Clinical Policy: Ambulatory Withdrawal Management With Extended Onsite Monitoring (ASAM 2 WM)

Reference Number: WNC.CP.290 Coding Implications
Last Review Date: 12/24 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]

Ambulatory Withdrawal Management with Extended On-Site Monitoring is an organized outpatient service that provides medically supervised evaluation, withdrawal management, and referral in a licensed facility. Services are provided in regularly scheduled sessions and should be delivered under a defined set of policies, procedures or medical protocols. This American Society of Addiction Medicine (ASAM) Criteria, Third Edition Level 2 WM service is for a Member who is assessed to be at moderate risk of severe withdrawal, free of severe physical and psychiatric complications and would safely respond to several hours of monitoring, medication, and treatment. These services are designed to treat the Member's level of clinical severity and to achieve safe and comfortable withdrawal from alcohol and other substances to effectively facilitate the Member's transition into ongoing treatment and recovery.

Definition:

- **Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR)** is defined as a tool used to assess an individual's alcohol withdrawal
- **The ASAM Criteria, Third Edition:** The American Society of Addiction Medicine Criteria is a comprehensive set of treatment standards for addictive, substance-related, and co-occurring conditions. The ASAM Criteria, Third Edition uses six dimensions to create a holistic, biopsychosocial assessment to be used for service planning and treatment. The six dimensions are:
    1. Acute Intoxication and Withdrawal Potential;
    2. Biomedical Conditions and Complications;
    3. Emotional, Behavioral, or Cognitive Conditions and Complications;
    4. Readiness to Change;
    5. Relapse, Continued Use, or Continued Problem Potential; and
    6. Recovery and Living Environment.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Ambulatory Withdrawal Management with Extended On-Site Monitoring services when the Member meets the following specific criteria:

A. Has a substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material; **AND**

B. Meets American Society of Addiction Medicine (ASAM) Level 2 WM Ambulatory Withdrawal Management with Extended On-Site Monitoring admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

II. Admission Criteria

Due to the nature of this crisis service, a Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA) is not required prior to admission to Ambulatory Withdrawal Management with Extended On-Site Monitoring services.

A. The physician or physician extender shall conduct an initial abbreviated assessment and physical exam, including a pregnancy test as indicated, to establish medical necessity for this service and develop a service plan as part of the admission process.

B. The initial abbreviated assessment (Reference 10A NCAC 27G .0205(a) or equivalent federally recognized tribal code or federal regulations) must consist of the following information:

1. The Member's presenting problem;
2. The Member's needs and strengths;
3. A provisional or admitting diagnosis;
4. A pertinent social, family, and medical history; **AND**
5. Other evaluations or assessments.

C. Within three (3) calendar days of the admission, a comprehensive clinical assessment CCA) must be completed by a licensed professional to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment is 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.

D. The program physician or physician extender may bill Evaluation and Management codes separately for the admission assessment and physical exam,

E. Evaluation and Management CPT codes, the comprehensive clinical assessment, individual therapy, laboratory tests and toxicology tests are billed separate from the Ambulatory Withdrawal Management with Extended On-Site Monitoring service.

F. This facility must be in operation a minimum of eight (8) hours per day, all five weekdays (Monday through Friday), and a minimum of four hours daily on the weekend (Saturday and Sunday). The hours of operation must be extended based on member need. This service must be available for admission seven (7) days per week. Program medical staff shall be available to provide 24-hour access for emergency medical consultation services, in-person or virtually.

III. Continued Stay and Discharge Criteria

A. The Member meets the criteria for continued stay if any **ONE** of the following applies:

1. The 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 CIWA-Ar score (or other comparable standardized scoring system) has not increased or decreased.

B. The Member meets the criteria for discharge if any **ONE** of the following applies:
1. The withdrawal signs and symptoms are sufficiently resolved so that the Member can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring;
2. The signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar) or other comparable standardized scoring system) indicating a need for transfer to a higher level of care;
3. The Member is unable to complete withdrawal management at Level 2 WM, indicating a need for more intensive services; **OR**
4. The Member or person legally responsible for the Member requests a discharge from the service.

IV. WellCare of North Carolina® shall NOT cover these activities:

A. Transportation for the Member or member's family is not billable under Ambulatory Withdrawal Management With Extended Onsite Monitoring (ASAM 2WM), program.
1. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina® Non-Emergency Medical Transportation benefit. Please refer to Clinical Coverage Policy WNC.CP.262 "Non-Emergency Medical Transportation," available at WellCare NC Clinical Coverage Guidelines for prior authorization information.
2. Medicaid Transportation information, for WellCare of North Carolina members, is available at WellCare NC Medicaid Transportation Services.

