

**North Carolina,  
Division of Mental Health, Developmental Disabilities,  
and Substance Use Services**

**State-Funded Clinically Managed Low-Intensity Residential Treatment  
Services**

**Date of Amendment- January 1, 2026**



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### Related Clinical Coverage Policies

Refer to <https://www.ncdhhs.gov/providers/provider-information/mental-health-development-disabilities-and-substance-use-services/state-funded-service-definitions> for the related coverage policies listed below:

State-funded Enhanced Mental Health and Substance Abuse Services  
State-funded Assertive Community Treatment (ACT) Program  
State-funded Facility-Based Crisis Service for Children and Adolescents  
State-funded Diagnostic Assessment  
State-funded Community Support Team (CST)  
State-funded Inpatient Behavioral Health Services  
State-funded Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers  
State-funded Psychiatric Residential Treatment Facilities for Children under the Age of 21 8D-2 Residential Treatment Services  
State-funded Peer Support Services

## 1.0 Description of the Service

Clinically Managed Low-Intensity Residential Treatment Services, American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.1 is provided in a 24-hour, seven (7) day a week community-based residential setting. This structured and supportive setting provides clinical and recovery services. This service is designed to treat a beneficiary experiencing functional limitations due to their substance use disorder (SUD). Functional limitations include:

- problems in the application of recovery skills;
- self-efficacy; and
- lack of connection to the community systems of work, education, or family life.

This service provides the beneficiary the opportunity to:

- develop and practice interpersonal and group living skills;
- strengthen their recovery skills;
- reintegrate into the community and family settings; and
- experience employment or academic pursuits.

Clinical and recovery services are characterized by individual, group and family therapy, medication management, and psychoeducation.

## 1.1 Definitions

### The ASAM Criteria, Third Edition<sup>1</sup>

The American Society of Addiction Medicine (ASAM) 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

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assessment to be used for service planning and treatment. The six dimensions are:

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

### **Medication Assisted Treatment (MAT)**

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), Medication Assisted Treatment (MAT) is “the use of medications, in combination with counseling and behavioral therapies, to provide a ‘whole patient’ approach to the treatment of substance use disorders. Medications used are approved by the Food and Drug Administration (FDA), and are clinically driven and tailored to meet each beneficiary’s needs.”

## **2.0 Eligibility Criteria**

### **2.1 Provisions**

An eligible individual shall be enrolled with the LME-MCO on or prior to the date of service, meet the criteria for a state-funded Benefit Plan that covers this service, and shall meet the criteria in Section 3.0 of this policy

Individuals may be ineligible for a state-funded service due to coverage by other payors that would make them ineligible for the same or similar service funded by the state (e.g., the individual is eligible for the same service covered by Medicaid, Health Choice, or other third-party payor).

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## **3.0 When the Service is Covered**

### **3.1 General Criteria Covered**

State funds 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; and
- 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 State Funds**

State funds shall cover Clinically Managed Low-Intensity Residential Treatment Services when the beneficiary meets the following specific criteria:

- a. has a current substance use disorder (SUD) 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 3.1 Clinically Managed Low-Intensity Residential Treatment Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

### 3.2.2 Admission Criteria

#### **Admission Criteria**

Clinically Managed Low-Intensity Residential Treatment Services require a comprehensive clinical assessment (CCA) or a diagnostic assessment (DA) to be completed prior to admission.

These assessments must confirm that the beneficiary has an SUD diagnosis using the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. These assessments must also confirm that the beneficiary meets ASAM Criteria, Third Edition, Level 3.1.

The assessment must be updated as new strengths and barriers are observed in the residential setting. Relevant diagnostic information must be obtained and documented in the Person-Centered Plan (PCP). The beneficiary must have documentation of a physical examination that was completed no more than 90 days prior to admission to Clinically Managed Low-Intensity Residential Treatment Services. If no prior physical examination documentation is available, a physical examination must be completed within the first 45 days of admission.

The amount, duration, and intensity of Clinically Managed Low-Intensity Residential Treatment Services must be documented in a beneficiary's PCP. The completion of the CCA, DA, laboratory, or toxicology tests can be billed separately.

