DRAFT

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:

8C- *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*
8B- *Inpatient Behavioral Health Services*
8A-10- *Clinically Managed Residential Withdrawal Services*
8A-7- *Ambulatory Withdrawal Management Without Extended On-Site Monitoring*
8A-8- *Ambulatory Withdrawal Management With Extended On-Site Monitoring*

1.0 Description of the Procedure, Product, or Service

Medically Monitored Inpatient Withdrawal Services is an organized inpatient substance abuse withdrawal management service. It is delivered by medical and nursing professionals and provides 24-hour medically directed observation, evaluation, monitoring, and withdrawal management in licensed inpatient facility. Services are delivered under a defined set of:

a. physician-developed and approved policies;
b. physician-monitored procedures; or
c. clinical protocols by medical professionals, clinicians, and support staff.

This is an American Society of Addiction Medicine (ASAM) Level 3.7-WM for beneficiaries whose withdrawal signs and symptoms are sufficiently severe to require 24-hour observation, monitoring, and treatment in a medically monitored inpatient setting. Beneficiaries at this level of care do not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

1.1 Definitions

Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR) is defined as a tool utilized to assess and individual's alcohol withdrawal.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC 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.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18

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.

Retroactively eligible beneficiaries are 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 Medically Monitored Inpatient Withdrawal Services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

b. NCHC

NCHC shall cover Medically Monitored Inpatient Withdrawal Services for an eligible beneficiary who is 18 years of age till he or she reaches their 19th birthday and meets the criteria in **Section 3.0** of this policy.

Retroactive eligibility does not apply to the NCHC program

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 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, 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/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who is not 18 years of age and does not meet the criteria within **Section 3.0** of this policy.

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 and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC shall cover Medically Monitored Inpatient Withdrawal Services when ALL the following criteria are met:

a. The beneficiary has a substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material **and**
b. The beneficiary meets American Society of Addiction Medicine (ASAM) Level 3.7 -WM Medically Monitored Inpatient Withdrawal Management admission criteria as defined in The ASAM Criteria, Third Edition, 2013 or any subsequent editions of this reference material.
c. The beneficiary must be at least 18 years of age.

3.2.2 Admission Criteria

a. A comprehensive clinical assessment (CCA) is not required before admission for Medically Monitored Inpatient Withdrawal Services.
b. The medical director, physician assistant, or nurse practitioner shall conduct an initial abbreviated assessment to establish medical necessity for this service and develop a service plan as a part of the admission process.
c. The initial abbreviated assessment must contain the following documentation in the service record:
    1. the beneficiary's presenting problem;
    2. the beneficiary's needs and strengths;
    3. a provisional or admitting diagnosis;
    4. a physical examination performed by the medical director, physician assistant, or nurse practitioner within 24 hours of admission, along with all appropriate laboratory and toxicology tests;
    5. a pertinent social, family, and medical history; and
    6. other evaluations or assessments as appropriate.
d. The physician, physician assistant, or nurse practitioner can bill an Evaluation and Management (E/M) code separately for the admission assessment and physical exam.

e. A licensed professional shall complete a comprehensive clinical assessment within three (3) calendar days of admissions to determine an ASAM level of care for discharge planning. The abbreviated assessment is used as part of the current comprehensive clinical assessment. Relevant diagnostic information obtained and becomes part of the treatment or service plan.

3.2.3 Continued Stay and Discharge Criteria

a. The beneficiary meets the criteria for continued say 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 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 to allow safe management in a less intensive environment, and the beneficiary can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring;
   2. The beneficiary has intensified symptoms increased CIWA-Ar score (or other comparable standardized scoring system) indicating a need for transfer to a more intensive level of withdrawal management services;
   3. The beneficiary is unable to complete withdrawal management at level 3.7-WM indicating a need for more intensive services; OR
   4. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

3.2.4 Medicaid Additional Criteria Covered

None apply.

3.2.5 NCHC Additional Criteria Covered

None apply.

