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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

Table of Contents

1.0 Description of the Procedure, Product, or Service 3
1.1 Definitions 3

2.0 Eligibility Requirements 3
2.1 Provisions 3
2.1.1 General 3
2.1.2 Specific 4
2.2 Special Provisions 4
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 4
2.2.2 EPSDT does not apply to NCHC beneficiaries 5
2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age 5

3.0 When the Procedure, Product, or Service Is Covered 6
3.1 General Criteria Covered 6
3.2 Specific Criteria Covered 6
3.2.1 Specific criteria covered by both Medicaid and NCHC 6
3.2.2 Medicaid Additional Criteria Covered 8
3.2.3 NCHC Additional Criteria Covered 8

4.0 When the Procedure, Product, or Service Is Not Covered 8
4.1 General Criteria Not Covered 8
4.2 Specific Criteria Not Covered 8
4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC 8
4.2.2 Medicaid Additional Criteria Not Covered 8
4.2.3 NCHC Additional Criteria Not Covered 8

5.0 Requirements for and Limitations on Coverage 9
5.1 Prior Approval 9
5.2 Prior Approval Requirements 9
5.2.1 General 9
5.2.2 Specific 9
5.3 Additional Limitations or Requirements 10

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service 12
6.1 Provider Qualifications and Occupational Licensing Entity Regulations 12
6.2 Provider Certifications 13

7.0 Additional Requirements 25
7.1 Compliance 25

8.0 Policy Implementation and History 25

Attachment A: Claims-Related Information 26
- A. Claim Type 26
- B. International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-9-CM) and Procedures Codes ..... **Error! Bookmark not defined.**
- C. Code(s) 26
- D. Modifiers 27
- E. Billing Units 27
- F. Place of Service 27
- G. Co-payments 27
- H. Reimbursement 27

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

Clinically Managed Population-Specific High Intensity Residential Program is an organized service delivered by trained and experienced medical and nursing professionals, clinical, and professional staff to support beneficiaries with both substance use disorder (SUD) and traumatic brain injury (TBI.) This is an American Society of Addiction Medicine (ASAM) Level 3.3 substance use disorder treatment service that provides 24-hour care in a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional and cognitive limitations of beneficiaries to support recovery from substance use disorders. The effects of the substance use disorder combined with the cognitive limitations are such that outpatient or other levels of residential care would not be feasible or effective. The treatment primarily focuses on rehabilitation, but can include some components of habilitation, and the pacing of treatment can be slowed to ensure that beneficiaries have support that meets their level of functioning.

1.1 Definitions

Traumatic Brain Injury (TBI)- An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all of the following criteria:

a. Involves an open or closed head injury;
b. Resulted from a single event or resulted form a series of events which many include multiple concussions;
c. Occurs with or without a loss of consciousness at the time of injury;
d. Results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem-solving, sensory, perceptual and motor abilities, psychosocial behavior, physical functions, information processing, and speech, and
e. Does not include brain injuries that are congenital or degenerative.

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 18 years of age.

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.

Retroactively eligible beneficiaries are 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.

Medicaid shall cover Medically Monitored Inpatient Withdrawal Management services for an eligible beneficiary who is 18 years of age and older and meets the criteria in **Section 3.0** of this policy.

b. NCHC

NCHC shall cover Medically Monitored Inpatient Withdrawal Management services for an eligible beneficiary who is 18 years of age till he or she reaches their 19th birthday and meets the criteria in **Section 3.0** of this policy.

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 is not 18 years of age and does not meet the criteria within **Section 3.0** of this policy.

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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 Clinically Managed Population Specific High Intensity Residential Program services when ALL following criteria are met:

a. The beneficiary 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 3.3 Clinically Managed Population Specific High-Intensity Residential Program admission criteria as defined in The ASAM Criteria, Third Edition, 2013 or any subsequent editions of this reference material; and
c. The beneficiary has a documented diagnosis of TBI as defined in Section 1.1-Definitions.

