAT, physical health and specialist appointments to ensure a beneficiary can access needed care services in accordance with the PCP. The Health Services Coordinator facilitates transportation to and from scheduled MAT, physical health and specialist appointments and ensures safe and secure transportation of any prescribed medications from the MAT provider to the residential program. The Health Services-Coordinator collaborates with the medical staff and Program Director to ensure information regarding MAT, physical health, and specialist appointments are reflected in the beneficiary's PCP and clinical record. The Health Services coordinator completes progress notes on a beneficiary who receives MAT, physical health, and specialist appointment coordination support, to include detailing the secure custody procedures that were followed, the date and time of appointments, provider

		contact information and ensuring release of information forms are completed and filed.

A minimum of two (2) awake staff shall be onsite at all times when a beneficiary is present. Clinical staff must be available seven days per week for clinical interventions. Programs shall develop and adhere to staffing ratio policies that consider the number of beneficiaries currently residing in the program to ensure health, safety, and availability of clinical supports.

Note: According to 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.)."

D. Population Specific Training Requirements

Time Frame	Training Required	Who
Prior to Service Delivery	▪ Crisis Response* ▪ Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose); ▪ Harm Reduction ▪ Clinically Managed Medium-Intensity (Adolescent Population Specific)	All Staff

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Time Frame	Training Required	Who
	Residential Service Definition Required Components	
	▪ Medication Administration	Program Manager, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant, Support Staff
Within **90 calendar days** of hire to provide service	▪ Substance Use Disorder and Adolescent Specific Needs and Considerations* ▪ Reproductive Planning and Health Education	All Staff
	▪ ASAM Criteria ▪ PCP Instructional Elements	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, CPSS
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing*	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant,
	▪ Trauma informed care* ▪ Co-occurring conditions* ▪ Evidence-based practice for adolescents with SUD or co-occurring SUD and mental illness*	All Staff
Annually	▪ Continuing education in evidence-based treatment practices, which must include crisis response training and cultural competency*	All Staff

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.

*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), North Carolina Social Work Certification and Licensure Board (NCSWCLB), American Psychological Association (APA), and Motivational Interviewing Network of Trainers (MINT).

Documentation of training activities shall be maintained by the provider.

E. Population Specific Expected Outcomes

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

a. Developing and fostering a recovery identity and social skills that facilitate return to family and community;
b. Beneficiary and family or caregivers' engagement in the recovery process;
c. Providing family and significant supports with education on how to support the beneficiary's continued recovery journey, including identification and management of triggers, cues, and symptoms;
d. Increased use of available natural and social supports by the beneficiary and family or caregivers;
e. Increase use of leisure activities and skills that support continued recovery;
f. Reduction of symptoms and behaviors that interfere with the beneficiary's daily living, such as negative effects of substance use, psychiatric symptoms, or both;
g. The family or caregivers have increased capacity to monitor and manage the beneficiary's behavior, the need for residential treatment for substance use disorder has been reduced or eliminated, and the beneficiary's needs can be met at a lower level of care;
h. Improved anger management;
i. Acquisition of conflict resolution skills; and
j. Development of effective behavioral contingency strategies.

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Attachment C: Clinically Managed High-Intensity Residential Service – Adult

A. Adult Population Specific Service Definition and Required Components

This level of care is for an adult beneficiary 18 years of age or older with a primary substance use disorder. The beneficiary's functional limitations necessitate a safe and stable living environment to develop and demonstrate sufficient recovery skills. This level of care is designed to prevent immediate relapse or continued use in an imminently dangerous manner upon transfer to a lower, less intensive level of care. An adult beneficiary meeting this level of care may have significant mental health support needs along with psychological and self-management functional limitations. The beneficiary may have a history of:

1. physical, sexual, or emotional trauma;
2. a history of, or current involvement with, the justice system;
3. limited education or work history;
4. inadequate anger management skills; and
5. extreme impulsivity.

Clinically Managed High-Intensity Residential Service – Adult has protocols in place for the management of medical and behavioral health emergencies. Programs are staffed by clinicians and professional staff who have training and experience working with adults diagnosed with primary substance use disorders and co-occurring mental health conditions. Clinicians and professional staff are available 24 hours a day. Support systems must have:

1. the availability of specialized medical consultation;
2. the ability to arrange for medical procedures, including indicated laboratory and toxicology testing;
3. the ability to arrange for medical and psychiatric treatment through consultation, referral to off-site concurrent treatment services, or transfer to another level of care; and
4. direct affiliations with other levels of care to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

Clinically Managed High-Intensity Residential Service – Adult providers shall have collaborative agreements in place with Individual Placement and Support (IPS) providers and Division of Vocational Rehabilitation (DVR) offices to facilitate the direct referral of a beneficiary to these services for support in identifying and attaining employment and achieving education related goals.