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 and NCHC 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 both Medicaid and NCHC

None apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid and Health Choice 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 Medically Monitored Inpatient Withdrawal 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; and
j. Payment for room and board; and
k. Beneficiaries under the age of 17.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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

Upon admission to Medically Managed Intensive Inpatient Withdrawal Services, a beneficiary is allowed an initial three day (calendar days) pass-through. An authorization from the approved Department of Health and Human Services (DHHS) utilization review contractor is required after the initial three day pass-through.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Prepaid Inpatient Health Plan (PIHP), Prepaid Health Plan (PHP), or utilization management (UM) contractor the following:

a. the prior approval request; and

b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

5.2.2.1 Specific Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the PIHP, PHP, or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization after the pass-through units have been used, the CCA, service order for medical necessity, the service plan, and the required NC Medicaid authorization request form must be submitted to the PIHP, PHP, or utilization management contractor within the first 3 calendar days of service initiation. **Medicaid can cover up to 7 calendar days for the initial authorization period.**

5.2.2.2 Specific Reauthorization

NC Medicaid can cover up to 5-days for reauthorization.
Reauthorization shall be submitted by the provider before the initial or concurrent authorization expires. Authorizations are based on medical necessity documented in the service plan, the authorization request form, and supporting documentation.

5.3 Additional Limitations or Requirements

a. A beneficiary shall receive the Medically Managed Intensive Inpatient Withdrawal Service from only one provider organization during any active authorization period.

b. Medically Managed Intensive Inpatient Service must not be billed on the same day (except day of admission or discharge) as:

1. Residential levels of care
2. Other withdrawal management services
3. Outpatient treatment services
4. Substance Abuse Intensive Outpatient Program
5. Substance Abuse Comprehensive Outpatient Treatment
6. Assertive Community Treatment
7. Community Support Team
8. Supported Employment
9. Psychiatric Rehabilitation
10. Peer Support Services
11. Mobile Crisis Management
12. Partial Hospitalization
13. Facility Based Crisis (adult)

5.4 Service Orders

a. Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. The physician, physician assistant, or nurse practitioner shall complete and sign a service order according to their scope of practice. Service orders are valid for the episode of care. Medical necessity must be revisited, and service ordered is based on the current episode of care if multiple episodes of care are required in a twelve (12) month period.

b. ALL the following apply to a service order:

1. Backdating of the service order is not allowed.
2. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
3. 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 or NCHC, providers must 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. The staff person who provides the service must sign and date the written entry. The signature must include credentials for the staff member who provided the service. The service plan and a documented discharge plan must be discussed with the beneficiary and included in the service record. All beneficiaries shall have a Medication Administration Record (MAR) or electronic Medication Administration Record (eMAR)

completed at admission by qualified staff. The MAR or eMAR is a record of all medications administrated and updates any medication changes made.

5.5.1 Contents of a Shift Note

A shift note is required for each beneficiary for each shift they are enrolled in Medically Monitored Inpatient Withdrawal Services. A shift note must document ALL following elements:

a. Beneficiary name;
b. Medicaid identification number;
c. Date of service;
d. Type of contact (face-to-face, phone call, collateral);
e. Purpose of the contact;
f. Description of the provider's interventions;
g. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
h. Shift/coverage hours (Third Shift: 11:30 pm- 7:30 am);
i. Assessment of the effectiveness of the interventions and the beneficiary's progress towards meeting the beneficiary's goals; and
j. Date, signature and credentials or job title of staff providing the service.

5.5.2 Contents of A Service Notes

A complete service note for each contact or intervention provided due to a life event in a beneficiary's life that requires additional activities or interventions for each service, written and signed by the person who provided the service is required. A service note must document ALL following elements:

a. Beneficiary name;
b. Medicaid identification number;
c. Date of service;
d. Type of contact (face to face, collateral contact, phone call);
e. Place of service;
f. Purpose of contact;
g. Implementation of the treatment plan;
h. Details of beneficiary's response to treatment plan;
i. Description of the provider's interventions.
j. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
k. Duration of service, amount of time spent performing the intervention;
l. Assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
m. Date, signature, and credentials or job title of staff providing the service.

5.5.3 Content of a Medication Administration Record

A MAR or eMAR of all drugs administered to each beneficiary must be kept current. Medications administered are recorded immediately after administration. The MAR or eMAR documents all of the following:

a. Beneficiary's name;
b. Name, strength, and quantity of the medication;
c. Instructions for administering the medication;
d. Date and time the medication is administered; and
e. Name or initials of person administering the medication.

f. Detoxification rating scale tables, CIWA-AR and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been developed in coordination with the beneficiary and is also documented before discharge.