Admission Criteria

An initial abbreviated assessment must be conducted by the medical director, physician assistant, or nurse practitioner to establish medical necessity for this service and the development of a service plan as a part of the admission process.

The initial assessment must contain the following documentation in the service record:

a. the beneficiary's presenting problem

b. the beneficiary's needs and strengths

c. a provisional or admitting diagnosis

d. a physical examination by the medical director, physician assistant, or nurse practitioner within 24 hours of admission, including appropriate laboratory and toxicology tests

e. confirmed TBI diagnosis;

e. a pertinent social, family, and medical history; and

f. other evaluations or assessments as appropriate.

The medical director, physician assistant, or nurse practitioner can bill an E/M code separately for the admission assessment and physical exam.

Within three calendar days of the admission, a Comprehensive Clinical Assessment (CCA) shall be completed by a licensed professional to determine an ASAM level of care for discharge planning. Information from the abbreviated assessment may be utilized as a part of the current CCA. The CCA should include observational information obtained during the first three days of treatment in the program. The assessment should continuously be updated as new strengths and barriers are observed in the residential setting. Relevant diagnostic information must be obtained and be included in the Person-Centered Plan.

The CCA process must include the completion of the NC TBI Waiver Risk Support Needs Assessment and the NC TBI Waiver Wellness Assessment, which evaluates for traumatic brain injury, assists in the clinical evaluation of the extent and severity of the brain injury and the identification of rehabilitation goals. The assessment also includes information on the specific functional limitations the beneficiary is experiencing.

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 some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid level of functioning, are possible or can be achieved;

c. The beneficiary is not making progress or regressing; 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. Beneficiary has achieved positive life outcomes that support stable and ongoing recovery;

b. The beneficiary's signs and symptoms have failed to respond to treatment, and have intensified indicating a transfer to a more intensive level of residential care is indicated;

c. Beneficiary is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services; or

d. Beneficiary or legally responsible person no longer wishes to receive Clinically Managed Population Specific High-Intensity Residential Program.

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 assistance;
d. Clinical and administrative supervision of 3.3 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 beneficiary's service plan;
j. 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 Person Centered Plan; and
k. Payment for room and board

4.2.2 Medicaid Additional Criteria Not Covered

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.

5.1 Prior Approval

Medicaid shall require prior approval for Clinically Managed Population Specific High Intensity Residential Program services. The provider shall obtain prior approval before admission to this program. Prior authorization is required on the first day of this service.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the PIHP, PHP, or utilization management 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.

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, PHP, 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.

Medicaid covers 90 days for the initial authorization period based on medical necessity documented on the authorization request form and supporting documentation. Refer to **Subsection 3.2.1.**

To request an initial authorization, a service order for medical necessity completed by a physician, physician assistant, or nurse practitioner, the CCA or DA, the service plan, and the required NC Medicaid authorization request form must be submitted to the PIHP, PHP, or utilization management contractor within the first three calendar days of service initiation.

Reauthorization
NC Medicaid may cover an additional 90-day reauthorization.
Reauthorization shall be submitted prior to initial or concurrent authorization expiring. Authorizations are based on medical necessity documented in the service plan, the authorization request form, and supporting documentation.

5.3 Additional Limitations or Requirements

A beneficiary can receive the Clinically Managed Population Specific High Intensity Residential Program service from only one provider organization during any active authorization period.

Clinically Managed Population Specific High Intensity Residential Program services cannot be billed on the same day (except day of admission or discharge) as:

- residential levels of care,
- other withdrawal management services,
- outpatient treatment services,
- Substance Abuse Intensive Outpatient Program,
- Substance Abuse Comprehensive Outpatient Treatment,
- Assertive Community Treatment,
- Community Support Team,
- Supported Employment,
- Psychiatric Rehabilitation,
- Peer Support Services,
- Mobile Crisis Management,
- Partial Hospitalization,
- Facility Based Crisis (adult), and
- all TBI Waiver services.

