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:
8A, Enhanced Mental Health and Substance Abuse Services
8A-6, Community Support Team (CST)
8A-8, Ambulatory Withdrawal Management With Extended On-Site Monitoring
8C, Outpatient Behavioral Health Services

1.0 Description of the Procedure, Product, or Service

Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring is an organized outpatient service that provides medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Services are provided in regularly scheduled sessions to be delivered under a defined set of policies and procedures or medical protocols.

This is an American Society of Addiction Medicine (ASAM) Level 1-WM service for a beneficiary who is assessed to be at minimal risk of severe withdrawal, free of severe physical and psychiatric complications and can be safely managed at this level. These services are designed to treat the beneficiary's level of clinical severity and to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the beneficiary's transition into ongoing treatment and recovery.

1.1 Definitions

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised CIWA-Ar:
Is defined as a tool utilized to assess an 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

Medicaid shall cover Ambulatory Withdrawal Management without Extended On-Site Monitoring 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 Ambulatory Withdrawal Management without Extended On-Site Monitoring 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.

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 does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 necessary Ambulatory Withdrawal Management without Extended On-site Monitoring services when ALL of the following criteria are met:

a. The beneficiary shall have a substance use disorder (SUD) diagnosis or co-occurring disorder as defined by the current DSM-5 edition, or any subsequent editions of this reference material; and

b. The beneficiary shall meet American Society of Addiction Medicine (ASAM) Level 1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring admission criteria as defined in The ASAM Criteria, Third Edition, 2013 or any subsequent editions of this reference material.

3.2.1.1 Admission Criteria

Due to the nature of this crisis service, a comprehensive clinical assessment (CCA) is not required before admission for Ambulatory Withdrawal Management without Extended On-Site Monitoring services. The physician shall conduct an initial abbreviated assessment and physical exam to establish medical necessity for this service and the development of a service plan as part of the admission process.

The initial abbreviated assessment (Reference 10A NCAC 27G .0205(a)) must consist of the following information:

a. the beneficiary's presenting problem;

b. the beneficiary's needs and strengths;

c. a provisional or admitting diagnosis;

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

e. other evaluations or assessments as appropriate to the beneficiary's needs.

The program physician can bill an Evaluation and Management (E/M) code separately for the admission assessment and physical exam.

Within three calendar days of the admission, a comprehensive clinical assessment must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment is utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and documented in the treatment or service plan.

3.2.1.2 Continued Stay and Discharge Criteria

a. The beneficiary meets the criteria for continued stay if any ONE of the following applies:

   1. The beneficiary's withdrawal symptoms have not been sufficiently resolved to allow either discharge to a lower level of care or safe management in a less intensive environment; or

   2. The beneficiary's CIWA-Ar score 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 that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring;
2. The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (confirmed by CIWA-Ar or comparable score) indicating a need for transfer to a higher level of care.
3. The beneficiary is unable to complete withdrawal management at level 1-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.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 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

Medicaid and NCHC 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 1-WM 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.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

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

Medicaid and NCHC shall not require prior approval for Ambulatory Withdrawal Management without Extended On-Site Monitoring. Upon admission, a beneficiary is allowed up to 84 units of service for an initial seven-day (calendar days) pass-through.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review 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 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, as verified by the DHHS Utilization Management Review 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 efficacious 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, the Comprehensive Clinical Assessment (CCA), service order for medical necessity, the service plan, and the required NC Medicaid authorization request form must be submitted to the DHHS approved Utilization Management Review Contractor within the first seven calendar days of service initiation. **Medicaid shall cover up to 36 units for three calendar days for the initial authorization period.**

5.2.2.2 Reauthorization

Reauthorization shall be submitted before initial or concurrent authorization has expired. 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 beneficiary shall receive the Ambulatory Withdrawal Management without Extended On-Site Monitoring service from only one provider organization during any active authorization period.

Ambulatory Withdrawal Management without Extended On-Site Monitoring services cannot be provided during the same authorization period as any other service except Substance Abuse Comprehensive Outpatient Treatment and Community Support Team.

5.3.1 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by a physician, physician assistant, or nurse practitioner, according to his or her scope of practice. Service orders are valid for 12- months. Medical necessity must be revisited, and service must be ordered at least annually, based on the date of the original service order.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must;
c. indicate the date on which the service was ordered; and
d. 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.