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 or NCHC 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

Medically Monitored Inpatient Withdrawal Service must be delivered by providers employed by substance abuse provider organizations that:

a. Meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
b. Meet the requirements of 10A NCAC 27G RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE FACILITIES AND SERVICES;
c. Demonstrate 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, achieve national accreditation with at least one of the designated accrediting agencies; and
e. Become 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 facility shall be licensed under 10A NCAC 27G .3100 NONHOSPITAL MEDICAL DETOXIFICATION FOR INDIVIDUALS WHO ARE SUBSTANCE ABUSERS rules unless provided by a IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t Licensing and 1647a Nondiscrimination under Federal Health Care Programs.

NC Division of Health Service Regulation
Mental Health Licensure and Certification Section
Refer to https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html

6.2 Provider Certifications

Staffing Requirements

Position	FTEs	Minimum Requirements	Responsibilities
Medical Director (MD)	0.5 FTE physician	Must be licensed physician and in good standing with the NC Medical Board and have at least one year of SUD treatment experience	The **medical director** is responsible for providing medical services and supervising physician extender staff according to the physician approved policies and protocols of the Medically Monitored Inpatient Withdrawal Service. The medical director shall be available for emergency medical consultation services 24 hours a day, seven days a week, 365 days a year, either for direct consultation or for consultation with the physician extender. Responsibilities also include the following: • Develop and revise Medically Monitored Inpatient Withdrawal Service policies and procedures • Perform a medical history upon admission • Complete a physical exam within 24 hours of admission • Determine diagnosis of substance use disorder per program eligibility requirements • Responsible for monitoring the Controlled Substance Reporting System (CSRS) • Provide direct supervision to physician extenders • Participate in the development of service plans • Evaluate medication or non-medication methods of withdrawal management • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions • Evaluate, prescribe, and monitor all medications currently being taken by the beneficiary including

			coordination with other prescribers • Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects • Order medications as medically appropriate • Order and interpret medically necessary toxicology and laboratory tests • Provide case consultation with interdisciplinary treatment team • Assess for co-occurring medical and psychiatric disorders • Make appropriate referrals and follow up for treatment of co-occurring medical and/or psychiatric disorders; and • Coordinate care with other medical and/or psychiatric providers.
Physician Extender	0.5 FTE, on-call coverage Physician Assistant (PA) or Nurse Practitioner (NP)	Must have a minimum of 2 years of experience working with adults with SUD and be licensed/certified to work as a physician extender	The **physician extender** is responsible for providing medical services according to the physician approved policies and protocols of the Medically Monitored Inpatient Withdrawal Service. The physician extender shall be available for emergency medical consultation services 24 hours a day, 365 days a year. Responsibilities also include the following: • Perform a medical history upon admission • Complete a physical exam within 24 hours of admission • Determine diagnosis of substance use disorder per program eligibility requirements • Responsible for monitoring the Controlled Substance Reporting System (CSRS) • Participate in the development of service plans • Evaluate medication or non-medication methods of withdrawal management • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the

			appropriate treatment and monitoring of those conditions • Evaluate, prescribe, and monitor all medications currently being taken by the beneficiary including coordination with other prescribers • Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects • Order medications as medically appropriate • Order and interpret medically necessary toxicology and laboratory tests • Provide case consultation with interdisciplinary treatment team • Assess for co-occurring medical and psychiatric disorders • Make appropriate referrals and follow up for treatment of co-occurring medical and/or psychiatric disorders; and • Coordinate care with other medical and/or psychiatric providers.
Nursing Staff	2.5 FTE Registered Nursing (RN) **AND** 2.5 FTE Licensed Practical Nursing (LPN)	Must be registered and in good standing with the NC Board of Nursing	The **Nursing Staff** is responsible for maintaining an adequate level of nursing for the program's dispensing and medical operations under the supervision of the Medical Director. Nursing staff responsibilities also include the following, as allowed by clinical and practice scopes: • Conducts a nursing evaluation upon admission in accordance with their scope of work • Responsible for monitoring the Controlled Substance Reporting System (CSRS), when delegated by a physician • Overseeing the monitoring of the beneficiary's progress and medication administration by nursing staff on an hourly basis, if needed • Provides daily assessment (or less frequent, if the beneficiary's withdrawal severity is mild or stable), planning and evaluation of the

