NC Medicaid Substance Abuse Comprehensive Outpatient	Medicaid and Health Choice Clinical Coverage Policy No: Amended Date:Treatment (SACOT)

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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Substance Abuse Comprehensive Outpatient Treatment (SACOT) is a clinically intensive partial hospitalization program that provides skilled treatment service, a structured outpatient recovery environment, for adults with a substance use disorder (SUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), or any subsequent editions of this reference material. SACOT is an American Society of Addiction Medicine (ASAM) level 2.5 service that delivers 20 or more hours of clinically intensive programming per week as specified in the beneficiary's Person-Centered Plan (PCP) and consisting of individual counseling, group counseling, medication management through consultation and referral, family therapy, service coordination activities including medication needs, educational groups and other therapies. Services are provided in the amounts, frequencies, and intensities appropriate to the objectives of the beneficiary's treatment plan.

SACOT can be designed for clinically homogeneous groups of beneficiaries (examples may include pregnant beneficiaries or parents; beneficiaries with co-occurring mental health and substance use disorders; beneficiaries with human immunodeficiency virus (HIV); or beneficiaries with similar cognitive levels of functioning.

1.1 Definitions

None Apply

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
    1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
    2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC 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.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

A retroactively eligible beneficiary is entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

b. NCHC

Retroactive eligibility does not apply to the NCHC Program.

2.2 Special Provisions

2.2.1 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.

b. **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/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover SACOT services when ALL following criteria at met:

1. The beneficiary has a substance use disorder (SUD) diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) or any subsequent editions of this reference manual; and
2. Meets ASAM Level 2.5 criteria of the American Society of Addiction Medicine (ASAM) Criteria Third Edition or any subsequent editions of this reference manual.

Admission Criteria

A comprehensive clinical assessment (CCA) or Diagnostic Assessment (DA) will be completed by a licensed professional to determine an ASAM level of care for admission and discharge planning: The CCA or DA, which demonstrates medical necessity, must be completed prior to the provision of this service. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal and state requirements, it may be utilized as part of the current CCA or DA. Relevant diagnostic information must be obtained and documented in the beneficiary's Person-Centered Plan (PCP). The assessment should continuously be updated as changes, new strengths and barriers are observed during the treatment process.

A service order for SACOT 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 SACOT services are provided.

The amount, duration, and frequency of SACOT Service must be included in a beneficiary's PCP. Services may not be offered less frequently than the structured program set forth in the service description in **Section 1.0**.

Continued Stay Criteria

The beneficiary meets the criteria for continued stay if any ONE of the following applies:

a. The beneficiary has achieved initial PCP goals and requires this service in order to meet additional goals;
b. The beneficiary is making progress, but hasn't achieved goals yet, so continuing at the present level of care is indicated; or

c. The beneficiary is not making progress, is regressing, or new symptoms have been identified and has the capacity to resolve problems. Beneficiary is actively working towards goals so continue at the present level of care is indicated, and the PCP must be modified to identify more effective interventions.

Discharge Criteria

The beneficiary meets the criteria for discharge if any ONE of the following applies:

a. The beneficiary's Substance Use Disorder (SUD) signs and symptoms are resolved such that the beneficiary can participate in self-directed recovery or ongoing treatment without the need for SACOT services.

b. The beneficiary's signs and symptoms of SUD are not responding to treatment, and have intensified indicating a transfer to a more intensive level of SUD treatment services is required; or

c. The beneficiary or person legally responsible for the beneficiary requests a discharge from the service.

3.2.2 Medicaid Additional Criteria Covered

None Apply

3.2.3 NCHC Additional Criteria Covered

None Apply

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid shall not cover these activities:

a) Transportation for the beneficiary or family members;
b) Any habilitation activities;
c) Time spent doing, attending, or participating in recreational activities unless tied to specific planned social skill building or therapy;
d) Clinical and administrative supervision of SACOT 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 substitutes for education;
h) Interventions not identified on the beneficiary's service plan;
i) Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the service plan; and
j) Payment for room and board.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover…
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

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5.1 Prior Approval

Medicaid and NCHC shall not require an initial prior approval for SACOT. Upon admission to SACOT, a beneficiary is allowed a 60-day pass-through. The pass-through is available once per treatment episode in a fiscal year. An authorization from the Prepaid Inpatient Health Plan (PIHP) or utilization management (UM) contractor is required after the initial 60-day pass-through.
Refer to Subsection 5.3 for additional limitations.