### 3.2.3 Continued Stay Criteria

Each of the six dimensions of the ASAM criteria, as referenced in section 1.1 of this policy, must be reviewed and documented in the beneficiary's service record to document the determination for continued stay, discharge, or transfer to another level of care.

- a. The beneficiary meets the criteria for continued stay if any ONE of the following applies:
  1. The beneficiary has achieved initial PCP goals and requires this level of care 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 symptoms at this level of care. The PCP must be modified to identify more effective interventions; or
  4. The beneficiary is actively working towards goals, so continuing at the present level of care is indicated, and the PCP must be modified to identify more effective interventions.

### 3.2.4 Transition and Discharge Criteria

- a. The beneficiary meets the criteria for discharge if any ONE of the following applies:
  1. The beneficiary has achieved goals articulated in the PCP, resolving the symptom(s) that justified admission to the present level of care. Continuing the chronic disease management of the beneficiary's condition at a less intensive level of care is indicated;
  2. The beneficiary has been unable to resolve the symptom(s) that justified admission to the present level of care, or symptom(s) have intensified. Despite amendments to the PCP, an updated CCA or DA indicates transfer to a different level of care is needed;
  3. The beneficiary has demonstrated a lack of progress due to diagnostic or co-occurring conditions that limit the ability to alleviate the beneficiary's symptom(s). An updated CCA or DA indicates transfer to a different level of care is needed; or
  4. The beneficiary or their legally responsible person requests a discharge from Clinically Managed Low-Intensity Residential Services.

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## 4.0 When the Service is Not Covered

### 4.1 General Criteria Not Covered

State funds 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 Services Not Covered

#### 4.2.1 Specific Criteria Not Covered by State funds

State funds shall not cover the following:

- a. transportation for the beneficiary or family members;
- b. any habilitation activities;
- c. time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill assistance;
- d. clinical and administrative supervision of Clinically Managed Low-Intensity Residential Treatment Services staff, which is covered as an indirect cost and part of the rate;
- e. covered services that have not been rendered;
- f. childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
- g. services provided to teach academic subjects or as a substitute for education;
- 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.
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## **5.0 Requirements for and Limitations on Coverage**

### **5.1 Prior Approval**

State funding shall not require prior approval for Clinically Managed Low-Intensity Residential Treatment Services.

### **5.2 Prior Approval Requirements**

#### 5.2.1 General

None Apply.

#### 5.2.2 Specific

None Apply.

### **5.3 Additional Limitations and Requirements**

#### 5.3.1 Additional Limitations

A beneficiary shall receive Clinically Managed Low-Intensity Residential Treatment Services from only one provider organization during any active episode of care. Clinically Managed Low-Intensity Residential Treatment Services must not be provided and billed on the same day (except day of admission or discharge) as:

- a. Clinically managed residential services;
- b. Clinically Managed Residential Withdrawal Management (ASAM Criteria, Level 3.2 WM);
- c. Medically Monitored Inpatient Withdrawal Management (ASAM Criteria, Level 3.7 WM);
- d. Clinically Managed Population-Specific High-Intensity Residential Programs (ASAM Criteria, Level 3.3);
- e. Clinically Managed High-Intensity Residential Services (ASAM Criteria Level, 3.5);
- f. Medically Monitored Intensive Inpatient Services (ASAM Criteria Level, 3.7);
- g. Substance Abuse Comprehensive Outpatient Treatment (SACOT);
- h. Assertive Community Treatment (ACT); or
- i. Community Support Team (CST).

The case management component of Assertive Community Treatment (ACT) or Community Support Team (CST) may be billed concurrently with Clinically Managed Low-Intensity Residential Treatment Services, for the first and last 30 days, according to the beneficiary's Person-Centered Plan (PCP) and the clinical coverage policies.



A beneficiary may receive Peer Support Services during the same episode of care as Clinically Managed Low-Intensity Residential Treatment Services.

## 5.4 Service Orders

A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the beneficiary's needs. A signed service order must be completed prior to or on the first day that Clinically Managed Low-Intensity Residential Treatment Services are provided. The service order must be completed by a physician, physician assistant, nurse practitioner, or licensed psychologist according to their scope of practice. A service order is valid for the episode of care. Medical necessity must be revisited, and service must be ordered based on episode of care, if multiple episodes of care are required within a twelve (12) consecutive month period.

