To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

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)
8B, Inpatient Behavioral Health Services
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 in a licensed facility. 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) Criteria, Third Edition, 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 (CIWA-Ar):

Is a tool used to assess an individual's alcohol withdrawal.

The ASAM Criteria, Third Edition

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

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

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

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

Medicaid shall cover 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.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

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

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

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

Medicaid shall cover Ambulatory Withdrawal Management without Extended On-site Monitoring services when the beneficiary meets the following specific criteria:

a. has 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. meets the 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.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 Admission Criteria

a. Due to the nature of this crisis service, a Comprehensive Clinical Assessment (CCA) and Diagnostic Assessment (DA) is not required before admission to Ambulatory Withdrawal Management without Extended On-Site Monitoring services.

b. The physician or physician extender shall conduct an initial abbreviated assessment and physical exam, including a pregnancy test as indicated, to establish medical necessity for this service and develop a service plan as part of the admission process.

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

1. the beneficiary's presenting problem;
2. the beneficiary's needs and strengths;
3. a provisional or admitting diagnosis;
4. a pertinent social, family, and medical history; and
5. other evaluations or assessments.

The program physician or physician extender can bill Evaluation and Management codes 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.

3.2.4 Continued Stay and Discharge Criteria

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

   1. The 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 CIWA-Ar score, or other comparable standardized scoring system, has not increased or decreased.

b. The beneficiary meets the criteria for discharge if any ONE of the following applies:

   1. The withdrawal signs and symptoms are sufficiently resolved so that the beneficiary can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring;

   2. The signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) or other comparable standardized scoring system) 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.

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

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

4.1 General Criteria Not Covered

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

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**

b. the beneficiary does not meet the criteria listed in **Section 3.0;**

c. the procedure, product, or service duplicates another provider's procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover these activities:

a. Transportation for the beneficiary or family members;
b. Any habilitation activities;
c. Time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of Level 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.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for Ambulatory Withdrawal Management without Extended On-site Monitoring upon admission through the first three calendar days of services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Utilization Management and Additional Limitations or Requirements

5.3.1 Utilization Management

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. All utilization review activity must be documented in the service record and be maintained by the program.

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, as verified by the Prepaid Health Plan (PHP), Prepaid Inpatient Health Plan (PIHP), 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.

5.3.2 Initial Authorization

To request an initial authorization, the CCA or DA, 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 three calendar days of service initiation.

Concurrent reviews determine the ongoing medical necessity for the service or a lower or higher level of care. Providers shall submit an updated service plan and any authorization or reauthorization forms required by the PIHP, PHP, or utilization management contractor.

5.3.3 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 may not be provided on the same day as Substance Use Disorder Withdrawal Management or Residential Services, except on day of admission or discharge.

5.4 Service Order

A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the beneficiary's needs. A signed service order must be completed by a physician, physician assistant, or nurse practitioner, according to their scope of practice. A service order is 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 of the following apply to a service order:

a. Backdating of the service order is not allowed;

b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and

c. A service order must be in place before or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. Service notes must meet the requirements of the DHHS Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet requirements of 10A NCAC 27G .0209 (c)(4).

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Ambulatory Withdrawal Management without Extended On-Site Monitoring services must be delivered by a provider employed by an organization that:

a. meets the provider qualification policies, procedures, and standards established by NC Medicaid;

b. meets the requirements of 10A NCAC 27G Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services;

c. demonstrates that they meet these standards by being credentialed and contracted by the DHHS designated contractor;

d. within one year of enrollment as a provider with NC Medicaid, achieves national accreditation with at least one of the designated accrediting agencies; and

e. becomes established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

This service must be provided in a facility licensed by the NC Division of Health Service Regulation Mental Health Licensure and Certification Section under 10A NCAC 27G .3300 Outpatient Detoxification for Substance Abuse waiver rules. Refer to Tribal & Urban Indian Health Centers | HRSA when the service is provided by an Indian Health Service (IHS) or 638 contract or compact operated by a Federally Recognized Tribe as allowed in 25 USC Ch. 18: INDIAN HEALTH CARE §1621t Licensing and §1647a Nondiscrimination under Federal health care programs in qualifications for reimbursement services.

