Clinical Policy: Enhanced Mental Health and Substance Abuse Services

Reference Number: WNC.CP.114 Coding Implications
Last Review Date03/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

This document describes policies and procedures that direct-enrolled providers shall follow to receive reimbursement for covered enhanced benefit behavioral health services provided to eligible WellCare of North Carolina members. It sets forth the basic requirements for qualified providers to bill mental health and substance abuse services. Members who utilize "Enhanced Services" under NC Medicaid Managed Care, paired with certain diagnoses as outlined in the link below may be transitioned to BH/I/DD Tailored Plan.
https://files.nc.gov/ncdhhs/BH-IDD-TP-Eligibility-Enrollment-Update-02.02.2021.pdf
Select 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 *WNC.CP.193 Telehealth, Virtual Communications and Remote Patient Monitoring*.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Enhanced Mental Health and Substance Abuse Services meet criteria for coverage as follows:

A. Prior Approval
   1. Required on the first day of service, with the following **exceptions**:
      a. Mobile Crisis Management;
      b. Substance Abuse Intensive Outpatient Program (SAIOP); **and**
      c. Substance Abuse Comprehensive Outpatient Treatment (SACOT).

B. *Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), Intensive In-Home Services, Multi-systemic Therapy Services, Child and Adolescent Day Treatment, Psychosocial Rehabilitation, Substance Abuse Non-Medical Community Residential Treatment and Substance Abuse Medically Monitored Community Residential Treatment* are not covered under the NC Medicaid Standard Plans (e.g. WellCare of NC) but may be allowed when prior authorization is obtained for members eligible for EPSDT services.

C. Service Orders
   1. Backdating of service orders is not allowed.
   2. Each service order must be signed and dated by the authorizing professional and must indicate the **date** on which the service was ordered.
   3. A service order must be in place **prior to or on the day** that the service is initially provided in order to bill for the service.
   4. Valid for one year from the date of plan entered on a Person-Centered Plan (PCP). Medical necessity must be reviewed, and services must be ordered at least annually, based on the Date of Plan.

D. Clinical or Professional Supervision
   1. Covered services are provided to members by agencies that are directly enrolled in the Medicaid programs and that employ Licensed Professionals (LPs), Qualified Professionals (QPs), Associate Professionals (APs), and Paraprofessionals. Clinical or professional supervision must be provided according to the supervision and staffing requirements outlined in each service definition. Medically necessary services delivered by APs are delivered under the supervision and direction of the LP or QP. Medically necessary services delivered by Paraprofessionals are delivered under the supervision and direction of the LP, QP or, when the service definition does not specify a more stringent supervision requirement, an AP. Supervision shall be provided at the frequency and for the duration indicated in the individualized supervision plan created for each AP and Paraprofessional upon hire. Each supervision plan must be reviewed annually.
   2. The Licensed Professional or QP personally works with beneficiary's families, and team members to develop an individualized PCP. The LP or QP meets with the members receiving services throughout the course of treatment to monitor the services being delivered and to review the need for continued services. The supervising professional assumes professional responsibility for the services provided by staff who do not meet QP status and spends as much time as necessary directly supervising the staff member providing the service to ensure that the goals outlined on each PCP are being implemented and that members are receiving services in a safe and efficient manner in accordance with accepted standards of practice.
   3. The terms of employment with the directly enrolled provider agency must specify that each supervising professional is to provide adequate supervision for the APs, Paraprofessionals, and other staff in the agency who are assigned to him or her. The provider agency shall ensure that supervisory ratios meet any requirements that are specified in the service definition, are reasonable and ethical, and provide adequate opportunity for the supervising professional to effectively supervise the staff member(s) assigned. Documentation must be kept on file to support the supervision provided to AP and Paraprofessional staff in the delivery of medically necessary services.

E. Person Centered Plan (PCP)
   1. A process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths, rehabilitation and recovery, and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning and for treatment, service, and support options. The individual with a disability, the legally responsible person, or both direct the process and share authority and responsibility with system professionals for decisions made.
   2. For all members receiving services, it is important to include people who are important in the person's life, such as family members, the legally responsible person, professionals, friends and others identified by the member (for example, employers, teachers, and faith leaders). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid, unpaid, natural and public specialty resources uniquely tailored to the individual or family

needs and desires. It is important for the person-centered planning process to explore and use all these resources.

3. Before any service can be billed to Medicaid, a written PCP for the delivery of medically necessary services must be in place. The PCP must be completed at the time the member is admitted to a service. Information gathered from discussions with the person or family receiving services and others identified by them, along with recommendations and other information obtained from the comprehensive clinical assessment, together provide the foundation for the development of the PCP.
4. If limited information is available at admission, staff shall document on the PCP whatever is known and update it when additional information becomes available.
5. PCP Reviews and Annual Rewriting
    a. All PCPs must be updated as needed and must be rewritten at least annually.
    b. At a minimum, the PCP must be reviewed by the responsible professional based upon the following:
        i. target date or expiration of each goal each goal on the PCP must be reviewed separately, based on the target date associated with it. Short-range goals in the PCP may never exceed 12 months from the Date of Plan;
        ii. change in the member's needs;
        iii. change in service provider; **and**
        iv. addition of a new service.