### **ALL of the following apply to a service order:**

- a. Backdating of the service order is not permitted;
- b. Each service order must be signed and dated by the authorizing professional and must indicate the date that the service was ordered; and
- c. A service order must be in place prior to or on the first day that the service is initially provided, to bill state funds for the service. Even if the beneficiary is retroactively eligible for state funds, the provider shall not bill state funds without a valid service order.

If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in the beneficiary's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation must reflect why a verbal service order was obtained in lieu of a written service order. The appropriate professional must countersign the service order with a dated signature within seventy-two (72) hours of the date of the verbal service order.

## 5.5 Documentation Requirements

### 5.5.1 Contents of a Service Record

The service record documents the nature and course of a beneficiary's progress in treatment. To bill state funds, 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 State funds. Service notes must meet the requirements of the Department of Health and Human Services DHHS Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (c)(4) or federal regulations.

## 6.0 Provider(s) Eligible to Bill for the Service

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

- a. meet State Funded Benefit Plan 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 licensing entity.

### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Clinically Managed Low-Intensity Residential Treatment Services must be delivered by a substance use disorder treatment provider organization that:

- a. meets the provider qualification policies, procedures, and standards established by NC DMH/DD/SUS;
- b. meets the requirements of 10A NCAC 27G;
- c. demonstrates that they meet these standards by being credentialed and contracted by the LME-MCO;
- d. adheres to the service-specific checklist which includes the following:
  1. Rules for Mental Health, Developmental Disability, and Substance Use Facilities and Services
  2. Confidentiality Rules
  3. Client Rights Rules in Community MH/DD/SU Services
  4. *Records Management and Documentation Manual*
  5. DMH/DD/SUS Communication Bulletins
  6. Implementation Updates to rules, revisions, and policy guidance
  7. *Person-Centered Planning Instruction Manual*
  8. DMH/DD/SUS NC Tracks Benefit Plan Criteria
- e. within one year of enrollment as a provider receiving state funds for reimbursement, achieves national accreditation with at least one of the designated accrediting agencies; and
- f. becomes established as a legally constituted entity capable of meeting all the requirements of the LME-MCO Enrollment Agreement, Joint Communication 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 .5600 Supervised Living for Individuals of all Disability Groups. Facilities must be licensed under an approved rule waiver, if applicable.

Providers and organizations that provide Clinically Managed Low-Intensity Residential Treatment Services shall provide crisis response 24 hours-a-day, seven (7) days a week to a beneficiary who is receiving Clinically Managed Low-Intensity Residential Treatment Services.

## 6.2 Provider Certifications

### 6.2.1 Staffing Requirements

Required Position	Minimum Qualifications	Responsibilities
<p><b>Program Manager</b></p>	<p><b>Qualified Professional in Substance Abuse (QP)</b>, in accordance with 10A NCAC 27G .0104 or federal regulations.</p> <p>This position may be filled by a Paraprofessional or Associate Professional (AP) if the Program Manager held the position as of the original effective date of this policy. <b>Refer to Section 8.0 of this policy.</b></p>	<p>The <b>Program Manager</b> is responsible for general oversight of the program and supervision of the staff. The Program Manager ensures adequate staffing is in place, manages admissions and discharges, and ensures the program is adhering to the policy, rules, and statutes. The Program Manager or designee is responsible for ensuring there is 24-hour, seven day a week access to on-call staff who can provide immediate support in person, via telehealth, or telephonically. This position shall develop program policies and procedures to include secure transportation and storage of any medications administered for Medication Assisted Treatment (MAT).</p>