Clinically Managed High-Intensity Residential Service – Adult providers shall coordinate with housing providers (local housing authorities, Oxford Houses) and a beneficiary's Care Manager or care coordinator to support the beneficiary in having safe and stable housing to transition to after discharge.

B. Population Specific Provider Requirements

In addition to the program requirements identified above, Clinically Managed High-Intensity Residential Service – Adult providers shall be expected to provide:

a. Daily clinical services to improve the ability to structure and organize the tasks of daily living and recovery, and to develop and practice prosocial behaviors;
b. Planned clinical program activities including individual and group counseling and therapy, to support reduction or elimination of substance use, and to help develop and apply recovery skills;

c. Counseling and clinical monitoring, using trauma informed interventions that support successful reintegration into work, family, and the community;
d. Medication education and management;
e. Referral and coordination with IPS or DVR staff to support a beneficiary identifying and attaining employment and achieving education related goals;
f. Planned clinical activities to enhance understanding of substance use or mental disorders; and
g. Daily scheduled professional services that can include relapse prevention, exploring interpersonal choices, development of a social network, and family therapy. Services may also include occupational therapy or physical therapy through linkage or referral.

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 .5600 Supervised Living for Individuals of All Disability Groups. Facilities must be licensed under an approved rule waiver, if applicable.

Refer to Tribal & Urban Indian Health Centers | HRSA when the service is provided by an Indian Health Service (his) 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.

C. Population Specific Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Program Director	**Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS), or Clinical Supervisor Intern (CSI)** Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board. Shall have at least one year of experience working with adults diagnosed with a SUD.	The **Program Director** is responsible for clinical and general oversight of the program, to include development of clinical policies, procedures, and operations. The program director shall oversee and manage admissions and discharges and provide direct clinical services. The Program Director will identify, develop and lead quality improvement projects, and monitor and evaluate services provided by the team to determine effectiveness of program activities. The Program Director develops supervision plans and provides staff and clinical program supervision to ensure the program is adhering to the policy, rule, and statutes. The Program Director or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically, for consultation with the

		Program Manager, Clinical Staff, and Support Staff.
Program Manager	**Qualified Professional in Substance Abuse (QP)** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s). Shall have at least one year of experience working in a residential SUD facility.	The **Program Manager** is responsible for the general oversight of the program, as delegated by the Program Director, to include administrative oversight and management of staff. The Program Manager manages admissions, discharges, transitions of care and ensures the program is adhering to the policy, rule and statutes. They shall organize and oversee daily activities and maintain programmatic standards of satisfaction, quality and performance. The Program Manager or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically for emergency program oversight. All responsibilities of the Program Manager must be covered by the Program Director when a Program Manager is not available or not staffed.
Licensed Clinical Staff	The Licensed Clinical Staff shall meet one of the following: Be a LCAS or LCAS-A with a valid licensed from the NC Addictions Specialist Professional Practice Board; Be a LCSW or LCSWA with a valid license from the NC Social Work Certification and Licensure Board; Be a LCMHC or LCMHCA with a valid license from the NC Board of Licensed Clinical Mental Health Counselors; or Be a LMFT or LMFTA with a valid license from the NC	The **Licensed Clinical Staff** provides substance use focused and co-occurring assessment and treatment services, develops an ASAM Level of Care determination, and provides referral and coordination for SUD treatment and recovery resources. The Licensed Clinical Staff shall provide after-hours phone consultation to on-site staff, and coordinate with the Program Director regarding clinical situations.

	of Marriage and Family Therapy Licensure Board. AND Shall have at least one year of experience working with adults diagnosed with a SUD.	
Certified Clinical Staff	**Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor Intern (CADC-I), or Registrant (Alcohol and Drug Counselor)*** Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board. *A Registrant shall: • meet the requirements for a Paraprofessional, Associate Professional (AP), or Qualified Professional (QP); and • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of the effective date of this policy (**Refer to Section 8.0**); or • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of hire.	The **CADC, CADC-I, or Registrant*** coordinates with the Licensed Clinical Staff and Program Manager to ensure that the beneficiary has access to counseling supports, psychoeducation, and crisis interventions. The Certified Clinical Staff play a lead role in case management and coordination of care functions and shall assist in developing relapse prevention and disease management strategies. Licensed clinical staff shall fulfill these responsibilities if CADCs are not included in the staffing for this program. All responsibilities of the Certified Clinical Staff must be covered by a Licensed Clinical Staff when Certified Clinical Staff is not available or not staffed.