6.2 Provider Certifications

Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Medical Director	**Medical Director** shall be a licensed physician and in good standing with the NC Medical Board. Medical Director shall 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, seven days a week, either for direct consultation or for consultation with the physician extender, in-person or virtually. In addition to the above, the Medical Director is responsible for 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; • Evaluate medication or non-medication methods of withdrawal management; • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the treatment and monitoring of those conditions; • Evaluate, prescribe, or monitor all medications currently being taken by the beneficiary including coordination with other prescribers;

Required Position	Minimum Qualifications	Responsibilities
		• Provide education to the beneficiary regarding prescribed medications, potential drug interactions and side effects; • Order medications as medically necessary; • Order medically necessary toxicology and laboratory tests; • Provide case consultation with interdisciplinary treatment team; • Assess for co-occurring medical and psychiatric disorders; • Make referrals and follow up for treatment of co-occurring medical and psychiatric disorders; and • Coordinate care with other medical or psychiatric providers.
Physician Extender	**Physician Assistant (PA) or Nurse Practitioner (NP)** Licensed physician assistant or nurse practitioner in good standing with the NC Medical Board or NC Nursing Board, respectively. Physician Extender shall 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 may provide coverage for emergency medical consultation services 24 hours a day, seven days a week, in-person or virtually. In addition to the above, the Physician Extender is responsible for 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; • Evaluate medication or non-medication methods of withdrawal management; • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the 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;

Required Position	Minimum Qualifications	Responsibilities
		• Order medications as medically necessary; • Order medically necessary toxicology and laboratory tests; • Provide case consultation with interdisciplinary treatment team; • Assess for co-occurring medical and psychiatric disorders; • Make medically necessary referrals and follow up for treatment of co-occurring medical or psychiatric disorders; and • Coordinate care with other medical or psychiatric providers.
Nursing Staff	**Nursing Staff** Registered Nurse (RN) and Licensed Practical Nurse (LPN) shall be registered and in good standing with the NC Board of Nursing.	The **Nursing Staff** 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. In addition to the above, the Nursing Staff is responsible the following: • Conduct 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; • Provide 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; • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the treatment and monitoring of those conditions; • Prepare and dispense medication to the beneficiary, 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; • Ensure medical orders are being followed and carried out;

Required Position	Minimum Qualifications	Responsibilities
		• Provide psychoeducation, including HIV, AIDS, TB, Hepatitis C, pregnancy, and other health education services; • Coordinate medical treatment and referral for biomedical problems; • Perform auxiliary testing based on medical orders; • Consult with the program physician for guidance in medical matters concerning the well-being of a beneficiary; and • Participate in staff meetings and treatment team meetings.
Clinical Staff	**LCAS or LCAS-A** shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	The **Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)** is responsible for providing substance use focused and co-occurring assessment services, developing an ASAM Level of Care determination, and providing referral and coordination to appropriate substance use disorder treatment and recovery resources. In addition to the above, the LCAS or LCAS-A is responsible for the following: • Develop individualized, person-centered service plan and its ongoing revisions in coordination with the beneficiary, and ensure its implementation; • Begin discharge planning upon admission; • Provide ongoing assessment and reassessment of the beneficiary based on their service plan and goals; • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the treatment and monitoring of those conditions; • Provide individual therapy based on the beneficiary's individualized service plan; • Provide crisis interventions, when clinically necessary; • Arrange involvement of family members or significant others in the withdrawal management process, with consent; • Provide education to family members or significant others regarding the withdrawal management process; • Assist in accessing transportation services;

Required Position	Minimum Qualifications	Responsibilities
		• Provide substance use, health, and community services education; • Provide coordination and consultation with medical, clinical, familial, and ancillary relevant parties with beneficiary consent; • Ensure linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations; • Provide linkage and referrals for recovery services and supports; • Provide linkage and coordination with care management or other care coordination; • Inform the beneficiary about benefits, community resources, and services; • Advocate for and assist the beneficiary in accessing benefits and services; • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan; • Maintain accurate service notes and documentation for all interventions provided; and • Participate in staff meetings and treatment team meetings.

