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:
1H, Telehealth, Virtual Communications and Remote Patient Monitoring
8A, Enhanced Mental Health and Substance Abuse Services
8A-1, Community Support Team (CST)
8A-5, Diagnostic Assessment
8A-6, Assertive Community Treatment (ACT)
8B, Inpatient Behavioral Health Services
8C, Outpatient Behavioral Health Services
8D-2, Residential Treatment Services
8G, Peer Support Services

1.0 Description of the Procedure, Product, or Service

Substance Abuse Comprehensive Outpatient Treatment (SACOT) is a clinically intensive partial hospitalization program that provides skilled treatment services in a structured outpatient recovery environment, for a beneficiary 18 years of age and older with a primary substance use disorder (SUD) diagnosis.

SACOT is an American Society of Addiction Medicine (ASAM), Third Edition, Level 2.5 service that provides 20 or more hours of clinically intensive programming per week, as specified in the beneficiary's Person-Centered Plan (PCP). SACOT services consist of individual, group, and family counseling, medication management through consultation and referral, and service coordination activities. In addition, SACOT must include access to psychiatric, medical, and laboratory services, educational groups, and other therapies.

Services are provided in the amounts, frequencies, and intensities appropriate to the objectives of the beneficiary's PCP. SACOT services can be provided during the day, weekend, or evening.

1.1 Definitions

The ASAM Criteria, Third Edition

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

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

Medication Assisted Treatment (MAT)

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), Medication Assisted Treatment (MAT) is "the use of medications, in

combination with counseling and behavioral therapies, to provide a 'whole patient' approach to the treatment of substance use disorders. Medications used are approved by the Food and Drug Administration (FDA), and are clinically driven and tailored to meet each beneficiary's needs."

Telehealth

Per Clinical Coverage Policy **1-H, Telehealth, Virtual Communications and Remote Patient Monitoring**, "Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations."

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 Substance Abuse Comprehensive Outpatient Treatment for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.1.1 Telehealth

a. Services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in Clinical Coverage Policy **1-H, Telehealth, Virtual Communications and Remote Patient Monitoring, at** https://medicaid.ncdhhs.gov/.
b. The determination to provide services via telehealth must be for the benefit of the beneficiary.
c. A provider shall consider the beneficiary's behavioral, physical, and cognitive abilities to participate in services provided via telehealth.
d. A beneficiary is not required to seek services through telehealth, and shall have access to in person services.
e. Services must be provided in person at least five (5) days per week.
f. Services may be provided via telehealth if a beneficiary:
    1. has a documented, unexpected transportation barrier, and the provider is working with the beneficiary to address the transportation need;
    2. has documentation from a medical provider stating the beneficiary is unable to attend services in-person due to a time-limited medical condition; or
    3. has documentation indicating the beneficiary has an active, communicable infection that poses a risk to others in the SACOT setting.

3.2 Specific Criteria Covered

3.2.1 Specific Criteria Covered by Medicaid

Medicaid shall cover SACOT services when the beneficiary meets the following specific criteria:

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

b. meets the American Society of Addiction Medicine (ASAM) Level 2.5 Substance Abuse Comprehensive Outpatient Treatment (SACOT) 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 comprehensive clinical assessment (CCA) or diagnostic assessment (DA) must be completed by a licensed professional to determine an ASAM level of care for admission and discharge planning. The CCA or DA, which demonstrates medical necessity, must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be used as part of the current CCA or DA. Relevant diagnostic information must be obtained and documented in the beneficiary's Person-Centered Plan (PCP). The assessment and PCP must be updated as changes and new strengths and barriers are observed during the treatment process.

A service order for SACOT must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to their scope of practice, prior to or on the first day that SACOT services are provided. Refer to **Section 5.4** for service order requirements.

The amount, duration, frequency, and intensity of SACOT services must be documented in the beneficiary's PCP. Services must not be offered less frequently than the structured program set forth in the service description in **Section 1.0** of this policy.