F. Documentation Requirements
1. Responsibility for Documentation
    a. The staff person who provides the service must sign the written entry. The signature must include credentials (professionals) or a job title (paraprofessionals).
    b. A QP is not required to countersign service notes written by a staff person who does not have QP status.
2. Contents of a Service Note
    a. More than one intervention, activity, or goal may be reported in one service note, if applicable.
    b. Service notes unless otherwise noted in the service definition, must include all of the following:
        i. date of service provision;
        ii. name of service provided (for example, Mobile Crisis Management);
        iii. type of contact (in-person, telehealth, phone call, collateral);
        iv. place of service, when required by service definition;
        v. purpose of the contact as it relates to the goal(s) in the PCP;
        vi. description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated. For case management–type services, a description of the case management activity fulfills this requirement;
        vii. duration of service: Amount of time spent performing the intervention;
        viii. assessment of the effectiveness of the intervention and the member's progress toward the member's goal. For case management–type services, a description of the result or outcome of the case management activity fulfills this requirement;

ix. signature and credentials or job title of the staff member who provided the service.

3. Other Service Documentation Requirements
   a. Services that are billed must comply with WellCare of NC reimbursement guidelines, and all documentation must relate to goals in the member's PCP.

Note: Please refer to https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies for additional details for documentation and goals.

G. Provider Qualifications
   1. Staff with the following classifications must be licensed or certified, as appropriate, according to North Carolina General Statutes and shall practice within the scope of practice defined by the applicable practice board.
      a. Licensed Professional Counselor or Licensed Clinical Mental Health Counselor
      b. Licensed Professional Counselor Associate or Licensed Clinical Mental Health Counselor Associate
      c. Licensed Clinical Addiction Specialist
      d. Licensed Clinical Addiction Specialist Associate
      e. Certified Clinical Supervisor
      f. Licensed Marriage and Family Therapist
      g. Licensed Marriage and Family Therapist Associate
      h. Licensed Clinical Social Worker
      i. Licensed Clinical Social Worker Associate
      j. Doctor of Osteopathy
      k. Licensed Psychologist
      l. Licensed Psychological Associate
      m. Nurse Practitioner
      n. Licensed Physician
      o. Certified Clinical Nurse Specialist (only if certified as an advanced practice psychiatric clinical nurse specialist)
      p. Certified Substance Abuse Counselor or Certified Alcohol and Drug Counselor; **and**
      q. Physician Assistant
   2. The following staff may provide services according to10A NCAC 27G .0104— Staff Definitions:
      a. Qualified Professional (QP)
      b. Associate Professional (AP)
      c. Paraprofessional

Background[1]

I. Mental Health Services

A. **Mobile Crisis Management**
   1. Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24-hours-a-day, 7-days-a-week, 365-days-a-year. Crisis response provides an immediate evaluation, triage and access to acute mental health,

intellectual/developmental disabilities, or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports or services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

2. Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services must be specified in a member's Crisis Plan, which is a component of all PCPs.
3. Criteria
   a. Initial
      i. the beneficiary or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH; **and**
      ii. the beneficiary or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis. **or**
      iii. the beneficiary or family members evidences impairment of judgment, impulse control, cognitive or perceptual disabilities; **or**
      iv. the beneficiary is intoxicated or in withdrawal, in need of substance use disorder treatment and unable to access services without immediate assistance.

   Priority should be given to a beneficiary with a history of multiple crisis episodes or who are at substantial risk of future crises.

   b. Continued Service - The beneficiary is eligible to continue this service if the crisis has not been resolved **or** his or her crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.
   c. Discharge - The beneficiary meets the criteria for discharge if any **one** of the following applies:
      i. the beneficiary's crisis has been stabilized and his or her need for ongoing treatment or supports has been assessed **or**
      ii. if the beneficiary has continuing treatment or support needs, a linkage to ongoing treatment or supports has been made.

B. **Intensive In-Home Services**

1. The Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This service may only be provided to beneficiaries through age 20. This medically necessary service directly addresses the beneficiary's mental health or substance use disorder diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-5, or any subsequent editions of this reference material), with documentation of symptoms and effects reflected in the Comprehensive Clinical Assessment and the Person-Centered Plan (PCP). This team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year.

2. This is a time-limited, intensive child and family intervention based on the clinical needs of the beneficiary. The service is intended to accomplish the following:
   a. Reduce presenting psychiatric or substance use disorder symptoms;
   b. Provide first responder intervention to diffuse current crisis;
   c. Ensure linkage to community services and resources; **and**
   d. Prevent out of home placement for the beneficiary.
3. Program Requirements
   a. For IIH beneficiaries, all aspects of the delivery of this service occurring per date of service shall equal one per diem event of a two-hour minimum. It is the expectation that service frequency shall decrease over time: at least 12 in-person contacts per beneficiary are required in the first month, and at least 6 in-person contacts per beneficiary per month are required in the second and third months of IIH services. The IIH service varies in intensity to meet the changing needs of beneficiaries, families, and caregivers; to assist them in the home and community settings; and to provide a sufficient level of service as an alternative to the beneficiary's need for a higher level of care.
   b. The IIH team works together as an organized, coordinated unit under the direct supervision of the team leader. The team meets at least weekly to ensure that the planned interventions are implemented by the appropriate staff members and to discuss beneficiary's progress toward goals as identified in the PCP.
4. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following criteria are met:
   a. There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability;
   b. Based on the current comprehensive clinical assessment, this service was indicated, and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective;
   c. The beneficiary has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk-taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use);
   d. The beneficiary's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the beneficiary's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions;
   e. The beneficiary is at imminent risk of out-of-home placement based on the beneficiary's current mental health or substance use disorder clinical symptomatology, or is currently in an out of home placement and a return home is imminent; **and**
   f. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent