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. A signed service order must be completed by the medical director, a physician assistant, or nurse practitioner, per his or her scope of practice. Service orders are valid for the episode of care. Medical necessity

must be revisited, and service must be ordered based on episode of care if multiple episodes of care are required within a twelve (12) month period.

ALL the following apply to a service order:
a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
c. A service order must be in place 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 cannot bill Medicaid without a valid service order.

a. 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. This service requires a shift note to be completed for every eight hours of service provided. Significant events in a beneficiary's life which require additional activities or interventions shall be documented over and above the minimum frequency requirement. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service must sign and date the written entry. The signature must include credentials for the staff member who provided the service. The service plan and a documented discharge plan must be discussed with the beneficiary and included in the service record. All beneficiaries will have a Medication Administration Record (MAR) completed at admission by qualified staff, as medication is administered, and updated as any medication changes are made.

5.5.1 Contents of a Shift Note

A shift note is required for each beneficiary for each eight hour shift they are enrolled in Clinically Managed Population Specific High Intensity Residential Program services. A shift note must document ALL following elements:

a. Beneficiary name;
b. Medicaid identification number;
c. Date of service;
d. Type of contact (face-to-face, phone call, collateral)
e. Purpose of the contact
f. Description of the provider's interventions. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
g. Shift/coverage hours (Third Shift: 11:30 pm- 7:30 am)
h. Assessment of the effectiveness of the interventions and the beneficiary's progress towards meeting the beneficiary's goals; and
i. Date and signatures and credentials or job title of staff providing the service.

5.5.2 Contents of A Service Note

A full service note for each contact or intervention provided due to a significant life event in a beneficiary's life that required additional activities or interventions for each service, written and signed by the person who provided the service is required. A service note must document ALL following elements:

a. beneficiary name;

b. Medicaid identification number;
c. date of service;
d. type of contact;
e. place of service;
f. purpose of contact;
g. implementation of the treatment plan;
h. details of beneficiary's response to treatment plan;
i. description of the provider's interventions. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
j. duration of service, amount of time spent performing the intervention;
k. assessment of the effectiveness and of interventions and the beneficiary's progress towards the beneficiary's goals; and
l. date and signatures and credentials or job title of staff providing the service.

5.5.3 Content of a Medication Administration Record

A Medication Administration Record (MAR) of all drugs administered to each beneficiary must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:

a. beneficiary's name;
b. name, strength, and quantity of the drug;
c. instructions for administering the drug;
d. date and time the drug is administered; and
e. name or initials of person administering the drug.

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

Clinically Managed Population Specific High Intensity Residential Program services must be delivered by providers employed by substance use provider organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Medicaid;
b. meet the requirements of 10A NCAC 27G;
d. demonstrate that they meet these standards by being credentialed and contracted by the DHHS designated contractor;
e. within one year of enrollment as a provider with NC Medicaid, achieve national accreditation with at least one of the designated accrediting agencies; and
f. 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 .#### rules unless provided by a IHS or compact operated by a Federally Recognized Tribe as allowed in 25 USC 1621t and 1647a.

NC Division of Health Service Regulation
Mental Health Licensure and Certification Section
Refer to https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html

6.2 Provider Certifications

Staffing Requirements

Position	FTEs	Minimum Requirements	Responsibilities
Medical Director (MD)	A minimum 0.25 FTE Medical Director	Must be licensed physician and in good standing with the NC Medical Board, have at least one year of SUD treatment experience, and preferred experience working with beneficiaries with TBI	The **medical director** is responsible for providing medical services and supervising physician extender staff according to the physician approved policies and protocols of the Clinically Managed Population Specific High-Intensity Residential program. The medical director shall be available for emergency medical consultation services 24 hours a day, 365 days a year, either for direct consultation or for consultation with the physician extender. Responsibilities also include the following: • Develop policies and procedures for the program, in collaboration with the Program Manager • Provide supervision to the physician extenders and nursing staff • Perform a medical history and physical exam upon admission • Determine diagnosis of substance use disorder per program eligibility requirements • Monitor the Controlled Substance Reporting System (CSRS) • Ensure there is emergency medical backup and coverage available for consultation 24 hours a day, seven days a week • Participate in the development of service plans • Evaluate, prescribe and monitor all medications currently being taken by