			beneficiary's progress during withdrawal management and any treatment changes • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions. • Prepares and dispenses medication to beneficiaries, maintaining medication inventory records and logs in compliance with state regulations • Provide documentation in the beneficiary's service record of all nursing activities performed related to beneficiary care • Ensures medical orders are being followed and carried out • Provide psychoeducation, including HIV/AIDS, TB, Hepatitis C, pregnancy, and other health education services • Coordinates medical treatment and referral for biomedical problems • Performs auxiliary testing based on medical orders • Consults with other program medical staff for guidance in medical matters concerning the well-being of beneficiaries; and • Participates in staff meetings and treatment team meetings.
Clinical Staff	1.5 FTE LCAS or LCAS-A	Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board	The **Licensed Clinical Addiction Specialist or Licensed Clinical Addiction Specialist-Associate** is responsible for providing substance use focused and co-occurring assessment services, development of an ASAM Level of Care determination and provide referral and coordination to appropriate substance use disorder treatment and recovery resources LCAS or LCAS-A responsibilities also include the following: • Leads the development of an individualized service plan and its ongoing revisions in coordination

			with the beneficiary and ensures its implementation • Discharge planning shall begin upon admission • Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals • Provides clinical supervision to the Certified Alcohol and Drug Counselors (CADCs) • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions • Provides individual and group therapy based on the beneficiary's individualized, service plan • Provides crisis interventions, when clinically appropriate • Arranges involvement of family members or individuals identified by the beneficiary as being important to their care and recovery in the withdrawal management process, as appropriate • Provides education to family members or individuals identified by the beneficiary as being important to their care and recovery regarding withdrawal management process, as appropriate • Provides substance use, health, and community services education • Provides coordination and consultation with medical, clinical, familial, and ancillary relevant parties with beneficiary consent • Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations • Provides appropriate linkage and referrals for recovery services and supports • Informs the beneficiary about benefits, community resources, and services • Advocates for and assists the

			beneficiary in accessing benefits and services • Monitors and documents the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Maintains accurate service notes and documentation for all interventions provided • Developing and implementing supervision plans that meet the requirements of 10A NCAC 27G .0104, and • Participates in staff meetings and treatment team meetings.
Clinical Staff	2.0 FTE Certified Alcohol and Drug Counselor (CADC)	Must 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 to ensure that beneficiaries have access to counseling supports, psychoeducation, and crisis interventions when needed. They play a lead role in case management and coordination of care functions. CADC responsibilities also include the following: • Participates in the initial development, implementation, and ongoing revision of the service plan • Assists the LCAS or LCAS-A with behavioral and substance use disorder interventions • Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions • Provides crisis interventions, when clinically appropriate • Provides psychoeducation as indicated in the service plan • Provide substance use case

			management • Monitors and documents the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Provides substance use, health, and community services education • Assists with the development or relapse prevention and disease management strategies • Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and as outlined in the person-centered service plan • Engage with family members or individuals identified by the beneficiary as being important to their care and recovery in the withdrawal management process, as appropriate • Provides education to family members or individuals identified by the beneficiary as being important to their care and recovery regarding withdrawal management process, as appropriate • Provides appropriate linkage and referrals for recovery services and supports • Maintains accurate service notes and documentation for all interventions provided, and • Participates in staff meetings and treatment team meetings.
Professional Staff	2.0 FTE Associate Professional (AP)	Must have at least 1-year experience working with beneficiaries with substance use disorders	**Associate Professional** staff are responsible for the delivery of therapeutic interventions to both beneficiaries and their family and natural supports. Using the person-centered service plan, they implement identified interventions, document progress, and actively participate in all team and service planning meetings. AP responsibilities also include the following:

			• Participate in the initial development, implementation, and ongoing revision of the person-centered service plan • Assists the LCAS or LCAS-A and CADC with substance use and behavioral disorder interventions • Monitors signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate monitoring of those conditions • Assist with providing crisis interventions, when clinically appropriate • Provide psychoeducation and recovery supports as indicated in the individualized service plan • Monitors and documents the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Provide health and community services education • Informs the beneficiary about benefits, community resources, and services • Assist in accessing transportation services • Advocates for and assists the beneficiary in accessing benefits and services • Provides appropriate linkage and referrals for recovery services and supports • Advocates for and assists the beneficiary in accessing benefits and services • Maintains accurate service notes and documentation for all interventions provided • Participates in staff meetings and treatment team meetings • Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and CADC as outlined in the person-centered

