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**Related State-Funded Service Definition Policies**

Refer to https://www.ncdhhs.gov/providers/provider-information/mental-health-development-disabilities-and-substance-use-services/service-definitions for the related policies listed below:
State-Funded Ambulatory Withdrawal Management Without Extended On-Site Monitoring
State-Funded Ambulatory Withdrawal Management With Extended On-Site Monitoring
State-Funded Medically Monitored Inpatient Withdrawal Management Services
State-Funded Inpatient Behavioral Health Services
State-Funded Enhanced Mental Health & Substance Use Services
State-Funded Diagnostic Assessment
State-Funded Outpatient Behavioral Health Services
State-Funded Opioid Treatment Program

# 1.0 Description of the Service

Clinically Managed Residential Withdrawal Management Service is an organized facility-based service that is delivered by trained staff who provide 24-hour supervision, observation, and support for an individual who is intoxicated or experiencing withdrawal. This an American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.2-WM service intended for an individual who is not at risk of severe withdrawal symptoms or severe physical and psychiatric complications. Moderate withdrawal symptoms can be safely managed at this level of care.

This service emphasizes the utilization of peer and social supports to safely assist an individual through withdrawal. Programs must have established clinical protocols developed and supported by a physician who is available 24 hours a day. Support systems must include direct coordination with other levels of care. This service is designed to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the individual'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

a. 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 and shall meet the criteria in **Section 3.0** of this policy.
b. Provider(s) shall verify each individual's eligibility each time a service is rendered.

### 2.1.2 Specific

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

State funds shall cover the Clinically Managed Residential Withdrawal Management Services for an eligible individual who is 18 years old or over and meets the criteria in **Section 3.0** of this policy.

# 3.0 When the Service Is Covered

## 3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and:

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

## 3.2 Specific Criteria Covered

### 3.2.1 Specific criteria covered by State Funds

Stand funds shall cover Clinically Managed Residential Withdrawal Management Services when the individual meets the following specific criteria:

a. has a substance use disorder (SUD) diagnosis as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; and
b. meets the American Society of Addiction Medicine (ASAM) Level 3.2-WM Clinically Managed Residential Withdrawal Management Services admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

### 3.2.2 Admission Criteria

a. Due to the nature of this crisis service, a comprehensive clinical assessment (CCA) or diagnostic assessment (DA) is not required before admission to Clinically Managed Residential Withdrawal Management Services.

b. An initial abbreviated assessment must be completed by clinical staff and protocols must be developed and in place to determine when a physical exam must be conducted by the medical director or physician extender.

c. The initial abbreviated assessment must be used to establish medical necessity for this service and develop of a service plan as a part of the admission process.

d. The initial abbreviated assessment must contain the following documentation in the individual's service record:

1. presenting problem;
2. needs and strengths;
3. a provisional or admitting diagnosis when the assessment is completed by a licensed professional;
4. an ASAM level of care determination;
5. a physical examination including pregnancy testing, as indicated, performed by the physician or physician extender if self-administered withdrawal management medications are to be used;
6. a pertinent social, family, and medical history; and
7. other evaluations or assessments.

e. Within three (3) calendar days of the admission, a CCA or DA must be completed by a licensed professional to determine an ASAM level of care for discharge planning. The ASAM level of care determination must provide information on how this score is supported under each of the six ASAM dimensions. Information from the abbreviated assessment may be utilized as a part of the current comprehensive clinical assessment. Relevant diagnostic information must be obtained and be included in the treatment or service plan.

f. The licensed clinician can bill separately for the completion of the CCA or DA.

### 3.2.3 Continued Stay and Discharge Criteria

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

1. The individual's withdrawal symptoms have not been sufficiently resolved to allow either discharge to a lower level of care or safe management in a less intensive environment; or
2. The individual's CIWA-Ar score (or comparable standardized scoring system) has not increased or decreased.

