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 Behavioral Health Services
8A-1: Assertive Community Treatment (ACT)
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-2: Residential Treatment Services
8G: Peer Support Services

1.0 Description of the Procedure, Product, or Service

Clinically Managed Residential Withdrawal Management Service is an organized facility-based service that is delivered by trained staff who provide 24-hour supervision, observation, and support for a beneficiary who is intoxicated or experiencing withdrawal. This an American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.2 WM service intended for a beneficiary who is not at risk of severe withdrawal symptoms or severe physical and psychiatric complications. Moderate withdrawal symptoms can be safely managed at this level of care.

This service emphasizes the utilization of peer and social supports to safely assist a beneficiary through withdrawal. Programs must have established clinical protocols developed and supported by a physician who is available 24 hours a day. Support systems must include direct coordination with other levels of care. This service is designed to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

1.1 Definitions

Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar):
Defined as a tool used to assess an individual's alcohol withdrawal.

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*);
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 Residential Withdrawal Management Services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

2.2 Special Provisions

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

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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

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

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

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does not eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

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

a. has a substance use disorder (SUD) diagnosis as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; and

b. meets American Society of Addiction Medicine (ASAM) Level 3.2 WM Clinically Managed Residential Withdrawal Management Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

3.2.2 Medicaid Additional Criteria Covered

Admission Criteria

A comprehensive clinical assessment (CCA) or diagnostic assessment (DA) is not required before admission to Clinically Managed Residential Withdrawal Management Services.

An initial abbreviated assessment must be completed by clinical staff and protocols must be developed and in place to determine when a physical exam must be conducted by a physician or physician extender.

The initial abbreviated assessment must be used to establish medical necessity for this service and develop a service plan as a part of the admission process. If a beneficiary is not able to fully cooperate with all elements of the initial abbreviated assessment upon admission, the provider may take up to 24 hours to fully complete all elements. At admission, the provider must ensure and document that the beneficiary is medically appropriate to remain at this level of care or determine if a higher level of care is necessary.

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

a. beneficiary's presenting problem;

b. beneficiary's needs and strengths;

c. a substance-related disorder diagnosis when the assessment is completed by a licensed clinician;

d. an ASAM level of care determination;

e. a physical examination including pregnancy testing, as indicated, performed by a physician or physician extender, if self-administered withdrawal management medications are to be used;

f. an addiction-focused history; and

g. other evaluations or assessments.

Within three (3) calendar days of admission, a CCA or DA must be completed by a licensed clinician to determine an ASAM level of care for discharge planning. The ASAM level of care determination must provide information on how this score is supported under each of the six ASAM dimensions. Information from the abbreviated assessment may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and be included in the treatment or service plan.

The licensed clinician can bill separately for the completion of the CCA or DA. Any laboratory or toxicology tests completed for the CCA or DA can be billed separately.

3.2.3 Continued Stay and Discharge Criteria

a. The beneficiary meets the criteria for continued stay if any ONE of the following applies:
    1. The beneficiary's withdrawal symptoms have not been sufficiently resolved to allow either discharge to a lower level of care or safe management in a less intensive environment; or
    2. The beneficiary's CIWA-Ar score (or other comparable standardized scoring system) has not increased or decreased.

b. The beneficiary meets the criteria for discharge if any ONE of the following applies:
    1. The beneficiary's withdrawal signs and symptoms are sufficiently resolved so that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical withdrawal management monitoring;
    2. The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system) indicating a transfer to a more intensive level of withdrawal management services is indicated;
    3. The beneficiary is unable to complete withdrawal management in Clinically Managed Residential Withdrawal Management service indicating a need for more intensive services; or
    4. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

Note: Each of the six dimensions of the ASAM criteria (refer to **section 1.1**) 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.

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 attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of Clinically Managed Residential Withdrawal Management Services staff, which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified on the beneficiary's service plan;
i. Services provided to children, spouse, parents, or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the service plan;
j. Payment for room and board; and
k. A beneficiary under the age of 18.

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

a. Residential levels of care;
b. Other 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;
j. Peer Support Services;
k. Mobile Crisis Management (MCM);
l. Partial Hospitalization; and
m. Facility Based Crisis (Adult)

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 by a physician or physician extender, consistent with 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 current episode of care if multiple episodes of care are required within a twelve (12) month period.

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.

ALL the following apply to a service order:

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

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, 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 are documented over and above the minimum frequency requirement.

