To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available, 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
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1.0 Description of the Procedure, Product, or Service

Clinically Managed Population Specific High-Intensity Residential Program is a therapeutic rehabilitation service delivered by trained and experienced medical and nursing professionals, as well as clinical and support staff. This service is for a beneficiary with both substance use disorder (SUD) and traumatic brain injury (TBI). This is an American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.3 service that provides a 24-hour structured recovery environment in combination with high-intensity clinical services.

This service is designed to meet the functional and cognitive limitations of a beneficiary and to support recovery from substance use disorders. The effects of the substance use disorder combined with the cognitive limitations are such that outpatient or other levels of residential care are not feasible or effective. This treatment service focuses on overcoming a lack of awareness or ambivalence about the effects of addiction and preventing relapse. The service also focuses on promoting reintegration into the community.

1.1 Definitions

Traumatic Brain Injury (TBI)

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

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

The ASAM Criteria, Third Edition

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

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

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.

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

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

Medicaid shall cover Clinically Managed Population Specific High-Intensity Residential Program services when the beneficiary meets the following specific criteria:

a. has a current substance use disorder (SUD) diagnosis as defined by the 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 3.3 Clinically Managed Population Specific High-Intensity Residential Program admission criteria as defined in The ASAM Criteria, Third Edition, 2013;
c. has a documented diagnosis of TBI as defined in **Section 1.1**; and
d. is able to actively engage in treatment services with identified support according to their Person-Centered Plan.

3.2.2 Medicaid Additional Criteria Covered

Admission Criteria

Clinically Managed Population Specific High Intensity Residential Treatment Services requires that an initial abbreviated assessment be conducted by a physician as a part of the admission process. This initial abbreviated assessment establishes medical necessity for this service in the development of a Person-Centered Plan (PCP).

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

a. the beneficiary's presenting problem;

b. the beneficiary's needs and strengths;

c. a provisional or admitting diagnosis;

d. an ASAM level of care determination;

e. a physical examination, including pregnancy testing, as indicated, performed by a physician or physician extender within 24 hours of admission, along with medically necessary laboratory and toxicology tests;

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

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

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

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

A Registered Nurse (RN) shall conduct an alcohol or other drug-focused nursing assessment at the time of admission. The RN is responsible for monitoring the beneficiary's progress and medication administration.

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

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

3.2.3 Continued Stay 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 service to meet additional goals;
   2. The beneficiary is making progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated;
   3. The beneficiary is not making progress, is regressing, or new problems have been identified and the beneficiary has the capacity to resolve the problems; or
   4. The beneficiary is actively working towards goals, so continuing at the present level of care is indicated, 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 positive life outcomes that support stable and ongoing recovery;
   2. The beneficiary's admitting signs and symptoms have failed to respond to treatment, and have intensified, indicating a transfer to a more intensive level of residential care is indicated;
   3. The beneficiary is not making progress, or is regressing, and all realistic treatment options have been exhausted indicating a need for more intensive services; or
   4. The beneficiary or their legally responsible person requests discharge from the Clinically Managed Population Specific High-Intensity Residential Program.

4.0 When the Procedure, Product, or Service Is Not Covered

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

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

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 Population Specific High-Intensity Residential Program staff, which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified on the beneficiary's PCP;
i. Services provided to children, spouse, parents, or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the PCP; and
j. Payment for room and board.

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 Population Specific High-Intensity Residential Program 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 Population Specific High Intensity Residential Program services from only one provider organization during any active episode of care. Clinically Managed Population Specific High-Intensity Residential Program services must not be provided and billed on the same day (except day of admission or discharge) as:

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

The case management component of Assertive Community Treatment (ACT) or Community Support Team (CST) may be billed concurrently with Clinically Managed Population Specific High-Intensity 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 Population Specific High-Intensity Residential Program provider. Outpatient therapy services 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 the 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 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 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 when 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 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 that require additional activities or interventions must be 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 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 Population Specific High-Intensity Residential Program 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 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 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 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.