5.4 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. 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 contain the credentials for the staff member who provided the service. The service plan and a documented discharge plan must be discussed with the beneficiary and contained in the service record. All beneficiaries must have a Medication Administration Record (MAR) completed at admission by qualified staff, as medication is administered, and updated as any medication changes are made.

5.4.1 Contents of A Service Note

A complete service note for each contact or intervention for each date of 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 (such as face-to-face, collateral or 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 used. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
j. duration of service, amount of time spent performing the intervention;
k. assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
l. date, signatures and credentials or job title of staff providing the service.

5.4.2 Content of a Medication Administration Record

A Medication Administration Record (MAR) of all drugs administered to each beneficiary must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:

a. beneficiary name;
b. name, strength, and quantity of the drug;
c. instructions for administering the drug;
d. date and time the drug is administered; and
e. name or initials of person administering the drug.

Detoxification rating scale tables Clinical Institute Withdrawal Assessment-Alcohol, Revised (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

Ambulatory Withdrawal Management without Extended On-Site Monitoring services 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
f. requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

This facility must be licensed under 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse, unless provided by a Indian Health Service (IHS) or compact operated by a Federally Recognized Tribe according to 25 USC §1621t Licensing and 25 USC § 1647a.

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	A minimum .50 FTE Medical Director	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 all medical services according to the policies and protocols of the Ambulatory Withdrawal Management without Extended On-Site Monitoring program. The medical director shall be available for emergency medical consultation services 24 hours a day, 365 days a year. Responsibilities are the following: • Perform a medical history and physical exam upon admission; • Determine diagnosis of substance use disorder per program eligibility requirements; • Responsible for monitoring the Controlled Substance Reporting System (CSRS); • Develop service plans or person-centered 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 or 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 medically necessary toxicology and laboratory tests;

Staffing Requirements Position	FTEs	Minimum Requirements	Responsibilities
			• 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 or psychiatric providers.
Physician Extender	A minimum 0.5 FTE Physician Assistant (PA) or Nurse Practitioner (NP)	Must be licensed physician assistant or nurse practitioner and in good standing with the NC Medical Board or NC Nursing Board and have at least one year of SUD treatment experience	The **physician extender** is responsible for providing medical services according to the physician approved policies and protocols of the Ambulatory Withdrawal Management without Extended On-Site Monitoring program. The physician extender shall be available for emergency medical consultation services 24 hours a day, 365 days a year. Responsibilities are the following: • Perform a medical history and physical exam upon admission; • Determine diagnosis of substance use disorder per program eligibility requirements; • Responsible for monitoring the Controlled Substance Reporting System (CSRS); • Develop service plans or person-centered 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 or 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;

Staffing Requirements Position	FTEs	Minimum Requirements	Responsibilities
			• Order 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 or psychiatric disorders; and • Coordinate care with other medical or psychiatric providers.
Nursing Staff	1.5 FTE Registered Nurse	Must be registered and in good standing with the NC Board of Nursing	The **Registered Nurse** shall be responsible for maintaining an adequate level of nursing for the program's dispensing and medical operations under the supervision of the program physician. Nursing staff responsibilities are the following: • 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; • 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

Staffing Requirements Position	FTEs	Minimum Requirements	Responsibilities
			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 the program physician for guidance in medical matters concerning the well-being of beneficiaries; and • Participates in staff meetings and treatment team meetings.
Clinical Staff	1.0 FTE LCAS or LCAS-A	Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board	The **Licensed Clinical Addiction Specialist (LCAS) or Licensed Clinical Addiction Specialist-Associate (LCAS-A)** 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 are the following: • Develops individualized, person-centered 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; • 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 therapy based on the beneficiary's individualized, service plan; • Provides crisis interventions, when

Staffing Requirements Position	FTEs	Minimum Requirements	Responsibilities
			clinically appropriate; • Arranges involvement of family members or significant others in the withdrawal management process, as appropriate; • Provides education to family members or significant others regarding withdrawal management process, as appropriate; • Assist in accessing transportation services; • 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; and • Participates in staff meetings and treatment team meetings.