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. Service notes must meet the requirements of the Department of Health and Human Services (DHHS) Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (c)(4) 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 appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Clinically Managed Residential Withdrawal Management Services must be delivered by a provider employed by a substance use treatment 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 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 calendar 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 .3200 Social Setting Detoxification for Substance Abuse 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	**Medical Director** shall be a licensed physician in good standing with the NC Medical Board. Medical Director shall have at least one year of experience working with a beneficiary with SUD.	The **Medical Director** is responsible for ensuring the provision of medical services, including supervision of the physician extender staff, according to the physician approved policies and protocols of the Clinically Managed Residential Withdrawal Management Program. The Medical Director shall ensure the evaluation, prescription, and monitoring of all medications currently being taken by the beneficiary, including coordination with other prescribers. In addition, the Medical Director is responsible for ensuring the monitoring of the Controlled Substance Reporting System (CSRS). The Medical Director shall be available for emergency medical consultation services 24 hours a day, seven days a week, either for direct consultation or for consultation

Required Position	Minimum Qualifications	Responsibilities
		with the physician extender, in-person, via telehealth or telephonically
Physician Extender	**Physician Assistant (PA) or Nurse Practitioner (NP)** Licensed Physician Assistant or Nurse Practitioner in good standing with the NC Medical Board or NC Nursing Board, respectively.	The **Physician Extender** is responsible for providing medical services according to the physician approved policies and protocols of the Clinically Managed Residential Withdrawal Management program. The Physician Extender shall evaluate, prescribe, and monitor all medications currently being taken by the beneficiary including coordination with other prescribers. The physician extender may provide coverage for emergency medical consultation services 24 hours a day, seven days a week, in-person, via telehealth or telephonically. The Medical Director shall fulfill these responsibilities if a Physician Extender is not included in the staffing for this program.
Program Manager	**Qualified Professional in Substance Abuse (QP)** according to 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulations. 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** shall be responsible for general oversight of the program, to include ensuring staffing and supervision is in place, managing admission and discharges, and ensuring the program is adhering to the policy, rules, and statutes. The Program Manager shall be available for emergency program oversight responsibilities 24 hours a day, seven days a week, in-person, via telehealth, or telephonically.
Licensed Clinical Staff	**Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)**	The **Licensed Clinical Addictions Specialist or Licensed Clinical Addictions Specialist-Associate** is responsible for providing substance use focused and co-occurring assessment services, developing an ASAM Level of Care determination and providing referral and coordination to substance use disorder treatment and recovery resources. The LCAS or LCAS-A provides clinical program

Required Position	Minimum Qualifications	Responsibilities
	Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	supervision to the Certified Alcohol and Drug Counselors (CADC).
Certified Clinical Staff	**Certified Alcohol and Drug Counselor (CADC)** shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board.	The **Certified Alcohol and Drug Counselor (CADC)** coordinates with the LCAS or LCAS-A 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. 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 the Licensed Clinical Staff when Certified Clinical Staff are not included in the staffing for this program.
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.	**Certified Peer Support Specialist (CPSS)** provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries.
Support Staff	**Paraprofessional, Associate Professional (AP), or Qualified Professional in Substance Abuse (QP)** according to 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulations.	**Support Staff** are responsible for tasks that ensure the beneficiary is clinically able to receive support at this level of care. Support Staff work closely with clinical staff to ensure monitoring is completed and recorded, and with clinical staff to support the provision of recovery-oriented interventions.

Clinical staff (LCAS, LCAS-A, or CADC) shall be available seven (7) days a week for clinical interventions. Certified Peer Support Specialist services shall be available seven (7) days a week to support recovery-related activities.

A minimum of two (2) staff shall be on-site at all times and the staffing ratio must be at least one (1) staff to nine (9) beneficiaries.

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

6.3 Program Requirements

a. Clinically Managed Residential Withdrawal Management Service is an organized facility-based service that is provided by trained clinicians who provide clinically supervised evaluations, and certified staff and paraprofessionals who provide withdrawal management and referral services. Staff refer for medical evaluation if clinically necessary. A beneficiary eligible for this service is experiencing signs of intoxication and withdrawal and the symptoms are sufficiently severe to require 24-hour structure and support, but do not require extensive medical or nursing care. This service is designed to safely assist the beneficiary through withdrawal without the need for immediate on-site access to medical personnel.

b. Protocols, developed and supported by a Medical Director knowledgeable in addiction medicine, must be in place to determine the nature of the medical interventions that may be required. Protocols must include under what conditions physician care is warranted and when transfer to a medically monitored facility or an acute care hospital is necessary.

c. Clinically Managed Residential Withdrawal Management Service providers shall have staff to screen and accept admissions a minimum of twelve (12) hours a day, seven (7) days a week. At least five (5) of these twelve (12) hours must occur during second shift. The Clinically Managed Residential Withdrawal Management Services Medical Director shall develop agency specific policies and procedures that address admission expectations, how the intake process must be handled, and staffing expectations to include back-up and consultation coverage.

d. Clinically Managed Residential Withdrawal Management Service providers shall provide access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) covered by the Medicaid formulary for the beneficiary that meets medical necessity for that service. MAT may be administered by the provider, or through a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) with another provider that is no further than 60 minutes from the facility.

