Clinical Policy: Medically Monitored Inpatient Withdrawal Management Service (ASAM 3.7 WM)

Reference Number: WNC.CP.281 Coding Implications
Last Review Date: 02/24 Revision Log

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

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

Description[1]
Medically Monitored Inpatient Withdrawal Management Service is an organized facility based service that is delivered by medical and nursing professionals who provide 24-hour medically directed observation, evaluation, monitoring, and withdrawal management in licensed facility.

Services are delivered under a defined set of:

1. Physician-developed and approved policies;
2. Physician-monitored procedures; **AND**
3. Clinical protocols by medical professionals, clinicians, and support staff.

This is an American Society of Addiction Medicine (ASAM) Criteria, Third Edition Level 3.7 WM for a Member whose withdrawal signs and symptoms are sufficiently severe to require 24-hour observation, monitoring, and treatment in a medically monitored inpatient setting. A Member at this level of care does not need the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program.

A. Definition:
Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-AR) is defined as a tool used to assess an individual's alcohol withdrawal

B. The ASAM Criteria, Third Edition
The American Society of Addiction Medicine (ASAM) Criteria is a comprehensive set of treatment standards for addictive, substance-related, and co-occurring conditions. The ASAM Criteria, Third Edition uses six dimensions to create a holistic, biopsychosocial assessment to be used for service planning and treatment. The six dimensions are:

1. Acute Intoxication and Withdrawal Potential;
2. Biomedical Conditions and Complications;
3. Emotional, Behavioral, or Cognitive Conditions and Complications;
4. Readiness to Change;
5. Relapse, Continued Use, or Continued Problem Potential; and
6. Recovery and Living Environment.

Policy/Criteria[1]

WellCare of North Carolina® shall cover Medically Monitored Inpatient Withdrawal Management Service when the Member meets the following specific criteria:

- **A.** The member has a substance use disorder (SUD) diagnosis as defined by the DSM-5, or any subsequent editions of this reference material **AND**
- **B.** The Member meets American Society of Addiction Medicine (ASAM) Level 3.7 -WM Medically Monitored Inpatient Withdrawal Management admission criteria as defined in The ASAM Criteria, Third Edition, 2013.

I. Admission Criteria

- **A.** The physician or physician extender shall conduct an initial abbreviated assessment to establish medical necessity for this service and develop a service plan as a part of the admission process.
- **B.** The initial abbreviated assessment must contain the following documentation in the service record:
  1. the Member's presenting problem;
  2. the Member's needs and strengths;
  3. a provisional or admitting diagnosis;
  4. an ASAM level of care determination;
  5. a physical examination, including pregnancy testing, as indicated, performed by the physician or physician extender within 24 hours of admission, along with medically necessary laboratory and toxicology tests;
  6. a pertinent social, family, and medical history; and
  7. other evaluations or assessments.
- **C.** The physician or physician extender can bill an Evaluation and Management code separately for the admission assessment and physical exam.
- **D.** A licensed professional shall complete a Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA) within three (3) calendar days of admission to determine an ASAM level of care for discharge planning. The abbreviated assessment is used as part of the current comprehensive clinical assessment. Any relevant diagnostic information obtained must become part of the treatment or service plan.
- **E.** The licensed clinician can bill separately for the completion of the CCA or DA. Any laboratory or toxicology tests completed for the CCA or DA can be billed separately.

II. Continued Stay and Discharge Criteria

- **A.** The Member meets the criteria for continued say if any ONE of the following applies:
  1. The Member's withdrawal symptoms have not been sufficiently resolved to allow either discharge to a lower level of care or safe management in a less intensive environment; **OR**
  2. The Member's CIWA-Ar score (or other comparable standardized scoring system) has not increased or decreased.
- **B.** The Member meets the criteria for discharge if any ONE of the following applies:
  1. The Member's withdrawal signs and symptoms are sufficiently resolved to allow safe management in a less intensive environment, and the Member can participate in self-

directed recovery or ongoing treatment without the need for further medical or nursing withdrawal management monitoring;
2. The Member has intensified symptoms or increased CIWA-Ar score (or other comparable standardized scoring system) indicating a need for transfer to a more intensive level of withdrawal management services;
3. The Member is unable to complete withdrawal management at Level 3.7 WM, indicating a need for more intensive services; **OR**
4. The Member or person legally responsible for the Member requests a discharge from the service.