A service order must be signed prior to or on the first day SACOT services are rendered. Refer to **Subsection 5.4** of this policy.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary. All utilization review activity shall be documented in the Service Record.

Initial Authorization
Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, as verified by the PIHP or utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an authorization, the CCA or DA, service order for medical necessity, the PCP, and the required NC Medicaid authorization request form must be submitted to the PIHP or utilization management contractor within the first 30 calendar days of service initiation.

Reauthorization
NC Medicaid may and NCHC may cover 60 calendar days for each reauthorization. Reauthorization shall be submitted prior to initial or concurrent

authorization expiring. Authorizations are based on medical necessity documented in the PCP, the authorization request form and supporting documentation.

5.3 Additional Limitations or Requirements

SACOT cannot be billed during the same authorization as:

- SA Intensive Outpatient Services (SAIOP)
- Individual, family or group therapy for treatment of substance use disorder
- Clinically Managed residential services
- Clinically managed residential withdrawal management
- Medically monitored inpatient withdrawal management
- Clinically managed low-intensity residential treatment services
- Clinically managed population-specific high-intensity residential programs
- Clinically managed high-intensity residential services
- Medically monitored intensive inpatient services
- Community Support Team (CST)
- Assertive Community Treatment (ACT)
- Outpatient services except for situation as noted below

Outpatient therapy services can be billed separately when the beneficiary needs specialized therapy that cannot be provided by the SACOT provider (Dialectical Behavioral Therapy, exposure therapy, Eye Movement Desensitization and Reprocessing.)

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered;
c. 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. Even if the beneficiary is retroactively eligible for Medicaid the provider shall not bill Medicaid without a valid service order; and
d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP service order.

5.5 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To bill Medicaid or NCHC, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is

responsible for accurately documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must include credentials for the staff member wo provided the service. The service plan and a documented discharge plan must be discussed with the beneficiary and included in the service record.

5.5.1 Contents of Service Notes

A full service note for each contact or intervention for each date of service, written and signed by the person who provided the service is required. A service note must document ALL following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;
e. Type of contact (in-person, phone);
f. Place of service;
g. Purpose of contact as it relates to the PCP goals:
h. Description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
i. Duration of service, amount of time spent performing the intervention;
j. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goals; and
k. Date and signature and credentials or job title of the staff member who provided the service.

6.0 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 or NCHC 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

SACOT services must be delivered by providers employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
b. meet the requirements of 10A NCAC 27G;
c. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
d. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and

e. become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards.

This facility must be licensed under 10A NCAC 27G .4500 rules unless service is provided by an Indian Health Service (IHS) or 638 compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a.

Providers and Organizations that provide SACOT must provide "first responder" crisis response on a 24-hours-a day, 7 days-a-week, 365 days-a-year basis, to beneficiary's who are receiving SACOT services.

6.2 Provider Certifications

Staffing Requirements

Position	FTEs	Minimum Requirements	Responsibilities
Clinical Supervisor	1.0 FTE Licensed Clinical Addiction Specialist (LCAS) or Certified Clinical Supervisor (CCS)	Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board.	**The Clinical Supervisor** is responsible for clinical oversight of the program, to include ensuring adequate staffing supervision is in place, managing admission and discharges, and ensuring the program is adhering to the policy, the rules and statues and the provision of direct clinical care. <u>Clinical Supervisor responsibilities also include the following</u>: • Overseeing the clinical operation of the SACOT program and be on-site 100% of time SACOT is in operation and ensure on-site backup coverage when needed • Supervising clinical staff to assure the delivery of best and ethical practices • Maintains review of service notes and documentation to ensure accuracy. • Conducts staff meetings and treatment team meetings • Develop and monitor the implementation of a programming calendar that ensures beneficiaries have access to the intensity and frequency of service indicated in their PCP