e. Clinically Managed Residential Withdrawal Management Service 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.

f. Components of this service include the following:
   1. A CCA or DA within three (3) calendar days of admission;
   2. An initial abbreviated assessment at admission;
   3. A physical examination, to be completed by a physician or physician extender, when clinically indicated;
   4. Assessment for co-occurring medical and psychiatric disorders;
   5. Individualized service plan, including problem identification in ASAM, Third Edition dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
   6. Daily assessment of progress during withdrawal management and any treatment changes;
   7. Provide monitoring of the beneficiary, to include the beneficiary's general condition and vital signs (pulse rate, blood pressure and temperature) based on documented severity of signs and symptoms of withdrawal;
   8. Provide 24-hour access to emergency medical consultation services;
   9. Provide behavioral health crisis interventions, when clinically necessary;
   10. Ability to arrange for laboratory and toxicology tests, which can be point-of-care testing;
   11. Staff supervision of self-administered medications for the management of withdrawal, as needed;
   12. Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
   13. Health education services, based on the needs of the beneficiary;
   14. Reproductive health planning education, and referral to external partners based on the needs of the beneficiary;
   15. Provide clinical services, including individual and group counseling, to enhance the beneficiary's understanding of addiction, the completion of the withdrawal management process, and referral to a level of care for continuing treatment;
   16. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
   17. Arrange involvement of family members or others to provide education on and engagement in the withdrawal management process, based on the needs of the beneficiary, with informed consent;
   18. Ability to assist in accessing transportation services for a beneficiary who lacks safe transportation;
   19. Coordination with psychiatric or psychological consultation and supervision, as indicated, to ensure appropriate management of biomedical, emotional, behavioral, and cognitive problems that can be safely managed in this level of care;
   20. Linkage and coordination with care management services and supports;

21. Inform the beneficiary about benefits, community resources, and services; this can be done directly or by linkage to organizations which can directly provide this information;
22. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals for counseling, medical, psychiatric, and continuing care; and
23. Discharge and transfer planning, beginning at admission.

g. This facility must be in operation 24 hours a day, seven (7) days a week. The facility must have a physician available to provide medical evaluations and consultation 24 hours a day, according to treatment and transfer practice protocols and guidelines. The physician and physician extender shall have the availability to schedule and provide medical evaluations per policy requirements. This service must be available for admission seven (7) days per week. Program medical staff shall be available to provide 24-hour access for emergency medical consultation services. Staffing ratios must not exceed 1:9, one direct care staff to nine beneficiaries.

6.4 Staff Training Requirements

Time Frame	Training Required	Who
Prior to service delivery	▪ Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Crisis Response ▪ Harm Reduction ▪ Clinically Managed Residential Withdrawal Management Service Definition Required Components	All Staff
Within **90 calendar days** of hire to provide service	▪ Medically supervised withdrawal management including assessing and managing intoxication and withdrawal states ▪ Pregnancy, Substance Use Disorder and Withdrawal Management	Physician, Physician Extender
	▪ Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, Treatment and Monitoring of the Condition and Facilitation into Ongoing Care ▪ Pregnancy, Substance Use Disorder and Withdrawal Management	Program Manager, LCAS, LCAS-A, CADC, CPSS, Support Staff
	▪ ASAM Criteria	Program Manager, LCAS, LCAS-A, CADC
	▪ 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.) ▪ Medication Administration	Program Manager, LCAS, LCAS-A, CADC, Support Staff

Time Frame	Training Required	Who
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing* (MI)	Program Manager, LCAS, LCAS-A, CADC,
	▪ Trauma informed care* ▪ Co-occurring conditions*	Program Manager, LCAS, LCAS-A, CADC, CPSS, 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 for the population being served was completed no more than 48 months prior to 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 for original effective date.**

Training identified with an asterisk (*) must be reviewed and approved by a NC DHHS recognized accreditation entity (e.g., Commission on Accreditation of Rehabilitation Facilities), or 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 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 service plan. The expected outcomes are the following:

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

7.0 Additional Requirements

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

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Federally recognized tribal and IHS providers may be exempt from one or more of these items in accordance with Federal law and regulations. All providers shall be in compliance with 42 CFR Part 2- Confidentiality of Substance Use Disorder Patient Records.

8.0 Policy Implementation and History

Original Effective Date: January 1, 2026

History:

Date	Section or Subsection Amended	Change
01/01/2026	All Sections and Attachment(s)	New Clinical Coverage Policy for Clinically Managed Residential Withdrawal Management Services

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.

Note: 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 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
H0011	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.

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

F. Place of Service

This is a facility-based service.

G. Co-payments

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

H. Reimbursement

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

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 Withdrawal Management Service.

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