Psychiatry, American Psychiatric Association, American Society of Addiction Medicine)

5. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; **or**
   b. The beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.
   c. **AND One** of the following applies:
      i. the beneficiary has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
      ii. the beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
      iii. the beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; **or**
      iv. the beneficiary fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.
6. Discharge Criteria - The beneficiary meets the criteria for discharge if any one of the following applies:
   a. The beneficiary has achieved goals and is no longer in need of IIH services;
   b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
   c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
   d. The beneficiary or legally responsible person no longer wishes to receive IIH services; **or**
   e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association)

C. **Multisystemic Therapy (MST)**
1. MST is a program designed for youth generally between the ages 7 through 17 who:
   a. Have antisocial, aggressive or violent behaviors;
   b. Are at risk of out-of-home placement due to delinquency;
   c. Adjudicated youth returning from out-of-home placement;
   d. Chronic or violent juvenile offenders; **or**
   e. Youth with serious emotional disturbances or a substance use disorder and their families.

2. Program Requirements - MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to beneficiaries and their families. Services include:
   a. An initial assessment to identify the focus of the MST intervention
   b. Individual therapeutic interventions with the beneficiary and family;
   c. Peer intervention;
   d. Case management; **and**
   e. Crisis stabilization.
3. Specialized therapeutic and rehabilitative interventions are available to address special areas such as:
   a. A substance use disorder;
   b. Sexual abuse;
   c. Sex offending; and
   d. Domestic violence.

   Services are available in-home, at school, and in other community settings. The duration of MST intervention is 3 to 5 months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

   MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions 24-hours-a-day, 7-days-a-week, by staff that will maintain contact and intervene as one organizational unit.
4. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following criteria are met:
   a. There is a mental health or substance use disorder diagnosis present, other than a sole diagnosis of intellectual and developmental disability;
   b. The beneficiary must be between the ages of 7 through 17;
   c. The beneficiary displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors;
   d. The beneficiary is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within 30 days of referral; **and**
   e. The beneficiary has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.
5. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's PCP **or**

b. The beneficiary continues to be at risk for relapse based on history, or the tenuous nature of the functional gains, **or**
c. Any **one** of the following apply:
    i. beneficiary continues to exhibit willful behavioral misconduct; **and** there is a reasonable expectation that the beneficiary shall continue to make progress in reaching overarching goals identified in MST in the first 4 weeks; **OR**
    ii. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; **OR**
    iii. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

6. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
    a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, or no longer benefits from this service. The decision shall be based on **one** of the following:
        i. beneficiary has achieved 75 percent of the PCP goals, discharge to a lower level of care is indicated;
        ii. beneficiary is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted;
        iii. the beneficiary or family requests discharge and is not imminently dangerous to self or others; **or**
        iv. the beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).

D. **Psychosocial Rehabilitation (PSR)**

1. A PSR service is designed to help adults with psychiatric disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention. PSR focuses on skill and resource development related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals. The service is based on the principles of recovery, including equipping beneficiaries with skills, emphasizing self-determination, using natural and community supports, providing individualized intervention, emphasizing employment, emphasizing the "here and now", providing early intervention, providing a caring environment, practicing dignity and respect, promoting beneficiary choice and involvement in the process, emphasizing functioning and support in real world environments, and allowing time for interventions to have an effect over the long term. There should be a supportive, therapeutic relationship between the providers, beneficiary, and family which addresses or implements interventions outlined in the Person-Centered Plan (PCP) in **ANY** of the following skills development, educational, and pre-vocational activities:
    a. community living, such as housekeeping, shopping, cooking, use of transportation facilities, money management;
    b. personal care such as health care, medication self-management, grooming;

c. social relationships;
d. use of leisure time;
e. educational activities which include assisting the beneficiary in securing needed education services such as adult basic education and special interest courses; **or**
f. prevocational activities which focus on the development of positive work habits and participation in activities that would increase the participant's self-worth, purpose and confidence (these activities are not to be job specific training)

2. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following criteria are met:
   a. There is a mental health diagnosis present;
   b. Level of Care Criteria are met;
   c. The beneficiary has impaired role functioning that adversely affects **at least two** of the following:
      i. employment;
      ii. management of financial affairs;
      iii. ability to procure needed public support services;
      iv. appropriateness of social behavior; **or**
      v. activities of daily living.
   d. The beneficiary's level of functioning may indicate a need for psychosocial rehabilitation if the beneficiary has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.
3. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP **or**
   b. The beneficiary continues to be at risk for relapse based on history, or the tenuous nature of the functional gains, **or**
   c. Any **one** of the following apply:
      i. beneficiary has achieved initial rehabilitation goals in the PCP goals and continued services are needed in order to achieve additional goals;
      ii. beneficiary is making satisfactory progress toward meeting rehabilitation goals;
      iii. beneficiary is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with the beneficiary's rehabilitation goals are possible or can be achieved;
      iv. beneficiary is not making progress; the rehabilitation goals must be modified to identify more effective interventions; or e. beneficiary is regressing; the PCP must be modified to identify more effective interventions.
4. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
   a. Beneficiary's level of functioning has improved with respect to the rehabilitation goals outlined in the PCP, inclusive of a transition plan to step down, or no

longer benefits, or has the ability to function at this level of care **and ANY** of the following apply:

i. beneficiary has achieved rehabilitation goals, discharge to a lower level of care is indicated;
ii. beneficiary is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted; **or**
iii. beneficiary requires a more intensive level of care or service.