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment will be effective the date the related rule change for 10A NCAC 27G is finalized.

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

6.3 Program Requirements

Ambulatory Withdrawal Management 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, including a pregnancy test, as indicated, at admission by a physician or physician extender;
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 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, and with informed consent;
j. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
k. Provide crisis interventions, when clinically appropriate;
l. Provide 24-hour access to emergency medical consultation services;
m. Provide education to family members or significant others regarding withdrawal management process;
n. Ability to assist in accessing transportation services for a beneficiary who lacks safe transportation;
o. Provide linkage and coordination with care management;
p. Affiliation with other ASAM levels of care and behavioral health providers for 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, all five weekdays (Monday through Friday), and a minimum of four hours daily on the weekend (Saturday and Sunday). The hours of operation must be extended based on beneficiary need. This service must be available for admission seven days per week. Program medical staff shall

be available to provide 24-hour access for emergency medical consultation services, in-person or virtually.

6.4 Staff Training Requirements

Time Frame	Training Required	Who
Prior to service delivery	▪ Opioid Antagonist administration (Administering Naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Crisis Response* ▪ Harm Reduction ▪ Ambulatory Withdrawal Management without Extended On-Site Monitoring Service Definition Required Components	All Staff
Within **90 calendar days** of hire to provide service	▪ ASAM Criteria	All Staff
	▪ Medically Supervised Withdrawal Management including Assessing and Managing Intoxication and Withdrawal States ▪ Pregnancy, Substance Use Disorder and Withdrawal Management ▪ MAR training	Physician, Physician Extender, Nursing Staff
	▪ Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, Appropriate Treatment and Monitoring of the Condition and Facilitation into Ongoing Care ▪ Pregnancy, Substance Use Disorder and Withdrawal Management	LCAS, LCAS-A
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing* (MI) ▪ Trauma informed care* ▪ Co-occurring conditions*	LCAS, LCAS-A, Nursing staff
Annually	▪ Continuing education in evidence-based treatment practices, which must include crisis response training and cultural competency	All Staff

The initial training requirements may be waived by the hiring agency if the staff can produce documentation certifying that training appropriate for the population being served was completed no more than 48 months before the hire date.

Staff hired prior to the effective date of this policy shall complete the required training identified in the above Staff Training Requirements chart. Training must be completed within one (1) year of the original effective date of this policy. **Refer to Section 8.0 of this policy for original effective date.**

*Training must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical professionals. Approved programs include

North Carolina Addictions Specialist Professional Practice Board (NCASPPB), National Association for Addiction Professionals (NAADAC), National Board for Certified Counselors (NBCC), Approved Continuing Education Provider (ACEP), National Association of Social Work (NASW), and Motivational Interviewing Network of Trainers (MINT).

Documentation of training activities must be maintained by the program.

6.5 Expected Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments, medical evaluation and meeting the identified goals in the beneficiary's service plan. Expected outcomes are as follows:

a. Reduction or elimination of withdrawal signs and symptomatology;

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

8.0 Policy Implementation and History

Original Effective Date: 10/01/2024

History:

Date	Section or Subsection Amended	Change
10/01/2024	All Sections and Attachment(s)	Initial Implementation of Policy

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P 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.

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).

F. Place of Service

Services are provided in an outpatient licensed facility as identified in **Section 6.0**.

G. Co-payments

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

H. Reimbursement

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

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