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

1. The individual's withdrawal signs and symptoms are sufficiently resolved so that they can participate in self-directed recovery or ongoing treatment without the need for further medical withdrawal management monitoring;
2. The individual's signs and symptoms of withdrawal have failed to respond to treatment, and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system) indicating a transfer to a more intensive level of withdrawal management services is indicated;
3. The individual is unable to complete withdrawal management in Clinically Managed Residential Withdrawal Management service indicating a need for more intensive services; or
4. The individual or person legally responsible for the individual requests a discharge from the service.

#### 3.2.4 State Funds Additional Criteria Covered

None Apply.

## 4.0 When the Service Is Not Covered

### 4.1 General Criteria Not Covered

State funds shall not cover the service related to this policy when:

a. the individual does not meet the eligibility requirements listed in **Section 2.0;**
b. the individual does not meet the criteria listed in **Section 3.0;**
c. the service duplicates another provider's service; or
d. the service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria Not Covered

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

State funds shall not cover these activities:

a. Transportation for the individual or family members;
b. Any habilitation activities;
c. Time spent attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Clinical and administrative supervision of Clinically Managed Residential Withdrawal Management Services staff, which is covered as an indirect cost and part of the rate;
e. Covered services that have not been rendered;
f. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
g. Services provided to teach academic subjects or as a substitute for education personnel;
h. Interventions not identified on the individual's service plan;
i. Services provided to children, spouse, parents, or siblings of the individual

under treatment or others in the life to address problems not directly related to the individual's needs and not listed on the service plan; and

j. Payment for room and board; and

k. An individual under the age of 18.

#### 4.2.2 State Funds Additional Criteria Not Covered

None Apply.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

State funds shall not require prior approval for Clinically Managed Residential Withdrawal Management Services upon admission through the first three (3) 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

#### 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 individual who is eligible for this service.

Services are based upon a finding of medical necessity, must be directly related to the individual's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the individual's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the LME/MCO 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 individual'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 LME/MCO authorization request form must be submitted to the LME/MCO or utilization management contractor within the first three (3) 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 LME/MCO or utilization management contractor.

### 5.3.3 Additional Limitations

An individual can receive the Clinically Managed Residential Withdrawal Management Service from only one provider organization during any active authorization period.

Clinically Managed Residential Withdrawal Management Services must not be billed on the same day (except day of admission or discharge) as:

a. Residential levels of care
b. Other withdrawal management services
c. Outpatient treatment services
d. Substance Abuse Intensive Outpatient Program (SAIOP)
e. Substance Abuse Comprehensive Outpatient Treatment (SACOT)
f. Assertive Community Treatment (ACT)
g. Community Support Team (CST)
h. Supported Employment
i. Psychiatric Rehabilitation
j. Peer Support Services
k. Mobile Crisis Management (MCM)
l. Partial Hospitalization
m. Facility Based Crisis (Adult)

## 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 individual's needs. A signed service order must be completed by the physician or physician extender, consistent with their scope of practice. Service orders are 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) month period.

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

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must 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 state funds for the service.

### 5.5 Documentation Requirements

The service record documents the nature and course of an individual's progress in treatment. To bill state funds, providers shall ensure that their documentation is consistent with the requirements contained in this policy. This service requires a shift note to be completed for every shift of service provided. Events in an individual's life which require additional activities or interventions are documented over and above the minimum frequency requirement.

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by 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).

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

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

a. meet State 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 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

Clinically Managed Residential Withdrawal Management Services must be delivered by a provider employed by a substance use treatment organization that:

a. meets the provider qualification policies, procedures, and standards established by the state funds;

b. meets the requirements of 10A NCAC 27G Rules for Mental Health, Developmental Disabilities & 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 receiving state funds, 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 Enrollment Agreement, DMHDDSUS 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 a 10A NCAC 27G Section .3200 Social Setting Detoxification for Substance Abuse licensure 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.

