Clinical Policy: Clinically Managed Residential Withdrawal Management Services (ASAM 3.2 WM)

Reference Number: WNC.CP.288 Coding Implications
Last Review Date: 01/2026 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]

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 a member who is intoxicated or experiencing withdrawal. This an American Society of Addiction Medicine (ASAM) Criteria, Third Edition, Level 3.2 WM service intended for a member 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 a member 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 member's transition into ongoing treatment and recovery.

Definitions

I. Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR)
Defined as a tool used to assess an individual's alcohol withdrawal.

II. 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:

- **A.** Acute Intoxication and Withdrawal Potential;
- **B.** Biomedical Conditions and Complications;
- **C.** Emotional, Behavioral, or Cognitive Conditions and Complications;
- **D.** Readiness to Change;
- **E.** Relapse, Continued Use, or Continued Problem Potential; and
- **F.** Recovery and Living Environment.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Clinically Managed Residential Withdrawal Management Services when the member 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 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.

II. **Admission Criteria**

- **A.** 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 a physician or physician extender.
- **C.** The initial abbreviated assessment must be used to establish medical necessity for this service and develop a service plan as a part of the admission process. If a member is not able to fully cooperate with all elements of the initial abbreviated assessment upon admission, the provider may take up to 24 hours to fully complete all elements. At admission, the provider must ensure and document that the member is medically appropriate to remain at this level of care or determine if a higher level of care is necessary.
- **D.** The initial abbreviated assessment must contain the following documentation in the service record:
  1. Member's presenting problem;
  2. Member's needs and strengths;
  3. A substance-related disorder diagnosis when the assessment is completed by a licensed clinician;
  4. An ASAM level of care determination;
  5. A physical examination including pregnancy testing, as indicated, performed by a physician or physician extender, if self-administered withdrawal management medications are to be used;
  6. An addiction-focused history; and
  7. Other evaluations or assessments.
- **E.** Within three (3) calendar days of admission, a CCA or DA must be completed by a licensed clinician 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. Any laboratory or toxicology tests completed for the CCA or DA can be billed separately.

III. Continued Stay Criteria

A. The member meets the criteria for continued stay if any **ONE** of the following applies:
1. The member'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 member's CIWA-Ar score (or other comparable standardized scoring system) has not increased or decreased.

IV. Discharge Criteria

A. The member meets the criteria for discharge if any ONE of the following applies:
1. The member's withdrawal signs and symptoms are sufficiently resolved so that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical withdrawal management monitoring;
2. The member'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 member is unable to complete withdrawal management in Clinically Managed Residential Withdrawal Management service indicating a need for more intensive services; or
4. The member or person legally responsible for the member requests a discharge from the service.

Note: *Each of the six dimensions of the ASAM criteria (refer to section 1.1) must be reviewed and documented in the member's service record to document the determination for continued stay, discharge, or transfer to another level of care.*

V.

WellCare of North Carolina® **SHALL NOT cover** the following activities:

A. Transportation for the member or member's family is not billable under this policy. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina's® Non-Emergency Medical Transportation benefit. See related policy, Non-Emergency Medical Transportation: WNC.CP.262, available at WellCare NC Clinical Coverage Guidelines WNC.CP.262 NEMT for prior authorization information. Information for WellCare of North Carolina® members is available at WellCare NC Medicaid Transportation Services

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 member's service plan;
I. Services provided to children, spouse, parents, or siblings of the member under treatment or others in the member's life to address problems not directly related to the member's needs and not listed on the service plan;
J. Payment for room and board; AND
K. A member under the age of 18.

BACKGROUND

I. Requirements for and Limitations on Coverage

A. Additional Limitations and Requirements:

1. A member shall receive the Clinically Managed Residential Withdrawal Management Service from only one provider organization during any active episode of care.
2. 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; and
   m. Facility Based Crisis (Adult).

B. Service Order

1. A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the member's needs. A signed service order must be completed by a physician or physician extender, consistent with their scope of practice.

2. Service orders are valid for the episode of care. Medical necessity must be revisited, and service must be ordered based on current episode of care if multiple episodes of care are required within a twelve (12) month period.
3. If an urgent or emergent situation presents the need for a verbal service order, basic procedures must be followed for the verbal service order to be valid. Treatment may proceed based on a verbal service order by the appropriate professional as long as the verbal service order is documented in the member's service record on the date that the verbal service order is given. The documentation must specify the date of the verbal service order, who gave the order, who received the order, and identify each distinct service that was ordered. The documentation must reflect why a verbal service order was obtained in lieu of a written service order. The appropriate professional must countersign the service order with a dated signature within seventy-two (72) hours of the date of the verbal service order.
4. **ALL of the following apply to a service order:**
    c. Backdating of the service order is not allowed;
    d. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
    e. A service order must be in place before or on the first day that the service is initially provided, to bill WellCare of North Carolina® for the service. Even if the member is retroactively eligible for WellCare of North Carolina® the provider cannot bill WellCare of North Carolina® without a valid service order.

C. Documentation Requirements:

1. The service record documents the nature and course of a member's progress in treatment. To bill WellCare of North Carolina®, 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.
2. Events in a member's life which require additional activities or interventions are documented over and above the minimum frequency requirement.
3. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by WellCare of North Carolina®.
4. Service and shift notes must meet the requirements of the Department of Health and Human Services (DHHS) Records Management and Documentation Manual.
5. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (c)(4) or equivalent federally recognized tribal code or federal regulations.

D. Expected Outcomes:

1. The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments, medical evaluation and meeting the identified goals in the member's service plan. The expected outcomes are the following:
    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 member 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; or
e. Reduction or elimination of psychiatric symptoms, if applicable.

II. Provider Eligibility, Provider Qualifications and Occupational Licensing Entity Regulations, Provider Certifications, Staffing Requirements, Program Requirements, and Staff Training Requirements: Please refer to North Carolina Medicaid State Policy Site for Clinically Managed Residential Withdrawal Management Services Clinical Coverage Policy No: 8A-10 at **https://medicaid.ncdhhs.gov/media/12302/download?attachment**

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 2025, 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.

HCPCS ®* Codes	Description	Billing Unit
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)	1 Unit = 1 Day

Note: *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***.**

Note: *WellCare of North Carolina® shall not reimburse for conversion therapy.*

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/2026	01/2026

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:8A-10 Clinically Managed Residential Withdrawal Management Services. Program Specific Clinical

Coverage Policies | NC Medicaid (ncdhhs.gov). Published January 1, 2026. Accessed January 1, 2026.

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);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

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/meetingsnotices/medicaid-state-plan-public-notices

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.