			the beneficiary, including coordination with off-site prescribers • Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects • Order medically necessary toxicology and laboratory tests • Provide case consultation with interdisciplinary treatment team, including consultation with the TP Care Manager • Assess for traumatic brain injury, co-occurring medical and psychiatric disorders • Make appropriate referrals and follow up for treatment of co-occurring medical and/or psychiatric disorders • Coordinate care with other medical and/or psychiatric providers.
Physician Extender	A minimum 0.50 FTE Physician Assistant (PA) or Nurse Practitioner (NP)	Must be licensed physician assistant or nurse practitioner and in good standing with the NC Medical Board or NC Nursing Board, have at least one year of SUD treatment experience, and preferred experience working with beneficiaries with TBI	The **physician extender** is responsible for providing medical services according to the physician approved policies and protocols of the Clinically Managed Population Specific High-Intensity Residential program. The physician extender shall be available for emergency medical consultation services 24 hours a day, 365 days a year. <u>Responsibilities also include the following, as delegated by the Medical Director</u>: • Perform a medical history and physical exam upon admission • Determine diagnosis of substance use disorder per program eligibility requirements • Monitor the Controlled Substance Reporting System (CSRS) • Provide emergency medical back up and coverage available for consultation 24 hours a day, 7 days a week, as directed by the Medical Director • Participate in the development of service plans • Evaluate, prescribe and monitor all medications currently being taken by the beneficiary including coordination with other prescribers

			• Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects • Order medications as medically appropriate • Order medically necessary toxicology and laboratory tests • Provide case consultation with interdisciplinary treatment team, including consultation with the TP Care Manager • Assess for traumatic brain injury, co-occurring medical and psychiatric disorders, with supervision as required • Make appropriate referrals and follow up for treatment of co-occurring medical and/or psychiatric disorders • Coordinate care with other medical and/or psychiatric providers.
Nursing Staff	1.5 FTE RN AND 2.5 FTE LPN/CMA/CNA	Must be registered and in good standing with the NC Board of Nursing	The **Nursing Staff** will be responsible for maintaining an adequate level of nursing for the program's dispensing and medical operations under the supervision of the Medical Director. <u>Nursing staff responsibilities also include the following, as allowed by clinical and practice scopes</u>: • Conduct a nursing evaluation upon admission in accordance with their scope of work • Monitor the Controlled Substance Reporting System (CSRS), when delegated by a physician • Oversee the monitoring of the beneficiary's progress and medication administration by nursing staff on an hourly basis, if needed • Provide daily assessment of the beneficiary's progress and any treatment changes • Monitor signs and symptoms of alcohol and other drug intoxication and withdrawal, as needed, as well as the appropriate treatment and monitoring of those conditions. • Prepare and dispense medication to

			beneficiaries, maintain medication inventory records and logs in compliance with state regulations • Document in the beneficiary's service record of all nursing activities performed related to beneficiary care • Ensure medical orders are being followed and carried out • Provide psychoeducation, including HIV/AIDS, TB, Hepatitis C, pregnancy, and other health education services • Coordinate medical treatment and referral for biomedical problems • Perform auxiliary testing based on medical orders • Consult with other program medical staff for guidance in medical matters concerning the well-being of beneficiaries • Participate in staff meetings and treatment team meetings.
Program Director	1.0 FTE, full-time dedicated Qualified Professional	Must be a Certified Brain Injury Specialist (CBIS) or a Certified Brain Injury Specialist Trainer (CBIS-T).	The **Program Manager** will be responsible for general oversight of the program, to include ensuring adequate staffing is in place, managing admission and discharges, and ensuring the program is adhering to the policy, rules and statues. The Program Manager is responsible for ensuring there is 24/7/365 access to an on-call staff that can provide immediate support to facility staff supporting beneficiaries experiencing a behavioral crisis, either directly or for telephonic/telehealth back up. <u>Program Manager responsibilities also include the following</u>: • Oversee the administrative operation of the Clinically Managed Population Specific High-Intensity Residential program • Coordinate with the Medical Director to develop program policies and procedures • Ensure the physical and environmental layout of the residential program takes into consideration the unique needs of