## 6.2 Provider Certifications

**Staffing Requirements**

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| **Medical Director** | **Medical Director** shall be a licensed physician in good standing with the NC Medical Board.<br><br>Medical Director shall have at least one year of SUD treatment experience. | The **Medical Director** is responsible for providing medical services and supervising physician extender staff according to the physician approved policies and protocols of the Clinically Managed Residential Withdrawal Management 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.<br><br>In addition to the above, the Medical Director is responsible for the following, either through direct provision of the function or through ensuring provision by other staff within their scope and function:<br><br>• Perform a medical history and physical exam upon admission<br>• Determine diagnosis of substance use disorder per program eligibility requirements<br>• Monitor the Controlled Substance Reporting System (CSRS)<br>• Ensure there is emergency medical backup and coverage available for consultation 24 hours a day, seven days a week<br>• Contribute to service plan development<br>• Evaluate medication or non-medication methods of withdrawal management<br>• Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the treatment and monitoring of those conditions<br>• Evaluate, prescribe, and monitor all medications currently being taken by the individual including coordination with other prescribers |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | • Provide education to an individual regarding prescribed medications, potential drug interactions and side effects<br>• Order medications as medically necessary<br>• Order medically necessary toxicology and laboratory tests<br>• Provide case consultation with interdisciplinary treatment team<br>• Assess for co-occurring medical and psychiatric disorders<br>• Make referrals and follow up for treatment of co-occurring medical and psychiatric disorders<br>• Coordinate care with other medical and psychiatric providers. |
| **Physician Extender** | **Physician Assistant (PA) or Nurse Practitioner (NP)**<br><br>Licensed physician assistant or nurse practitioner in good standing with the NC Medical Board or NC Nursing Board, respectively.<br><br>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 Clinically Managed Residential Withdrawal Management program. The physician extender may provide coverage for emergency medical consultation services 24 hours a day, seven days a week, in-person or virtually.<br><br>In addition to the above, the Physician Extender is responsible for the following, either through direct provision of the function or through ensuring provision by other staff within their scope and function:<br><br>• Perform a medical history and physical exam upon admission<br>• Determine diagnosis of substance use disorder per program eligibility requirements<br>• Monitor the Controlled Substance Reporting System (CSRS)<br>• Provide emergency medical back up and coverage and be available for consultation 24 hours a day, seven days a week, as directed by the Medical Director<br>• Contribute to service plan development<br>• Evaluate medication or non-medication methods of withdrawal management<br>• Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | as well as the treatment and monitoring of those conditions<br>• Evaluate, prescribe, and monitor all medications currently being taken by the individual including coordination with other prescribers<br>• Provide education to an individual regarding prescribed medications, potential drug interactions and side effects<br>• Order medications as medically necessary<br>• Order medically necessary toxicology and laboratory tests<br>• Provide case consultation with interdisciplinary treatment team<br>• Assess for co-occurring medical and psychiatric disorders<br>• Make referrals and follow up for treatment of co-occurring medical and psychiatric disorders<br>• Coordinate care with other medical and psychiatric providers. |
| **Program Manager** | The **Program Manager** shall be a Qualified Professional and have a minimum of two years of experience working with adults with SUD. | The **Program Manager** shall be responsible for general oversight of the program, to include ensuring staffing is in place, managing admission and discharges, and ensuring the program is adhering to the policy, rules, and statutes. The program manager shall be available for emergency program oversight responsibilities 24 hours a day, seven days a week, in-person or virtually.<br><br>In addition to the above, the Program Manager is responsible for the following:<br><br>• Oversee the administrative operation of the withdrawal program<br>• Provide programmatic supervision to staff to assure the delivery of best and ethical practices<br>• Coordinate the initial and ongoing assessment activities<br>• Facilitate any recurring program meetings<br>• Monitor and evaluate the services, interventions, and activities provided by the team<br>• Assist with crisis interventions<br>• Participate in service and discharge planning meetings |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | • Facilitate transition to the next level of care and community-based resources<br>• Work with an individual's natural supports<br>• Develop collaborative working relationships with community-based providers and organizations to facilitate warm handoffs at discharge<br>• Develop and implement supervision plans that meet the requirements of 10A NCAC 27G .0104 |