B. Any habilitation activities;
C. Time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill assistance;
D. Clinical and administrative supervision of Level 2 WM 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; **AND**
J. Payment for room and board.

Background[1]

I. Additional Limitations or Requirements

A. A Member shall receive the Ambulatory Withdrawal Management with Extended On-Site Monitoring service from only one provider organization during any episode of care.

B. Ambulatory Withdrawal Management with Extended On-Site Monitoring services may not be provided on the same day as other Substance Use Disorder Withdrawal Management or Residential Services, except on day of admission or discharge.

II. Service Orders

A. A signed service order must be completed by a physician, physician assistant, or nurse practitioner, per their scope of practice. **ALL the following apply to a service order:**

1. Backdating of the service order 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; **AND**
3. A service order must be in place prior to or on the first day that the service is initially provided, to bill Medicaid for the service.

III. Expected Outcomes

A. 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. Expected outcomes are as follows:

1. Reduction or elimination of withdrawal signs and symptomatology;
2. Linkage to treatment services post discharge;
3. Increased links to community-based resources to address unmet social determinants of health; AND
4. Reduction or elimination of psychiatric symptoms, if applicable.

IV. Documentation Requirements, Provider Qualifications and Occupational Licensing Entity Regulations, Staffing Requirements and Service Requirements:

For additional details, please refer to North Carolina Medicaid State Policy site for Ambulatory Withdrawal Management With Extended Onsite Monitoring (ASAM 2WM) ***Clinical Coverage Policy No: 8A-8*** at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov)

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 2024, 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
H0014 HF	Alcohol and/or drug services; ambulatory detoxification	1 Unit = 15 Minutes

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	02/24	02/24
Criteria I. added 'or Diagnostic Assessment' and changed 'before' to 'prior to' Criteria I.B.4. deleted "an ASAM level of care determination. Criteria I.C. 'deleted 'or diagnostic assessment' Criteria I.D. changed 'can' to 'may' Criteria I.E., added "Evaluation and Management CPT codes, the comprehensive clinical assessment, individual therapy, laboratory tests and toxicology tests are billed separate from the Ambulatory Withdrawal Management with Extended On-Site Monitoring service." Deleted "the licensed clinical can bill separately…' Criteria I.F. added "This facility must be in operation a minimum of eight (8) hours per day, all five weekdays (Monday through Friday), and a minimum of four hours daily on the weekend (Saturday and Sunday). The hours of operation must be extended based on member need. This service must be available for admission seven (7) days per week. Program medical staff shall be available to provide 24-hour access for emergency medical consultation services, in-person or virtually." Background II.A. added "All utilization review activity must be documented in the service record and be maintained by the program." Criteria II.B. changed 'pcp' to 'service plan.' Background III.A. added 'the required' to "…the service plan, and the required authorization…" Background IV. Changed verbiage to read "Providers shall submit an updated service plan and any authorization or reauthorization forms required by WellCare North Carolina® Background V.B. added 'other' to "as other Substance…" Background VI. Changed 'according to' to 'Per their' Background VIIIB. deleted "Note: program medical staff shall be available to provide 24 hours access for emergency consultation services, in person or virtually."	08/24	08/24
Annual Review. Removed text from Background VI.A.3. 'Even if the Member is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order." HCPCS code reviewed.	11/24	11/24
Criteria I created for "shall cover" comment, then Admission became II., etc. Criteria II.B. added "or equivalent federally recognized tribal code or	12/24	12/24

federal regulations).” Deleted Background I. Prior Approval, II. Utilization Management, III. Initial Authorization, IV. Concurrent Reviews, VII. Documentation Requirements, VIII. Program Requirements, then, Additional Limitations & Requirements became I., Service Orders became II. Expected outcomes became III., and Documentation Requirements became IV. Background I. A. changed “active authorization” to “episode of care.” Background II. A. deleted ‘a service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the Member’s needs.” And deleted “A service order is valid for 12 months…” then A. became B.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:8A-8 Ambulatory Withdrawal Management With Extended On-Site Monitoring. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published December 31, 2024. Accessed December 31, 2024.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
3. 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

- 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:

I. that is unsafe, ineffective, or experimental or investigational.

II. 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

- 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.
- **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:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. 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:

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

- 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.