<b>Licensed Clinical Staff</b>	<p>The Licensed Clinical Staff shall meet one of the following:</p> <p>Be a Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist – Associate (LCAS-A) with a valid license from the NC Addictions Specialist Professional Practice Board; or</p> <p>Be a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Social Worker Associate (LCSWA) with a valid license from the NC Social Work Certification and Licensure Board; or</p> <p>Be a Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Clinical Mental Health Counselor – Associate (LCMHCA) with a valid license from the NC Board of Licensed Clinical Mental Health Counselors; or</p>	<p><b>The Licensed Clinical Staff</b> provides substance use focused and co-occurring assessment and treatment services and develops an ASAM Level of Care determination.</p> <p>The Licensed Clinical Staff shall provide referral and coordination to appropriate substance use disorder treatment and recovery resources and develop a PCP. The Licensed Clinical Staff provides clinical program supervision to the Certified Clinical Staff.</p>
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	<p>Be a Licensed Marriage and Family Therapist (LMFT) or Licensed Marriage and Family Therapist Associate (LMFTA) with a valid license from the NC Marriage and Family Therapy Licensure Board; or</p> <p>Be a Licensed Psychologist with a valid license from the NC Psychology Board;</p> <p>AND</p> <p>Meet criteria of a Qualified Professional (QP) in Substance Abuse in accordance with 10A NCAC 27G .0104 or federal regulation(s).</p>	
<p><b>Certified Clinical Staff</b> (may be substituted with LCAS or LCAS-A at the discretion of the provider)</p>	<p><b>CADC, CADC-I, Registrant (Alcohol and Drug Counselor)*</b></p> <p>Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board (NCASPPB).</p> <p>*A Registrant must :</p> <ul style="list-style-type: none"> <li>• meet the requirements for a Paraprofessional, Associate Professional (AP), or Qualified Professional (QP); and</li> <li>• be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of the effective date of this policy (<b>Refer to Section 8.0</b>); or</li> </ul>	<p>The <b>Certified Alcohol and Drug Counselor (CADC), Certified Alcohol and Drug Counselor (CADC-I), or Registrant*</b> coordinates with the Licensed Clinical Staff and Program Manager to deliver and ensure that a beneficiary has access to counseling supports, psychoeducation, and crisis intervention. Certified clinical staff will participate in the development of the PCP, relapse prevention plan and disease management strategies. They play a lead role in case management and coordination of care functions. Licensed clinical staff shall fulfill these responsibilities if CADCs are not included in the staffing for this program. All responsibilities of the Certified Clinical Staff must be covered by the Licensed Clinical Staff when Certified Clinical Staff are not included in the staffing for this program.</p>

	<ul style="list-style-type: none"> <li>• be designated as an Alcohol and Drug Counselor Intern by the NCASPPB within one year of hire.</li> </ul>	
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<p><b>Support Staff</b></p>	<p><b>Paraprofessionals, Associate Professionals (AP), or Qualified Professional in Substance Abuse (QP)</b>, in accordance with 10A NCAC 27G .0104 or equivalent federally recognized or federal regulations.</p>	<p><b>Support Staff</b> are responsible for tasks that ensure a beneficiary has 24 hour a day, seven (7) day a week access to supports to meet their behavioral health and physical needs. They work closely with clinical staff to support and monitor the acquisition of new skills, ensure basic daily needs and activities of daily living are completed and recorded, and support recovery-oriented interventions. Support Staff may coordinate with the beneficiary’s primary physician when needed.</p>

<b>Health Services Coordinator</b>	At minimum, must be a Paraprofessional as defined in 10A NCAC 27G .0104 Must have a current NC driver's license.	<b>The Health Services Coordinator</b> organizes and coordinates MAT appointments for a beneficiary receiving Clinically Managed Low-Intensity Residential Treatment Services. The Health Services Coordinator organizes and coordinates physical health and specialist appointments to ensure that a beneficiary is able to access needed physical health care services without disrupting treatment. The Health Services Coordinator facilitates transportation to and from scheduled MAT, physical health, and specialist appointments. This position ensures safe and secure transportation of any prescribed medications from the MAT provider to the residential program. The Health Services Coordinator collaborates with the medical staff and Program Manager to ensure information regarding MAT is reflected in the beneficiary's PCP and clinical record. The Health Services MAT Coordinator completes progress notes on a beneficiary who receives MAT, physical health, and specialist appointment coordination support, to include detailing the secure custody procedures that were followed, the date and time of appointments, and provider contact information. The Health Services Coordinator ensures release of information forms are completed and filed.
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### 6.2.2 Staff Training Requirements