E. **Child and Adolescent Day Treatment**

1. Day Treatment is a structured treatment service in a licensed facility, for children or adolescents and their families, that builds on strengths and addresses identified needs. This medically necessary service directly addresses the beneficiary's diagnostic and clinical needs, which are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by the DSM-5, or any subsequent editions of this reference material), with symptoms and effects documented in a comprehensive clinical assessment and the PCP. This service is designed to serve children who, as a result of their mental health or substance use disorder treatment needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting.
   The provider implements therapeutic interventions that are coordinated with the beneficiary's academic or vocational services available through enrollment in an educational setting. These interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the beneficiary's capacity to function in an educational setting, or to be maintained in community-based services. It is available for children 5 to 17 years of age (20 or younger for those who are eligible for Medicaid). Day Treatment must address the age, behavior, and developmental functioning of each beneficiary to ensure safety, health and appropriate treatment interventions within the program milieu. Day Treatment provides mental health or substance use disorder interventions in the context of a therapeutic treatment milieu.
   This service is focused on providing clinical interventions and service to support the beneficiary in achieving functional gains that support the beneficiary's integration in educational or vocational settings, is developmentally appropriate, is culturally relevant and sensitive, and is child and family centered. Each Child and Adolescent Day Treatment provider must follow a clearly identified clinical model(s) or evidence-based treatment(s) consistent with best practice. The selected model(s) must be specified and described in the provider's program description. The clinical model(s) or Evidence-Based Practices (EBPs) should be expected to produce positive outcomes for this population.
2. Eligibility Criteria - Children 5 through 17 (20 or younger for those who are eligible for Medicaid) are eligible for this service when **all** of the following criteria are met:

a. There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of an intellectual and developmental disability;
b. For children with a substance use disorder diagnosis, The ASAM Criteria are met for Level 2.1;
c. **Both** of the following shall apply:
    i. evidence that less restrictive mental health or substance abuse rehabilitative services in the educational setting have been unsuccessful as evidenced by documentation from the school (e.g., Functional Behavioral Assessment, Functional Behavioral Plan, Individual Education Plan, 504 Plan, behavior plans); **and**
    ii. the beneficiary exhibits behavior resulting in significant school disruption or significant social withdrawal.
d. The beneficiary is experiencing mental health or substance use disorder symptoms (not solely those related to an individual's diagnosis of intellectual and developmental disability) related to his or her diagnosis that severely impair functional ability in an educational setting which may include vocational education; **and**
e. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

3. Continued Service Criteria - The beneficiary is eligible to continue this service if:
    a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; **or**
    b. The beneficiary continues to be unable to function in an appropriate educational setting, based on ongoing assessments, history, and the tenuous nature of the functional gains.
    c. AND **One** of the following applies.
        i. the beneficiary has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
        ii. the beneficiary is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
        iii. the beneficiary is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible; **or**
        iv. the beneficiary fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis shall be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.
4. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:

a. The beneficiary has achieved goals and is no longer in need of Day Treatment services;
b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a plan to transition to a lower level of care or appropriate educational setting;
c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
d. The beneficiary or legally responsible person no longer wishes to receive Day Treatment services;
e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

F. **Partial Hospitalization**

1. Partial Hospitalization (PH) is a short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include group activities or therapy, individual therapy, recreational therapy, community living skills or training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission or discharge decisions. Physician involvement shall be one factor that distinguishes Partial Hospitalization from Day Treatment Services.
2. Therapeutic Relationship and Interventions
   a. Partial Hospitalization is designed to offer in-person therapeutic interventions to provide support and guidance in preventing, overcoming, or managing identified needs on the service plan to aid with improving the member's level of functioning in all domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.
3. Structure of Daily Living
   a. Partial Hospitalization offers a variety of structured therapeutic activities including medication monitoring designed to support a member remaining in the community that are provided under the direction of a physician, although the program does not have to be hospital - based. Other identified providers shall carry out the identified individual or group interventions (under the direction of the physician). This service offers support and structure to assist the individual member with coping and functioning on a day-to-day basis to prevent hospitalization or to step down into a lower level of care from inpatient setting.
4. Cognitive and Behavioral Skill Acquisition
   a. Partial Hospitalization includes interventions that address functional deficits associated with affective or cognitive problems or the member's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows members to develop their strengths and establish peer and community relationships.

5. Service Type
    a. This is day or night service that shall be provided a minimum of 4 hours per day, 5 days per week, and 12 months a year (exclusive of transportation time), excluding legal or governing body designated holidays.
    b. Service standards and licensure requirements are outlined in10A NCAC 27G .1100.
6. Resiliency or Environmental Intervention
    a. Partial Hospitalization assists the member in transitioning from one service to another (an inpatient setting to a community-based service) or preventing hospitalization. This service provides a broad array of intensive approaches, which may include group and individual activities.
7. Service Delivery Setting
    a. Partial Hospitalization is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based.
8. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following criteria are met:
    a. Beneficiary must have a mental health or substance use disorder diagnosis;
    b. Level of Care Criteria;
    c. The beneficiary is experiencing difficulties in **at least one** of the following areas:
        i. functional impairment, crisis intervention, diversion, aftercare needs, or at risk for placement outside the natural home setting; **AND**
        ii. the beneficiary's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any **one** of the following apply:
            a) being unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalizations, or institutionalization;
            b) presenting with intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting;
            c) being at risk of exclusion from services, placement or significant community support system as a result of functional behavioral problems associated with diagnosis;
            d) requires a structured setting to monitor mental stability and symptomology, and foster successful integration into the community through individualized interventions and activities; **or**
            e) service is a part of an aftercare planning process (time limited or transitioning) and is required to avoid returning to a higher, or more restrictive level of service.
9. Continued Service Criteria - The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's service plan **or** the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or ANY** of the following applies:

