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.

Table of Content

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
8B, ASAM Level 4, Medically Managed Intensive Inpatient Services
8B, ASAM Level 4WM, Medically Managed Intensive Inpatient Withdrawal Management
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 Low-Intensity Residential Treatment Services, American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.1 is provided in a 24-hour, seven (7) day a week community based residential setting. This structured and supportive setting provides clinical and recovery services. This service is designed to treat a beneficiary experiencing functional limitations due to their substance use disorder (SUD). Functional limitations include:

1. problems in the application of recovery skills;
2. self-efficacy; and
3. lack of connection to the community systems of work, education, or family life.

This service provides the beneficiary the opportunity to:

1. develop and practice interpersonal and group living skills;
2. strengthen their recovery skills;
3. reintegrate into the community and family settings; and
4. experience employment or academic pursuits.

Clinical and recovery services are characterized by individual, group, and family therapy, medication management, and psychoeducation.

1.1 Definitions

The ASAM Criteria, Third Edition

The American Society of Addiction Medicine (ASAM) 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 can become retroactively eligible for Medicaid while receiving covered services.

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

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

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

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

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

b. meets the American Society of Addiction Medicine (ASAM) Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

3.2.2 Medicaid Additional Criteria Covered

Admission Criteria

Clinically Managed Low-Intensity Residential Treatment Services requires a comprehensive clinical assessment (CCA) or a diagnostic assessment (DA) to be completed prior to admission.

These assessments must confirm that the beneficiary has a SUD diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. These assessments must also confirm that the beneficiary meets ASAM Criteria, Third Edition, Level 3.1.

The assessment must be updated as new strengths and barriers are observed in the residential setting. Relevant diagnostic information must be obtained and documented in the Person-Centered Plan (PCP). The beneficiary must have documentation of a physical examination that was completed no more than 90 days prior to admission to Clinically Managed Low-Intensity Residential Treatment Services. If no prior physical examination documentation is available, a physical examination must be completed within the first 45 days of admission.

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

The completion of the CCA, DA, laboratory, or toxicology tests can be billed separately.

3.2.3 Continued Stay Criteria and Discharge Criteria

Each of the six dimensions of the ASAM criteria, as referenced in section 1.1 of this policy, 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
   3. The beneficiary is not making progress, 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 articulated in the PCP, resolving the symptoms(s) that justified admission to the present level of care. Continuing the chronic disease management of the beneficiary's condition at 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. Despite amendments to the PCP, 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 that limit the ability to alleviate the beneficiary's symptom(s). An updated CCA or DA indicates transfer to a different level of care is needed; or
4. The beneficiary or their legally responsible person requests a discharge from Clinically Managed Low-Intensity 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 the following:

a. transportation for the beneficiary or family members;
b. any habilitation activities;
c. time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill assistance;
d. clinical and administrative supervision of Clinically Managed Low-Intensity Residential Treatment Services staff, which is covered as an indirect cost and part of the rate;
e. covered services that have not been rendered;
f. childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. services provided to teach academic subjects or as a substitute for education;
h. interventions not identified on the beneficiary's PCP;
i. services provided to children, spouse, parents, or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the PCP; and
j. payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for Clinically Managed Low-Intensity Residential Treatment Services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations and Requirements

5.3.1 Additional Limitations

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

a. Clinically managed residential services
b. Clinically Managed Residential Withdrawal Management (ASAM Criteria, Level 3.2 WM)
c. Medically Monitored Inpatient Withdrawal Management (ASAM Criteria, Level 3.7 WM)
d. Clinically Managed Population-Specific High-Intensity Residential Programs (ASAM Criteria, Level 3.3)
e. Clinically Managed High-Intensity Residential Services (ASAM Criteria Level, 3.5)
f. Medically Monitored Intensive Inpatient Services (ASAM Criteria Level, 3.7)
g. Substance Abuse Comprehensive Outpatient Treatment (SACOT);
h. Assertive Community Treatment (ACT); or
i. 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 Low-Intensity Residential Treatment Services, for the first and last 30 days, according to the beneficiary's Person-Centered Plan (PCP) and the clinical coverage policies.

A beneficiary may receive Peer Support Services during the same episode of care as Clinically Managed Low-Intensity Residential Treatment Services.