3.2.4 Continued Stay and Discharge Criteria

Each of the six dimensions of the ASAM criteria must be reviewed and documented in the beneficiary's service record to document the determination for continued stay, discharge, or transfer to another level of care.

a. The beneficiary meets the criteria for continued stay at the present level of care if any ONE of the following applies:
    1. The beneficiary has achieved initial PCP goals and requires this present level of care in order to meet additional goals;
    2. The beneficiary is making some progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated;
    3. The beneficiary is not making progress, is regressing, or new symptoms have been identified and the beneficiary has the capacity to resolve these problems; or
    4. The beneficiary is actively working towards goals so continuation at the present level of care is indicated, and the PCP must be modified to identify more effective interventions.
b. The beneficiary meets the criteria for discharge if any ONE of the following applies:

1. The substance use disorder (SUD) signs and symptoms are resolved such that the beneficiary can participate in self-directed recovery or ongoing treatment without the need for SACOT services;
2. The signs and symptoms of SUD have failed to respond to treatment, and have intensified, indicating a transfer to a more intensive level of SUD treatment services is indicated; or
3. The beneficiary or their legally responsible person 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:

b. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
c. the beneficiary does not meet the criteria listed in **Section 3.0**;
d. 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 building or therapy;
d. Clinical and administrative supervision of SACOT 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 substitutes for education personnel;
h. Interventions not identified on the beneficiary's PCP;
i. Services provided to children, spouse, parents, or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the PCP; and
j. Payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for SACOT upon admission through the first 60 calendar days of service. The pass through for SACOT is available once per fiscal year for a beneficiary.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Utilization Management and Additional Limitations

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 PCP. Medical necessity is determined by North Carolina community practice standards, according to 10A NCAC 25A .0201, as verified by the Prepaid Inpatient Health Plan (PIHP), Prepaid Health Plan (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.

5.3.2 Initial Authorization

To request an initial authorization, the CCA or DA, service order for medical necessity, the PCP, and the required NC Medicaid authorization request form must be submitted to the PIHP, PHP, or utilization management contractor within the first 60 calendar days of service initiation.

Concurrent reviews determine the ongoing medical necessity for the service or a lower or higher level of care. The provider shall submit an updated PCP and any

authorization or reauthorization forms required by the PIHP, PHP, or utilization management contractor.

5.3.3 Additional Limitations

SACOT must not be provided and billed during the same authorization period (except on the day of admission or discharge) as:

a. Substance Abuse Intensive Outpatient Services (SAIOP)
b. Individual, family or group therapy for treatment of substance use disorder
a. Clinically Managed Residential Withdrawal Management (ASAM Criteria, Level 3.2 WM)
b. Medically Monitored Inpatient Withdrawal Management (ASAM Criteria, Level 3.7 WM)
c. Clinically Managed Low-Intensity Residential Treatment Services (ASAM Criteria, Level 3.1)
c. Clinically Managed Population-Specific High-Intensity Residential Programs (ASAM Criteria, Level 3.3)
d. Clinically Managed High-Intensity Residential Services (ASAM Criteria, Level 3.5)
e. Medically Monitored Intensive Inpatient Services (ASAM Criteria, Level 3.7)
f. Partial Hospitalization (PH)

A beneficiary can receive SACOT services from only one provider organization during any authorization period.

Peer Support Services that are medically necessary may be billed during the same authorization period as SACOT.

For the purposes of helping a beneficiary who is transitioning to or from Assertive Community Treatment (ACT) or Community Support Team (CST), the case management component of these services may be billed concurrently with SACOT, for the first and last 30 days, in accordance with the beneficiary's Person-Centered Plan (PCP) and the clinical coverage policies.

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, nurse practitioner, or licensed psychologist per their scope of practice. A service order is valid for twelve (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 prior to or on the first day that the service is initially provided to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider shall not bill Medicaid without a valid service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid, a provider shall 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.

