CHAPTER 504 SUBSTANCE USE DISORDER SERVICES

TABLE OF CONTENTS

SECTION **PAGE NUMBER**

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 Human Services (DoHS) 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 DoHS 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 to 21 years old. 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 Social Services (BSS), 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

This chapter describes the provider enrollment, training, staffing, documentation, and other administrative and clinical requirements that licensed behavioral health centers (LBHCs), certified community behavioral health clinics (CCBHCs), and comprehensive behavioral health centers (CBHCs) must comply with in order to deliver SUD services covered by this chapter.

In order to bill for covered SUD services, LBHCs, CCBHCs, and CBHCs must comply with all requirements of this Chapter.

Providers permitted to deliver peer recovery support specialist (PRSS) services pursuant to this Chapter that are not LBHCs, including CCBHCs or CBHCs, must comply with all requirements as described in Section 504.15, Peer Recovery Support Specialist Services and be in compliance with all requirements found in the applicable BMS Policy Manual for the following provider type:

- Federally qualified health centers pursuant to *Chapter 522, Federally Qualified Health Center and Rural Health Clinic Services*.
- Hospitals pursuant to *Chapter 510, Hospital Services' Policy 510.4, Outpatient Hospital Services, Section 510.4.1.2, Emergency Room Services.*
- Drug-Free Moms and Babies pursuant to *Chapter 521, Behavioral Health Outpatient Services' Appendix 521B, Drug-Free Mom and Baby Programs.*

504.1 MEMBER ELIGIBILITY

SUD Waiver services are available to all adult Medicaid members with a known or suspected SUD. 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 the 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, licensed psychologist, licensed independent clinical social worker (LICSW) or licensed professional counselor (LPC)
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 guided by the American Society of Addiction Medicine (ASAM®) criteria and assessment.

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 the 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

All providers delivering services covered by this Chapter must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*.

LBHCs, including CCBHCs, and CBHCs delivering services under this Chapter must follow Enrollment Requirements as described in *Chapter 503. Licensed Behavioral Health Centers, Section 503.3, Provider Enrollment.*

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

Effective January 1, 2026, all residential SUD treatment facilities, including facilities already in operation as of January 1, 2026, must obtain accreditation in addition to the West Virginia licensure within one year of operation. New residential providers enrolled after January 1, 2026, will have one year within starting operations to meet this requirement. Residential treatment facilities must be licensed by the West Virginia Office of Health Facility Licensure and Certification (OHFLAC) and accredited by one of the following entities: the Commission on Accreditation of Rehabilitative Facilities (CARF), Joint Commission, or Det Norske Veritas (DNV).

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 the 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 Variance for Peer Recovery Support Specialist

A variance is available to applicants for 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 VariancesWVcares@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

Providers delivering services under this Chapter must ensure that all staff delivering direct services receive appropriate clinical supervision.

All providers must adhere to service-specific supervision and other requirements as noted throughout this Chapter. LBHCs and CBHCs delivering services under this Chapter must follow the requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.5. Clinical Supervision*. LBHCs, that are CCBHCs, must follow additional requirements as described in *Appendix 503I, Certified Behavioral Health Clinics*.

504.6 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES REQUIREMENTS

Enrollment requirements, as well as the 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 the BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Information* and are subject to review by state and federal auditors.

504.7 PROVIDER REVIEWS

LBHCs, including CCBHCs and CBHCs delivering services under this Chapter, must follow Provider Review requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.8, Licensed Behavioral Health Center Provider Reviews*. Drug-Free Mom and Baby Programs, federally qualified health

centers (FQHC), and Emergency Department (ED) providers must follow Provider Review requirements pursuant to *Appendix 521B, Drug-Free Mom and Baby Programs*, *Chapter 522, Federally Qualified Health Center and Rural Health Clinic Services* and *Chapter 510.4, Section 504.4.1.2, Emergency Room Services.*

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

LBHCs, CCBHCs, and CBHCs delivering services under this Chapter must follow administrative requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.10. Other Administrative Requirements*.

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. 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

LBHCs, CCBHCs, and CBHCs delivering services under this Chapter must follow Documentation requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.13, Documentation* in addition to confidentiality and Health Insurance Portability and Accountability Act (HIPAA) adherence requirements below.