Recovery Supports	**Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC)** Shall be licensed with the NC Board of Recreational Therapy Licensure. Note: Federally recognized tribal and Indian Health Service providers may engage a Cultural Coordinator or Cultural Advisor in lieu of the Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC).	The **Licensed Recreation Therapist (LRT), Art Therapist-Registered (AT-R), or Music Therapist-Board Certified (MT-BC)** uses recreation, art, or music to support a beneficiary as they foster healthy ways to manage their symptoms and begin to experience recovery from substance use disorder. The LRT, AT-R or MT-BC helps the beneficiary develop positive social and communication skills, and explore new recovery-oriented leisure activities that address the beneficiary's emotional, recreational, and sensory needs.
Recovery Supports	**Certified Peer Support Specialist (CPSS)** Shall be certified as a peer support specialist in NC. Shall have similar lived experience as the population being served.	The **Certified Peer Support Specialist (CPSS)** provides services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. The CPSS shall be scheduled and available seven days a week to support recovery-related activities.
Support Staff	**Paraprofessional, Associate Professional (AP), or Qualified Professional in Substance Abuse (QP)** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s).	**Support Staff** are responsible for tasks that ensure a beneficiary has 24 hour a day, seven day a week access to supports to meet their behavioral health and physical needs. Support Staff 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 met, ensure monitoring is completed and recorded, and support in the provision of recovery-oriented interventions.

Health Services Coordinator	At minimum, shall be a paraprofessional and have a current NC driver's license.	**The Health Services Coordinator** organizes and coordinates MAT, physical health and specialist appointments to ensure a beneficiary can access needed care services in accordance to the PCP. The Health Services Coordinator facilitates transportation to and from scheduled MAT, physical health and specialist appointments and ensures safe and secure transportation of any prescribed medications from the MAT provider to the residential program. The Health Services Coordinator collaborates with the medical staff and Program Director to ensure information regarding MAT, physical health, and specialists appointments are reflected in the beneficiary's PCP and clinical record. The Health Services coordinator completes progress notes on a beneficiary who receives MAT, physical health, and specialist appointment coordination support, to include detailing the secure custody procedures that were followed, the date and time of appointments, provider contact information and ensuring release of information forms are completed and filed.

A minimum of (2) two staff shall be onsite at all times when a beneficiary is present. Clinical staff must be available seven days per week for clinical interventions. Programs shall develop and adhere to staffing ratio policies that consider the number of beneficiaries currently residing in the program to ensure health, safety, and availability of clinical supports.

Note: According to 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.)."

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D. Population Specific Training Requirements

Time Frame	Training Required	Who
Prior to Service Delivery	▪ Crisis Response* ▪ Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose); ▪ Harm Reduction ▪ Clinically Managed Adult Population Specific Residential Service Definition Required Components	All Staff
	▪ Medication Administration	Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant, Support Staff
Within **90 calendar days** of hire to provide service	▪ Substance Use Disorder and Adult Specific Needs and Considerations* ▪ Reproductive Planning and Health Education	All Staff
	▪ ASAM Criteria ▪ PCP Instructional Elements	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A CADC, CADC-I, Registrant, CPSS
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing*	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant,
	▪ Trauma informed care* ▪ Co-occurring conditions*	Program Director, Program Manager,

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Time Frame	Training Required	Who
	▪ Evidence-based practice for adults with SUD or co-occurring SUD and mental illness*	LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant, Support Staff
Annually	▪ Continuing education in evidence-based treatment practices, which must include crisis response training and cultural competency*	All Staff

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.

* 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), National Association of Social Work (NASW), North Carolina Social Work Certification and Licensure Board (NCSWCLB), American Psychological Association (APA), and Motivational Interviewing Network of Trainers (MINT).

Documentation of training activities must be maintained by the provider.