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

SACOT 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;
c. demonstrates that it meets these standards by being credentialed and contracted by the DHHS designated contractor;
d. achieves national accreditation with at least one of the designated accrediting agencies within one (1) year of enrollment as a provider with NC Medicaid; 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 .4500 Substance Abuse Comprehensive Outpatient Treatment Program rules waiver. Refer to Tribal & Urban Indian Health Centers | HRSA when the service is provided by an Indian Health Service (IHS) or 638 contract or compact operated by a Federally Recognized Tribe as allowed in 25 USC Ch. 18: INDIAN HEALTH CARE §1621t Licensing and §1647a Nondiscrimination under Federal health care programs in qualifications for reimbursement services.

Providers and organizations that provide SACOT shall provide crisis response 24-hours-a-day, seven-days-a-week, to a beneficiary who is receiving SACOT services, either in person or virtually, based on the beneficiary's need.

6.2 Provider Certifications

Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
Clinical Supervisor	**Licensed Clinical Addictions Specialist (LCAS) or Certified Clinical Supervisor (CCS)** Clinical Supervisor position may be divided by up to two staff. Shall be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	The **Clinical Supervisor** is responsible for clinical oversight of the program, ensuring that staff supervision is in place, managing admission and discharges, and ensuring that the program is adhering to the policy, rules, and statutes, as well as providing direct clinical care. In addition to the above, the Clinical Supervisor is responsible for the following: • Oversee the clinical operation of the SACOT program and ensure on-site backup coverage; • Supervise clinical staff to ensure the delivery of best and ethical practices; • Maintain and review service notes and documentation to ensure accuracy; • Conduct staff meetings and treatment team meetings; • Develop and monitor the implementation of a programming calendar that ensures the beneficiary has access to the intensity and frequency of service indicated in their PCP; • Track services offered to ensure all required program elements are available to the beneficiary; • Complete routine monitoring to ensure services identified in the PCP are offered; • Monitor and evaluate the services, interventions, and activities provided by the team; • Assist with crisis interventions; • Facilitate individual, group and family therapy sessions; • Participate in PCP development and updates; • Facilitate service and discharge planning meetings; • Facilitate transition to the next level of care and community-based resources; • Work with beneficiary's natural supports, with beneficiary consent;

		• Develop collaborative working relationships with community-based providers and organizations to facilitate discharge; • Facilitate program clinical meetings; • Develop and implement supervision plans for staff that meet the requirements of 10A NCAC 27G .0203 and .0204
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, providing substance use disorder treatment services or referral, and coordinating medically necessary substance use disorder treatment and recovery resources. In addition to the above, the LCAS or LCAS-A is responsible for the following: • Discharge planning must begin upon admission; • Lead in the development of an individualized PCP and ongoing revisions; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals; • Facilitate individual, group, and family therapy sessions; • Facilitate service coordination to address the needs of the beneficiary; • Monitor signs and symptoms of alcohol and other drug use, intoxication, and withdrawal, as well as the appropriate treatment and monitoring of those conditions; • Provide crisis interventions, when clinically appropriate; • Engage with family members or significant others and provide education regarding SUD treatment and the recovery process, with beneficiary consent; • Provide coordination and consultation with medical, clinical, familial, and ancillary relevant parties, with beneficiary consent; • Assess and determine clinically appropriate services that support recovery; • Coordination with Care Management provider(s) to ensure the beneficiary is

