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BACKGROUND

On October 10, 2017, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid Section 1115 waiver application for the West Virginia Department of Health and Human Resources (DHHR) to develop a continuum of Substance Use Disorder (SUD) treatment benefits designed to address the immediate and long-term physical, mental, and social needs of individuals and to promote and sustain long-term recovery. The West Virginia Medicaid program offers a comprehensive scope of medically necessary SUD services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal regulations. All Medicaid members, including those in managed care, will have these services available to them. West Virginia Medicaid will work with providers and other stakeholders to ensure that all parties are aware of and committed to the expectations for achieving a comprehensive continuum of SUD prevention and treatment services. This chapter is organized into sections based on SUD service planning and placement following the American Society of Addiction Medicine (ASAM®) Criteria Continuum of Care. Any service, procedure, item, or situation not discussed in the West Virginia Provider Manuals must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

The policies and procedures set forth herein are promulgated as regulations governing the provision of SUD services in the Medicaid program administered by the DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the WV State Code.

SUD Medicaid enrolled providers must give priority to children that have been identified as being in the foster care system including those ages 18 – 21 years. Medicaid enrolled providers must make a good faith effort to complete assessments in a timely manner to ensure that information is shared timely with Bureau for Children and Families (BCF), court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid members have the right to freedom of choice when choosing a provider for treatment. A Medicaid member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid members are in violation of their provider agreement.

In order to facilitate coordination of care, the provider is required to contact and confirm the member is enrolled with the identified Managed Care Organization (MCO) within 48 hours of initiation of any SUD services being provided to a Medicaid MCO member.

All Medicaid enrolled providers should coordinate care if a Medicaid member receives different Medicaid services at different locations with other providers to ensure that quality care is taking place and that safety is the forefront of the member's treatment.

POLICY

504.1 MEMBER ELIGIBILTY

SUD Waiver services are available to all Medicaid members with a known or suspected substance use disorder. If prior authorization is required, each member's level of services will be determined when prior authorization for SUD Waiver services is requested through the Utilization Management Contractor (UMC) or Managed Care

Organization (MCO) authorized by BMS to perform administrative review. The prior authorization process is explained in Section 504.23, Prior Authorization.

504.2 MEDICAL NECESSITY

All SUD Waiver services covered in this chapter are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
- Provided for the diagnosis or direct care of an illness;
- Within the standards of good practice;
- Not primarily for the convenience of the plan member or provider; and
- The most appropriate level of care that can be safely provided.

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

1. Diagnosis (as determined by a physician or licensed psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Service is the appropriate level of care

The level of care is determined by ASAM® criteria in accordance with the six ASAM® Dimensions below:

- Dimension 1: Acute Intoxication and/or Withdrawal Potential
- Dimension 2: Biomedical Condition and Complication
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery Environment

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. Evidence-based diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

Providers rendering services that require prior authorization must receive authorization before rendering such services. Prior authorization does not guarantee payment for services rendered. See Section 504.23, Prior Authorization.

504.3 PROVIDER ENROLLMENT

In order to participate in the West Virginia Medicaid program and receive payment from the BMS, providers of SUD Waiver services must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*.

504.3.1 Enrollment Requirements: CBHC and LBHC Administration

Comprehensive Behavioral Health Centers (CBHC) and Licensed Behavioral Health Centers (LBHC) must develop and maintain a Credentialing Committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring the following activities:

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be specific to age and populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.
- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the employer. Based on this review, the employer must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records. Utilization of nationally recognized clearinghouses for degree confirmation is enough for verification.

Participating CBHC and LBHC providers must develop standards for staff training, supervision, and compliance monitoring in accordance with existing state policy and federal regulations.

504.3.2 Enrollment Requirements: Staff Qualifications

Services may be rendered to Medicaid members by a physician assistant (PA) appropriate to their scope of work.

Services may also be rendered to Medicaid members by an advanced practice registered nurse (APRN) as defined by regulations set forth in WV Code, Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses.

Psychologists who are on the West Virginia Board of Examiners of Psychologists approved list of supervisors may only bill for up to four supervised psychologists. Board Approved Supervisors may not "trade" supervisees for billing Medicaid services.

Independent providers must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board.

Documentation including required licenses; certifications; proof of completion of training; contracts between physicians and PAs; collaborative agreements for prescriptive authority, if applicable; proof of psychiatric certification, as applicable; and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the location where the services are provided.

All further staff qualifications will be indicated under the service codes. All documentation for staff including college transcripts, certifications, credentials, background checks, and trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS, their contractors, or state and federal auditors.

504.4 FINGERPRINT-BASED BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for fingerprint-based background check requirements.

504.4.1 Variances for Peer Recovery Support Specialist

A variance is available to applicants for peer recovery support specialist (PRSS) for an ineligible fitness determination. The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within 30 days of an ineligible fitness determination. A variance may be granted if mitigating circumstances surrounding the disqualifying offense are provided, and it is determined that the individual will not pose a danger or threat to residents or their property. Requests for a variance may be submitted to the designated mailbox *peersupportwvcares@wv.gov* for peer recovery support specialist variances. If a variance is granted and the employee chooses to seek employment with another provider, they must resubmit the request for a variance. Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for more information.

504.5 CLINICAL SUPERVISION

The purpose of clinical supervision for CBHCs and LBHCs is to improve the quality of services for every member while ensuring adherence to West Virginia Medicaid policy, therefore the provider must have a policy for clinical supervision including guidelines for the following:

- The responsibilities of the supervisor;
- Credentialing requirements of the supervisor; and
- The minimum frequency for which supervision should occur.

Each agency shall have a chart demonstrating clinical chain of command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision structure.

The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals. This applies to all SUD services rendered. For PRSS, see Section 504.15.1 for supervision requirements.

504.6 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information*

and are subject to review by state and federal auditors.

504.7 PROVIDER REVIEWS

The primary means of monitoring the quality of SUD services is through provider reviews conducted by the Office of Health Facility Licensure and Certification (OHFLAC) and the contracted agents as determined by the BMS as defined by their statement of work.

The contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site SUD provider reviews and/or desk reviews may be conducted by OHFLAC and/or the contracted agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

Upon completion of each provider review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the contracted agent will make available to the provider, a draft exit report and a POC to be completed by the SUD service provider. If potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent. After the 30-day comment period has ended, the BMS will review the draft exit report and any comments submitted by the SUD service provider and issue a final report to the SUD service provider's executive director. The final report reflects the service provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of SUD services. A cover letter to the SUD service provider's executive director will outline the following options to effectuate repayment:

- Payment to the BMS within 60 days after the BMS notifies the provider of the overpayment; or
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the SUD service provider disagrees with the final report, the SUD service provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information.* The SUD service provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner, Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the contracted agent review, then the SUD service provider will receive a final letter and report from BMS.

For information relating to additional audits that may be conducted for services contained in this chapter, please see *Chapter 800, Program Integrity* that identifies other State/Federal auditing bodies and related procedures.

Plan of Correction (POC): In addition to the draft exit report sent to the SUD service providers, the contracted agent will also send a draft POC electronically. SUD service providers are required to complete the POC and electronically submit a POC to the contracted agent for approval within 30 calendar days of receipt of the draft POC from the contracted agent. The BMS may place a hold on payment of claims if an approved POC is not received by the contracted agent within the specified time frame. The POC must include the following:

- How the deficient practice for the services cited in the report will be corrected;
- What system will be put into place to prevent recurrence of the deficient practice;
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
- The date the POC will be completed; and
- Any provider-specific training requests related to the deficiencies.

504.8 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for SUD Waiver providers and other interested parties as approved by the BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

All providers of services in this Chapter (both referring and treating) must follow the ASAM® Criteria available at the American Society of Addiction Medicine website. Additional resources relating to ASAM® Criteria are available on the BMS Substance Use Disorder (SUD) Waiver webpage.

504.9 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must assure implementation of the BMS policies and procedures pertaining to documentation and case record review, as well as the following:

- All documentation completed on a member should be recorded and maintained in the member's individual record, whether electronic or written.
- Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid members records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.

- In addition to the documentation requirements described in this chapter, SUD Waiver service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information,* and *Chapter 300, Provider Participation Requirements*.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Electronic signature is an acceptable form of submission as long as it contains a time and date stamp.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a provider and a member except for targeted case management services.
- SUD Waiver services provided via Telehealth must align with *Chapter 519.17, Telehealth Services*. Medicaid will reimburse according to the fee schedule for services provided.
- All residential treatment providers must be approved by the BMS prior to providing services. No provider will be reimbursed for residential services unless the provider has been approved by the BMS and the services have been prior authorized.
- MCOs may only utilize BMS-approved residential treatment providers.

504.10 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services through Telehealth to allow easier access to services for Medicaid members. To utilize Telehealth, providers will need to document that the service was rendered under that modality. When filing a claim, the provider will bill the service code with a GT Modifier and 02 place of service. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate. Services provided through Telehealth must align with requirements in *Chapter 519.17, Telehealth Services*.

504.11 DOCUMENTATION

The BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy-based system. When services require documentation, BMS will accept both types of documentation. Electronic-based systems will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Any document that is printed must have a handwritten signature and must be dated.

504.11.1 Confidentiality

An appropriate release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, the parent or legal guardian (when the member is a minor), authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need to know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of Medicaid members are to be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays or for promotional materials, are prohibited. All Medicaid member information is kept locked in a secure place.