E. Population Specific Expected Outcomes

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

a. Stabilization of addiction signs and symptoms;
b. Initiation or restoration of the recovery process;
c. Decreased interactions with the justice system;
d. Engagement in employment or educational activities;
e. Increased or improved social networks and supports;
f. Increased use of coping skills that support recovery;
g. Increased use of recreation or creative expressive arts for wellness and recovery;
h. Linkage to local community housing resources;
i. Preparation for ongoing recovery in the ASAM continuum of care; and
j. Increased or improved social networks and recovery support.

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Attachment D: Clinically Managed High-Intensity Residential Services - Pregnant and Parenting

A. Pregnant and Parenting Population Specific Service Definition and Required Components

This level of care is for a beneficiary with substance use, or co-occurring mental health issues, who would benefit from a structured, residential level of care. This level of service provides supports to strengthen the parent-child dyad. Services must be designed to provide a safe and healthy environment for parents and their children.

A beneficiary meeting this level of care can benefit from targeted substance use interventions that:

1. increase the incidence of prenatal visits;
2. improve birth outcomes, lower overall health costs; and
3. improve health outcomes for the mother, infant, and other children.

It is critical that the beneficiary has an environment and interventions that support the learning and use of positive parenting skills that include:

1. trauma-informed parenting supports;
2. how to establish and maintain recovery while parenting;
3. developing, and improving basic understanding of child development; and
4. how to support healthy child development.

Providers shall ensure the treatment needs of the pregnant or parenting beneficiary are assessed. Providers shall ensure that children receive age and developmentally appropriate screening and assessments, and evidence-based treatments, and therapies based on medically necessary needs. A pregnant or parenting beneficiary and their dependent children may have a history of:

1. physical, sexual, or emotional trauma;
2. limited education or work history; and
3. a history of, or current involvement with, the child welfare and justice systems.

B. Population Specific Provider Requirements

In addition to the program requirements identified above, Clinically Managed High-Intensity Residential Services – Pregnant or Parenting providers shall be expected to directly link to medical care (prenatal, postpartum, pediatric, and primary) to support both the beneficiary and the infant and other children through a MOU or MOA.

This service shall directly link to education services for children and adolescents residing in the program. Education services must be provided according to local regulations. These services must be designed to maintain the educational and intellectual development of the children and adolescents residing in the program. When indicated, programs must provide opportunities to remedy deficits in the educational level of children and adolescents who are not performing at grade or developmental level and require remedial supports. If the program is coordinating with a local school district for educational supports, this must be documented in a MOU or MOA.

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The Clinically Managed High-Intensity Residential Service - Pregnant or Parenting provider shall coordinate with the local Department of Social Services (DSS) office when working with a beneficiary who has a DSS case worker or DSS involvement.

Clinically Managed High-Intensity Residential Service – Pregnant and Parenting providers shall coordinate with housing providers (local housing authorities, Oxford Houses) and a beneficiary's Care Manager or care coordinator to support the beneficiary in having safe and stable housing to transition to after discharge.

In addition to **Section 6.3 of this policy**, the Clinically Managed High-Intensity Residential Service - Pregnant or Parenting provider shall ensure the following interventions and supports are available to a beneficiary and their children, as needed:

a. Evidence-based therapy to acquire, improve, and implement positive parenting skills;
b. Trauma-informed parenting training;
c. Support to develop and improve a basic understanding of child development;
d. Therapies and support to educate, enlist, and support the beneficiary to provide nurturing care for their child(ren);
e. Therapies that address prenatal, perinatal, and postpartum mental and physical health concerns;
f. Prenatal and post-delivery treatment services such as postpartum depression screening, support for parenting a newborn, choices about breast feeding, integration with other children and family members, and continuing to pursue recovery goals;
g. Access to specialized medical consultations. This may include providing direct referrals to prenatal and postpartum care providers, arranging for preventative care and well visits for the dyad, and developmental screening and testing for infants and toddlers;
h. Ability to arrange for needed medical procedures, including laboratory and toxicology testing;
i. Ability to arrange for and support engagement in medical, psychological, and psychiatric assessment and treatment through consultation and referral to external providers;
j. Referral to off-site concurrent treatment services, including occupational therapy, physical therapy, and speech therapy;
k. Therapies for children that focus on enhancing resilience, support for achieving developmental benchmarks, achieving healthy social interactions, and coping with diversity;
l. Training in therapeutic parenting skills;
m. Basic independent living skills;
n. Child supervision;
o. One-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to school and work environments; and
p. Therapeutic mentoring.