		informed about benefits, community resources, and services; • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP; • Maintain accurate service notes and documentation for all interventions provided • Participate in staff meetings and treatment team meetings.
Clinical Staff	**CADC, CSAC, CADC-I, CSAC-I, Registrant (Alcohol and Drug Counselor)*** Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board. *An individual who is a Registrant with the NC Addictions Specialist Professional Practice Board (NCASPPB) in accordance with 21 NCAC 68 .0202 (d) shall be designated as an Alcohol and Drug Counselor Intern no later than October 31, 2024, by the NCASPPB.	The **Certified Alcohol and Drug Counselor (CADC)**, **Certified Substance Abuse Counselor (CSAC), Certified Alcohol and Drug Counselor Intern (CADC-I), Certified Substance Abuse Counselor Intern (CSAC-I), and Registrant (Alcohol and Drug Counselor)*** coordinates with the LCAS or LCAS-A and Clinical Supervisor to ensure that the beneficiary has access to counseling supports, psychoeducation, and crisis interventions. The CADC, CSAC, CADC-I, CSAC-I, and Registrant* play a lead role in case management and coordination of care functions. In addition to the above, the CADC, CSAC, CADC-I, CSAC-I, and Registrant* is responsible for the following: • Participate in the initial development, implementation, and ongoing revision of the PCP; • Facilitate individual and group counseling sessions; • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals; • Monitor signs and symptoms of alcohol and other drug use, intoxication, and withdrawal, as well as the appropriate treatment and monitoring of those conditions; • Coordinate with Medication Assisted Treatment (MAT) providers; • Provide crisis interventions, when clinically appropriate; • Provide psychoeducation as indicated in the PCP;

		• Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP; • Provide substance use, health, and community services education; • Assist with the development of relapse prevention and disease management strategies; • Communicate the beneficiary's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and Clinical Supervisor as outlined in the PCP; • Provide education to family members or significant others regarding the withdrawal management process, with beneficiary consent; • Coordinate with Care Management provider(s) to ensure the beneficiary is informed about benefits, community resources, and services; • Coordinate with Care Management provider(s) to ensure beneficiary is provided linkage and referrals for needed services and supports; • Participate in staff meetings and treatment team meetings.

For a SACOT program, there must be at least one (1) Clinical Staff as identified in **Section 6.2** for every ten (10) or fewer beneficiaries, when facilitating a group counseling session.

The Clinical Supervisor may cover caseloads on a temporary basis in emergency situations as a result of staffing shortages and counts towards the staff to beneficiary ratio for group counseling sessions.

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

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

6.3 Program Requirements

SACOT must operate at least 20 hours per week offering a minimum of four (4) hours scheduled services per service day, with the availability of in person SACOT services at least five (5) days per week, with no more than two (2) consecutive days without services available. A SACOT program may have variable lengths of stay and reduce a beneficiary's frequency of attendance as recovery becomes established and the beneficiary can resume day to day obligations of living. A licensed professional (CCS, LCAS, LCAS-A) included in **Section 6.2 of this policy** shall be on site when SACOT is in operation.

Required components of this service must contain the following:

a. Individual counseling, therapy, and support;
b. Group counseling, therapy, and support;
c. Family counseling, training, and support, which involves family members, guardians, or significant other(s) in the assessment, treatment, and continuing care of the beneficiary, with informed consent;
d. Coordination and referral for ancillary services;
e. Biochemical assessments to identify recent drug use (includes urine drug screens);
f. Education on relapse prevention and development of support systems in treatment;
g. Education on life skills and crisis contingency planning;
h. Education on physical health management;
i. Reproductive planning and health education;
j. A planned format of therapies, delivered on an individual and group basis and adapted to the beneficiary's developmental stage and comprehension level; and
k. Service coordination activities.

While receiving SACOT services, the beneficiary shall have continuous access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating co-occurring substance use and mental health disorders. SACOT programs shall have an agreement with a provider to ensure that services are available. The provider shall:

a. be familiar with the SACOT program treatment plan for each beneficiary seen in consultation;
b. have access to the beneficiary's SACOT program treatment records; and
c. be able to consult by phone or in-person with the CCS, LCAS, or LCAS-A, providing SACOT program services.