| **Clinical Staff** | **Licensed Clinical Addictions Specialist (LCAS) or Licensed Clinical Addictions Specialist-Associate (LCAS-A)**<br><br>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 substance use disorder treatment and recovery resources.<br><br>In addition to the above, the LCAS or LCAS-A is responsible for the following:<br><br>• Discharge planning must begin upon admission<br>• Participate in the development of an individualized service plan and ongoing revisions<br>• Provide ongoing assessment and reassessment of the individual based on their service plan and goals<br>• Provide clinical program supervision to CADC or CSAC<br>• Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the treatment and monitoring of those conditions<br>• Provide crisis interventions, when clinically necessary<br>• Engage with family members or individuals identified by the individual as being important to their care and recovery in the withdrawal management process with the individual's consent<br>• Provide education to family members or individuals identified by the individual as being important to their care and recovery regarding withdrawal management process |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | • Provide support with the coordination and consultation with medical, clinical, familial, and ancillary relevant parties with the individual's consent<br>• Ensure linkage to medically necessary services including arranging for psychological and psychiatric evaluations<br>• Inform the individual about benefits, community resources, and services<br>• Monitor and document the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the service plan<br>• Maintain accurate service notes and documentation for all interventions provided<br>• Participate in staff meetings and treatment team meetings. |
| **Clinical Staff** | **Certified Alcohol and Drug Counselor (CADC) or Certified Substance Use Counselor (CSAC)**<br><br>Shall be certified and in good standing with the NC Addictions Specialist Professional Practice Board. | The **Certified Alcohol and Drug Counselor (CADC) or Certified Substance Use Counselor (CSAC)** coordinates with the LCAS or LCAS-A and Program Manager to ensure that an individual has access to counseling supports, psychoeducation, and crisis interventions. The CADC and CSAC play a lead role in case management and coordination of care functions.<br><br>In addition to the above, the CADC or CSAC is responsible for the following:<br><br>• Facilitate the initial development, implementation, and ongoing revision of the service plan<br>• Assist the LCAS or LCAS-A with behavioral and substance use disorder interventions<br>• Direct coordination with the individual's State-Funded Comprehensive Case Manager (CCM), Care Management or Care Coordination provider to ensure all care management functions are clearly assigned and monitored to avoid duplication of efforts |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | • Provide ongoing assessment and reassessment of the individual based on their service plan and goals<br>• Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the treatment and monitoring of those conditions<br>• Provide crisis interventions, when clinically necessary<br>• Provide psychoeducation as indicated in the service plan<br>• Monitor and document the status of the individual's progress and the effectiveness of the strategies and interventions outlined in the service plan<br>• Provide substance use, health, and community services education<br>• Assist with the development of relapse prevention and disease management strategies<br>• Communicate the individual's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and Program Manager as outlined in the service plan<br>• Engage with family members or individuals identified by the individual as being important to their care and recovery in the withdrawal management process with the individual's consent<br>• Provide education to family members or individuals identified by the individual as being important to their care and recovery regarding withdrawal management process<br>• Inform the individual about benefits, community resources, and services<br>• Assist in accessing transportation services<br>• Provide linkage and referrals for recovery services and supports<br>• Advocate for and assists the individual in accessing benefits and services<br>• Maintain accurate service notes and documentation for all interventions provided<br>• Participate in staff meetings and treatment team meetings. |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| | | • Take, record and report out vital signs as ordered by medical staff |
| **NC Certified Peer Support Specialist (NC CPSS)** | **NC CPSS**<br><br>Shall have at least one year of experience working with adults with SUD and be fully certified as a peer support specialist in NC. | The **NC Certified Peer Support Specialist (NC CPSS)** uses their lived experience and recovery to provide support and share hope as they walk with an individual through the first steps of their recovery journey.<br><br>In addition to the above, the CPSS is responsible for the following:<br><br>• Share lived experience to support, encourage and enhance an individual's treatment and recovery<br>• Model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience<br>• Explore with an individual the importance and creation of a recovery and wellness identity<br>• Promote an individual's opportunity for personal growth by identifying teachable moments for building relationship skills to empower the individual and enhance personal responsibility<br>• Model and share examples of healthy social interactions and facilitate familiarity with, and connection to, the local community, including mutual aid groups and self-help resources<br>• Guide and encourage the individual to take responsibility for and actively participate in their own recovery<br>• Assist the individual with self-determination and decision-making<br>• Model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience<br>• Teach and promote self-advocacy to the individual<br>• Assist with crisis interventions<br>• Participate in team meetings and provide input into the service planning process |