Protecting confidentiality is critical in substance abuse treatment. Confidentiality is governed by federal law (42 U.S.Code § 290dd-2) and regulations (42 CFR Part 2) that outline under what limited circumstances information about the member's treatment may be disclosed with and without the member's consent. Appropriate Releases of Information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

504.11.2 HIPAA Regulations

Providers must comply with all requirements of the HIPAA and all corresponding federal regulations and rules. The enrolled provider will provide, upon request of the BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of the BMS. Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

504.12 SBIRT ASAM® LEVEL 0.5 EARLY INTERVENTION

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, evidenced-based, integrated, public health approach for early identification and intervention with individuals whose patterns of alcohol and/or drug use puts their health at risk. The SBIRT process is composed of three separate sections including the Screening (S) - a set of brief questions used to determine problematic alcohol and/or substance use and severity; Brief Intervention (BI) - focuses on education, increasing the individual's insight and awareness about risks related to unhealthy substance use, and enhances motivation towards healthy behavioral change; and finally, Referral to Treatment (RT) - is used to help facilitate access to addiction assessment and treatment.

SBIRT is a required documentation component, regardless of the suspected diagnosis, for the following CPT and HCPCS codes for individuals age 10 years and older:

- 90791
- 90792
- H0031

The SBIRT is required ONLY for initial evaluations under these codes. There are separate screenings tools that can be used based on the member's age at the time of assessment.

504.12.1 Mental Health Assessment By Non-Physician

Procedure Code: **H0031**
Service Unit: Event
Service Limits: Prior Authorization Required
Telehealth: Available

Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse (RN). Supervision and oversight by an individual with a minimum of a master's

degree is required. See *Section 504.5 Clinical Supervision*. Staff must be properly credentialed by the agency's internal credentialing committee.

Definition: Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the DHHR for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

Approved Causes for Utilization:

1. Intake/Initial evaluation;
2. Alteration in level of care except for individuals being stepped down related to function of their behavioral health condition to a lesser level of care;
3. Critical treatment juncture, defined as the occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or Designated Legal Representative (DLR) and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;
5. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services;
6. No one under the age of three will have a Mental Health Assessment by Non-Physician conducted on them. The Medicaid member under the age of the three should be referred to the Birth to Three program. If the child is aging out of the Birth to Three program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted;
7. Re-assessment should be specifically documented.

Documentation for initial/intake (may include use of standardized screening tools):

- Demographic data (name, age, date of birth, etc.);
- Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
- Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
- History of behavioral health and health treatment (recent and remote);
- History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
- Medical problems and medications currently prescribed;
- Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
- Analysis of available social support system at present;
- Mental status examination;
- Recommended treatment (initial);

- Diagnostic impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice);
- Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator;
- Efficacy of and compliance with past treatment (if past treatment is reported);
- Past treatment history and medication compliance (if past treatment is reported);
- Completed SBIRT and appropriate follow-up is required for individuals age 10 years and older; and
- Rationale for diagnostic impression.

Documentation for re-assessment:

- Date of last comprehensive assessment;
- Current demographic data;
- Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such);
- Changes in situation, behavior, functioning since prior evaluation;
- Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
- Mental status examination;
- Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
- Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional;
- Place of evaluation, date of evaluation, start/stop times, signature and credentials of evaluator; and
- Rationale for diagnostic impression.

Note: H0031, T1023HE, and **90791 or 90792** are not to be billed at the same initial intake or re-assessment unless the **H0031** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using **90791 or 90792**.

504.12.2 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: **90791**
Service Unit: Event (Completed Evaluation)
Service Limits: Prior Authorization Required
Telehealth: Available

Staff Credentials: Must be performed by a Physician, PA, APRN, Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Counselor (LPC), West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, or a supervised psychologist who is supervised by a Board Approved Supervisor.

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the

date of service.

- Date and location of service;
- Purpose of evaluation;
- Procedure Code;
- Psychiatrist's/Psychologist's signature with credentials;
- Presenting problem;
- History of Medicaid member's presenting illness;
- Duration and frequency of symptoms;
- Current and past medication efficacy and compliance;
- Psychiatric history up to present day;
- Medical history related to behavioral health condition;
- Mental Status Exam - the mental status exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Members diagnosis per current DSM or ICD methodology;
- Rationale for diagnosis;
- Medicaid member's prognosis for treatment;
- Rationale for prognosis;
- Appropriate recommendations consistent with the findings of the evaluation; and
- Completed SBIRT and appropriate follow-up is required for individuals age 10 years and older.

504.12.3 Psychiatric Diagnostic Evaluation With Medical Services (Includes Prescribing of Medications)

Procedure Code: **90792**
Service Unit: Event (Completed Evaluation)
Service Limits: Prior Authorization Required
Telehealth: Available

Staff Credentials: Must be completed by a physician, PA, or APRN.

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other studies.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date and location of service;
- Purpose of the evaluation;
- Procedure Code;
- Psychiatrist's signature with credentials;
- Documentation that Medicaid member was present for the evaluation;
- Documentation that the medical evaluation was completed;
- Presenting problem;
- History of the Medicaid member's presenting illness;
- Duration and frequency of symptoms;
- Current and past medication including efficacy and compliance;
- Psychiatric history up to present day;
- Medical history related to behavioral health condition;
- Mental Status Exam - the mental status exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Medicaid member's diagnosis per current DSM and ICD methodology;
- Rationale for diagnosis;
- Medicaid member's prognosis for treatment;
- Rationale for prognosis;
- Appropriate recommendations consistent with the findings of the evaluation; and
- Completed SBIRT and appropriate follow-up is required for individuals age 10 years and older.

504.13 METHADONE MEDICATION ASSISTED TREATMENT (MAT)

Procedure Code: **H0020 (Bundle Code)**
Service Unit: Weekly
Service Limits: Per Calendar Week
Prior Authorization: Not required
Telehealth: Professional Therapy and Physician Services Only

Description: This is a bundle code that will include medication, treatment services, and laboratory services. The following codes are included in the weekly bundled rate and may not be billed outside of this bundled code:

- G9008
- H0004, H0004HO, H0004HQ, H0004HOHQ
- H2011
- H2014 with all modifiers
- H0031, H0032, H0032AH

- T1017
- T1023HE
- 80305, 80306, 80307
- 90791, 90792
- 90832
- 90834
- 90837
- 90839, 90840
- 90853
- 90877

504.13.1 Staff Credentials

The following are the minimum supervision requirements per degree/credential type:

- **Bachelor's Degree in Human Services without Alcohol and Drug Counselor Credential*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, Licensed Independent or Clinical Social Worker.
- **Master's Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, Licensed or Independent Clinical Social Worker.
- **Doctoral Level, Non-Licensed*:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor, Certified Clinical Counselor, Master Addiction Counselor, Licensed Psychologist, Licensed Professional Counselor, or Licensed Independent Clinical Social Worker.

The following providers do not require supervision*:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Board Supervised Psychologist
- Licensed Professional Counselor
- National Certified Addiction Counselor II
- Master Addiction Counselor
- Bachelor's Degree in Human Services with Alcohol and Drug Counselor Credential
  *Certification requirements for the West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) may be different than those included above. This policy is not meant to circumvent any requirements as set forth by this organization.

504.13.2 Assessing a Member for Opioid Treatment Program (OTP) Initiation

Procedure Code:	**T1001**
Modifier:	HF
Service Unit:	Event Code
Service Limits:	4 Per Calendar Year
Prior Authorization:	Not required

Telehealth: Not Available

Description: This is an observation code made available to the licensed practical nurse (LPN), RN, APRN, PA, or physician to monitor the first-time administration of methadone to a member to ensure that the medication is not contraindicated.

Documentation: There are several important areas on which to concentrate regarding a member history for this population. Complete all documentation requirements of H0031, 90791, and 90792, which must include:

- Date and start/end times of service;
- Member response to medication;
- Reports of any side or adverse effects including changes to level of consciousness;
- Signature with credentials;
- Potential risks for methadone toxicity prior to opioid treatment program initiation (benzodiazepine) use, age, etc.;
- Patterns of use of all major drug classes (including tobacco, alcohol, and caffeine);
- Previous addiction treatment history and response;
- High risk behavior such as needle sharing and exchanging sex for drugs;
- Legal history;
- Psychiatric history and current mental status including suicidal ideation;
- Social-economic situation including, employment, housing, supports, child custody, and partner's drug-use history;
- Details regarding chronic or recurrent pain; and
- A list of current medications.

504.13.3 Therapy and Phases

Medicaid members receiving the medication methadone must meet the minimum therapy requirements to continue this Medication Assisted Treatment (MAT) program. The therapy services that are rendered under MAT must follow the requirements of Chapter 503 Licensed Behavioral Health Centers and/or Chapter 521 Behavioral Health Outpatient Services. All urine drug screens rendered must follow the requirements found in Chapter 529 Laboratory Services.

Phase 1: During their first 12 months of MAT, a member is required to have at least four hours of therapy per month from their date of intake. The four hours must contain a minimum of one hour of individual professional therapy session per month. The other three hours of professional therapy can be a choice of individual, group, or family as based on the member's service plan and assessed need.

Phase 2: A member who has completed 12 months of MAT and shown compliance with urine drug screens and therapy requirements is required to have a minimum of one hour of therapy per calendar month. This therapy may be a group, individual or family session based on the member's service plan.