			• Monitors and evaluates the services, interventions, and activities provided by the team • Assist with crisis interventions • Complete CCAs for new referrals to the SACOT program and provide ongoing assessments as appropriate • Facilitate individual and group therapy sessions • Participating in service and discharge planning meetings • Facilitating transition to the next level of care and community-based resources • Working with beneficiary's natural supports • Developing collaborative working relationships with community-based providers and organizations to facilitate discharge • Facilitates any recurring program clinical meetings • Developing and implementing supervision plans that meet the requirements of 10A NCAC 27G .0104
Clinical Staff	**LCAS or LCAS-A** **Program must have 1.0 FTE LCAS or LCAS-A for every 20 individuals (per caseload) based on the total census of the SACOT program.**	Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board	The **Licensed Clinical Addiction Specialist (LCAS) or Licensed Clinical Addiction Specialist-Associate (LCAS-A)** is responsible for providing substance use focused and co-occurring assessment services, development of an ASAM Level of Care determination, provide substance use disorder treatment services or referral and coordination to appropriate substance use disorder treatment and recovery resources <u>LCAS or LCAS-A responsibilities also include the following</u>: • Discharge planning shall begin upon admission • Lead in the development of an individualized, person-centered service plan and ongoing revisions • Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals

			• Facilitate individual, group and family therapy sessions • Facilitate Service Coordination to address the needs of the beneficiary • Monitors signs and symptoms of alcohol and other drug use, intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions • Provides crisis interventions, when clinically appropriate • Engage with family members or significant others when needed • Provides education to family members or significant others regarding SUD treatment and the recovery process • Provides coordination and consultation with medical, clinical, familial and ancillary relevant parties with beneficiary consent • Assess and determine clinically appropriate services that support recovery • Informs the beneficiary about benefits, community resources, and services • Monitors and documents the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Maintains accurate service notes and documentation for all interventions provided • Participates in staff meetings and treatment team meetings
	CADC or CSAC **Program must have 1.0 FTE CADC or CSAC for every 10 individuals (per caseload)**	Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board	The **Certified Alcohol and Drug Counselor (CADC) or Certified Substance Abuse Counselor (CSAC)** coordinates with the LCAS or LCAS-A and Program manager to ensure that beneficiaries have access to counseling supports, psychoeducation, and crisis interventions when needed. They play a lead role in case management and coordination of care functions.

	based on the total census of the SACOT program.		CADC and CSAC responsibilities also include the following: • Participates in the initial development, implementation, and ongoing revision of the PCP • Provides ongoing assessment and reassessment of the beneficiary based on their service plan and goals • Monitors signs and symptoms of alcohol and other drug use, intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions • Coordinates with Medication for Opioid Use Disorder providers • Provides crisis interventions, when clinically appropriate • Provides psychoeducation as indicated in the PCP • Monitors and documents the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Provides substance use, health and community services education • Assists with the development of relapse prevention and disease management strategies • Communicates the beneficiary's progress and the effectiveness of the strategies and interventions to the LCAS or LCAS-A and Program Manager as outlined in the person-centered service plan • Engage with family members or significant others in the withdrawal management process, as appropriate • Provides education to family members or significant others regarding withdrawal management process, as appropriate • Coordination with Care Management to ensure the beneficiary is informed about benefits, community resources, and services

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			• Coordination with Care Management to ensure beneficiary is provided appropriate linkage and referrals for needed services and supports • Participates in staff meetings and treatment team meetings

- For an adult SACOT program, ten (10) adult beneficiaries to one SACOT staff is the maximum in-person staff-to-beneficiary ratio in group counseling sessions

- The Clinical Supervisor may cover caseloads on a temporary basis in emergency situations as a result of staffing shortages and count towards the 1:10 LCAS, LCAS-A or Certified Alcohol & Drug Counselor to beneficiary staff ratio

Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, the certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendments(s) will be effective the date the related rule for 10A NCAC 27G is finalized.