			service plan • Linkage and referral to formal and informal supports • Monitoring follow up
Peer Support Specialists	1.5 FTE NC CPSS	Must have at least 2 years' experience working with beneficiaries with substance use disorders	The **Certified Peer Support Specialist (CPSS)** uses their lived experience and recovery to provide support to beneficiaries and share hope as they walk with a beneficiary through the first steps of their recovery journey. CPSS responsibilities also include the following: • Knowledge of peer support principles, values, and ethics • Ability to share lived experience to support, encourage and enhance a beneficiary's treatment and recovery • Possess recovery-oriented skills and knowledge to provide peer support services • Ability to model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for beneficiaries served and promote a recovery environment in the community, residence, and workplace • Ability to explore with a beneficiary served the importance and creation of a wellness identity through open sharing and challenging viewpoints • Ability to promote a beneficiary's opportunity for personal growth by identifying teachable moments for building relationship skills to empower the beneficiary and enhance personal responsibility • Ability to model and share examples of healthy social interactions and facilitate familiarity with, and connection to, the local community • Participates in team meetings and provides input into the individualized service plan

			• Guides and encourages beneficiaries to take responsibility for and actively participate in their own recovery • Assists the beneficiary with self-determination and decision-making • Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience • Teaches and promotes self-advocacy to the beneficiary • Supports and empowers the beneficiary to exercise his/her legal rights within the community • Assists with crisis interventions • Assists with the development of relapse prevention and disease management strategies
Paraprofessional Staff	3.0 FTE Paraprofessional staff	Must have 1-year experience working with adults with SUD	**Paraprofessional staff** are responsible for tasks that ensure beneficiaries are medically able to receive support at this level of care. They work closely with medical staff to ensure monitoring is completed and recorded, and with clinical staff to support in the provision of recovery-oriented interventions. Paraprofessional responsibilities also include the following: • Use psychoeducation strategies and recovery interventions to support beneficiaries with SUD • Ability to take, record and report out vital signs as ordered by medical staff • Ability to communicate observations and recommendations effectively in written and verbal form • Assist with crisis interventions • Ability to follow the service plan and clinical orders • Ability to work independently and as a member of a team • Ability to communicate effectively with beneficiaries, staff, and others • Ability to learn and apply recovery-oriented practices and person-centered approaches when working with beneficiaries

			• Participate in team meetings and provide input into the individualized service planning process

6.3 Program Requirements

Medically Monitored Inpatient Withdrawal Service must have written policies in place that establish procedures for monitoring each beneficiary's general condition and vital signs during at least the first 72 hours of the detoxification process, and procedures for monitoring and recording each beneficiary's pulse rate, blood pressure and temperature at least every four hours for the first 24 hours, and at least three times daily thereafter. The medical director (refer to minimum requirements found in Subsection 6.2) develops and supports written protocols. The protocols are in place to determine the nature of the medical or nursing interventions needed. Protocols must document what conditions nursing and physician care is warranted and when to transfer to a medically monitored facility or an acute care hospital is necessary.

Staffing patterns must ensure that a beneficiary admitted to Medically Monitored Inpatient Withdrawal Service completes a physical examination by the medical director, physician assistant, or nurse practitioner within 24 hours of admission. A physician shall be available by phone for consultative purposes 24 hours a day, 7 days a week. Providers must ensure that a minimum of one direct care staff is on duty for every nine or fewer beneficiaries.

a. Required components of this service consist of the following:

1. An initial assessment that consists of an addiction focused history by the medical director, physician assistant, or nurse practitioner upon admission;
2. Physical examination of the beneficiary by the medical director, physician assistant, or nurse practitioner within 24 hours of admission;
3. A nursing evaluation upon admission;
4. A comprehensive clinical assessment within 3 calendar days of admission;
5. Individualized service plan, including problem identification in ASAM dimensions 2 through 6, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
6. Access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) for beneficiaries that meet medical necessity for that service. MAT may be provided on-site by the provider or through a memorandum of agreement (MOA) or memorandum of understanding (MOU) with an off-site provider that is no further than 60 minutes from the facility;
7. A planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for beneficiaries and their family that includes licensed, certified, and/or registered clinicians as well as certified peer support specialists;
8. Daily assessment of progress during withdrawal management and any treatment changes;