Time Frame	Training Required	Who
<b>Prior to Service Delivery</b>	<ul style="list-style-type: none"> <li>• Crisis Response</li> <li>• Opioid antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose)</li> <li>• Harm Reduction</li> <li>• Clinically Managed Low-Intensity Residential Treatment Services Definition Required Components</li> </ul>	All Staff
Within <b>90 calendar days</b> of hire to provide service	<ul style="list-style-type: none"> <li>• ASAM Criteria</li> <li>• PCP Instructional Elements</li> <li>• Designated therapies, practices or modalities used in Clinically Managed Low-Intensity Residential Treatment Services*</li> <li>• Reproductive Planning and Health Education</li> </ul>	All Staff
Within <b>180 calendar days</b> of hire to provide this service	<ul style="list-style-type: none"> <li>• Trauma informed care*</li> <li>• Co-occurring conditions*</li> <li>• Introductory Motivational Interviewing*</li> </ul>	All Staff
<b>Annually</b>	<ul style="list-style-type: none"> <li>• Continuing education in evidence-based treatment practices including crisis response and cultural competency training*</li> </ul>	All Staff

The initial training requirements may be waived by the hiring agency if the staff can produce documentation certifying that training 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. Documentation of staff training activities must be maintained by the program.

Training identified with an asterisk (\*) must be reviewed and approved by a NC DHHS recognized accreditation entity (e.g., Commission on Accreditation of Rehabilitation Facilities), or must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical



professionals. Some examples of 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).

### **6.3 Program Requirements**

- a. Clinically Managed Low-Intensity Residential Treatment Services are provided in a 24-hour licensed facility in accordance with 10A NCAC 27G .5600 Supervised Living for Individuals of all Disability Groups. Clinically Managed Low-Intensity Residential Treatment Services shall provide a minimum of at least five (5) hours of clinically directed program activities per week. The beneficiary receiving this service can attend work, school, and substance use or behavioral health treatment services.
- b. Clinically Managed Low-Intensity Residential Treatment Services programs shall support a beneficiary who is prescribed medications to address their substance use or mental health diagnosis. Coordination of care with the prescribing physician or physician extender is required.
- c. Clinically Managed Low-Intensity Residential Treatment providers shall ensure access to Medication Assisted Treatment (MAT). MAT may be administered by the provider, or through a Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) with another provider that is no further than 60 minutes from the facility.
- d. Clinically Managed Low-Intensity Residential Treatment Services providers shall ensure that all programs have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist on site. Providers shall ensure that all staff have training and education on the use of naloxone in suspected opioid overdoses. Providers shall develop policies that detail the use, storage and education provided to staff regarding naloxone.
- e. A comprehensive clinical assessment (CCA), diagnostic assessment 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 and documented in the beneficiary's PCP.
- f. Clinically Managed Low-Intensity Residential Treatment Services include the following:
  1. A CCA or DA completed prior to admission;
  2. Interdisciplinary assessments and treatment designed to develop and apply recovery skills;

3. A PCP documenting problem identification in the ASAM Criteria, Third Edition dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives, needs, strengths, skills, and priority formulation of short-term goals and preferences, and activities designed to achieve those goals;
4. At least 5 hours per week of planned and professionally directed clinical program activities, including individual, group and family counseling and therapy, case management, and other recovery supports. Interventions are designed to improve the beneficiary's ability to structure and organize their tasks of daily living and recovery, develop and practice prosocial behaviors, stabilize and maintain the stability of the beneficiary's addiction symptoms, and help the beneficiary develop and apply recovery skills;
5. A range of evidence-based cognitive, behavioral, and other therapies that address primary substance use disorder as well as co-occurring substance use and mental health disorder;
6. Motivational enhancement and engagement strategies appropriate to the beneficiary's stage of readiness and desire to change;
7. Trauma informed practices and interventions tailored to the specific population being served;
8. Monitor signs and symptoms of substance use, intoxication, and withdrawal, and the treatment of those conditions;
9. Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the beneficiary's PCP;
10. Medication education and addiction pharmacotherapy;
11. Regular monitoring of the beneficiary's adherence in taking any prescribed and over the counter medications;
12. Counseling and clinical interventions to facilitate teaching the skills needed for successful reintegration into family, community living, work, and school;
13. Educational skill building and occupational or recreational activities;
14. Reproductive planning and health education, including referral to external partners to access necessary services and supports;
15. Daily assessment of progress and any treatment changes, based on the beneficiary's PCP goals;
16. Behavioral health crisis interventions, when clinically appropriate;
17. Arrange for the involvement of family members or significant others to provide education on and engagement in the treatment process, with informed consent;
18. Direct coordination with the justice system and Department of Social Services, when the beneficiary has current involvement with either of these systems;
19. Affiliation with other ASAM levels of care, or close coordination through referral to more and less intensive levels of care and other services such as:
  - i. medical, clinical, familial, and ancillary services;