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 a 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, is 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 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 the 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

Refer to *Chapter 503, Licensed Behavioral Health Centers. Section 503.14 Assessment Services*.

504.12.1 Mental Health Assessment by Non-Physician

Refer to *Chapter 503, Licensed Behavioral Health Centers Section 503.14.1, Mental Health Assessment by Non-Physician*.

504.12.2 Psychiatric Diagnostic Evaluation (No Medical Services)

Refer to *Chapter 503, Licensed Behavioral Health Centers, Section 503.14.2, Psychiatric Diagnostic Evaluation*.

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

Refer to *Chapter 503, Licensed Behavioral Health Centers Section 503.14.3, Psychiatric Diagnostic Evaluation with Medicaid Services*.

504.13 METHADONE MEDICATION ASSISTED TREATMENT (MAT)

Refer to *Chapter 519.22, Mental Health Counseling and Substance Use Treatment, Section 519.22.2 Methadone Opioid Treatment Program*.

504.14 NALOXONE ADMINISTERED BY EMERGENCY MEDICAL SERVICES (EMS)

Refer to *Chapter 519.22, Mental Health Counseling and Substance Use Treatment, Section 519.22.4, Naloxone Administered by Emergency Medical Services*.

504.15 PEER RECOVERY SUPPORT SPECIALIST SERVICES

PRSS services facilitate recovery from SUD. 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.

PRSS services are delivered by individuals who have common life experiences with addiction, treatment, and recovery and are certified through the appropriate entity as defined by the BMS. Individuals with SUD, who are successful in their own recovery, have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. Peers bring hope to people in recovery and promote a sense of belonging within the community. PRSS services is a nationally recognized, evidence-based model of care which consists of a qualified PRSS who assists members with their recovery. These services can be an important component in promoting and sustaining long-term recovery.

PRSS are for individuals with SUD or co-occurring substance use and mental health disorders. PRSS services may be provided to eligible individuals ages 16 years or older for SUD/co-occurring mental health disorders with the SUD being the primary focus. PRSS working with eligible 16- and 17-year-old members must provide services using a family engagement approach, working with both the member and their family to help support the member's needs in an age-appropriate manner.

PRSS services are delivered through community providers or through ED-based providers.

PRSS services delivered in the community (community PRSS services) are provided by a qualified and certified PRSS employed by one of the following provider types:

- CBHC or LBHC, as defined in Chapter 64 of the WV State Code;
- CCBHC, as defined in *Appendix 503I, Certified Community Behavioral Health Clinics*;
- FQHC that meets the definition of an FQHC at 42 CFR § 405.2401 and defined in West Virginia Legislative Rules 64 CSR-70.3.10;
- Drug-Free Mom and Baby programs, per *Appendix 521B, Drug-Free Mom and Baby Programs*.

ED-based PRSS services (PRSS-ED) are delivered in a Hospital ED that meets the requirements as described in West Virginia Code Health and Human Resources Licensure Sec. 64-12-8.11. See Section 504.15.2, Peer Recovery Support Specialist Emergency Department Services. PRSS-ED services delivered in the Emergency Department must directly relate to the primary reason for the visit, as documented by the patient's history, physical findings, or laboratory results. The individual must also be alert and oriented to benefit from these services. For instance, PRSS-ED services should not be administered in situations where there is an absence of recent problematic substance use, or when the individual is sedated or experiencing severe psychosis or delirium.

504.15.1 Community Peer Recovery Support Specialist Services

Procedure Code:	H0038; with modifier HB added for FQHCs (billed outside the FQHC encounter rate on CMS 1500 Form).
Service Units:	15 Minutes
Service Limits:	12 units per Calendar Day per member
Prior Authorization:	Required
Telehealth:	Available

Staffing Limitations: A member may not be receiving services from more than one PRSS at a time, unless in cases of crisis or similar extenuating circumstances. ***Group and/or parent peer support services are not a covered service.***

Community PRSS services are included in the CCBHC per diem rate. Refer to *Appendix 503I, Certified Community Behavioral Health Clinics*.

Community PRSS services are included in the Drug-Free Mom and Babies (DFMB) Program bundled rate. Refer to *Chapter 521 Appendix B Drug-Free Mom and Babies Programs*.