a. Beneficiary has achieved initial service plan goals and additional goals are indicated;
b. Beneficiary is making satisfactory progress toward meeting goals;
c. Beneficiary is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the beneficiary's premorbid level of functioning are possible or can be achieved;
d. Beneficiary is not making progress; the service plan must be modified to identify more effective interventions; **or**
e. Beneficiary is regressing; the service plan must be modified to identify more effective interventions.

10. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
    a. Beneficiary's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, **or** no longer benefits, **or** has the ability to function at this level of care **and any** of the following apply:
        i. beneficiary has achieved goals, discharged to a lower level of care is indicated; **or**
        ii. beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

G. Professional Treatment Services in Facility-Based Crisis Program
1. This service provides an alternative to hospitalization for adults who have a mental illness or substance use disorder. This is a 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting. This can be provided in a non-hospital setting for members in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.
2. Therapeutic Relationship and Interventions
    a. This service offers therapeutic interventions designed to support a member remaining in the community and alleviate acute or crisis situations that are provided under the direction of a physician, although the program does not have to be hospital based. Interventions are implemented by other staff under the direction of the physician. These supportive interventions assist the member with coping and functioning on a day-to-day basis to prevent hospitalization.
3. Structure of Daily Living
    a. This service is an intensified short-term, medically supervised service that is provided in certain 24-hour service sites. The objectives of the service include assessment and evaluation of the condition(s) that have resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs; to implement intensive treatment, behavioral management interventions, or detoxification protocols; to stabilize the immediate problems that have resulted in the need for crisis intervention or detoxification; to ensure the safety of the member by closely monitoring his or her medical condition and response to the treatment protocol; and to arrange for linkage to services that will provide further treatment or rehabilitation upon discharge from the Facility Based Crisis Service.

4. Cognitive and Behavioral Skill Acquisition
    a. This service is designed to provide support and treatment in preventing, overcoming, or managing the identified crisis or acute situations on the service plan to assist with improving the member's level of functioning in all documented domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.
5. Service Type
    a. This is a 24-hour service that is offered seven days a week.
6. Resiliency or Environmental Intervention
    a. This service assists the member with remaining in the community and receiving treatment interventions at an intensive level without the structure of an inpatient setting. This structured program assesses, monitors, and stabilizes acute symptoms 24-hours-a-day.
7. Service Delivery Setting
    a. This service can be provided in a licensed facility that meets 10A NCAC 27G .5000 licensure standards.
8. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following are met:
    a. There is a mental health or substance use disorder diagnosis present or the beneficiary has a condition that may be defined as an intellectual and developmental disability as defined in GS 122C-3 (12a);
    b. Level of Care Criteria, Level D NC-SNAP (NC Supports or Needs Assessment Profile) **or** The ASAM Criteria;
    c. The beneficiary is experiencing difficulties in at least **one** of the following areas:
        i. functional impairment,
        ii. crisis intervention, diversion, or after-care needs, **or**
        iii. at risk for placement outside of the natural home setting; **and**
    d. The beneficiary's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any **one** of the following apply:
        i. unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, or institutionalization;
        ii. intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting; **or**
        iii. at risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.
9. Continued Service Criteria - The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's service plan **or** the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or** any **one** of the following applies:
    a. Beneficiary has achieved initial service plan goals and additional goals are indicated;
    b. Beneficiary is making satisfactory progress toward meeting goals;

c. Beneficiary is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
d. Beneficiary is not making progress; the service plan must be modified to identify more effective interventions; **or**
e. Beneficiary is regressing; the service plan must be modified to identify more effective interventions.

10. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
    a. Beneficiary's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step-down **or** no longer benefits **or** has the ability to function at this level of care **and ANY** of the following apply:
        i. beneficiary has achieved goals, discharge to a lower level of care is indicated; **or**
        ii. beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

II. Substance Abuse Services

A. Substance Abuse Intensive Outpatient Program (SAIOP)

1. SAIOP means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent beneficiaries to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a day, at least 3 days a week, with no more than 2 consecutive days between offered services and distinguishes between those beneficiaries needing no more than 19 hours of structured services per week (ASAM Level 2.1). The beneficiary must be in attendance for a minimum of 3 hours a day in order to bill this service.
   SAIOP services shall include a structured program consisting of, but not limited to, the following services:
   a. Individual counseling and support;
   b. Group counseling and support;
   c. Family counseling, training or support;
   d. Biochemical assays to identify recent drug use (e.g., urine drug screens);
   e. Strategies for relapse prevention to include community and social support systems in treatment;
   f. Life skills;
   g. Crisis contingency planning;
   h. Disease Management; and
   i. Treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.
2. Eligibility Criteria - The beneficiary is eligible for this service when **ALL** of the following criteria are met:
   a. There is a substance use disorder diagnosis present; **and**

b. The beneficiary meets ASAM Level 2.1 criteria.

3. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP **or**
   b. The beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or**
   c. Any **one** of the following applies.
      i. the beneficiary has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated;
      ii. the beneficiary is making satisfactory progress toward meeting goals;
      iii. the beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
      iv. the beneficiary is not making progress; the PCP must be modified to identify more effective interventions; **or**
      v. the beneficiary is regressing; the PCP must be modified to identify more effective interventions.
4. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
   a. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care **and** any of the following apply.
      i. the beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
      ii. the beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; **or**
      iii. the beneficiary no longer wishes to receive SAIOP services.
5. Service Exclusions and Limitations
   a. SAIOP cannot be billed during the same authorization as SA Comprehensive Outpatient Treatment, all detoxification services levels, Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

B. **Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)**

1. The SACOT program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery.
   SACOT Program is a service emphasizing:
   a. Reduction in use of substances or continued abstinence;
   b. The negative consequences of substance use;
   c. Development of social support network and necessary lifestyle changes;
   d. Educational skills;
   e. Vocational skills leading to work activity by reducing substance use as a barrier to employment;
   f. Social and interpersonal skills;

g. Improved family functioning;
h. The understanding of addictive disease; and
i. The continued commitment to a recovery and maintenance program.

These services are provided during day and evening hours to enable beneficiaries to maintain residence in their community, continue to work or go to school, and to be a part of their family life.

2. The following types of services are included in the SACOT Program:
   a. Individual counseling and support;
   b. Group counseling and support;
   c. Family counseling, training or support;
   d. Biochemical assays to identify recent drug use (e.g., urine drug screens);
   e. Strategies for relapse prevention to include community and social support systems in treatment;
   f. Life skills;
   g. Crisis contingency planning;
   h. Disease management; and
   i. Treatment support activities that have been adapted or specifically designed for beneficiaries with physical disabilities; or beneficiaries with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability and substance use disorder.

   Beneficiaries may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the beneficiary's residence. This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day, with availability at least 5 days per week with no more than 2 consecutive days without services available. The beneficiary must be in attendance for a minimum of 4 hours a day in order to this for this service. Group counseling services must be offered each day the program operates. Services must be available during both day and evening hours.
3. Eligibility Criteria - The beneficiary is eligible for this service when the following criteria are met:
   a. There is a substance use disorder diagnosis present; **AND**
   b. The beneficiary meets ASAM Level 2.5 criteria.
4. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP **or**
   b. The beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or**
   c. Any **one** of the following applies:
      i. beneficiary has achieved initial PCP goals and continued service at this level is needed to meet additional goals;
      ii. beneficiary is making satisfactory progress toward meeting goal;
      iii. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;

iv. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; or
v. beneficiary is regressing; the PCP must be modified to identify more effective interventions.

d. Utilization review must be conducted **every 30 days** and is so documented in the PCP and the service record.

5. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
   a. Beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, **or**
   b. No longer benefits, **or**
   c. Has the ability to function at this level of care **and** any of the following apply:
      i. beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
      ii. beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; **or**
      iii. beneficiary or family no longer wishes to receive SACOT services.

C. **Substance Abuse Non-Medical Community Residential Treatment (NMCRT)**

1. Substance Abuse NMCRT is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who:
   a. Work intensively with adults with substance use disorders; and
   b. Provide or have the potential to provide primary care for their minor children.
2. This is a rehabilitation facility, without 24 hour per day medical nursing or monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for beneficiaries with an addiction disorder.
   These programs shall include:
   a. Assessment;
   b. Referral;
   c. Individual and group therapy;
   d. Family therapy;
   e. Recovery skills training;
   f. Disease management;
   g. Symptom monitoring;
   h. Monitoring medications and self-management of symptoms;
   i. Aftercare; and
   j. Follow-up and access to preventive and primary health care including psychiatric care.
3. The facility may utilize services from another facility providing psychiatric or medical services. Services shall:
   a. Promote development of a social network supportive of recovery;
   b. Enhance the understanding of addiction;
   c. Promote successful involvement in regular productive activity (such as school or work);
   d. Enhance personal responsibility; and
   e. Promote successful reintegration into community living.

4. Services shall be designed to provide a safe and healthy environment for beneficiaries and their children. Program staff shall:
   a. Arrange, link or integrate multiple services as well as assessment and reassessment of the beneficiary's need for services;
   b. Inform the beneficiary about benefits, community resources, and services;
   c. Assist the beneficiary in accessing benefits and services;
   d. Arrange for the beneficiary to receive benefits and services; and
   e. Monitor the provision of services.
5. Eligibility Criteria - The beneficiary is eligible for this service when **ALL** of the following criteria are met:
   a. There is a substance use disorder diagnosis present; **and**
   b. Meets ASAM Level 3.5 criteria.
6. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP, **or**
   b. The beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains, **or**
   c. ANY **one** of the following applies:
      i. beneficiary has achieved initial PCP goals and requires this service in order to meet additional goals;
      ii. beneficiary is making satisfactory progress toward meeting goals;
      iii. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible or can be achieved;
      iv. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; **or**
      v. beneficiary is regressing; the PCP must be modified to identify more effective interventions.
   d. Utilization review must be conducted every 90 calendar days (after the initial 30 calendar day UR) for the parents with children programs and is so documented in the PCP and the service record.

D. **Substance Abuse Medically Monitored Community Residential Treatment (MMCRT)**

1. Substance Abuse MMCRT is a non-hospital rehabilitation facility for adults, with 24-hour-a-day medical or nursing monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for beneficiaries with alcohol and other drug problems or addiction occurs.
   MMCRT is staffed by physicians who are available 24- hours-a-day by telephone to provide consultation. The physician's assessment must be conducted within 24 hours of admission. A service order for MMCRT must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.
2. Eligibility Criteria - The beneficiary is eligible for this service when **ALL** of the following criteria are met:

a. There is a substance use disorder diagnosis present; **and**
b. The beneficiary meets ASAM Level 3.7 criteria.