| Required Position | Minimum Qualifications | Responsibilities |
|---|---|---|
| **Support Staff** | **Support Staff** can be paraprofessionals, associate professionals (AP) or qualified professionals (QP).<br><br>Shall have one year of experience working with adults with SUD. | **Support staff** are responsible for tasks that ensure the individual is medically able to receive support at this level of care. Support Staff work closely with medical staff to ensure monitoring is completed and recorded, and with clinical staff to support the provision of recovery-oriented interventions.<br><br>In addition to the above, the Support Staff is responsible for the following:<br><br>• Use psychoeducation strategies and recovery interventions to support the individual<br>• Take, record and report out vital signs as ordered by medical staff<br>• Communicate observations and recommendations effectively in written and verbal form<br>• Assist with crisis interventions<br>• Follow the service plan or clinical orders<br>• Work independently and as a member of the team<br>• Communicate effectively with the individual, staff, and others<br>• Learn and apply recovery-oriented practices and person- centered approaches when working with an individual<br>• Participate in team meetings and provide input into the service planning process |

Clinical staff (LCAS, LCAS-A, CSAC or CADC) shall be available seven (7) days a week for clinical interventions. Certified Peer Support Specialist services shall be available seven (7) days a week to support recovery-related activities.

A minimum of two (2) staff shall be on site at all times and the staffing ratio must be at least one (1) staff to nine (9) beneficiaries.

**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

a. Clinically Managed Residential Withdrawal Management Service is an organized facility-based service that is provided by trained clinicians who provide clinically supervised evaluations and certified staff and paraprofessionals who provide withdrawal management and referral services. Staff refer for medical evaluation if clinically necessary. An individual that is eligible for this service is experiencing signs of intoxication and withdrawal and the symptoms are sufficiently severe to require 24-hour structure and support, but do not require extensive medical or nursing care. This service is designed to safely assist the individual through withdrawal without the need for immediate on-site access to medical personnel.

b. Protocols, developed and supported by a medical director knowledgeable in addiction medicine, must be in place to determine the nature of the medical interventions that may be required. Protocols must include under what conditions physician care is warranted and when transfer to a medically monitored facility or an acute care hospital is necessary.

c. Clinically Managed Residential Withdrawal Management Service providers shall have staff to screen and accept admissions a minimum of twelve (12) hours a day, seven (7) days a week. At least five (5) of these twelve (12) hours must occur during second shift. The Clinically Managed Residential Withdrawal Management Services Medical Director shall develop agency specific policies and procedures that address admission expectations, how the intake process must be handled, and staffing expectations to include back-up and consultation coverage.

d. Clinically Managed Residential Withdrawal Management Service providers shall provide access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) for the individual that meets medical necessity for that service. MAT may be provided on-site by the provider or through a memorandum of agreement (MOA) or memorandum of understanding (MOU) with an off-site provider that is no further than 60 minutes from the facility.

e. Clinically Managed Residential Withdrawal Management Service providers shall ensure that all programs 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.

f. Required components of this service include the following:
   1. A CCA or DA within three (3) calendar days of admission;
   2. An initial assessment at admission;
   3. A physical examination, to be completed by a physician or physician extender, when clinically indicated;

4. Individualized service plan, including problem identification in ASAM Third Edition dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
5. Daily assessment of progress during withdrawal management and any treatment changes;
6. Provide monitoring of the individual, to include the individual's general condition and vital signs (pulse rate, blood pressure and temperature) based on documented severity of signs and symptoms of withdrawal;
7. Provide 24-hour access to emergency medical consultation services;
8. Provide behavioral health crisis interventions, when clinically necessary;
9. Ability to arrange for laboratory and toxicology tests, which can be point-of-care testing;
10. Staff supervision of self-administered medications for the management of withdrawal, as needed;
11. Provide education to the individual regarding prescribed medications, potential drug interactions and side effects;
12. Health education services;
13. Reproductive planning and health education, and referral to external partners as necessary;
14. Provide clinical services, including individual and group counseling, to enhance the individual's understanding of addiction, the completion of the withdrawal management process, and referral to a level of care for continuing treatment;
15. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
16. Arranges involvement of family members or others to provide education on and engagement in the withdrawal management process, with informed consent;
17. Ability to assist in accessing transportation services for an individual who lacks safe transportation;
18. Direct coordination with other levels of care, including specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
19. Linkage and coordination with care management services and supports
20. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals for counseling, medical, psychiatric, and continuing care; and
21. Discharge and transfer planning, beginning at admission.