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

A. Transportation for the Member or member's family is not billable under Medically Monitored Inpatient Withdrawal Management Service (ASAM 3.7 WM), program.
1. Medically necessary transportation for medical appointments may be covered under WellCare of North Carolina® Non-Emergency Medical Transportation benefit. Please refer to Clinical Coverage Policy WNC.CP.262 "Non-Emergency Medical Transportation," available at WellCare NC Clinical Coverage Guidelines for prior authorization information.
2. Medicaid Transportation information, for WellCare of North Carolina members, is available at WellCare NC Medicaid Transportation Services.

B. Any habilitation activities;
C. Time spent attending or participating in recreational activities unless tied to specific planned social skill assistance;
D. Clinical and administrative supervision of Medically Monitored Inpatient Withdrawal Management Service staff, which is covered as an indirect cost and part of the rate;
E. Covered services that have not been rendered;
F. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
G. Services provided to teach academic subjects or as a substitute for education personnel;
H. Interventions not identified on the Member's service plan;
I. Services provided to children, spouse, parents, or siblings of the Member under treatment or others in the Member's life to address problems not directly related to the Member's needs and not listed on the service plan; **AND**
J. Payment for room and board; **AND**
K. Members under the age of 18.

Background[1]

I. Prior Approval

A. Medicaid shall not require prior approval for Medically Monitored Inpatient Withdrawal Management Service upon admission through the first three (3) calendar days of services.

II. Utilization Management

A. 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 Member.

B. Services are based upon a finding of medical necessity, must be directly related to the Member's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the Member's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by WellCare of North Carolina®, who evaluates the request to determine if medical necessity supports intensive services.

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

III. Initial Authorization

A. To request an **initial authorization** the CCA or DA, service order for medical necessity, service plan, and authorization request form must be submitted to the WellCare of North Carolina®, within the first three (3) calendar days of service initiation.

IV. Concurrent reviews

Concurrent reviews will determine the ongoing medical necessity for this service or the medical necessity for a higher or lower level of care. Providers shall submit, prior to the expiration of the initial/concurrent authorization, an updated service plan including documentation demonstrating continued medical necessity for the member to continue treatment at the requested ASAM level of care.

V. Additional Limitations or Requirements

A. A Member shall receive the Medically Monitored Inpatient Withdrawal Management Service from only one provider organization during any active authorization period.

B. Medically Monitored Inpatient Withdrawal Management Service must not be billed on the same day (except day of admission or discharge) as:

1. Residential levels of care
2. Other withdrawal management services
3. Outpatient treatment services
4. Substance Abuse Intensive Outpatient Program (SAIOP)
5. Substance Abuse Comprehensive Outpatient Treatment (SACOT)
6. Assertive Community Treatment (ACT)
7. Community Support Team (CST)
8. Supported Employment
9. Psychiatric Rehabilitation
10. Peer Support Services
11. Mobile Crisis Management (MCM)
12. Partial Hospitalization
13. Facility Based Crisis (Adult)

VI. Service Orders

A service order is a mechanism to demonstrate medical necessity for a service and is based upon an assessment of the Member's needs. The physician, physician assistant, or nurse practitioner shall complete and sign a service order according to their scope of practice. Service orders are valid for the episode of care. Medical necessity must be revisited, and service ordered is based on the current episode of care if multiple episodes of care are required in a twelve (12) month period.

A. ALL the following apply to a service order:

1. Backdating of the service order is not allowed;
2. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; **AND**
3. A service order must be in place before or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the Member is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

VII. Documentation Requirements

A. The service record documents the nature and course of a Member's progress in treatment. To bill Medicaid, providers shall ensure that their documentation is consistent with the requirements contained in this policy. This service requires a shift note to be completed for every shift of service provided. Events in a Member's life which require additional activities or interventions are documented over and above the minimum frequency requirement.

B. The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid. Service notes must meet the requirements of the Department of Health and Human Services (DHHS) Records Management and Documentation Manual. Medication administration records (MAR) or electronic MARs must meet the requirements of 10A NCAC 27G .0209 (c)(4).