3. Continued Service Criteria - The beneficiary is eligible to continue this service if:
   a. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP **or**
   b. The beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or**
   c. **ANY** of the following applies:
      i. beneficiary has achieved positive life outcomes that supports stable and ongoing recovery and services need to be continued to meet additional goals;
      ii. beneficiary is making satisfactory progress toward meeting treatment goals;
      iii. beneficiary is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible or can be achieved;
      iv. beneficiary is not making progress; the PCP must be modified to identify more effective interventions; **or**
      v. beneficiary is regressing; the PCP must be modified to identify more effective interventions.
4. Discharge Criteria - The beneficiary meets the criteria for discharge if any **one** of the following applies:
   a. Beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down, **or**
   b. No longer benefits, **or**
   c. Has the ability to function at this level of care **and ANY** of the following apply:
      i. beneficiary has achieved positive life outcomes that support stable and ongoing recovery;
      ii. beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; **or**
      iii. beneficiary no longer wishes to receive MMCRT services. (**Note** that although a beneficiary may no longer wish to receive MMCRT services, the beneficiary must still be provided with discharge recommendations that are intended to help the beneficiary meet expected outcomes).

E. **Ambulatory Detoxification**

1. Ambulatory Detoxification is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the member's level of clinical severity and to achieve safe and comfortable withdrawal from mood altering drugs (including alcohol) and to effectively facilitate the member's transition into ongoing treatment and recovery.
2. Ambulatory detoxification is staffed by physicians who are available 24- hours-a-day by telephone to provide consultation. The physician's assessment must be conducted within 24 hours of admission in-person or via telehealth. A service order for Ambulatory Detoxification must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

3. Eligibility Criteria - The beneficiary is eligible for this service when **all** of the following criteria are met:
   a. There is a substance use disorder diagnosis present; **and**
   b. The beneficiary meets ASAM Level I-WM criteria.
4. Continued Service and Discharge Criteria - The beneficiary continues in Ambulatory Detoxification until **ANY** of the following criteria are met:
   a. Withdrawal signs and symptoms are sufficiently resolved such that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing detoxification monitoring; **or**
   b. The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

F. **Non-Hospital Medical Detoxification**

1. Non-Hospital Medical Detoxification is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols.
2. Non-Hospital Medical Detoxification is staffed by physicians, who are available 24-hours-a-day by telephone and who conducts an assessment within 24 hours of admission. Physician assessments may be conducted in-person or via telehealth. A service order for Medically Monitored Detoxification must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.
3. Eligibility Criteria - The beneficiary is eligible for this service when all of the following criteria are met:
   a. There is a substance use disorder diagnosis present; **and**
   b. Meets ASAM Level 3.7-WM criteria.
4. Continued Service and Discharge Criteria - The beneficiary continues in Non-Hospital Medical Detoxification until **ANY** of the following criteria are met:
   a. Withdrawal signs and symptoms are sufficiently resolved the beneficiary can be safely managed at a less intensive level of care; **or**
   b. The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

G. **Medically Supervised or ADATC Detoxification Crisis Stabilization**

1. Medically Supervised or ADATC Detoxification Crisis Stabilization is an organized service delivered by medical and nursing professionals that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Members are often in crisis due to co-occurring severe mental disorders (e.g., acutely suicidal or severe mental health problems and co-occurring substance use disorder) and are in need of short-term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation. The service has restraint and

seclusion capabilities. Established clinical protocols are followed by staff to identify members with severe biomedical conditions who are in need of medical services beyond the capacity of the facility and to transfer such members to the appropriate level of care.

2. A service order for Medically Supervised or ADATC Detoxification Crisis Stabilization must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.
3. Eligibility Criteria - The beneficiary is eligible for this service when all of the following criteria are met:
   a. There is a substance use disorder diagnosis present; **and**
   b. Meets ASAM Level 4.0.
4. Continued Service and Discharge Criteria - The beneficiary continues in Medically Supervised or ADATC Detoxification Crisis Stabilization until **ANY** of the following criteria are met:
   a. Withdrawal signs and symptoms are sufficiently resolved that the beneficiary can be safely managed at a less intensive level of care;
   b. The signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated;
   c. The addition of other clinical services is indicated.

H. **Outpatient Opioid Treatment**

1. Outpatient Opioid Treatment is a service designed to offer the member an opportunity to effect constructive changes in his lifestyle by using methadone or other drug approved by the Food and Drug Administration (FDA) for the treatment of opiate addiction in conjunction with the provision of rehabilitation and medical services. It is a tool in the detoxification and rehabilitation process of an opiate-dependent individual.
2. Guidelines
   a. Services in this type include methadone or buprenorphine administration for:
      i. treatment; **OR**
      ii. maintenance.
   b. Only direct face-to-face time with member to be reported.
   c. Staff travel time to be reported separately.
   d. Preparation and documentation time NOT reported.
3. Payment Unit

   One unit equals one on-site dose or one take-home dose. Take home doses may be provided in accordance with the requirements in 42 CFR 8.12(h)(4)(i).**Note**: No more take-home doses can be provided then is outlined in 10A NCAC 27G.3600.
4. Therapeutic Relationship and Intervention
   a. This service involves the administration of methadone or other drug approved by the FDA for the treatment of opiate addiction in a licensed opioid treatment program. Administration of methadone to members with opiate addiction disorders for purposes of methadone maintenance or detoxification is the only activity billable to Medicaid under this service code. Medicaid members can only

be approved to receive methadone whereas self-pay and pioneer members are eligible to receive levomethadyl acetate hydrochloride (LAAM) or other FDA approved drugs as clinically indicated.