Service Definition: Community PRSS services are direct recovery services and supports delivered in the community that assist members in their recovery from SUD. Community PRSS services can be provided at the beginning of SUD treatment and may continue through the entire continuum of care. All community PRSS services are delivered pursuant to the members' Person-Centered Service Plan, and in coordination with the member's treatment team, to support the achievement of specific goals as documented in the individual's current service plan. A specific recovery plan is to be developed as part of the Service Plan, and express the individual's health and wellness goals, plans for building a support network, and short and long-term recovery goals as identified by the individual.

A member may not receive PRSS services from more than one agency at a time.

PRSS services are delivered by an identified, primary PRSS. PRSS services may be provided by an alternate PRSS if, due to documented, unforeseen, or urgent circumstances, the primary PRSS is temporarily unavailable to provide PRSS services.

Community PRSS services include one or more of the following activities:

- Coaching, modeling, and mentoring to help the member restore skills to:
  - Fully engage in making informed, healthy, and independent choices to further their recovery goals.
  - Develop informal networks for information and recovery support.
  - Manage self-referral, access appropriate care, and communicate effectively with health care providers.
- Providing guidance and support to the member in developing and implementing a recovery, crisis, and/or relapse plan, including:
  - Providing education on relapse prevention
  - Helping the member identify early signs of relapse
  - Developing/sharing/practicing strategies with the member to manage stress, prevent crisis or avoid relapse
  - Identifying and providing linkages to pro-social activities and alternatives to substance use
  - Providing guidance to the member on how to effectively implement the recovery, crisis, or relapse plan.
- Sharing and explaining information and resources about prevention, treatment, and recovery within the behavioral health system and in the community.
- At the individual's request, advocating for and/or amplifying the concerns of the individual related to medication or other treatment interventions.
- Coordinating with the member's treatment team to enhance treatment and recovery goals, including goals for health-related social needs such as housing and employment.

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

Role Description: A PRSS provides Community PRSS services as described in this section, as a self-identified individual successful in the recovery process with lived experience with SUD or co-occurring mental health disorder and SUD. The PRSS should not perform services outside of the boundaries and scope of their expertise, should be aware of the limits of their training and capabilities, and should collaborate with other professionals and recovery support specialists to best meet the needs of the member served.

The BMS only recognizes PRSS as individuals who have direct, lived, personal experience with addiction and recovery.

Providers should ensure that the services that are delivered are based upon the service definition of the procedure code that is being billed. Individuals may fulfill several roles such as PRSS, supportive counselor, targeted case manager, or paraprofessional, but services are limited to the definition of the service code and documents must be signed using the correct credential. Furthermore, providers must ensure that dual role employees are not subjected to ethical conflicts or boundary issues that arise from possible dual relationships.

Community PRSS services are provided pursuant to a person-centered service plan, which must be developed as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.16 Service Planning Requirements*. The plan must include participation by the PRSS who shall have a specific goal/goals and objective(s) that pertain to his/her activities and responsibilities with the member.

Prior authorization for community PRSS services is required. Members may receive a maximum of three hours (12 units) of services per calendar day. Additional units of services may be approved as an exception with documentation of medical necessity. Providers must request prior authorization for any additional units of services provided over the 12-unit limit. Members requiring consistent or consecutive daily use of large number of units in any four-week period must be reassessed for the need for a higher level of care. This assessment should be documented in the members' file and conducted pursuant to *Chapter 503, Licensed Behavioral Health Center, Section 503.14, Assessment Services*. Members must have their Service Plan reviewed at least every 90 days. The PRSS shall perform and document a review of the recovery plan with the member at least every 30 days. If the recovery plan review results in a change in services, frequency, or other material change, the recovery plan shall be reviewed with the team and signed by the team clinician.

Community PRSS Service Criteria: In order to receive Community PRSS services, individuals must meet the following:

1. An individual has a SUD, based on an assessment using nationally recognized assessment tool or equivalent evidence-based assessment, meets at least ASAM® level 1.0, indicating the need for outpatient substance use treatment, and
    a. Has a demonstrated need as described in the members' Service Plan for Community PRSS services in order to gain skills and supports to:
        i. Initiate, engage, or stay engaged in treatment and recovery and/or
        ii. Manage recovery and self-care of physical and behavioral health, including building capacity for self-help and self-advocacy, relapse prevention, crisis planning, and accessing crisis and other community supports needed for recovery.