			beneficiaries with traumatic brain injury (lighting, volume and noise level, privacy considerations) • Provide programmatic supervision to staff to assure the delivery of best and ethical practices, especially as it relates to supporting beneficiaries with traumatic brain injury • Facilitate recurring trainings on best practices for working with beneficiaries with traumatic brain injury • Coordinate the initial and ongoing assessment activities • Model behaviors through service provision for the purpose of staff supervision • Facilitate any recurring program meetings • Monitor and evaluates the services, interventions, and activities provided by the team • Assist with crisis interventions • Participate in service and discharge planning meetings • Facilitate transition to the next level of care and community-based resources • Work with natural supports • Develop collaborative working relationships with the TP Care Manager, community-based providers and organizations to facilitate warm handoffs at discharge • Develop and implement supervision plans that meet the requirements of 10A NCAC 27G .0104
Clinical Staff	1.50 FTE LCAS or LCAS-A	Must be licensed and in good standing with the NC Addictions Specialist Professional Practice Board	The **Licensed Clinical Addiction Specialist or Licensed Clinical Addiction Specialist-Associate** is responsible for providing substance use focused and co-occurring assessment services, development of an ASAM Level of Care determination and provide 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 • Complete a comprehensive clinical assessment and updates accordingly • Lead the development of the PCP and ongoing revisions • Provide ongoing assessment and reassessment of the beneficiary based on their PCP and goals • Plan and deliver clinical and didactic motivational interventions appropriate to the beneficiary's stage of readiness to change • Facilitate individual and group therapy sessions • Provide clinical supervision to CADCs • Provide crisis interventions, when clinically appropriate • Engage with family members or significant others and provide education and supports, as appropriate • Provide support with the coordination and consultation with medical, clinical, familial and ancillary relevant parties with beneficiary consent • Ensure linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations • Inform the beneficiary about benefits, community resources, and services • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the service plan • Maintain accurate service notes and documentation for all interventions provided • Participate in staff meetings and treatment team meetings.
Certified Alcohol and Drug Counselor (CADC)	2.0 FTE CADC	Must be certified and in good standing with the NC Addictions Specialist Professional Practice Board	The **Certified Alcohol and Drug Counselor** (CADC) 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.

			CADC responsibilities also include the following: • Participate in the development, implementation, and ongoing revision of the PCP • Assist the LCAS or LCAS-A with behavioral and substance use disorder interventions • Provide ongoing assessment and reassessment of the beneficiary based on their service plan and goals • Provide crisis interventions, when clinically appropriate • Provide psychoeducation as indicated in the PCP • Monitor and document the status of the beneficiary's progress and the effectiveness of the strategies and interventions outlined in the PCP • Provide substance use, health and community services education • Support the beneficiary in skill building interventions • Assist with the development of relapse prevention and disease management strategies • Communicate 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 PCP • Engage with family members or significant others and provide education and supports, as appropriate • Inform the beneficiary about benefits, community resources, and services • Provide appropriate linkage and referrals for recovery services and supports • Advocate for and assist the beneficiary in accessing benefits and services • Maintain accurate service notes and documentation for all interventions provided • Participate in staff meetings and