VIII. Program Requirements

Program Requirements (For additional program requirements not listed here, please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 8A-11, "Medically Monitored Inpatient Withdrawal Management Services," Section 6.0 at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies).

A. Staffing patterns must ensure that a Member admitted to Medically Monitored Inpatient Withdrawal Management Service completes a physical examination by the physician within 24 hours of admission. A physician, physician assistant, or nurse practitioner shall be available by phone for consultative purposes 24 hours a day, seven days a week.

B. Required components of this service consist of the following:

1. An initial assessment that consists of an addiction focused history by the medical director or physician extender upon admission;
2. Physical examination, including a pregnancy test, as indicated by the physician or physician extender within 24 hours of admission;
3. A nursing evaluation upon admission;
4. A comprehensive clinical assessment within three calendar days of admission;

5. Individualized service plan, including problem identification in ASAM, Third Edition dimensions two through six, development of treatment goals, measurable treatment objectives, and activities designed to meet those objectives;
6. Access to all approved Federal Drug Administration (FDA) medications for Medication Assisted Treatment (MAT) covered by the Medicaid formulary for a Member that meets medical necessity for that service. MAT may be provided on-site by the provider or through a memorandum of agreement (MOA) or memorandum of understanding (MOU) with an off-site provider that is no further than 60 minutes from the facility;
7. Medically Monitored Inpatient Withdrawal Management Service providers shall ensure that all programs have access to naloxone or other Federal Food and Drug Administration approved opioid antagonist for drug overdose on site, and that all staff have training and education on the use of naloxone in suspected opioid overdoses;
8. A planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for the Member and their family that includes licensed, certified, and registered clinicians as well as certified peer support specialists;
9. Daily assessment of progress during withdrawal management and any treatment changes;
10. Provide monitoring of the Member, to include the Member's general condition and vital signs (pulse rate, blood pressure and temperature) based on documented severity of signs and symptoms of withdrawal;
11. Oversee the monitoring of the Member's progress and medication administration by nursing staff on an hourly basis, if needed;
12. Provide 24-hour access to emergency medical consultation services;
13. Provide behavioral health crisis interventions, when clinically necessary;
14. Ability to conduct laboratory and toxicology tests, which can be point-of-care testing;
15. Provide education to Member regarding prescribed medications, potential drug interactions and side effects;
16. Health education services;
17. Reproductive and health planning education, and referral to external partners as necessary;
18. Provide clinical services, including individual and group counseling, to enhance the Member's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment;
19. Availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems, as indicated;
20. Peer support services that focus on mutual aid, recovery, wellness, and self-advocacy;
21. Arrange involvement of family members or individuals identified by the Member as being important to their care and recovery in the withdrawal management process, with informed consent;
22. Provide education to family members or individuals identified by the Member as being important to their care and recovery regarding withdrawal management process;
23. Assist in accessing transportation services for a Member who lacks safe transportation;

24. Affiliation with other ASAM levels of care and behavioral health providers for linkage and referrals to care management services and supports for counseling, medical, psychiatric, and continuing care; and
25. Discharge and transfer planning must begin at admission.

IX. Expected Outcomes

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

1. Reduction or elimination of withdrawal signs and symptomatology;
2. Increased use of peer support services to support withdrawal management, facilitate recovery and link beneficiaries to community-based peer support and mutual aid groups;
3. Linkage to treatment services based on ASAM level of care determination post discharge;
4. Increased links to community-based resources to address unmet social determinants of health; **AND**
5. Reduction or elimination of psychiatric symptoms, if applicable.

X. Provider Eligibility, Provider Qualifications & Occupational Licensing Entity Regulations, Provider Certifications, and Staff Training Requirements;

Please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 8A-11, "Medically Monitored Inpatient Withdrawal Management Services (ASAM 3.7)," Section 6.0 at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

Coding Implications[1]

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description	Billing Unit
H0010	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)	1 Unit = 1 Day

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	02/24	02/24

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:8A-11 Medically Monitored Inpatient Withdrawal Service. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published February 1, 2024, Accessed February 1, 2024.

North Carolina Guidance

Eligibility Requirements

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

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

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

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

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

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

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

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

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health

problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

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

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

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

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of

specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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

Important Reminder

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

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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

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

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

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