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 Low-Intensity Residential Treatment 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 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 permitted;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date that 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 shall not 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.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy.

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

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 (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.

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

6.2 Provider Certifications

Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Program Manager	**Qualified Professional in Substance Abuse (QP),** in accordance with 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** is responsible for general oversight of the program and supervision of the staff. The Program Manager ensures adequate staffing is in place, manages admissions and discharges, and ensures the program is adhering to the policy, rules, and statutes. The Program Manager, or designee is responsible for ensuring there is 24-hour, seven day a week access to on-call staff who can provide immediate support, in person, via telehealth, or telephonically. This position shall develop program policies and procedures to include secure transportation and storage of any medications administered for Medication Assisted Treatment (MAT).
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; or Be a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Social Worker Associate (LCSWA) with a valid license from the NC Social Work Certification and Licensure Board; or Be a Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Clinical Mental Health Counselor (LCMHCA) with a valid license from the NC Board of Licensed Clinical Mental Health Counselors; or	**The Licensed Clinical Staff** provides substance use focused and co-occurring assessment and treatment services and develops an ASAM Level of Care determination. The Licensed Clinical Staff shall provide referral and coordination to appropriate substance use disorder treatment and recovery resources and develop a PCP. The Licensed Clinical Staff provides clinical program supervision to the Certified Clinical Staff.

	Be a Licensed Marriage and Family Therapist (LMFT) or Licensed Marriage and Family Therapist Associate (LMFTA) with a valid license from the NC of Marriage and Family Therapy Licensure Board; or Be a Licensed Psychologist with a valid license from the NC Psychology Board; AND Meet criteria of a Qualified Professional (QP) in Substance Abuse in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation(s).	
Certified Clinical Staff (may be substituted with LCAS or LCAS-A at the discretion of the provider)	**CADC, CADC-I, Registrant (Alcohol and Drug Counselor)*** Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board (NCASPPB). *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 **Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor (CADC-I), or Registrant*** coordinates with the Licensed Clinical Staff and Program Manager to deliver and ensure that a beneficiary has access to counseling supports, psychoeducation, and crisis interventions. Certified clinical staff will participate in the development of the PCP, relapse prevention plan and disease management strategies. They 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.

Support Staff	**Paraprofessionals, Associate Professionals (AP), or Qualified Professional in Substance Abuse (QP),** in accordance with 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulations.	**Support Staff** are responsible for tasks that ensure a beneficiary has 24 hour a day, seven (7) day a week access to supports to meet their behavioral health and physical needs. They work closely with clinical staff to support and monitor the acquisition of new skills, ensure basic daily needs and activities of daily living are completed and recorded, and support recovery oriented interventions. Support Staff may coordinate with the beneficiary's primary physician when needed.
Health Services Coordinator	At minimum, shall be a Paraprofessional. Shall have a current NC driver's license.	**The Health Services Coordinator** organizes and coordinates MAT appointments for a beneficiary receiving Clinically Managed Low-Intensity Residential Treatment Services. The Health Services Coordinator-organizes and coordinates physical health and specialist appointments to ensure that a beneficiary is able to access needed physical health care services without disrupting treatment. The Health Services Coordinator facilitates transportation to and from scheduled MAT, physical health, and specialist appointments. This position 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 Manager to ensure information regarding MAT is reflected in the beneficiary's PCP and clinical record. The Health Services MAT 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, and provider contact information. The Health Services Coordinator ensures release of information forms are completed and filed.

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

6.3 Program Requirements

a. Clinically Managed Low-Intensity Residential Treatment Services are provided in a 24-hour licensed facility in accordance with 10A NCAC 27G .5600 Supervised Living for Individuals of all Disability Groups. Clinically Managed Low-Intensity Residential Treatment Services shall provide a minimum of at least five (5) hours of clinically directed program activities per week. The beneficiary receiving this service can attend work, school, and substance use or behavioral health treatment services.
b. Clinically Managed Low-Intensity Residential Treatment Services programs shall support a beneficiary who is prescribed medications to address their substance use or mental health diagnosis. Coordination of care with the prescribing physician or physician extender is required.
c. Clinically Managed Low-Intensity Residential Treatment providers shall ensure access to Medication Assisted Treatment (MAT) covered by the Medicaid formulary. 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.
d. Clinically Managed Low-Intensity Residential Treatment Services providers shall ensure that all programs have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist on site. Providers shall ensure that all staff have training and education on the use of naloxone in suspected opioid overdoses. Providers shall develop policies that detail the use, storage and education provided to staff regarding naloxone.
e. A comprehensive clinical assessment (CCA) or reassessment must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Relevant diagnostic information must be obtained and documented in the beneficiary's PCP.
f. Clinically Managed Low-Intensity Residential Treatment Services include the following:
    1. A CCA or DA completed prior to 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, needs, strengths, skills, and priority formulation of short-term goals and preferences, and activities designed to achieve those goals;