- ii. intensive outpatient treatment;
- iii. vocational assessment and placement;
- iv. literacy training and adult education;
- v. behavioral health providers;
- vi. Medication Assisted Treatment providers;
- vii. psychological and psychiatric consultation; and
- viii. supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
- g. Care coordination and care management for linkage and referrals for counseling, as well as medical, psychiatric, and continuing care;
- h. Ability to arrange for pharmacotherapy for psychiatric or substance use disorder medications;
- i. Ability to arrange for needed procedures including indicated laboratory and toxicology tests, as medically necessary; and
- j. Discharge and **transition** planning beginning at admission.

#### **6.4 Expected Outcomes**

The expected clinical outcomes for Clinically Managed Low-Intensity Residential Treatment Services are specific to recommendations resulting from clinical assessments 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 of risk of relapse, continued problems, or continued use;
- d. eventual reintegration of the individual into the community;
- e. linkage to other necessary treatment services concurrently and upon discharge;
- f. identification and linkage to community-based resources to address unmet social determinants of health; and
- g. increase in the identification and use of healthy coping skills.

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## **7.0 Additional Requirements**

### **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 DMH/DD/SUS's clinical policies (service definitions), guidelines, policies, provider manuals, implementation updates, and bulletins.

### **7.2 Audits and Compliance Reviews**

LME-MCOs are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance use services at the community level. An LME-MCO shall plan, develop, implement, and monitor services within a

specified geographic area to ensure expected outcomes for individuals eligible for state funded services within available resources, per NC GS § 122C-115.4(a).

The area authority or county program shall monitor the provision of mental health, developmental disabilities, or substance use services for compliance with law, which monitoring, and management shall not supersede or duplicate the regulatory authority or functions of agencies of the Department, per NC GS § 122C-111.

DMH/DD/SUS conducts annual monitoring of a sample of mental health and substance use disorder services funded with SUPTRS, CMHBG and state funds. The purpose of the monitoring is to ensure that these services are provided to individuals in accordance with federal & state regulations and requirements. The LME- MCO shall also conduct compliance reviews and monitor provider organizations under the authority of DMH/DD/SUS to ensure compliance with state funds and federal block grant regulations and requirements.

### 7.3 Regulatory Authority

The following resources, and the rules, manuals, and statutes referenced in them, give the Division of MH/DD/SUS the authority to set the requirements included in this policy:

- a. Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, Administrative Publication System Manuals (APSM)30-1
- b. DMHDDSUS Records Management and Documentation Manual, APSM 45-2
- c. DMHDDSUS Person-Centered Planning Instruction Manual
- d. N.C. Mental Health, Developmental Disabilities, and Substance Abuse Laws, 2001 (G.S. 122-C)

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## 8.0 Policy Implementation and History

- **Original Effective Date:** January 1, 2026

**History:**

Date	Section or Subsection Amended	Change
01/01/2026	All Sections and Attachment(s)	Initial implementation of stand-alone Clinically Managed Low-Intensity Residential Treatment Services policy.

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## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Joint Communications Bulletins, fee schedules, NC DMH/DD/SUS service definitions, and any other relevant documents for specific coverage and reimbursement for state funds.

### 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 Procedure 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 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.

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
H2034	1 Unit = 1 Day

Unlisted Procedure or Service

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

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

#### **D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

#### **E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).  
Clinically Managed Low-Intensity Residential Treatment Services is billed as a daily unit.

#### **F. Place of Service**

- This is a facility-based service.

#### **G. Co-payments**

- Not applicable

#### **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 Clinically Managed Low-Intensity Residential Treatment Services provider (Dialectical Behavioral Therapy, exposure therapy, Eye Movement Desensitization and Reprocessing).

The CCA, DA, toxicology testing, psychiatric and medical services, and medically necessary peer support services can be billed separately from Clinically Managed Low-Intensity Residential Treatment Services.