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 .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children. Facilities must be licensed under an approved rule waiver, if applicable.

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

C. Population Specific Staffing Requirements

Required Positions	Minimum Qualifications	Responsibilities
Program Director	**Certified Clinical Supervisor (CCS), Licensed Clinical Addictions Specialist (LCAS), or Clinical Supervisor Intern (CSI)** Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board. Shall have one year of experience working with women who are pregnant or parenting and have a SUD. This position may be filled by a Licensed Clinical Addictions Specialist-Associate (LCAS-A), Licensed Clinical Social Worker (LCSW), Licensed Clinical Social Worker Associate (LCSWA), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Clinical Mental Health Counselor Associate (LCMHCA), Licensed Marriage Family Therapist (LMFT), or a Licensed Marriage Family Therapist Associate (LMFTA) if the Program Director held the position as of the original effective date of this policy. **Refer to Section 8.0 of this policy.**	The **Program Director** is responsible for clinical and general oversight of the program, to include development of clinical policies, procedures, and operations. The Program Director will identify, develop and lead quality improvement projects, and monitor and evaluate services provided by the team to determine effectiveness of program activities. The Program Director develops supervision plans and provides staff and clinical program supervision to ensure the program is adhering to the policy, The Program Director or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically, for consultation with the Program Manager, clinical staff, and support staff.

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Program Manager	**Qualified Professional in Substance Abuse (QP)** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s). Shall have at least one year of experience working with women diagnosed with a SUD. This position may be filled by a Paraprofessional or Associate Professional (AP) if the Program Manager held the position as of the original effective date of this policy. **Refer to Section 8.0 of this policy.**	The **Program Manager** is responsible for the general oversight of the program, as delegated by the Program Director to include administrative oversight and management of staff. The Program Manager manages admissions, discharges and transitions of care ensuring the program is adhering to the policy, rule and statutes. They shall organize and oversee daily activities and maintain programmatic standards of satisfaction, quality, and performance. The Program Manager or designee shall be available 24 hours a day, seven days a week, in-person, via telehealth, or telephonically for emergency program oversight. All responsibilities of the Program Manager must be covered by the Program Director when a Program Manager is not available or not staffed.
Licensed Clinical Staff	The Licensed Clinical Staff shall meet one of the following: Be a LCAS or LCAS-A with a valid license from the NC Addictions Specialist Professional Practice Board; Be a LCSW or LCSWA with a valid license from the NC Social Work Certification and Licensure Board; Be a LCMHC or LCMHCA with a valid license from the NC Board of Licensed Clinical Mental Health Counselors; Be a LMFT or LMFTA with a valid license from the NC of Marriage and Family Therapy Licensure Board.	The **Licensed Clinical Staff** provides substance use focused and co-occurring assessment and treatment services, develops an ASAM Level of Care determination, and provides referral and coordination for SUD treatment and recovery resources. The Licensed Clinical Staff shall provide after-hours phone consultation to on-site staff, and coordinate with the Program Director regarding clinical situations.

	AND Shall have at least one year of experience working with adults diagnosed with a SUD.	
Certified Clinical Staff	**Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor Intern (CADC-I), or Registrant (Alcohol and Drug Counselor)*** Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board. *A Registrant shall: • meet the requirements for a Paraprofessional, Associate Professional (AP), or Qualified Professional (QP); and • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of the effective date of this policy (**Refer to Section 8.0)**; or • be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of hire.	The **CADC, CADC-I, or Registrant* coordinates** with the Licensed Clinical Staff to ensure that a beneficiary has access to counseling supports, psychoeducation, and crisis interventions. The Certified Clinical Staff plays a lead role in case management and coordination of care functions and shall assist in developing relapse prevention and disease management strategies. Licensed clinical staff shall fulfill these responsibilities if CADCs are not included in the staffing for this program All responsibilities of the Certified Clinical Staff must be covered by a Licensed Clinical Staff when a Certified Clinical Staff is not available or not staffed.
Child Family Specialist (CFS)	**The Child Family Specialist (CFS)** shall be a **LCAS, LCAS-A, Licensed Clinical Social Worker, Licensed**	The **Child Family Specialist (CFS)** works with families to build relationships that support family well-being, strong relationships between parents and their