The medical director or physician who is responsible for the member's MAT is required to move a member from Phase 2 to Phase 1 if there is non-compliance with therapy or urine drug screens. As part of this process, the physician or medical director must request a review of the therapeutic component in terms of effectiveness, relationship to medication adherence, the need for treatment adjustments, etc. The medical director or

physician/physician extender and the treating clinician will consult on revisions to the treatment plan and therapeutic approach that will be made to potentially improve adherence to the medication regimen.
Urine drug screen requirements: Phase 1 members are required to have two random urine drug screens per calendar month. Phase 2 members are required to have one random drug screen per month. In addition to urine screens, the medical director or physician/physician extender is responsible for monitoring alcohol use during treatment and assessing members for alcohol use disorders as appropriate.

These requirements are in addition to any requirements in the Legislative Rule 69 CSR 11 as governed by the OHFLAC.

504.13.3.1 Induction Phase

The medical director or physician/physician extender should base the initial methadone dose on the member's underlying risk for methadone toxicity. Sedating drugs, including over-the-counter medications such as diphenhydramine, prescribed medications such as antipsychotics, sedating antidepressants and therapeutic doses of benzodiazepines, or drugs of abuse, such as medical grade marijuana, can increase the risk of methadone toxicity and lead to an overdose. The medical director or physician/physician extender prescribing methadone should look for benzodiazepine use in the initial drug screen.

Opioid tolerance is difficult to establish by history, so it is safer to initiate methadone therapy at a lower dose. Lowered tolerance is likely in members who report non-daily opioid use, daily use of codeine, or daily use of oral opioids at moderate doses. Typically, members who use opioids intra-nasally have a lower tolerance than members who inject opioids. Tolerance is lower in members who have been abstinent for more than a few days, e.g., members who have been recently discharged from a correctional facility, detox center or treatment center.

Member factors to determine initial dose parameters:

- Recent abstinence from opioids = 10 mg or less
- Higher risk for methadone toxicity = 20 mg or less
- No risk factors and recent abstinence = 30 mg or less

504.13.3.2 Early Stabilization Phase (0 – 2 Weeks)

Dosage increases during the early stabilization phase should take place only after an in-person opioid treatment program medical director or physician assessment and for members who are experiencing cravings, ongoing opioid use, and/or several opioid withdrawal symptoms. Physicians or physician extenders in consultation with the physician should assess members at least once a week during this phase.

During the early stabilization phase, members should be on the same dose for at least three consecutive days with no missed doses before an increase. If two consecutive doses are missed during the early stabilization phase, the physician/physician extender should cancel the prescription until the member can be reassessed. The member must be reassessed in person by the medical director, physician or physician extender in consultation with the medical director and restarted at 30 mg or less.

504.13.3.3 Late Stabilization Phase (2 – 6 Weeks)

Dose increases during the late stabilization phase should be the same as during the early stabilization phase until a dose of 80 mg is reached. Dose increases during the late stabilization phase should take place with an in-person

opioid treatment program clinician discussion with members who are experiencing cravings, ongoing opioid use, and/or signs of multiple opioid withdrawal symptoms. Opioid treatment program clinical staff should assess members at least once weekly during this phase.

If three or more consecutive doses are missed during the late stabilization phase, the physician or physician extender after consultation with the physician should cancel the prescription until the member can be reassessed by the medical director, physician or physician extender in consultation with the medical director. The member must be reassessed in person by the medical director, physician or physician extender in consultation with the medical director. After three consecutive days missed, the dose should be decreased to 30 mg or 50% of the current dose. After four or more consecutive days missed, the dose should be decreased to 30 mg or less. Missed doses during maintenance should be treated the same as those for late stabilization.

504.13.3.4 Dosing Adjustments During Early and Late Stabilization Phases

- Recent abstinence from opioids = 5 mg or less every five days or more
- Higher risk for methadone toxicity = 5-10 mg every three to five days
- No risk factors and recent abstinence = 10-15 mg every three to five days

504.13.3.5 Maintenance Phase (6+ Weeks)

The medical director or physician can reach the maintenance dose for most their members within two to eight weeks of initiating methadone. However, all members must be treated on an individualized basis and some may not reach their optimal dose until up to 12 weeks. The optimal dose range for most opioid treatment program members is 60-120 mg. During the maintenance phase (when the dose is 80 mg or more), the medical director or physician/ should increase the dose by no more than 5-10 mg every five to seven days. Dose increases during the maintenance phase should take place with an in-person opioid treatment program physician assessment or physician extender in consultation with the medical director for members who are experiencing cravings, ongoing opioid use, and/or several opioid withdrawal symptoms. Opioid treatment program clinical staff should assess members once weekly when ongoing dose adjustments are occurring and less frequently thereafter as required.

504.13.4 Managing Missed Doses

Missed doses may indicate a variety of problems, including relapse to alcohol or other drug use. Therefore, the medical director, physician or physician extender in consultation with the medical director should reassess the member's clinical stability. As part of this process, the medical director, physician/physician extender must request a review of the therapeutic component in terms of effectiveness, relationship to medication adherence, the need for treatment adjustments, etc. The medical director, physician/physician extender and the treating clinician will consult on revisions to the treatment plan and therapeutic approach that will be made to potentially improve adherence to the medication regimen.

Dosing personnel should report missed doses to the opiate treatment program medical director, physician, or physician extender within 24 hours. A clinically significant loss of tolerance to opioids may occur within as little as three days without methadone; therefore, the opioid treatment clinician should reduce the methadone dose in members who have missed three consecutive days. The dose can be rapidly increased once the response to the lower dose is assessed.

Phase of Treatment	Missed Doses	Action	Dose Change
Early Stabilization	24 hours missed	No dose increase	No change
Early Stabilization	48 hours	Reevaluate member	Start from initial dose
Late Stabilization/ Maintenance	1-2 days	If member is not intoxicated, continue current dose.	No change
Late Stabilization/ Maintenance	3 days	Reassess Member Urine Drug Screen	Restart at 50% of dose, then increase dose to no more than 10 mg daily for a maximum of 3 days
Late Stabilization/ Maintenance	4 or more days	Reassess Member Urine Drug Screen	Restart at 30 mg or less and titrate per usual

504.13.5 Doses Below 60 mg

There is evidence that methadone doses of 60–100 mg are more effective than doses below 60 mg for reducing heroin use and retaining members in treatment. However, maintenance doses below 60 mg are justified for members who have no unauthorized opioid use, report no significant withdrawal symptoms or cravings, are at high-risk for methadone toxicity, or are on a tapering protocol.

504.13.6 Doses Above 120 mg

Opioids such as methadone have several side effects that may be dose related, including sedation, overdose leading to death, sleep apnea and sexual dysfunction. High methadone doses are also associated with a prolonged qualified treatment (QT) interval which can cause Torsades de Pointes, a ventricular arrhythmia.

504.13.6.1 Assessment, Monitoring and Management of High Doses

A trial of tapering is indicated for members who report sedation when on high doses. While tapering is based on the clinical assessment by the medical director or physician/physician extender clinical experience suggests that tapering by an overall decrease of 20-40 mg is tolerated well, and members often report that they feel more alert and energetic.

504.13.6.2 Ongoing Withdrawal Symptoms in Members with High Doses

Members with ongoing withdrawal symptoms despite high methadone doses require ongoing assessment by the medical director or physician/physician extender. Possible causes include the rapid metabolism of methadone. The use of medications that increase the metabolism of methadone such as phenytoin, chronic alcohol use, or the ongoing use of cocaine (a methadone inducer) in large doses may result in the member complaining of the need for a dose increase. Although controversial, peak and trough levels might be useful in members who continue to report withdrawal symptoms despite doses of 120 mg or higher.

Additional reasons for ongoing withdrawal symptoms may include the increased tolerance caused by ongoing opioid use and then opioid cessation or dose diversion, such as consuming partial amounts of the take-home dose and selling the rest.

"Pseudo-normalization" can occur after a methadone dose increase and some members experience very mild mood elevation. They develop tolerance to this effect after a few weeks, prompting them to seek another dose increase. Insomnia, anxiety, fatigue and other psychiatric symptoms are such a prominent feature of opioid withdrawal that members may incorrectly attribute these symptoms to withdrawal.

504.14 NALOXONE ADMINISTERED BY EMS

Procedure Code: **A0998 Bundled Code** (Includes two 2mg syringes of Naloxone Hydrochloride, administration fee, and atomizers)
Modifier Code: HF
Service Unit: 1
Service Limit: No Limit
Telehealth: Not Available

Staff Credentials: Emergency Medical Technicians (EMT), Paramedics, and Emergency Medical Services (EMS) providers as authorized by the West Virginia Office of Emergency Medical Services and the Emergency Medical Services system according to WV Code, §16-4C, known as the Emergency Medical Services Act (Act). Legislative rule 64CSR48 describes and implements all aspects of pre-hospital care as authorized under the Act. These providers are also referred to as prehospital providers. The system includes mandatory state-wide protocols which are physician standing orders for EMTs, Paramedics and all EMS providers. The state-wide, mandatory protocols permit consistent prehospital emergency medical treatment across the state. Prehospital providers cannot practice medicine independently. They must practice under the license of the agency medical director.

Definition: Naloxone is a pure opiate antagonist and prevents or reverses the effects of opioids including respiratory depression, sedation, and hypotension. It is sold under the brand name of Narcan®. Naloxone is administered to the member by the prehospital provider using a West Virginia state-wide protocol. This code may be billed regardless of whether the member is transported to the hospital for further medical treatment.