			treatment team meetings.
Certified Peer Support Specialist (CPSS)	2.0 FTE NC CPSS	Must be fully certified as a peer support specialist in NC and have at least 1-year experience working with beneficiaries with SUD. Prefer experience working with beneficiaries with traumatic brain injury.	The **Certified Peer Support Specialist (CPSS)** uses their lived experience and recovery to provide support to beneficiaries and share hope as they walk with a beneficiary through the first steps of their recovery journey. <u>CPSS responsibilities also include the following</u>: • Share lived experience to support, encourage and enhance treatment and recovery • Model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience • Explore the importance and creation of a recovery and wellness identity • Promote the opportunity for personal growth by identifying teachable moments for building relationship skills to empower the beneficiary and enhance personal responsibility • Model and share examples of healthy social interactions and facilitate familiarity with, and connection to, the local community, including mutual aid groups and self-help resources • Guide and encourage beneficiaries to take responsibility for and actively participate in their own recovery • Assist with self-determination and decision-making • Model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience • Teach and promote self-advocacy • Assist with crisis interventions • Participate in team meetings and the PCP process
Paraprofessional Staff	5.0 FTE	Must have 1-year experience working with adults with SUD	**Paraprofessional staff** are responsible for tasks that ensure beneficiaries are medically able to receive support at this level of care. They work closely with

		or adults with traumatic brain injuries	medical staff to ensure monitoring is completed and recorded, and with clinical staff to support in the provision of recovery- oriented interventions. Paraprofessional responsibilities also include the following: • Use psychoeducation strategies and recovery interventions to support beneficiaries with SUD • Take, record and report out vital signs as ordered by medical staff • Communicate observations and recommendations effectively in written and verbal form • Assist in skill building interventions • Assist with crisis interventions • Follow the service plan and/or clinical orders • Work independently and as a member of a team • Communicate effectively with beneficiaries, staff, and others • Learn and apply recovery-oriented practices and person- centered approaches • Participate in team meetings and provide input into the PCP.

Staffing ratios shall not exceed one staff to six beneficiaries. The Medical Director, Physician Extenders, and Program Director cannot count towards meeting the staff to beneficiary ratio.

6.3 Program Requirements

The Clinically Managed Population Specific High-Intensity Residential program provides a structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the unique functional limitations of beneficiaries with both a substance use disorder and TBI to support recovery from substance use related disorders. This service is provided by medical professionals, licensed clinicians, and by certified staff and paraprofessionals that have experience and training working with individuals that have substance use disorders and TBI. Beneficiaries eligible for this service experience significant impairments from their substance use disorder and TBI that make outpatient motivational or relapse prevention strategies not feasible or effective. Similarly, the beneficiary's cognitive limitations make it unlikely that he or she could benefit from other levels of residential care.

Protocols, developed and supported by a medical director knowledgeable in addiction medicine and a Program Director that is CBIS certified must be in place to determine the nature of the medical interventions that may be required. Protocols must include under what

conditions physician care is warranted and when transfer to a medically monitored facility or an acute care hospital is necessary.

Clinically Managed Population Specific High-Intensity Residential Program providers must be staffed to screen and accept admissions a minimum of eight hours a day, five days a week. The Clinically Managed Population Specific High-Intensity Residential Medical Director and Program Director shall develop agency specific policies and procedures that address admission expectations, how the intake process will be handled, and staffing expectations to include back-up and consultation coverage.

Required components of this service include the following:

- An initial assessment including an addiction focused history and physical examination completed at admission by the medical director, a physician assistant, or nurse practitioner, to include the completion of a traumatic brain injury assessment;
- A comprehensive clinical assessment within 3 calendar days of admission;
- Person Centered Plan completed within 30 days, which shall include including problem identification in ASAM dimensions 2 through 6, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
- Daily clinical services to improve the beneficiary's ability to structure and organizes the tasks of daily living and recovery, to include personal responsibility, personal appearance, punctuality, and family services;
- Planned clinical program activities designed to stabilize and maintain the stability of addiction symptoms, to include relapse prevention, interpersonal and social relationships, daily living skill building, and the development of a social network supportive of recovery;
- A range of cognitive, behavioral, and other therapies administered on an individual and group basis. Therapies should be delivered in a manner that is slower paced, more concrete and more repetitive;
- The ability to refer to vendors that provide cognitive rehabilitation services when those services are assessed as clinically needed;
- Counseling and clinical monitoring to assist with successful initial involvement or reinvolvement in regular, productive day activity;
- Regular monitoring of adherence in taking any prescribed mediations;
- Daily scheduled professional addiction and mental health treatment services;
- Clinical and didactic motivational interventions appropriate to the stage of readiness to change;
- Daily assessment of progress and any treatment changes;
- Provide monitoring of the beneficiary, to include the beneficiary's general condition and vital signs (pulse rate, blood pressure and temperature);
- Provide 24-hour access to emergency medical consultation services;
- Provide behavioral health crisis interventions, when clinically appropriate;
- Ability to arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing;
- Provide education to beneficiary regarding prescribed medications, potential drug interactions and side effects;
- Health education services;
- Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;