6.2 Provider Certifications

Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Medical Director	**Physician** Shall be a licensed physician and in good standing with the NC Medical Board. Shall have at least one year of experience working with a beneficiary with SUD. Shall have experience working with a beneficiary with TBI.	The **Medical Director** is responsible for providing medical services including evaluating, prescribing, and monitoring all medications currently being taken by the beneficiary. The Medical Director coordinates with off-site prescribers and monitors the controlled substance reporting system (CSRS). The Medical Director shall supervise the nursing staff according to the physician approved policies and protocols of the Clinically Managed Population Specific High-Intensity Residential Program.

		The Medical Director shall be available for emergency medical consultation services 24 hours a day either for direct consultation or for consultation with the nursing staff, in person, via telehealth, or telephonically.
Nursing Staff	**Supervising Registered Nurse (RN),** **Licensed Practical Nurse (LPN),** **and Certified Nursing Assistant (CNA)** The **Supervising Registered Nurse (RN)** shall have at least one year of experience working with adults with a substance use disorder. The Supervising RN shall hold active licensure as a RN and be in good standing with the NC Board of Nursing (NCBON). Additional nurses can be Licensed Practical Nurses (LPN), RNs, or Certified Nursing Assistants (CNA) working within their scope of practice, holding active licensure and in good standing with the NCBON. Supervision of the LPN and CNA shall be conducted by a RN or physician and the supervisor shall be on site or continually available to the LPN and CNA whenever providing beneficiary care. Continuous availability is the ability to be available by phone immediately, physically arrive within one hour, and be present on site in	The **Supervising Registered Nurse** is responsible for maintaining an adequate level of nursing for the program's dispensing and medical operations under the supervision of the Medical Director, either through direct provision of the function or through ensuring provision by other staff within their scope and function. The Nursing Staff shall provide assessment, planning and evaluation of the beneficiary's progress during withdrawal management and ensure any necessary treatment changes. The Nursing Staff shall maintain a medication inventory record and log in compliance with state regulations and provide documentation in the beneficiary's service record of all nursing activities related to beneficiary care.

	a timely manner, as much as needed, to address beneficiary assessment and care needs.	
Program Director	**Certified Brain Injury Specialist (CBIS) or Certified Brain Injury Specialist Trainer (CBIST)** Shall be certified or obtain the CBIS certification from the Brain Injury Association of America within one year from date of hire.	The **Program Director** shall be responsible for general oversight of the program. The Program Director provides staff supervision and promotes best practices when working with a beneficiary with a traumatic brain injury. The Program Director shall coordinate with the Medical Director ensuring the program adherence to the policy, rules, and statutes. The Program Director is responsible for ensuring there is 24-hour seven day a week access to on-call staff who can provide immediate support to facility staff supporting a beneficiary experiencing a behavioral crisis, either in person, via telehealth, or telephonically.
Licensed Clinical Staff	**Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)** Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	The **Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)** is responsible for providing substance use focused and co-occurring assessment and treatment services and developing an ASAM Level of Care determination. The LCAS or LCAS-A shall provide referral and coordination to appropriate substance use disorder treatment and recovery resources and develop a PCP. The LCAS or LCAS-A provides clinical program supervision to the Certified Alcohol and Drug Counselors (CADC). A LCAS or LCAS-A shall be available seven days a week for clinical interventions.
Clinical Staff	**LCAS, LCAS-A, LCSW, LCSWA, LMFT, LMFTA, LCMHC, LMHCA, CADC, CADC-I,** Shall be certified or licensed and in good standing with the NC Addictions Specialist	The **Licensed Clinical Addictions Specialist (LCAS), Licensed Clinical Addictions Specialist-Associate (LCAS-A), Licensed Clinical Social Worker (LCSW), Licensed Clinical Social Worker Associate (LCSWA), Licensed Marriage and Family Therapist (LMFT), Licensed Marriage and Family Therapist Associate (LMFTA),**

	Professional Practice Board, NC Social Work Certification and Licensure Board, NC Board of Licensed Clinical Mental Health Counselors, or NC Marriage and Family Therapy Licensure Board.	**Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor Intern (CADC-I)** coordinates with the LCAS or LCAS-A and Program Director in PCP development and implementation to ensuring the beneficiary has access to counseling, relapse prevention supports, psychoeducation, and crisis interventions. They play a lead role in coordinating services with care management and other care coordination entities. The Clinical Staff shall be available seven days a week for clinical interventions. 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. Shall have experience working with a beneficiary with traumatic brain injury.	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.