504.14.1 Referral to Treatment by EMS

Procedure Code: **H0050** Alcohol and/or Drug Services, Brief Intervention (while on the scene)
Modifier Code: HF
Service Unit: 15 Minutes
Service Limit: 2 Per Calendar Day
Telehealth: Not Available

Staff Credentials: EMTs, Paramedics, and EMS providers as authorized by the West Virginia Office of Emergency Medical Services and the Emergency Medical Services system according to WV Code, §16-4C, known as the Emergency Medical Services Act (Act). Legislative rule 64CSR48 describes and implements all aspects of pre-hospital care as authorized under the Act. These providers are also referred to as prehospital providers.

Definition: While on the scene, following Naloxone administration or when the member is identified by the prehospital provider as having a substance use disorder and in need of further treatment, the member should be provided informational material on the WV Helpline and treatment options. The prehospital provider should also determine if the member is interested and/or willing to enter treatment and, if so, contact the WV Helpline to make a referral.

The WV Helpline may be reached at 1-844-HELP4WV (1-844-435-7498). HELP4WV offers a 24/7 call, chat, and text line that provides immediate help for any West Virginian struggling with an addiction or mental health issue. Many of those answering the helpline are peer-support specialists or recovery coaches. This means that they have personal experience in recovery from a mental health or substance abuse issue. The helpline staff offers confidential support and resource referrals, including self-help groups, outpatient counseling, medication-assisted treatment, psychiatric care, emergency care, and residential treatment.

If the member is not interested in a referral to treatment at this time, the prehospital provider leaves the information with the member.

504.14.2 Naloxone Administration and Referral Billing Examples

The following are examples of when the prehospital provider may bill for Naloxone administration and/or referral to treatment:

	Step One	Step Two	Billing Code*
1	Naloxone is administered by prehospital provider	Member accepts and/or requires transportation to the emergency room for medical treatment	A0998 HF
2	Naloxone is administered by prehospital provider	Member refuses transport to the emergency room and referral to treatment	A0998 HF
3	Naloxone is administered by prehospital provider	Member refuses transport to the emergency room, accepts the informational material but refuses referral to treatment	A0998 HF H0050 HF
4	Naloxone is administered by prehospital provider	Member refuses transport to the emergency room, accepts the informational material and referral to treatment	A0998 HF H0050 HF
5	Naloxone is not administered by prehospital provider, but the member has a substance use disorder	Member refuses transport to the emergency room, accepts the informational material and accepts or refuses referral to treatment	H0050 HF
**Modifier Code HF must be used with codes A0998 and H0050*			

504.15 PEER RECOVERY SUPPORT SERVICES

Peer recovery support services facilitate recovery from substance use disorders. Services are delivered by trained and certified peers who have been successful in their own recovery process and can extend the reach of treatment beyond the clinical setting into a member's community and home environment to support and assist a member with staying engaged in the recovery process.

Peer recovery support services are delivered by individuals who have common life experiences with the people they are serving. People with substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. By sharing their experiences, peers bring hope to people in recovery and promote a sense of belonging within the community. Peer recovery support services are an evidence-based model of care which consists of a qualified peer recovery support specialist (PRSS) who assists members with their recovery. The experiences of PRSS as consumers of substance use services, can be an important component in promoting and sustaining long-term recovery.

A CBHC or LBHC, as defined in Chapter 64 of the WV State Code, may provide peer recovery support services.

Peer recovery support services are for individuals with substance use disorders or co-occurring substance use and mental health disorders. Peer recovery support services may be provided to eligible individuals ages 16 years or older who have a substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their recovery by other age-appropriate peers. An adult PRSS aged 18 or older must serve other adults ages 18 or older and cannot provide peer recovery support services to juveniles.

504.15.1 Peer Recovery Support Specialist Services

Procedure Code:	**H0038**
Service Unit:	15 Minutes
Service Limits:	16 units per Calendar Day
Prior Authorization:	Required
Telehealth:	Available
Staffing Limitations:	May not exceed 20 members per PRSS

Definition: A peer is an individual who shares the direct experience of addiction and recovery. Recovery support services are nonclinical services that assist individuals to recover from alcohol or drug problems. ***Group peer support services are not covered services***. A PRSS is a person who uses his or her own lived experience of recovery from addiction, in addition to skills learned in a formal training, to deliver services in substance use disorder settings to promote mind-body recovery and resiliency.

Staff Credentials: A PRSS is a person who has the qualifications, education, and experience established by BMS; and who has received certification in good standing by a certifying body recognized by the BMS. A PRSS is professionally qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of substance abuse disorders, to provide peer support as a self-identified individual successful in the recovery process with lived experience with substance use disorders, or co-occurring mental health and substance use disorders, and to offer support and assistance in helping others in the recovery and community-integration process. Documentation of all of the following requirements must be maintained in the PRSS personnel files by the LBHC or CMHC employers.

The PRSS requirements include:

- Self-identify as an individual with life experience of being diagnosed with a serious mental illness or substance use disorder which meets federal definitions;
- Must be well established in their own recovery; currently in recovery for a minimum of two years and not have received SUD treatment for the preceding six months, except for MAT which is considered a part of recovery;

- Have a high school diploma or GED equivalency (not applicable to 16-17-year old's applying to be a PRSS);
- The individual must be employed by either a CBHC or LBHC;
- Certification as a PRSS*;
- PRSS application which includes the Attestation of Recovery Statement and three letters of reference;
- Must be supervised by an individual who has a master's degree and is employed by the same provider;
- Not a family member of the individual receiving the peer support services;
- Continuing education of 30 hours must be completed every two years in the competency domains which must include six hours in ethics;
- Completes 40 contact hours of volunteer work or paid work at an agency or provider prior to Medicaid services being rendered;
- Current CPR/First Aid card;
- Fingerprint-Based Background Check. Please see Section 504.4 for more information; and
- Only peers under the age of 18 can provide peer recovery support services to other peers under the age of 18. No adult PRSS can provide services to a minor.

*BMS will accept any peer recovery support certification completed prior to July 1, 2018, to be grandfathered in for the purposes of meeting this requirement. Applicants who have not previously completed a certification prior to July 1, 2018, must complete the BMS PRSS webinar with an 80% or higher score in order to be certified. The applicant must provide proof that certification was completed prior to July 1, 2018 or must complete the certification of the BMS webinar on or after July 1, 2018.

The PRSS must complete specific training within 90 days of employment, and prior to billing for any services provided. This includes, but is not limited to:

- Member rights
- Confidentiality/HIPAA
- Crisis intervention
- Continuing education specific to recovery and wellness management

Documentation: Documentation report must be maintained in the member's medical record and contain the following:

- Member name
- Date, location, and start/stop time of service/meeting;
- Activity note (describing each activity):
    - Self Help: Cultivating the member's ability to make informed, independent choices. Helping the member develop a network of contacts for information and support based on experience of the PRSS. Assist in developing social skills, repairing, rebuilding, or establishing prevention networks.
    - System Advocacy: Assisting the individual to talk about what it means to have a substance use or co-occurring disorder to an audience or group. Assisting the individual with communicating about an issue related to their substance use and/or their recovery.
    - Individual Advocacy: Discussing concerns about medication at the individual's request. Assisting with developing independence in self-referral techniques, accessing appropriate care, and understanding clear communication and coordination with any health care provider.

  - Recovery Planning: Helping the member make appointments for all medical treatment when requested. Guiding the member toward a proactive role in health care, jointly assessing services, identifying triggers for use, developing a relapse plan, and building support network.
  - Crisis Support: Assisting the individual with the development of a personal crisis plan. Helping with stress management and developing positive strategies for dealing with potential stressors and crisis situations.
  - Relapse Prevention: Giving feedback to the member on early signs of relapse and how to request help to prevent a crisis. Assisting the member in learning how to use the crisis/relapse plan. Educating on relapse prevention and identifying relapse trigger, developing a relapse plan and prevention. Learn new ways to live life without the inclusion of drugs, skills building for such things as time management and connecting with prosocial activities.
  - Housing: Assisting the member with learning how to maintain stable housing through bill paying and organizing his or her belongings. Assisting the member in locating improved housing situations. Teaching the member to identify and prepare healthy foods according to cultural and personal preferences of the member and his/her medical needs.
  - Education/Employment: Assisting the member in gaining information about going back to school or job training. Facilitating the process of asking an employer for reasonable accommodation for psychiatric disability (mental health day, flex time, etc.).
- Type of Service:
  - Emotional: Should demonstrate empathy, caring, or concern to bolster a person's self-esteem and confidence.
  - Informational: Share knowledge and information and/or provide life or vocational skills training.
  - Instrumental: Provide concrete assistance to help others accomplish tasks.
  - Signature and credentials of the staff providing the service.
  - Facility where the provider is employed.
  - Affiliation Support: Facilitate contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.

NOTE: More than one activity can be utilized at any one meeting.

If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the plan. The activity note must include the reason for the service, symptoms and functioning of the member, and the member's response to the intervention and/or treatment.

Peer recovery support services may not be provided during the same time/at the same place as any other direct support Medicaid service. Targeted case management is the only service that can be billed as it is an indirect service.

Peer recovery support services may be provided in any location ***except*** at the PRSS' home and must be completed in a safe, harm-free environment. A fundamental feature of peer recovery support is that the services are provided in the natural environment as much as possible. Telehealth may be utilized for these services and must follow all West Virginia Medicaid guidelines.

Please refer to *Chapter 504, Appendix A Documentation for Peer Recovery Support Services* as a guideline for required documentation in the member's medical record.