Note: In accordance with 25 U.S.C. 1621t, licensed health professionals employed by a tribal health program are exempt, if licensed in any state, from the licensing requirements of the State (North Carolina) in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

6.3 Program Requirements

SACOT services must operate at least 20 hours per week offering a minimum of 4 hours scheduled service per service day, with availability of SACOT services at least 5 days per week with no more than 2 consecutive days without services available.

SACOT is a structured individual and group addiction service that is provided at an outpatient program consisting of the following services:

- Individual counseling, therapy and support
- Group counseling, therapy and support
- Family counseling, training and support, which involves family members, guardians, or significant other(s) in the assessment, treatment, and continuing care of the beneficiary
- Appropriate referral for occupational therapy or ancillary services
- Biochemical assays to identify recent drug use (includes urine drug screens);
- Education on relapse prevention and development of support systems in treatment
- Education on life skills and crisis contingency planning
- Education on physical health management
- Treatment support activities for beneficiaries with physical disabilities; co-occurring disorders or intellectual and developmental disability and substance use disorder
- A planned format of therapies, delivered on an individual and group basis and adapted to the beneficiary's developmental stage and comprehension level

- Service coordination activities;

While receiving SACOT consultation services, beneficiaries must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating co-occurring substance use and mental health disorders (major depression, schizophrenia, borderline personality disorder). SACOT must have an agreement with a provider to ensure that services are available and these services shall be delivered by psychiatrists who meet requirements as specified in NCAC 27G .0104. The providers shall be familiar with the SACOT Program treatment plan for each beneficiary seen in consultation, shall have access to SACOT Program treatment records for the beneficiary, and shall be able to consult by phone or in-person with CCS, LCAS,CADC or CSAC providing SACOT Program services.

Medical, psychological, psychiatric, laboratory, and toxicology services will be available through consultation or referral. Psychiatric and other medical consultation must be available by telephone, telehealth and in person.

SACOT programs shall support beneficiaries who are prescribed medications to address their substance use or mental health diagnosis. Coordination of care with prescribing physician is required.

SACOT providers shall ensure that all programs have access to naloxone on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses. SACOT programs shall develop policies that detail the use, storage and education provided to staff regarding naloxone.

Required components of this service include the following:

- An individual biopsychosocial assessment, which includes a substance use and addictive behaviors history obtained as part of the initial comprehensive assessment;
- Medical to include referral for physical examination when necessary, psychological, psychiatric, laboratory, and toxicology services;
- Individualized person-centered service plan (PCP), including problem identification in the ASAM dimensions, identifying needs, strengths and skills, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
- Monitoring the provision of services, routine review and updating of the PCP to track progress towards meeting identified goals, or when interventions should be modified to achieve greater therapeutic gains;
- Ongoing assessment of treatment activities and beneficiary progress on each day of SACOT and documented in the clinical record;
- Emergency services, which are available based on the beneficiary's needs when the treatment program is not in session;
- Provide behavioral health crisis interventions, when clinically appropriate;
- Provide reproductive and health planning education, and referral to external partners as necessary;
- Ability to assist in accessing transportation services for beneficiaries who lack safe transportation;

- Direct affiliation or coordination through referral to other levels of care, including specialized psychological and psychiatric services for biomedical, emotional, behavioral and cognitive problems;
- Affiliation with other ASAM levels of care and behavioral health providers for appropriate linkage and referrals for medical, psychiatric services;
- Discharge or transfer planning beginning at admission;
- Coordination with Care Management to ensure beneficiary is provided appropriate linkage and referrals for needed services and supports;
- Assessment and reassessment of the beneficiary's need for services;
- Coordination with Care Management to ensure that the beneficiary is informed about benefits, community resources, and services;

A comprehensive clinical assessment (CCA) or reassessment shall be completed by a licensed professional to determine an ASAM level of care for discharge planning. Relevant diagnostic information must be obtained and be included in the beneficiary's PCP. Needed toxicology testing and psychiatric and medical services may be billed separately from SACOT.