- Arranges involvement of family members or significant others to provide education on and engagement in the withdrawal management process, as appropriate and with informed consent;
- Direct coordination with other levels of care, including specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral and cognitive problems, as indicated;
- Affiliation with other ASAM levels of care and behavioral health providers for appropriate linkage and referrals for counseling, medical, psychiatric, and continuing care; and
- Discharge and transfer planning beginning at admission.

Evaluation and Management CPT codes, specifically with an addiction focused history and biopsychosocial screening assessments, the comprehensive clinical assessment, physical exam, laboratory tests and toxicology tests, and medical evaluation and consultation may be billed separate from the Clinically Managed Population Specific High-Intensity Residential Program service.

This facility must be in operation 24 hours a day, seven days a week, 365 days a year. The facility must have a physician available to provide consultation 24 hours a day, in accordance with treatment and transfer practice protocols and guidelines. This service must be available for admission five days per week. Program medical staff and staff trained to deliver crisis behavioral interventions must be available to provide 24-hour access for emergency consultation services.

Staff Training Requirements

Time Frame	Training Required	Who	Total Minimum Hours Required
Within **30 calendar days** of hire to provide service	▪ 2 hours Clinically Managed Population Specific High-Intensity Residential Program Service Definition Required Components ▪ 3 hours of Crisis Response training, with at least 1 hour of training on supporting individuals with brain injury experiencing crisis ▪ 2 hours of Substance Use and Traumatic Brain Injury Training ▪ 1.5 hours of behavioral and cognitive challenges associated with traumatic brain injury	All Staff	8.5 hours
	▪ 6 hours of ASAM Criteria Training	MD, PA, NP, Program Manager, LCAS/LCAS-A, CADC	6 hours
	▪ 3 hours Measuring Vital Signs (to include how to effectively and accurately obtain, record, and report the vital signs of	Program Manager, CADC, CPSS,	5 hours

Time Frame	Training Required	Who	Total Minimum Hours Required
	temperature, heart rate, respiratory rate, blood pressure, pulse oximetry, and pain.) ▪ 2 hours Medication Administration training	Paraprofessionals	
Within **90 calendar days** of hire to provide this service	▪ 6 hours of Introductory Motivational Interviewing* (MI)	Program Manager, LCAS/LCAS-A, CADC	6 hours
	▪ 2 hours Trauma informed care ▪ 2 hours Co-occurring conditions	Program Manager, LCAS/LCAS-A, CADC, CPSS, Paraprofessionals	4 hours
Annually	▪ 3 hours of Crisis Response Training**,** with at least 1 hour of training on supporting individuals with brain injury experiencing crisis ▪ 10 hours of continuing education in evidence-based and promising treatment practices, with at least 5 hours focusing specifically on working with beneficiaries with TBI	All Staff	13 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.

Documentation of training activities shall be maintained by the program.

Expected Outcomes

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

- Sustained improvement in health and psychosocial functioning
- Development of compensatory strategies to increase beneficiary's level of independence, self-sufficiency and independent activities of daily living

- A reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors
- Increased use of peer support services to facilitate recovery and link beneficiaries to community-based peer support and mutual aid groups
- Linkage to appropriate treatment and other supportive services post discharge
- Increased links to community-based resources to address unmet needs
- Reduction or elimination of psychiatric symptoms, if applicable

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
	All Sections and Attachment(s)	

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)

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.

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).

F. Place of Service

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

H. Reimbursement

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