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, 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.
Support Staff	**Paraprofessionals (PP), Associate Professionals (AP), or Qualified Professional in Substance Abuse (QP)** in accordance with 10A NCAC 27G .0104 or equivalent federally	**Support Staff** are responsible for tasks that ensure the beneficiary is medically able to receive support at this level of care. Support Staff work closely with medical staff to ensure monitoring is completed and recorded, and with clinical staff to support the provision of recovery-oriented interventions.

	recognized tribal code or federal regulations.	

A minimum of two (2) staff shall be on-site at all times when a beneficiary is present. Programs shall develop and adhere to staffing ratio policies that consider the number of beneficiaries currently residing in the program and their level of acuity, to ensure health, safety, and the 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.)."

6.3 Program Requirements

a. Program policies, procedures, and protocols, developed and supported by the Medical Director and Program Director, must be in place to determine the nature of the medical interventions that may be required. Protocols must include the conditions physician care is warranted, and when transfer to a medically monitored facility or an acute care hospital is necessary. The physical and environmental layout of the residential program must meet the unique needs of a beneficiary with traumatic brain injury (lighting, volume and noise level, privacy considerations). Protocols must ensure secure transportation, and the storage of medications administered for Medication Assisted Treatment.

b. Clinically Managed Population Specific High-Intensity Residential Program providers shall be staffed to screen and accept admissions a minimum of eight (8) hours a day, five (5) days a week. The Clinically Managed Population Specific High-Intensity Residential Medical Director and Program Director shall develop agency specific policies and procedures that address:

1. admission expectations;
2. how the intake process is handled; and
3. staffing expectations to consist of back-up and consultation coverage.

c. 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. Providers shall develop policies that detail the use, storage and education provided to staff regarding naloxone.

d. The facility shall operate 24 hours a day, seven (7) days a week. The facility shall have a physician available to provide consultation 24 hours a day, according to treatment and transfer practice protocols and guidelines. This service must be available for admission five days per week. Program medical staff as well as staff trained to deliver crisis behavioral interventions shall be available to provide 24-hour access to emergency consultation services.

e. Components of this service include **ALL** of the following:

1. An initial abbreviated assessment consisting of an addiction focused history and physical examination completed at admission by the physician along with the completion of a traumatic brain injury assessment;
2. Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the treatment and monitoring of those conditions;
3. A CCA or DA within seven (7) calendar days of admission;
4. Person-Centered Plan completed within 30 calendar days, which contains the problem identification in ASAM dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
5. Daily clinical services to improve the beneficiary's ability to structure and organize daily living tasks and recovery, to include personal responsibility, personal appearance, punctuality, and family services;
6. Planned clinical program activities designed to stabilize and maintain the stability of addiction symptoms, such as relapse prevention, interpersonal and social relationships, daily living skill building, and the development of a social network supportive of recovery;
7. A range of cognitive, behavioral, and other therapies administered individually and in family and group settings. Therapies must be delivered in a manner that is slowly paced, concrete, and repetitive;
8. Providers shall ensure access to approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) for a beneficiary who 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;
9. Providers shall ensure access to a Level I or Level II trauma hospital no further than 45 minutes from the facility that meets the requirements of 10A NCAC 13P .0901 Level I Trauma Center Criteria or 10A NCAC 13P .0901 Level II Trauma Center Criteria (ncdhhs.gov);
10. Referrals to vendors that provide cognitive rehabilitation services when those services are clinically necessary;
11. Counseling and clinical monitoring to assist with successful initial involvement or reinvolvement in regular, productive daily activities;
12. Regular monitoring of the beneficiary's prescribed or over the counter medications or supplement adherence;
13. Daily scheduled addiction and co-occurring treatment services;
14. Clinical and didactic motivational interventions appropriate to the stage of readiness to change;
15. Daily assessment of progress and any treatment changes;
16. Monitoring of the health of the beneficiary, such as the beneficiary's general condition and vital signs (pulse rate, blood pressure and temperature);
17. Provide 24-hour access to emergency medical consultation services;
18. Provide behavioral health crisis interventions, when clinically necessary;
19. Arrange for laboratory and toxicology tests, which can be point-of-care testing;