g. This facility must be in operation 24 hours a day, seven (7) days a week. The facility must have a physician available to provide medical evaluations and consultation 24 hours a day, in accordance with treatment and transfer practice protocols and guidelines. The physician and physician extender shall have the availability to schedule and provide medical evaluations per policy requirements. This service must be available for admission seven (7) days per week. Program medical staff shall be available to provide 24-hour access for emergency medical consultation services. Staffing ratios must not exceed 1:9, one direct care staff to nine individuals receiving services.

### 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)<br>▪ Crisis Response*<br>▪ Harm Reduction<br>▪ Clinically Managed Residential Withdrawal Management Service Definition Required Components | All Staff |
| Within **90 calendar days** of hire to provide service | ▪ Medically supervised withdrawal management including assessing and managing intoxication and withdrawal states<br>▪ Pregnancy, Substance Use Disorder and Withdrawal Management | Physician, PA, NP |
| | ▪ Signs and Symptoms of Alcohol and Other Drug Intoxication and Withdrawal, Treatment and Monitoring of the Condition and Facilitation into Ongoing Care<br>▪ Pregnancy, Substance Use Disorder and Withdrawal Management | Program Manager, LCAS, LCAS-A, CADC, CSAC, CPSS, Support Staff |
| | ▪ ASAM Criteria | All Staff |
| | ▪ Measuring Vital Signs (to include how to effectively and accurately obtain, record, and report the vital signs of temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, and pain.)<br>▪ Medication Administration | Program Manager, CADC, CSAC, Support Staff |
| Within **180 calendar days** of hire to provide this service | ▪ Introductory Motivational Interviewing* (MI) | Program Manager, LCAS, LCAS-A, CADC or CSAC |
| | ▪ Trauma informed care*<br>▪ Co-occurring conditions* | Program Manager, LCAS/LCAS-A, CADC, CSAC, CPSS, Support 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 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 the 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 individual's service plan. Expected outcomes as follows:

a. Reduction or elimination of withdrawal signs and symptomatology
b. Increased use of peer support services to support withdrawal management, facilitate recovery and link the individual to community-based peer support and mutual aid groups
c. Linkage to treatment services post discharge
d. Increased links to community-based resources to address unmet social determinants of health
e. Reduction or elimination of psychiatric symptoms, if applicable

## 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 DMHDDSUS's clinical policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by 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 from one or more of these items in accordance with Federal law and regulations.

## 8.0 Policy Implementation and History

**Original Effective Date:** May 1, 2024

**History:**

| Date | Section or Subsection Amended | Change |
|---|---|---|
| 5/1/24 | All Sections and Attachment(s) | Clinically Managed Residential Withdrawal Management Services is replacing the State-Funded Social Setting Detox service definition in the State-Funded Enhanced Mental Health & Substance Use Services document as a stand-alone service. Social Setting Detox service definition and all references have been removed from the document. |

# Attachment A: Claims-Related Information

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

## A. Claim Type

Professional (CMS-1500/837P transaction)

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 |
|---|---|
| H0011 | 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). Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

LME/MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME/MCOs shall assess network providers' adherence to service guidelines to assure quality services for the individual.

## 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 in accordance with LME/MCO policy.

Evaluation and Management CPT codes, specifically with an addiction focused history and biopsychosocial screening assessments, the comprehensive clinical assessment, and diagnostic assessment can be billed separate from the Clinically Managed Residential Withdrawal Management Services.

Note: The NC DMHDDSUS will not reimburse for conversion therapy.