6.3 Program Requirements

Ambulatory Withdrawal Management (WM) without Extended On-Site Monitoring is an organized outpatient service that provides medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Services are provided in regularly scheduled sessions to be delivered under a defined set of policies and procedures or medical protocols

Required components of this service must contain the following:

a. A comprehensive clinical assessment within three (3) calendar days of admission;
b. An initial assessment including an addiction focused history and physical examination of the beneficiary at admission by a physician;
c. A nursing evaluation upon admission;
d. Individualized service plan;
e. Daily assessment of progress during withdrawal management and any treatment changes;
f. Ability to conduct or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing;
g. Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
h. Medically necessary clinical services including individual therapy, as indicated;
i. Arranges involvement of family members or significant others in the withdrawal management process, as appropriate and with informed consent;
j. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
k. Provides crisis interventions, when clinically appropriate;
l. Provide 24-hour access to emergency medical consultation services;
m. Provide 24-hour first responder services for beneficiaries receiving services;
n. Provides education to family members or significant others regarding withdrawal management process, as appropriate;
o. Ability to assist in accessing transportation services for beneficiaries who lack safe transportation;
p. Affiliation with other ASAM levels of care and behavioral health providers for appropriate linkage and referrals for counseling, medical, psychiatric, and continuing care; and
q. Discharge planning beginning at admission.

Evaluation and Management CPT codes, the comprehensive clinical assessment, individual therapy, laboratory tests and toxicology tests are billed separate from the Ambulatory Withdrawal Management without Extended On-Site Monitoring service.

This facility must be in operation a minimum of eight hours per day, five days per weekday (Monday through Friday) and a minimum of four hours daily on the weekend (Saturday and Sunday). The hours of operation shall be extended based on beneficiary need. This service must be available for admission seven days per week. Program medical staff must be available to provide 24-hour access for emergency medical consultation services. Ambulatory Withdrawal Management without Extended On-Site Monitoring service provides 24 hours a day, seven days a week first responder services for beneficiaries.

6.3.1 Staff Training Requirements

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 calendar days** of hire to provide service	▪ 2 hours Ambulatory Withdrawal Management without Extended On-Site Monitoring Service Definition Required Components ▪ 6 hours of ASAM Criteria Training ▪ 3 hours of Crisis Response	All Staff	11 hours
	▪ 6 hours Medically Supervised Withdrawal Management including Assessing and Managing Intoxication and Withdrawal States ▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management ▪ 2 hours of MAR training	MD, Physician Extender & Nursing Staff	10 hours
	▪ 6 hours Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, Appropriate Treatment and Monitoring of the Condition and Facilitation into Ongoing Care ▪ 2 hours of Pregnancy, Substance Use Disorder and Withdrawal Management	LCAS/LCAS-A	8 hours
Within **90 calendar days** of hire to provide this service	▪ 13 hours of Introductory Motivational Interviewing* (MI) (mandatory 2-day training with MINT trainer) ▪ 2 hours Trauma informed care ▪ 2 hours Co-occurring conditions	LCAS/LCAS-A & Nursing staff	17 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 the 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.

*LCAS and LCAS-A staff that have completed the two-day ASAM training have met the six (6)-hour ASAM requirement for this service, and shall not require additional ASAM training

Documentation of training activities must be maintained by the program.

6.3.2 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:

a. Reduction or elimination of withdrawal signs and symptomatology.
b. Linkage to appropriate treatment services post discharge.
c. Increased links to community-based resources to address unmet social determinants of health; and
d. 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).

8.0 Policy Implementation and History

Original Effective Date: July 1, 1989

History:

Date	Section or Subsection Amended	Change
MM/DD/YYYY	All Sections and Attachment(s)	Ambulatory Withdrawal Management without Extended On-Site Monitoring

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:

A. Claim Type

Professional (CMS-1500/837P transaction)

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

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

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

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Billing Unit
H0014	1 unit = 15 minutes

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).

1 Unit = 15 minutes

PHPs, Prepaid Inpatient Health Plans (PIHPs) and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. PHPs and PIHPs shall assess network providers' adherence to service guidelines to assure quality services for beneficiaries.

F. Place of Service

Outpatient Facility, Physician's Office or in a beneficiary's primary private residence.

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//

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.

Retroactive eligibility does not apply to the NCHC program.