9. 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;
10. Overseeing the monitoring of the beneficiary's progress and medication administration by nursing staff on an hourly basis, if needed;
11. Provide 24-hour access to emergency medical consultation services;
12. Provide behavioral health crisis interventions, when clinically appropriate;
13. Ability to conduct appropriate laboratory and toxicology tests, which can be point-of-care testing;
14. Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
15. Health education services;
16. 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 an appropriate level of care for continuing treatment;
17. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
18. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
19. Arranges involvement of family members or individuals identified by the beneficiary as being important to their care and recovery in the withdrawal management process, as appropriate and with informed consent;
20. Provides education to family members or individuals identified by the beneficiary as being important to their care and recovery regarding withdrawal management process, as appropriate;
21. Ability to assist in accessing transportation services for beneficiaries who lack safe transportation;
22. Affiliation with other ASAM levels of care and behavioral health providers for appropriate linkage and referrals for counseling, medical, psychiatric, and continuing care; and
23. Discharge and transfer planning beginning at admission.

Evaluation and Management (E&M) CPT codes, specifically with an addiction focused history and biopsychosocial screening assessments, physical examination, medical evaluation and consultation, the comprehensive clinical assessment, laboratory tests and toxicology tests may be billed separate from the Medically Monitored Inpatient Withdrawal Service.

This facility must be in operation 24 hours a day, 7 days a week, 365 days a year. The facility must have a physician available to provide medical evaluations and consultation 24 hours a day, in accordance with treatment and transfer practice protocols and guidelines. This service must be available for admission 7 days per week. Program medical staff must be available to provide 24-hour access for emergency medical

consultation services. Staffing ratios cannot exceed one direct care staff to 9 beneficiaries.

Staff Training Requirements

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 calendar days** of hire to provide service	▪ 2 hours Medically Monitored Inpatient Withdrawal Service Definition Required Components ▪ 6 hours of ASAM Criteria Training ▪ 3 hours of Crisis Response	All Staff	11 hours
	▪ 6 hours Medically Supervised Withdrawal Service including Assessing and Managing Intoxication and Withdrawal States ▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management	MD, PA, NP & Nursing Staff	8 hours
	▪ 6 hours Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, including delirium tremens ▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management	LCAS, LCAS-A, CADC, AP, CPSS, paraprofessionals	8 hours
	▪ 3 hours Measuring Vital Signs (to include how to obtain, record, and report the vital signs of temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, and pain effectively and accurately.)	CADC, AP, CPSS, Paraprofessionals	3 hours
Within **90 calendar days** of hire to provide this service	▪ 6 hours of Introductory Motivational Interviewing* (MI)	LCAS, LCAS-A, CADC, AP & Nursing staff	6 hours
	▪ 2 hours Trauma informed care ▪ 2 hours Co-occurring conditions	LCAS, LCAS-A, CADC, AP, CPSS, Paraprofessional & Nursing staff	4 hours
Annually	▪ 3 hours of Crisis Response Training ▪ 10 hours of continuing education in evidence-based treatment practices	All Staff	13 hours

The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training appropriate for the population being served was completed no more than 24-months before hire date.

*Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer. If a staff person is a MINT trainer, they are not required to have this training. Documentation of training activities shall be maintained by the provider.

b. 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. Expected outcomes are as follows:

1. Reduction or elimination of withdrawal signs and symptomatology;
2. Increased use of peer support services to support withdrawal management, facilitate recovery and link beneficiaries to community-based peer support and mutual aid groups;
3. Linkage to treatment services based on ASAM level of care determination post discharge;
4. Increased links to community-based resources to address unmet social determinants of health; and
5. 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 to one or more of these items in accordance with Federal law and regulations.

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

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

DRAFT

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC. 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)

Institutional (UB-04/837I transaction)

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

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

ICD-10-CM Code(s)
F10.129
F10.229
F10.929
F10.10
F10.20
F11.10
F11.20
F11.129
F11.229
F11.929
F11.122
F11.222
F11.922
F11.23
F11.99
F13.10
F13.20
F14.10
F14.20
F12.10
F12.20
F16.10
F16.20
F18.10
F18.20
F19.10
F19.20
F15.10
F15.20

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)
H0013

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

This is a facility-based service.

G. Co-payments

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

For NCHC refer to NCHC 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/