504.16 INTENSIVE OUTPATIENT SERVICES

ASAM® Level 2.1 Intensive outpatient services are professionally directed assessment, diagnosis, treatment, and recovery services provided in an organized, non-residential treatment setting. Information about Intensive Outpatient Services can be found in *Chapter 503, Licensed Behavioral Health Centers (LBHC).*

504.17 PARTIAL HOSPITALIZATION PROGRAM

ASAM® Level 2.5 Partial Hospitalization Program (PHP) provides a 16 or 20 hour per week program of clinically intensive services based on individual treatment plans. Information about PHP can be found in *Chapter 510* Hospital Services, *Section 510.7 Acute Care Hospital Outpatient Services* of the BMS Provider Manual.

504.18 RESIDENTIAL ADULT SERVICES

Residential Adult Services (RAS) are comprehensive programs for adults ages 18 and older who have been diagnosed with a substance abuse and/or co-occurring substance abuse/mental health disorder. Short-term residential services are typically less than 30 days. Individuals placed in these levels of care are unable to be treated on an outpatient basis effectively. The level of care that individual is placed in is based upon medical necessity and the ASAM® Criteria.

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the member. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM® and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Clinical assessments, service/treatment planning, and discharge planning including recovery support preparations are required throughout the entire length of stay.

Family and support system involvement is an important piece to the recovery process as long as the treatment team does not feel that having the family involved in the treatment process would have a detrimental effect on the member's outcomes during treatment. The member should be:

- Encouraged to maintain contact with the family and provided with support in making such arrangements, unless not in the member's best interest;
- Provided information for the family about activities and progress toward the goals of stepping down to outpatient services when the appropriate releases of information are completed;
- Provided with assistance in maintaining the relationship with the family or support system through visits and shared activities;
- Prepared for the return to home, recovery housing, or other safe residences to continue the rehabilitation process; and
- Prepared for educating the family on substance abuse.

The residential program is responsible for:

- Visitation guidelines and/or restrictions;
- Facility responsibility for working with the family;
- Contraband guidelines and restrictions; and
- Any other appropriate issues.

To be reimbursed, the provider must be licensed by OHFLAC as an LBHC, be an enrolled Medicaid provider, and must be issued an approval certification through the BMS before rendering services. The provider must complete the entire application found in *Chapter 504, Appendix B Application for Residential Adult Services* and submit the application with a copy of the LBHC certification from OHFLAC that includes the physical address of the site(s) providing both residential and clinical services to the designated mailbox BMSSUDWaiver@wv.gov. The BMS will review the application within 30 days of receipt and will notify the provider of approval, disapproval, or request more information if needed to complete the certification review request. The certification is good for two years from the date of approval. The BMS reserves the right to terminate certification due to non-compliance of policy, state licensing revocation, or reports of abuse, fraud or other issues that are indicative of improper practice.

If a provider chooses to discontinue a program, they must provide a 30-day written notice to the BMS and must provide the discharge plans for each of the members being served in that program.

In addition to documentation requirements in Section 504.11, Documentation of this chapter, the following are required:

- A permanent clinical record must be maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies;
- The record must contain a written physician's/physician extender's order authorizing RAS and the member's individualized service plan;
- A daily summary of the individual's program participation, which includes identification of the supportive and therapeutic services received by the member, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary;
- Medication administration records;
- Urine drug screen records;
- Each member must have a sign-in/sign-out sheet. This sheet must be filled out if the member exits the residential site. This sheet must note the actual time the individual departs the site and returns to the site, as well as the reason for his/her absence. Each notation must be signed and dated by the agency staff;
- Within 72 hours of admission, a service plan must be developed and reviewed at least every seven calendar days thereafter, or when a critical juncture takes place;
- Services must be provided and documented in accordance with the minimum standards established by the BMS in this chapter of the Provider Manual, *Chapter 503, Licensed Behavioral Health Centers (LBHC) Services*, and with the certification standards established by WV State Code §64-CSR-11.
- A physical examination is required prior to admittance on all levels of RAS. For Level 3.7, the physical exam must take place within 24 hours of admission. For all other levels, the physical examination must take place within the first 72 hours.

Each member's level of care will be determined when prior authorization for Residential Adult Substance Abuse Services is requested through the Utilization Management Contractor (UMC) or MCO. The Prior Authorization process is explained in *Section 504.23*, Prior Authorization of this chapter.

Medicaid members accessing RAS may not receive Day Treatment or Assertive Community Treatment services.

Flexible capacity between 3.1 and 3.5 levels of care: Facilities approved to operate both a 3.1 and 3.5 level program at the same site may utilize flexible capacity between these two levels of care. At these sites, an approved Level 3.1 or 3.5 program may utilize any available program space for a member to enter the program,

but the member must still receive services according to the member's assessed level of need. **Note**: ASAM Level 3.3 and 3.7 programs cannot utilize flexible capacity.

Combined professional group and supportive group services for 3.1 and 3.5 program levels: Facilities approved to operate both a 3.1 and 3.5 level program at the same site may utilize group services between these two levels of care. Providers approved to operate both 3.1 and 3.5 programs at the same location must maintain the program integrity for each of the approved levels. Programs may integrate members across these two levels of care for supportive and professional group counseling. If a provider intends to utilize mixed groups, they must maintain all levels of approved programming based on the member's assessed need.

Service Planning: Development of the Service Plan, or addendums without the entire interdisciplinary team is not a billable service (see Service Plan development below for clarification and description of exceptions).

The Service Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessment(s) during the treatment process.

The Service Plan must be developed within 72 hours of admission and reviewed at least every seven calendar days from the date of admission and must include:

- Date and start/stop times of development of the plan;
- Participants in the development of the plan, including staff signatures with credentials;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the provider and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (interventions) to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives;
- Discharge plan;
- A date for review of the plan, timed in consideration of the expected duration of the program or service.

It is expected that objectives be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service.

Service Plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service Plans must be revisited at critical treatment junctures including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective the service plan must reflect consideration by the team of changes in the intervention strategy.

Treatment Team Composition: An individual service plan is required for all members receiving services through the SUD Waiver. The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers involved in the members treatment must be invited to participate in the service planning session. All members of the team must receive notice at least 72 hours prior to the treatment team meeting. If a member of the team does not come, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A physician extender may serve on the committee in place of the physician.

Service Plan Development: The Service Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessment(s) during the treatment process. Service Plan development includes team member participation and is part of the Residential service. A written Service Plan is a product of that process and serves as substantiation that the process took place. The Service Plan is developed within 72 hours of admission and must include:

- Date and start/stop times of development of the plan;
- Participants in the development of the plan, including staff signatures with credentials;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the provider and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (intervention) that are nationally recognized evidenced based practices for the treatment of SUD to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives;
- Discharge plan;
- A date for review of the plan, times in consideration of the expected duration of the program or service;
- Justification for continuation of medications prescribed prior to admission and continued until the assessment process is completed or justification for medications prescribed by the admitting physician;
- A summary of assessments and/or evaluations needed for the development of a full diagnostic and treatment perspective and recommendations;
- A description of specific, individual or group interventions to be provided prior to discharge;
- A description of any behavioral interventions or protocols considered likely to be necessary prior to the completion of the full assessment process; and
- A description of acute or chronic medical problems that may require treatment prior to the completion of the assessment process.

Service Plan Review/Revision: Service Plans must be flexible documents that must be reviewed at least every seven calendar days and modified by the team as necessary and clinically appropriate. Service Plans must be revisited at critical treatment junctures and required timelines including changes in level of services to more intensive or less intensive types of care. When an intervention proves to be ineffective the Service Plan must reflect consideration by the team of changes in the intervention strategy. The facility must provide coordination of care services to the members as needed.

Staff Qualifications: Staff providing services as described below must meet the credentials and qualifications for each service provided as described in *Chapter 503, Licensed Behavioral Health Centers (LBHC)*.

504.18.1 Residential Adult Services ASAM® Level 3.1

RAS Level 3.1 is a structured 24-hour adult substance use disorder residential treatment setting targeting adults with a confirmed ICD or DSM diagnosis of a substance use or co-occurring disorder. This level of care is designed for adults whose treatment needs cannot be met on an outpatient level of care.

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimensions 5 and 6 of the ASAM® criteria.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows members the opportunity to develop and practice skills while reintegrating into the community. This type of programming can be beneficial to individuals who do not acknowledge a substance use problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary due to deficits in the individual's recovery environment. This allows the individual to practice and master the application of recovery skills.

Procedure Code:	**H2036U1HF**
Service Unit:	24 hours
Prior Authorization:	Required
Service Limits:	One per calendar day - All units must be prior authorized. Reimbursement begins on the day of admission (regardless of the time of admission, prior to 12:00 midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: The following comprehensive array of services and included in procedure code **H2036U1HF**:

- Psychiatric Diagnostic Evaluation without medical services (90791); with medical service (90792)
- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development by a Non-Physician (H0032); by a Psychologist (H0032AH)
- Targeted Case Management (T1017)
- Skills Training and Development (H2014U1), 1:1 by a Paraprofessional; (H2014U4), 1:2-4 by a Paraprofessional
- Skills Training and Development (H2014HNU1), 1:1 by a Professional; (H2014HNU4), 1:2-4 by a Professional
- Behavioral Health Counseling, Supportive, Individual (H0004); Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO); Group (H0004HOHQ)
- Family Psychotherapy without patient present (90846); with patient present (90847)
- Crisis Intervention 24-hour Availability (H2011)
- Group Psychotherapy (90853)
- Peer Recovery Support (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Physician Coordinated Care Oversight Services (G9008)
- Comprehensive Medication Services (includes all nursing) (H2010)
- Drug Screenings (80305, 80306, 80307)

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503 Licensed Behavioral Health Centers (LBHC)* and Section 504.13 Methadone ASAM® Level Medication Assisted Treatment of this chapter for the policy on MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements as stated in Chapter 503.