	Clinical Social Worker-Associate, Licensed Clinical Mental Health Counselor, Licensed Clinical Mental Health Counselor-Associate, Licensed Marriage and Family Therapist, or Licensed Marriage and Family Therapist-Associate. Shall have at least one year of experience working with children and parents.	children, and ongoing learning and development for both parents and children. The CFS collaborates with community partners to build peer networks, links families and children to needed services, and supports successful transitions for children and families.
Recovery Supports	**Certified Peer Support Specialist (CPSS)** Shall be certified as a peer support specialist in NC. Shall have similar lived experience as the population being served.	The **Certified Peer Support Specialist (CPSS)** provides services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. The CPSS shall be scheduled and available seven days a week to support recovery-related activities.
Support Staff	**Paraprofessional, Associate Professional (AP), or Qualified Professional (QP) in Substance Abuse** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s).	**Support Staff** are responsible for tasks that ensure a beneficiary has 24 hour a day, seven day a week access to supports to meet their behavioral health and physical needs. Support Staff 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 met, ensure monitoring is completed and recorded, and support the provision of recovery-oriented interventions.
Health Services Coordinator	At minimum, shall be a paraprofessional and have a current NC driver's license.	**The Health Services Coordinator** organizes and coordinates MAT, physical health and specialist appointments to ensure a beneficiary can access needed care services in accordance with the PCP. The Health Services Coordinator facilitates transportation to and from scheduled MAT, physical health and specialist appointments and ensures safe and

		secure transportation of any prescribed medications from the MAT provider to the residential program. The Health Services Coordinator collaborates with the medical staff and Program Director to ensure information regarding MAT, physical health, and specialist appointments are reflected in the beneficiary's PCP and clinical record. The Health Services coordinator completes progress notes on a beneficiary who receives MAT, physical health, and specialist appointment coordination support, to include detailing the secure custody procedures that were followed, the date and time of appointments, provider contact information and ensuring release of information forms are completed and filed.

A minimum of two (2) staff shall be onsite at all times when a beneficiary is present. Clinical staff must be available seven days per week for clinical interventions. Programs shall develop and adhere to staffing ratio policies that consider the number of adults and children currently residing in the program to ensure health, safety, and availability of clinical supports.

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.)."

D. Population Specific Training Requirements

Time Frame	Training Required	Who
Prior to Service Delivery	▪ Crisis Response* ▪ Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose); ▪ Harm Reduction ▪ Clinically Managed Pregnant and Parenting Population Specific Residential Service Definition Required Components	All Staff
	▪ Medication Administration	Program Manager, LCAS, LCAS-A, LCSW, LCSW-

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Time Frame	Training Required	Who
		A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant, Support Staff
Within **90 calendar days** of hire to provide service	▪ Pregnancy and Substance Use Disorders* ▪ Protocols for Accessing Medical Services for Prenatal Care, Labor, and Delivery ▪ Reproductive Planning and Health Education	All Staff
	▪ Child Development and Positive Parenting ▪ Family Therapy* ▪ ASAM Criteria* ▪ Trauma informed care* ▪ Co-occurring conditions* ▪ PCP Instructional Elements	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, CADC, CADC-I, Registrant,
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing*	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A, , CADC-I, Registrant
	▪ Community Case Management	Program Director, Program Manager, LCAS, LCAS-A, LCSW, LCSW-A, LCMHC, LCMHC-A, LMFT, LMFT-A CADC, CADC-I, Registrant, Support Staff
Annually	▪ Continuing education in evidence-based treatment practices, which must include	All Staff

Time Frame	Training Required	Who
	trauma informed care, co-occurring conditions, and cultural competency*	

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 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), North Carolina Social Work Certification and Licensure Board (NCSWCLB), American Psychological Association (APA), and Motivational Interviewing Network of Trainers (MINT).

Documentation of training activities must be maintained by the provider.

E. Population Specific Expected Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments, medical evaluations, and meeting the identified goals in the beneficiary's PCP. Expected outcomes include, but are not limited to:

a. Initiation or restoration of the recovery process;
b. Improved parenting skills and interactions;
c. Increased understanding of child development;
d. Increase in and use of independent living skills;
e. Development or improvement of vocational skills;
f. Preparation for ongoing recovery in the ASAM continuum of care;
g. Coordination of care and transfer to a lower ASAM level of care;
h. Sustained improvement in health and psychosocial functioning;
i. Reduction in any psychiatric symptoms if present;
j. Increased involvement in activities and behaviors that support physical health;
k. Decreased or improved interaction with the justice system; and
l. Reduction in the risk of relapse.