20. Urine screens to shape behavior and reinforce treatment gains, when clinically necessary;
21. Provide education to the beneficiary regarding prescribed medications, potential drug interactions and side effects;
22. Health education services, including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis (TB), Hepatitis C, pregnancy and reproductive planning and other health education, including referral to external partners to access necessary services and supports;
23. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
24. Arrange for the involvement of family members or significant others, with informed consent;
25. Direct coordination with other levels of care, such as specialized medical, psychological, and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
26. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals for counseling, medical, psychiatric, and continuing care;
27. Linkage and coordination with care management or other case management services;
28. Inform the beneficiary about benefits, community resources, and services; and
29. Discharge and transfer planning beginning at admission.

6.4 Staff Training Requirements

Time Frame	Training Required	Who
Prior to Service Delivery	▪ Crisis Response, including supporting individuals with brain injury experiencing crisis* ▪ Opioid Antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Harm Reduction ▪ Clinically Managed Population Specific High-Intensity Residential Program Definition Required Components	All Staff
	▪ Medication Administration	RN, LPN, CNA, Program Director, LCAS, LCAS-A, LCSW, LCSW-A, LMFT, LMFT-A, LCMHC, LMHC-A, CADC, CADC-I
Within **90 calendar days**	▪ Substance Use and Traumatic Brain Injury Training	All Staff

Time Frame	Training Required	Who
of hire to provide service	▪ Behavioral and cognitive challenges associated with traumatic brain injury	
	▪ ASAM Criteria	Physician, Program Director, LCAS, LCAS-A, LCSW, LCSW-A, LMFT, LMFT-A, LCMHC, LMHC-A, CADC, CADC-I
	▪ Measuring Vital Signs (to include how to effectively and accurately obtain, record, and report the vital signs of temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, and pain.)	Program Director, LCAS, LCAS-A, LCSW, LCSWA, LMFT, LMFTA, LCMHC, LMHCA, CADC, CADC-I, Support Staff
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing*	Program Director, RN, LPN, CNA LCAS, LCAS-A, LCSW, LCSW-A, LMFT, LMFT-A, LCMHC, LMHC-A, CADC, CADC-I, CPSS, Support Staff
	▪ Trauma informed care* ▪ Co-occurring conditions*	Program Director, LCAS, LCAS-A, LCSW, LCSW-A, LMFT, LMFT-AA, LCMHC, LMHC-A, CADC, CADC-I, CPSS, Support Staff
Annually	▪ Crisis Response Training**,** including supporting individuals with brain injury experiencing crisis* ▪ Continuing education in evidence-based and promising treatment practices which must include crisis response training, cultural competency, substance use disorder and traumatic brain injury, and brain injury intervention strategies* ▪ Working with a beneficiary with TBI	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 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 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 PCP. Expected outcomes are as follows:

a. Sustained improvement in health and psychosocial functioning;
b. Development of compensatory strategies to increase the beneficiary's level of independence, self-sufficiency, and independent activities of daily living;
c. A reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors;
d. Increased use of peer support services to facilitate recovery and link the beneficiary to community-based peer support and mutual aid groups;
e. Linkage to treatment and other supportive services post discharge;
f. Increased links to community-based resources to address unmet needs; and
g. Reduction or elimination of psychiatric symptoms, if applicable.

7.0 Additional Requirements

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

7.1 Compliance

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

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
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.

Note: Federally recognized tribal and IHS providers may be exempt to one or more of these items according to 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 Population High-Intensity Residential Program 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 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.

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

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service

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

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

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

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

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