Admission Criteria: The following admission criteria must be met:

- Referral received by physician, physician extender, or provider of services;
- The member must receive medical clearance prior to entering the program;
- A physical exam must be completed within 72 hours of admission to the program;

- An evaluation or assessment that should include the six dimensions of the ASAM® criteria to ensure the appropriate level of care has been identified;
- The current ICD or DSM diagnosis of a substance use disorder; and
- Identified deficits include:
    - Inability to apply recovery skills.
    - Lack of personal responsibility in relation to diagnosis.
    - Inability to maintain employment, gain education, maintain healthy relationship, and/or involved in legal issues due to substance use.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the provider of services and the treatment team.

Discharge Criteria: One or more of the following discharge criteria must be met:

1. Member has completed goals and objectives of the program and can be stepped down to an outpatient setting; or
2. Member is unable to complete goals and objectives and must be put into an appropriate level of care; or
3. Member's medical issues become unmanageable in this residential level; or
4. Member refuses to comply with treatment.

Program Requirements: This service level must have a 24-hour structure with appropriately trained staff. The program must consist of at least five hours of clinical service per week in addition to structural supports in the residential setting and should be designed to help a member complete their goals and objectives to step down to outpatient level of care.

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of population as clinically described. Medication review services must be made available to all members at this level of care. Professional therapies should utilize nationally recognized evidence-based practices for the treatment of substance use disorders and co-occurring disorders.

Support Systems: Required support systems within this level include telephone or in-person consultations with a physician, PA, or APRN and emergency services, available 24 hours a day, seven days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services, such as literacy training and adult education. Programs must arrange for needed procedures as appropriate to the severity and urgency of the individual's condition. These programs must arrange for pharmacotherapy for psychiatric or anti-addiction medications.

504.18.2 Residential Adult Services ASAM® Level 3.3

RAS Level 3.3 is a structured 24-hour adult substance use residential treatment setting targeting adults with a confirmed ICD or DSM diagnosis of a substance use or co-occurring disorder. This level of care is designed for adults whose treatment needs cannot be met on an outpatient level of care.

These services provide a structured recovery environment in combination with medium intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower

pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for members at this level are primarily cognitive and can be temporary or permanent. The clients in this level of care have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The member's level of impairment is more severe at this level, requiring services be provided differently for maximum benefit to be received.

Procedure Code:	**H2036U3HF**
Service Unit:	24 hours
Prior Authorization:	Required
Service Limits:	One per calendar day - All units must be prior authorized Reimbursement begins on the day of admission (regardless of the time of admission, prior to 12:00 midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: The following comprehensive array of services are included **H2036U3HF**:

- Psychiatric Diagnostic Evaluation without medical services (90791); with medical service (90792)
- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development by a Non-Physician (H0032); by a Psychologist (H0032AH)
- Targeted Case Management (T1017)
- Skills Training and Development (H2014U1), 1:1 by a Paraprofessional; (H2014U4), 1:2-4 by a Paraprofessional
- Skills Training and Development (H2014HNU1), 1:1 by a Professional; (H2014HNU4), 1:2-4 by a Professional
- Behavioral Health Counseling, Supportive, Individual (H0004); Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO); Group (H0004HOHQ)
- Family Psychotherapy without patient present (90846); with patient present (90847)
- Crisis Intervention 24-hour Availability (H2011)
- Group Psychotherapy (90853)
- Peer Recovery Support (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); each additional 30 minutes (90840)
- Therapeutic Behavioral Services Development (H2019HO); Implementation (H2019)
- Physician Coordinated Care Oversight Services (G9008)
- Comprehensive Medication Services (includes all Nursing) (H2010)
- Drug Screenings (80305, 80306, 80307)

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503, Licensed Behavioral Health Centers (LBHC)* and Section 504.13 Methadone ASAM® Level Medication Assisted Treatment of this chapter for the policy on MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements as stated in Chapter 503.

Admission Criteria: The following admission criteria must be met:

- Referral received by physician, physician extender, or provider of services;
- An evaluation or assessment that shows the member is unable to be treated in an outpatient setting;

- The member must receive medical clearance prior to entering the program;
- A physical exam must be completed within 72 hours of admission to the program;
- The current ICD or DSM diagnosis of a substance use disorder; and
- Identified deficits include:
    - Member's impairment is considered more severe due to substance use issues and cognitive symptomology.
    - Inability to apply recovery skills.
    - Lack of personal responsibility in relation to diagnosis.
    - Inability to maintain employment, gain education, maintain healthy relationship, and/or involved in legal issues due to substance use.
    - Needs a more intense or structured environment due to substance use.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the provider of services and the treatment team.

Discharge Criteria: One or more of the following discharge criteria must be met:

1. Member has completed goals and objectives of the program and can be stepped down to a lower level of care; or
2. Member is unable to complete goals and objectives and must be put into an appropriate level of care; or
3. Member's medical issues become unmanageable in this residential level; or
4. Member refuses to comply with treatment.

Program Requirements: This service level must have 24-hour care with behavioral health technicians to stabilize members from imminent danger and with the use of group treatment for members with cognitive impairments or other impairments and are unable to utilize community-based treatment.

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of population as clinically described. Services must be rendered to each individual member with at least 10 clinical service hours in a week in addition to structural supports in the residential setting. Medication review services must be made available to all members at this level of care. Professional therapies should utilize national recognized evidence-based practices for the treatment of substance use disorders and co-occurring disorders.

Support Systems: Required support systems within this level include telephone or in-person consultations with a physician, PA, or APRN and emergency services, available 24 hours a day, seven days a week. They should have direct affiliations with other easily accessible levels of care or close coordination through referral to more and less intensive levels of care and other services. They need medical, psychiatric, psychological, laboratory and toxicology services available through consultation and referral as appropriate to the severity and urgency of the individual's condition.

504.18.3 Residential Adult Services ASAM® Level 3.5

RAS Level 3.5 is a structured 24-hour adult substance use residential treatment setting targeting adults with a confirmed ICD or DSM diagnosis of a substance use or co-occurring disorder. This level of care is designed for adults whose treatment needs cannot be met on an outpatient level of care.

These services are designed to treat members who have significant social and psychological problems. Treatment is directed toward diminishing member deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the member's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Members at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. As impairment is significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. The primary focus of treatment will be on habilitation services to learn or improve skills and functioning for daily living.

Procedure Code:	**H2036U5HF**
Service Unit:	24 hours
Prior Authorization:	Required
Service Limits:	One per calendar day - All units must be prior authorized. Reimbursement begins on the day of admission (regardless of the time of admission, prior to 12:00 midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: The following comprehensive array of services are included in **H2036U5HF**:

- Psychiatric Diagnostic Evaluation without medical services (90791); with medical service (90792)
- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development by a Non-Physician (H0032); by a Psychologist (H0032AH)
- Targeted Case Management (T1017)
- Skills Training and Development (H2014U1), 1:1 by a Paraprofessional; (H2014U4), 1:2-4 by a Paraprofessional
- Skills Training and Development (H2014HNU1), 1:1 by a Professional; (H2014HNU4), 1:2-4 by a Professional
- Behavioral Health Counseling, Supportive, Individual (H0004); Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO); Group (H0004HOHQ)
- Family Psychotherapy without patient present (90846); with patient present (90847)
- Crisis Intervention 24-hour Availability (H2011)
- Group Psychotherapy (90853)
- Peer Recovery Support (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); each additional 30 minutes (90840)
- Physician Coordinated Care Oversight Services (G9008)
- Comprehensive Medication Services (includes all nursing) (H2010)
- Drug Screenings (80305, 80306, 80307)

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503 Licensed Behavioral Health Centers (LBHC)* and Section 504.13 Methadone ASAM® Level Medication Assisted Treatment of this chapter for the policy on MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements as stated in Chapter 503.

Admission Criteria: The following admission criteria must be met:

- Referral received by physician, physician extender, or provider of services;
- An evaluation or assessment that shows the member is unable to be treated in an outpatient setting;
- The member must receive medical clearance prior to entering the program;
- A physical exam must be completed within 72 hours of admission to the program;
- The current ICD or DSM diagnosis of a substance use disorder; and
- Identified deficits which include:
    - Member's impairment is considered more severe due to substance use issues;
    - Member's inability to be treated in a lower level of care;
    - Inability to apply recovery skills;
    - Lack of personal responsibility in relation to diagnosis;
    - Inability to maintain employment, gain education, maintain healthy relationship, and/or involved in legal issues due to substance use;
    - Needs a more intense or structured environment due to substance use;
    - Has shown to be difficult to stabilize; and
    - Has displayed imminent danger or other behaviors and actions that require intense rehabilitation.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the provider of services and the treatment team.

Discharge Criteria: One or more of the following discharge criteria must be met:

1. Member has completed goals and objectives of the program and can be stepped down to a lower level of care; or
2. Member is unable to complete goals and objectives and must be put into an appropriate level of care; or
3. Member's medical issues become unmanageable in this residential level; or
4. Member refuses to comply with treatment.

Program Requirements: Providers of this program must be able to have a structured program available 24 hours a day, seven days a week that is staffed with therapists who can intervene and stabilize issues that arise at this treatment level. Therapists and staff at this level of care should develop services to address educational, vocational, and employment limitations. Services must be rendered to each individual member with at least 15 clinical service hours in a week in addition to structural supports in the residential setting. The program should be designed to help a member complete their goals and objectives to step down to outpatient level of care.