Medical, psychological, psychiatric, laboratory, and toxicology services are available through consultation or referral. Psychiatric and other medical consultation must be available by telephone, telehealth, and in person. Needed toxicology testing and psychiatric and medical services can be billed separately from SACOT.

A SACOT program shall support a beneficiary who is prescribed or would benefit from medications, including Medication Assisted Treatment (MAT), to address their substance use or mental health diagnosis. Coordination of care with a prescribing physician is required.

A SACOT provider shall ensure that all staff have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose on site, and

that all staff have training and education on the use of naloxone in suspected opioid overdoses. Programs shall develop policies that detail the use, storage and education provided to staff regarding naloxone.

A comprehensive clinical assessment (CCA), diagnostic assessment (DA), or reassessment must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Relevant diagnostic information must be obtained in the assessment or reassessment and documented in the beneficiary's PCP. The CCA and DA can be billed separately from SACOT.

6.4 Staff Training Requirements

Time Frame	Training Required	Who
Upon Hire, Prior to First Day Worked	▪ Crisis Response* ▪ Opioid Antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose) ▪ Harm Reduction ▪ Substance Abuse Comprehensive Outpatient Treatment (SACOT) ASAM Level 2.5 Definition Required Components	All Staff
Within **90 calendar days** of hire to provide service	▪ ASAM Criteria ▪ PCP Instructional Elements ▪ Trauma informed care* ▪ Co-occurring conditions*	All Staff
Within **180 calendar days** of hire to provide this service	▪ Introductory Motivational Interviewing ▪ Pregnancy and Substance Use Disorder (SUD) ▪ Designated therapies, practices, or modalities specific to the population(s) served in SACOT*	All Staff
Annually	▪ Continuing education in evidence-based treatment practices including crisis response and cultural competency*	All Staff

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

Staff hired prior to the effective date of this policy shall complete the required training identified in the above Staff Training Requirements chart. Training must be completed within one (1) year of the original effective date of this policy. **Refer to Section 8.0 of this policy 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), North Carolina Social Work Certification and Licensure Board (NCSWCLB), American Psychological Association (APA), and Motivational Interviewing Network of Trainers (MINT).

Documentation of staff training activities must be maintained by the program.

6.5 Expected Outcomes

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

a. Reduction or elimination of substance use and substance use disorder symptoms;
b. Sustained improvement in health and psychosocial functioning;
c. Reduction in involvement in the justice system;
d. Reduction of risk of relapse, continued problems, or continued use;
e. Reintegration of the individual into the community;
f. Linkage to other necessary treatment services concurrently and upon discharge;
g. Identification and linkage to community-based resources to address unmet social determinants of health concurrently and upon discharge;
h. Increase in the identification and use of healthy coping skills.

7.0 Additional Requirements

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

7.1 Compliance

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

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

8.0 Policy Implementation and History

Original Effective Date: 05/01/2024

History:

Date	Section or Subsection Amended	Change
05/01/24	All Sections and Attachment(s)	Initial implementation of stand-alone Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) policy.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid. Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with federal laws and regulations.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

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

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

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

C. Code(s)

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

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

HCPCS Code (s)	Billing Unit
H2035	1 unit = 1 hour

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.

Telehealth Claims: Modifier GT must be appended to the HCPCS code to indicate that a service has been provided via interactive audio-visual communication.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under federal laws and regulations.

A minimum of four (4) hours per day of SACOT services must be provided to a beneficiary for a provider to bill for services.

PHPs, PIHPs and provider agencies shall monitor utilization of service by conducting service 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 the beneficiary.

F. Place of Service

SACOT is a licensed service that must be provided in a facility licensed under 10A NCAC 27G .4500.

G. Co-payments

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

H. Reimbursement

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

Outpatient therapy services can be billed separately when the beneficiary needs specialized therapy that cannot be provided by the SACOT provider (Dialectical Behavioral Therapy, exposure therapy, Eye Movement Desensitization and Reprocessing).

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