4. At least 5 hours of planned and professionally directed clinical program activities, including individual, group and family counseling and therapy, case management, and other recovery supports. Interventions are designed to improve 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. A range of evidence-based cognitive, behavioral, and other therapies that address primary substance use disorder as well as co-occurring substance use and mental health disorder;
6. Motivational enhancement and engagement strategies appropriate to the beneficiary's stage of readiness and desire to change;
7. Trauma informed practices and interventions tailored to the specific population being served;
8. Monitor signs and symptoms of substance use, intoxication, and withdrawal, and the treatment of those conditions;
9. Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the beneficiary's PCP;
10. Medication education and addiction pharmacotherapy;
11. Regular monitoring of the beneficiary's adherence in taking any prescribed and over the counter medications;
12. Counseling and clinical interventions to facilitate teaching the skills needed for successful reintegration into family, community living, work, and school;
13. Educational skill building and occupational or recreational activities;
14. Reproductive planning and health education, including referral to external partners to access necessary services and supports;
15. Daily assessment of progress and any treatment changes, based on the beneficiary's PCP goals;
16. Behavioral health crisis interventions, when clinically appropriate;
17. Arrange for the involvement of family members or significant others to provide education on and engagement in the treatment process, with informed consent;
18. Direct coordination with the justice system and Department of Social Services, when the beneficiary has current involvement with either of these systems;
19. Affiliation with other ASAM levels of care, or close coordination through referral to more and less intensive levels of care and other services such as:
    a. medical, clinical, familial, and ancillary services;
    b. intensive outpatient treatment;
    c. vocational assessment and placement;
    d. literacy training and adult education;
    e. behavioral health providers;
    f. Medication Assisted Treatment providers;
    g. psychological and psychiatric consultation; and
    h. supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
20. Care coordination and care management for linkage and referrals for counseling, as well as medical, psychiatric, and continuing care;
21. Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications;

22. Ability to arrange for needed procedures including indicated lab and toxicology tests, as medically necessary; and
23. Discharge and transfer planning beginning at admission.

6.4 Staff 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 Low-Intensity Residential Treatment Services Definition Required Components	All Staff
Within **90 calendar days** of hire to provide service	▪ ASAM Criteria ▪ PCP Instructional Elements ▪ Designated therapies, practices or modalities used in Clinically Managed Low-Intensity Residential Treatment Services* ▪ Reproductive Planning and Health Education	All Staff
Within **180 calendar days** of hire to provide this service	▪ Trauma informed care* ▪ Co-occurring conditions* ▪ Introductory Motivational Interviewing*	All Staff
Annually	▪ Continuing education in evidence-based treatment practices including crisis response and cultural competency training*	All Staff

The initial training requirements may be waived by the hiring agency if the staff can produce documentation certifying that training 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. Documentation of staff training activities must be maintained by the program.

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).

6.5 Expected Outcomes

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

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

7.0 Additional Requirements

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

7.1 Compliance

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

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

Note: 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: January 1, 2026

History:

Date	Section or Subsection Amended	Change
01/01/2026	All Sections and Attachment(s)	Initial implementation of stand-alone Clinically Managed Low-Intensity Residential Treatment Services policy.

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 laws and regulations.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

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
H2034	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 Indian Health Service providers may be entitled to alternate reimbursement methodologies under federal law and regulations.

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

F. Place of Service

This is a facility-based service.

G. Co-payments

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

H. Reimbursement

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

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

The CCA, DA, toxicology testing, psychiatric and medical services, and medically necessary peer support services can be billed separately from Clinically Managed Low-Intensity Residential Treatment Services.