Staff Training Requirements

Time Frame	Training Required	Who	Total Minimum Hours Required
Upon hire, prior to first day worked	▪ 2 hours of Crisis Response, Narcan and Harm Reduction training	All Staff	2 hours
Within **30 calendar days** of hire to provide service	▪ 2 hours SACOT Services Definition Required Components ▪ 6 hours of ASAM Criteria Training	All Staff	8 hours
	• 3 hours of PCP Instructional Elements • 3 hours of designated therapies, practices or modalities used in SACOT • Trauma informed care** • Co-occurring conditions**	Clinical Supervisor, CCS, LCAS, LCAS-A, CSAC, or CADC	6 hours
Within **90 calendar days** of hire to provide this service	▪ 13 hours of Introductory Motivational Interviewing* (MI) ▪ 12 hours of designated therapies, practices or models specific to the population(s) served in SACOT.	Program Manager, CCS, LCAS, LCAS-A, CSAC, or CADC	25 hours *12 hours or commensu rate to the

Time Frame	Training Required	Who	Total Minimum Hours Required
Upon hire, prior to first day worked	▪ 2 hours of Crisis Response, Narcan and Harm Reduction training	All Staff	2 hours
Annually	▪ 10 hours of continuing education in evidence-based treatment practices including Crisis Response and Cultural Competency training**	All Staff	10 hours

The initial training requirements may be waived by the hiring agency if the employee can produce documentation certifying that training appropriate for the population being served was completed no more than 24-months prior to hire date.

*Motivational Interviewing training must be provided by a Motivational Interviewing Network of Trainers (MINT) trainer. If a staff person is a MINT trainer, they are not required to have this training.

** Training must be approved and certified by a nationally recognized program that issues continuing education for licensed or clinical professionals. Some examples of approved programs include North Carolina Addictions Specialist Professional Practice Board (NCASPPB), National Association for Addiction Professionals (NAADAC), National Board for Certified Counselors (NBCC) Approved Continuing Education Provider (ACEP), and National Association of Social Work (NASW.)

Documentation of staff training activities shall be maintained by the program.

Expected Outcomes
The expected clinical outcomes for SACOT are specific to recommendations resulting from clinical assessments, medical evaluation and meeting the identified goals in the beneficiary's service plan. Expected outcomes are as follows:

- Reduction or elimination of substance use;
- Sustained improvement in health and psychosocial functioning
- Reduction or elimination of psychiatric symptoms, if applicable;
- Reduction in involvement in the justice system;
- Reduction of risk of relapse, continued problems, or continued use, and promoting the eventual reintegration of the individual into the community;
- Linkage to treatment services post discharge;
- Linkage to community-based resources to address unmet social determinants of health.
- Increase in the identification and use of resources and healthy coping skills

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7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC 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).

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
2/1/2023	All Sections and Attachment(s)	Initial implementation of stand-alone Substance Abuse Comprehensive Outpatient Treatment Program (SACOT) policy.

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks 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 and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and 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.

ICD-10-CM Code(s)

ICD-10-PCS Code(s)

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.

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CPT Code(s)

Revenue Code(s)

HCPCS Code(s)

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

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

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Federally recognized tribal or Indian Health Service providers may be entitled to alternate reimbursement methodologies under Federal Law and Regulations.

SACOT service is billed as a daily unit. A minimum of 4 hours per day of service must be provided to the beneficiary to bill.

PHPs, PIHPs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. PHPs and PIHPs shall assess network providers' adherence to service guidelines to assure quality services for beneficiaries.

F. Place of Service

SACOT is a licensed clinic-based service that must be provided in a setting separate from the beneficiary's residence.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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H. Reimbursement

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

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