Support Systems: Required support systems within this level include telephone or in-person consultations with a physician, PA, or APRN and emergency services, available 24 hours a day, seven days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

504.18.4 Residential Adult Services ASAM® Level 3.7

These programs offer a structured regime of professional 24-hour directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. These programs operate in permanent facilities with individual beds and function under a set of defined policies, procedures and clinical protocols. These programs are for individuals with subacute biomedical and emotional, behavioral or severe cognitive problems that require individual treatment but do not require the full resources of an acute care general hospital or medically managed

individual program.

Requirements for admission to a Level 3.7 program include meeting the specifications in two Dimensions, at least one of which must be in Dimension 1, 2, or 3. The care provided in these programs is delivered by an interdisciplinary staff who are appropriately credentialed, including addiction credentialed physicians. The focus of treatment is specific to substance use disorders. The skills of this team and their availability can accommodate withdrawal management and/or intensive individual treatment of addiction, and/or integrated treatment of co-occurring subacute biomedical, and/or emotional, behavioral or cognitive conditions.

Procedure Code:	**H2036U7HF**
Service Unit:	24 hours
Prior Authorization:	Required
Service Limits:	One per calendar day - All units must be prior authorized. Reimbursement begins on the day of admission (regardless of the time of admission, prior to 12:00am midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: The following comprehensive array of services are included in **H2036U7HF**:

- Psychiatric Diagnostic Evaluation without medical services (90791); with medical service (90792)
- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development by a Non-Physician (H0032); by a Psychologist (H0032AH)
- Targeted Case Management (T1017)
- Skills Training and Development (H2014U1), 1:1 by a Paraprofessional; (H2014U4), 1:2-4 by a Paraprofessional
- Skills Training and Development (H2014HNU1), 1:1 by a Professional; (H2014HNU4), 1:2-4 by a Professional
- Behavioral Health Counseling, Supportive, Individual (H0004); Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO); Group (H0004HOHQ)
- Family Psychotherapy without patient present (90846); with patient present (90847)
- Crisis Intervention 24-hour Availability (H2011)
- Group Psychotherapy (90853)
- Peer Recovery Support (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); each additional 30 minutes (90840)
- Physician Coordinated Care Oversight Services (G9008)
- Psychological and Testing Evaluation Services (first hour) Psychological and Testing Evaluation Services (first hour) Report (96130)
- Psychological and Testing Evaluation Services (additional hour) (96131)
- Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (96136)
- Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (96137)
- Comprehensive Medication Services (includes all nursing) (H2010)
- Drug Screenings (80305, 80306, 80307)
- Any needed Evaluation/Management Services

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503 Licensed Behavioral Health Centers (LBHC)* and Section 504.13 Methadone ASAM® Level Medication Assisted Treatment of this chapter for the policy on MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements as stated in *Chapter 503 Licensed Behavioral Health Centers (LBHC).*

Admission Criteria: The following admission criteria must be met:

- Referral received by physician, physician extender, or provider of services;
- An evaluation or assessment that shows the member is unable to be treated in an outpatient setting;
- The member must receive medical clearance prior to entering the program;
- A physical exam must be completed within 24 hours of admission to the program;
- A current ICD or DSM diagnosis of a substance use disorder; and
- Identified deficits which include:
    - Member's impairment is considered more severe due to substance use issues;
    - Member's inability to be treated on a lower level of care;
    - Inability to apply recovery skills;
    - Lack of personal responsibility in relation to diagnosis;
    - Inability to maintain employment, gain education, maintain healthy relationship, and/or involved in legal issues due to substance use;
    - Needs a more intense or structured environment due to substance use;
    - Has shown to be difficult to stabilize;
    - Has displayed imminent danger or other behaviors and actions that require intense rehabilitation;
    - Hospital setting needed to ensure treatment can take place due to safety or medical reasons; and
    - Documentation that the member needs an acute setting with planned and structured programs.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the clinical provider and the treatment team.

Discharge Criteria: One or more of the following discharge criteria must be met:

1. Member has completed goals and objectives of the program and can be stepped down to a lower level of care; or
2. Member is unable to complete goals and objectives and must be put into an appropriate level of care; or
3. Member refuses to comply with treatment.

Program Requirements: Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of population as clinically described. Services must be rendered to each individual member with at least 22 hours clinical services in a week in addition to structural supports in the residential setting. Services are inclusive of structured supervision within the 24 hour a day, seven days a week program, provided by available trained therapists and staff who intervene to stabilize multidimensional aspects of imminent danger and other behaviors that are based in dysfunctional actions and require habilitation. Programs provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, and medical monitoring and addiction treatment. The service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting. The skills of the interdisciplinary team and the availability of support services can accommodate withdrawal management.

Support Systems: This level of care requires physician monitoring, nursing care, and observations are made available. The following staffing is required for this level of care: a physician, PA, or APRN must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; an appropriately credentialed nurse is responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological, laboratory, and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care are available through direct affiliation or a referral process. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to later. These services should be available within eight hours by telephone or 24 hours in person.

504.19 WITHDRAWAL MANAGEMENT

A withdrawal management program is defined as a licensed program that provides short-term medical services on a 24-hour basis for stabilizing intoxicated members, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment. Withdrawal management is provided as part of a continuum of the SUD treatment levels in the ASAM® Criteria. The SUD Waiver benefits include a continuum of care that ensures that members can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment levels. With current medication protocols, ASAM® notes that all but the most severe withdrawal syndromes can be managed effectively on an outpatient basis.

504.19.1 ASAM® Level 1 Withdrawal Management

ASAM® Level 1-Withdrawal Management (Intensive Outpatient Services) is withdrawal management that is medically monitored and managed but that does not require admission to an inpatient medically or clinically monitored or managed 24-hour treatment setting. Information about ASAM® Level 1-Withdrawal Management can be found in *Chapter 503, Licensed Behavioral Health Centers (LBHC)* of the BMS Provider Manual.

504.19.2 ASAM® Level 2 Withdrawal Management

ASAM® Level 2-Withdrawal Management (Community Psychiatric Supportive Treatment) may be delivered in a mental health or addiction treatment facility. Information about ASAM® Level 2-Withdrawal Management can be found in *Chapter 503, Licensed Behavioral Health Centers (LBHC)* of the BMS Provider Manual.

504.19.3 ASAM® Level 3.2 Withdrawal Management

ASAM® Level 3.2-Clinically Managed Residential Withdrawal Management is a clinically-managed service designed to safely assist members who are intoxicated or experiencing withdrawal. These programs are staffed by credentialed staff including addiction specialists who can implement physician-approved protocols for observation and supervision, determination of the appropriate level of care, and facilitate the member's transition to continuing care. Medical evaluation and consultation are available 24 hours a day. ASAM® Level 3.2-Clinically Managed Residential Withdrawal Management can only be rendered in a Residential Level 3.7 treatment program. Appropriately-trained staff provide 24-hour supervision, observation and support, must be able to obtain and interpret member information, provide treatment and monitoring of intoxication and withdrawal symptoms, and transition the member into ongoing care. A licensed physician, PA, and/or APRN should oversee the treatment process and assure quality of care and must perform physical examinations for all members admitted to this level of care.

The components of Withdrawal Management Level 3.2 services include:

- **Intake:** The process of admitting a member into a SUD treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment of treatment needs, and must include a physical examination within 24 hours of admission and laboratory testing necessary for SUD treatment.
- **Observation:** The process of monitoring the member's course of withdrawal as frequently as deemed appropriate for the member. This may include, but is not limited to, observation of the member's health status.
- **Medication Services:** The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.
- **Discharge Services:** Preparing the member for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.

Documentation includes progress notes of the member's responses to treatment; vital signs; and withdrawal rating scales.

Admission Criteria: Member must have the presence of multiple risk factors for admission to Withdrawal Management Level 3.2:

- Past history of seizures or delirium tremens
- Frequent sleep disturbance or nightmares during the previous week
- Sweating, tremor or pulse >100 while Blood Alcohol Level is >.10mg%
- Significant anxiety and moderate to severe tremor and may be withdrawing from substances other than alcohol but fully coherent
- Moderate anxiety, sweating, insomnia and mild tremor, withdrawing from alcohol only, and fully coherent
- Withdrawal symptoms with mild to moderate fever and/or moderate blood pressure elevation
- Moderate to severe co-occurring psychiatric symptoms
- Moderate to severe medical problems with potential to destabilize
- Ambivalent commitment to withdrawal process or questionable ability to reliably cooperate
- Absence of family or social support system, safe housing, and transportation assistance

Treatment Setting: Clinically Managed services are directed by non-physician addiction specialists, rather than physician and nursing personnel. The following are required in Withdrawal Management Level 3.2:

- Social Setting Services which provide 24-hour supervision, observation and support for members who are intoxicated or experiencing withdrawal;
- Established clinical protocols to identify members in need of medical services beyond the capacity of the treating facility with transfer to more appropriate levels of care, developed by a physician qualified in Addiction Medicine;
- Staffed by credentialed Chemical Dependency personnel with 24-hour physician access for evaluation and consultation;
- Facilities supervising self-administered medication have licensed/credentialed staff with policies and procedures in compliance with federal law;
- Direct affiliation with other levels of Substance Abuse/Addiction care; and the
- Ability to conduct or arrange for necessary laboratory and toxicology tests.