5. Service Type
   a. This is a periodic service. Methadone maintenance is the only opioid treatment for opiate addiction disorders that is Medicaid billable.
6. Service Delivery Setting
   a. This service must be provided at a licensed Outpatient Treatment Program under 10A NCAC 27G .3600.
7. This service may be a part of an aftercare planning process (time-limited step down or transitioning) and is required to avoid returning to a higher, more restrictive level of service. Service Order Requirement Service orders must be completed by a physician prior to or on the day services are to be provided.
8. Eligibility Criteria
   a. The member is eligible for this service when all of the following criteria are met:
      i. A DSM-5 (or any subsequent editions of this reference material) diagnosis of a severe Opioid Use Disorder;
      ii. American Society for Addiction Medicine (ASAM) for Opioid Treatment Services (OTS) level of care is met
9. Continued Stay Criteria
   a. The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the beneficiary's service plan **or** the beneficiary continues to be at risk for relapse based on history or the tenuous nature of the functional gains; **OR**
   b. The beneficiary meets any of the specifications listed in The ASAM Criteria for Dimension 5 Relapse, Continued Use or Continued Problem Potential for Opioid Treatment Services.
10. Discharge Criteria - The beneficiary meets the criteria for discharge if **any one** of the following applies:
    a. Beneficiary's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, **or** no longer benefits, **or** has the ability to function at this level of care **and ANY** of the following apply:
       i. beneficiary has achieved goals, discharge to a lower level of care is indicated; **or**
       ii. beneficiary is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
No applicable codes.	

HCPCS ®* Codes	Description	Billing Unit	Telehealth Eligible
H0010	Non- Hospital medical Detoxification	1 unit= 1 day (not to exceed more than 45 days in a 12-month period)	No
H0012	Substance Abuse Non-Medical Community Residential Treatment	1 unit= 1 day (not to exceed more than 45 days in a 12-month period) Bill W/Modifier HB	No
H0013	Substance Abuse Medically Monitored Community Residential Treatment	1 unit = 1 day (not to exceed more than 45 days in a 12-month period)	No
H0014	Ambulatory Detoxification	1 unit = 15 minutes	No
H0015	Substance Abuse Intensive Outpatient Program	1 unit= 1 event per day (3 hours minimum)	No
H0020	Outpatient Opioid Treatment	1 unit = 1 event (one on site or take-home dose)	No
H0035	Partial Hospitalization	1 unit =1 event	No
H2011	Mobile crisis management	1 unit =15 minutes	Yes (Use GT Modifier for Telehealth – NO)
H2012	Child and Adolescent Day Treatment	1 unit =1 hour Bill W/Modifier HA	NO
H2017	Psychosocial Rehabilitation	1 unit=15 minutes	No
H2022	Intensive In-Home Services	1 unit =1 day	No
H2033	Multisystemic Therapy	1 unit =15 minutes	NO
H2035	Substance Abuse Comprehensive Outpatient Treatment (	1 unit =1 hour	No
H2036	Medically Supervised Detoxification Crisis Stabilization	1 unit = 1 day (not to exceed more than 30 days in a 12-month period)	No
S9484	Professional Treatment Services in Facility-Based Crisis Programs – Adult	1 unit = 1 hour	No

NOTE: As specified within this policy, components of this service may be provided via telehealth by the psychiatrist. Due to this service containing other elements that are not permitted via telehealth, the GT modifier is not appended to the HCPCS code to indicate that a service component has been provided via telehealth."

NOTE: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote monitoring.

NOTE: Added language indicating that "telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth)."

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
No applicable codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	05/21
Added criteria for services available only to EPSDT members.	07/21	08/21
Added telehealth information in Description. Revised I.F.2.b.iii. Updated Provider Qualifications in Section I.G.1. Added telehealth column in HCPCS code grid. Deleted HCPCS code T1023. Updated "face-to-face" to "in-person" in multiple Background sections. Added physician assessment information in MMCRT and Background sections II.D., II.E.2, and II.F.2. Revised "Payment Unit" criteria in Background Section II.H.3.a.	05/22	08/22
Section I.B. Verbiage updated, HCPCS H0012, H2011, H2012 modifier verbiage added, HCPCS H0014 H0020 H0035 H2011 H2022 2035 H2036 S9484 Descriptions updated, HCPCS H2012 Child and Adolescent Day Treatment AND H2033 Multisystemic Therapy ADDED. Under HCPCS, NOTES added: "components of service…," "telehealth claims: Modifier GT…" and "telehealth claims, usual place of service codes…"	08/22	08/22
Annual review. HCPCS Codes reviewed. NCHC verbiage removed from NC Guidance Verbiage.	03/23	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8A Enhanced Mental Health and Substance Abuse Services. Program Specific

Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) . Published April 1, 2022. Accessed March 6, 2023.

North Carolina Guidance

Eligibility Requirements

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

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

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

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

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

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

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

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

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

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/

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.

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).

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

a. Claim Type - as applicable to the service provided:
   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.

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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.