Assessment and Treatment Plan: Elements of the assessment and treatment plan must include:

- A comprehensive nursing assessment performed at admission;
- Approval of the admission by a physician;
- A comprehensive history and physical exam performed within 12 hours of admission, accompanied by appropriate laboratory and toxicology tests;
- Addiction-focused history obtained as part of the assessment and reviewed by a physician during the admission process;
- Biopsychosocial screening assessments to determine placement and for an individualized care plan;
- Discharge or transfer planning, beginning at admission;
- Referral arrangements;
- An individualized treatment plan that includes problem identification in all six dimensions and development of treatment goals and measurable treatment objectives/activates designed to meet those objectives;
- Daily assessment of progress through withdrawal management and any treatment changes;
- Availability of physician to assess member no more than 24 hours after admission and availability to provide 24-hour monitoring when needed, as well as daily evaluation;
- RN-conducted nursing assessment on admission; and
- Daily assessment of member progress and any treatment changes.

Therapies: Therapies in Withdrawal Management Level 3.2 must include:

- A range of cognitive, behavioral, medical, mental health and other therapies. psychiatric or biomedical interventions to complement addiction treatment as necessary;
- Interdisciplinary individualized assessment and treatment;
- Health Education services;
- Services to families and significant others; and
- Discharge or transfer planning.

Discharge Criteria: Discharge criteria must include:

- Signs and symptoms have resolved sufficiently to allow safe transfer to a less intensive level of care;
- Failure to respond to treatment or intensification of symptoms to indicate need for transfer to a higher level of care; and
- Member is unable to complete withdrawal management despite an adequate trial.

504.20 TRANSPORTATION

For Transportation Services requirements for SUD services, please see *Chapter 524, Transportation Services* of the BMS Provider Manual.

504.21 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 100, General Administration and Information* of the Provider Manual.

504.22 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Administration and Information*, reimbursement is not allowed for the following services:

- Telephone consultations;
- Meeting with the member or member's family for the sole purpose of reviewing evaluation and/or results;
- Missed appointments, including but not limited to, canceled appointments and appointments not kept;
- Services not meeting the definition of Medical Necessity;
- Time spent in preparation of reports;
- A copy of medical report when the agency paid for the original service;
- Experimental services or drugs;
- Any activity provided for leisure or recreation; or
- Services rendered outside the scope of a provider's license.

504.23 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

In addition, BMS requires that providers register and receive prior authorization for **all** Behavioral Health Intensive Outpatient Services (IOS), Community Psychiatric Supportive Treatment Services, and PHP services. Prior authorization must be obtained from the BMS' UMC or MCO and requests must be submitted within the timelines and in the manner required by the BMS' UMC or MCO.

General information on prior authorization requirements for additional services and contact information for submitting a request may be obtained by contacting the BMS' UMC or MCO.

504.24 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. Providers must also comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service;
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater;
- Failure to maintain all required documentation may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request; and
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

504.25 BILLING PROCEDURES

Claims from providers must be submitted on the BMS' designated form or electronically transmitted to the BMS fiscal agent and must comply with the following:

- Must include all information required by the BMS to process the claim for payment;
- The amount billed to the BMS must represent the provider's usual and customary charge for the services delivered;
- Claims must be accurately completed with required information;
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures; and
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abuse and Neglect: As defined in and West Virginia Code §9-6-1 and West Virginia code §49-1-201.

Advanced Alcohol and Drug Counselor (AADC): Professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Advanced Practice Registered Nurse (APRN): As defined in West Virginia Code §30-7-1**:** An RN who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to members, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An APRN shall meet all the requirements set forth by the board by rule for an APRN that shall include, at a minimum, a valid license to practice as a Certified Registered Nurse Anesthetist, a Certified Nurse Midwife, a Clinical Nurse Specialist or a Certified Nurse Practitioner.

Alcohol and Drug Counselor (ADC): Professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

American Society of Addiction Medicine (ASAM®) Criteria: The ASAM® has established guiding criteria to be used for assessment, service planning and level of care placement.

Behavioral Health Condition: A mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment.

Clinical Staff: The individuals employed by or associated with a MAT program who provide treatment, care or rehabilitation to program members or members' families.

Clinical Supervisor (CS): Certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Contracted Agent: A party that has express (oral and written) or implied authority to act for the Department, performing specific tasks under contractual arrangements.

Coordination of Care: Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to Medicaid members.

Critical Juncture: Any time there is a significant event or change in the member's life that requires a treatment team meeting. The occurrence constitutes a change in the member's needs that require services, treatment, or interventions to be decreased, increased or changed. The member's needs affected would be related to their behavioral health, physical health, change in setting or crisis.

Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

Direct Access Personnel: An individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

Direct Supervision: Supervision that is provided by a licensed individual who monitors OTP providers, and is required to be present in the setting when services are being rendered.

External Credentialing: A process by which an individual's external credential is verified to provide Medicaid IOP services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Flexible Capacity: Facilities approved to operate both a 3.1 and 3.5 level program at the same site may utilize any available program space for a member to enter the program, but the member must still receive the services from the member's assessed level of need. Note: ASAM Level 3.3 and 3.7 programs cannot utilize flexible capacity.

Freedom of Choice: The guaranteed right of a member to select a participating provider of their choice.

Foster Child: The DHHR defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Human Services Degree: A master's or bachelor's degree granted by an accredited college or university in one of the following human services fields:

- Psychology
- Criminal Justice
- Nursing
- Sociology
- Social Work

- Counseling/Therapy
- Teacher Education
- Behavioral Health
- Other Degrees approved by the West Virginia Board of Social Work.

(Note: Some services require specific degrees as listed in the manual. See specific services for detailed information on staff qualification.)

Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Indirect Supervision: Supervision that is provided by a licensed individual who monitors OTP providers, but is not required to be present, in the setting when services are being rendered.

Intensive Outpatient Services (IOS): A combination of specific services for a targeted population to be used on a frequent basis for a limited period of time. Approval for an IOS program and prior authorization for members admitted to an IOS program must be obtained by contacting the UMC.

Internal Credentialing: An individual approved to provide SUD services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Licensed Independent Clinical Social Worker: An individual who has obtained Level D status as defined by the West Virginia Board of Social Work and by West Virginia Code §30-30-9.

Licensed Practical Nurse (LPN): An individual who has completed the Licensed Practical Nurse program from an accredited school and who is licensed by the WV State Board of Examiners for Licensed Practical Nurses.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the WV Board of Examiners of Psychologist and is in current good standing with the board.

Master Addiction Counselor: A voluntary national certification intended for professionals working within substance use disorder/addiction-related disciplines wishing to demonstrate their skills gained through supervised work experience and specific graduate course work.

Medication Assisted Treatment (MAT): The use of FDA-approved medications in combination with evidence-based behavioral therapies to provide a whole-member approach to treating SUDs.

Medical Clearance - Medical clearance means the patient is stable enough to benefit from the program and is not likely to experience medical complications that could prove harmful.

Methadone: A synthetic opiate. The most common medical use for methadone is as a legal substitute for heroin in treatment programs for drug addiction.

Naloxone: A drug that antagonizes morphine and other opiates. Naloxone is a pure opiate antagonist and prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension. Sold under the brand name of Narcan® and in combination with buprenorphine as Suboxone®.

National Certified Addiction Counselor (NCAC): A voluntary national certification intended for professionals working within substance use disorder/addiction-related disciplines wishing to demonstrate their skills gained through years of supervised work experience and specific course work. Designated as Level I or Level II.

Office of Health Facility Licensure and Certification (OHFLAC): The office designated by the DHHR to determine whether facilities comply with federal and state licensure and State certification standards.

Physician: As defined in West Virginia Code Annotated §30-3-10, an individual who has been issued a license to practice medicine in the state of West Virginia by the West Virginia Board of Medicine and is in good standing with the board; or an individual licensed by the West Virginia Board of Osteopathy in accordance with West Virginia Code Annotated 30-14-6.

Physician Assistant (PA): An individual who meets the credentials described in West Virginia Code Annotated, §30-3-13 and §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct member care services under the supervision of a physician.

Physician Extender: A medical professional including an APRN and PA functioning within his or her legal scope of practice.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered Professional Nurses.

Satellite Location: A small or branch facility that is physically at a distance from the original or main facility location.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Self-Administered Medicine: Self-Administration of a patient's medicine is accomplished by having a nurse or other identified staff member observe the member taking their own medication. The program must ensure that all medication for patients are kept in a secure area and only given to the patient during times for self-administration of their medicine.

Substance Use Disorder (SUD) Services: Services that are medical or remedial that recommended by a physician, physician extender, licensed psychologist, or supervised psychologist for the purpose of reducing a physical or mental disability and restoration of a member to his/her pre-morbid functioning level. These services are designed for all members with conditions associated with substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. SUDs occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the current DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. SUD Services may be provided to members in a variety of settings, including in the home, community, or a residential program, but do not include

services provided in an inpatient setting.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D, or Ed.D. and has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision program.

Utilization Management Contractor (UMC): The contracted agent of the BMS.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Substance Use Disorder Services	January 14, 2018
Entire Chapter	Added new policies in section 504.15 – 504.20 including, but not limited to, Residential Treatment Services and Peer Recovery Support Specialists Updated existing policies throughout including, but not limited to, Methadone Medication Assisted Treatment (MAT) in Section 504.13	July 1, 2018
Entire Chapter	Updated existing policies throughout including, but not limited to, Peer Recovery Support Specialists (504.15) and Residential Treatment Services (504.18).	July 1, 2019