Discharge Criteria: Continuing need for Community PRSS services must be documented in the member's person-centered service plan. Services may be terminated when it is determined that the member no longer needs Community PRSS services to support progress on the goals and objectives described in the member's Person-Centered Service Plan; when the member is deemed to no longer be receiving a benefit from the service as

documented in the service plan; when the member no longer wishes to receive the service as documented in the service plan; or when it is determined that the individual no longer meets eligibility criteria as described above.

Limitations/exclusions for community PRSS services include but are not limited to:

- Community PRSS services may be provided in any location except at the PRSS' home. Services must be delivered in a safe, harm-free environment that maintains confidentiality standards per HIPAA and 42 CFR Part 2.
- Telehealth may be utilized for community PRSS services per this Chapter and *Chapter 519.17, Telehealth Services* and must follow all West Virginia Medicaid Guidelines.
- Community PRSS services may not be provided while a member is at an Alcoholics Anonymous (AA) meeting or other SUD or behavioral health mutual support meeting.
- PRSS may not bill for time spent waiting with a member for the member's medical or other appointments.
- Community PRSS services may not be provided in lieu of foster care and/or family visitation services, or in transport to any other services.
- PRSS may not bill for drug screens administered to members.
- PRSS may not bill for leisure or recreational activities, or for attendance at faith-based gatherings.
- Community PRSS services may not occur during transportation of a member. Any travel time is accounted for within the existing PRSS hourly rate. Travel time may not be billed separately.
- Community PRSS services may not be provided during the same time at the same place as any other direct-support Medicaid service, except:
    - Community PRSS services may be billed in addition to a facility per diem rate or Diagnostic Related Group (DRG) case rate for services when provided in Hospital Emergency Departments and shall not duplicate services reimbursed under those payments.
    - Community PRSS services must be billed as a claim outside the encounter rate for other services when provided by FQHCs and shall not duplicate services reimbursed under the encounter rate.
    - Community PRSS services may be billed in addition to indirect (non-face-to-face) TCM services, but should not duplicate services reimbursed by TCM payments.

Staff Credentials: A PRSS is an individual who has the qualifications, education, and established experience to perform PRSS tasks. The PRSS is qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of SUDs, to provide peer support as a self-identified individual successful in the recovery process with lived experience with SUD, or co-occurring mental health and SUD, and to offer support and assistance in helping others in the recovery and community-integration process. BMS only recognizes certified PRSS who have direct, lived, personal experience with SUD and recovery.
PRSS must have a valid and active West Virginia Certification Board for Addiction and Prevention Professionals (WVCBAPP) Peer Recovery Certification and must maintain all requirements for continuation of that certification. Additional information and the application for the Peer Recovery certification can be found on the WVCBAPP website.

Additionally, a PRSS must:

- Have a National Provider Identifier (NPI) and be a Medicaid enrolled provider;
- Possess a current CPR/First Aid card;
- Complete a fingerprint-based background check. Please see Section 504.4, Fingerprint-Based Background Checks for more information;
  Be directly employed by, not contracted with, an approved provider; and
- Be enrolled with the fiscal agent through their employer and claims must include their NPI as the rendering provider.

The PRSS must complete specific training within 30 days of employment, and prior to billing for any services provided. This includes, but is not limited to:

- Member rights
- Confidentiality/HIPAA
- Crisis Intervention

Documentation of all requirements, including certification, must be maintained in the PRSS personnel files by the PRSS employer.

Supervision: PRSS must receive supervision from qualified supervisory staff in accordance with certification board supervision requirements. Refer to the WVCBAPP for supervision requirements.

Service Documentation: Community PRSS services are delivered pursuant to a member's current person-centered treatment plan; see policy manual *Chapter 503, Licensed Behavioral Health Centers, Section 503.15.1, Psychological Testing with Interpretation and Report*.

Documentation of all services delivered must be maintained in the member's medical record and include the following:

- Member name;
- Date, location, and start/stop time of service/meeting;
- Signature and credentials of the staff providing the service;
- Facility where the provider is employed;
- Activity note; for each service, describe:
    - The goal or objective referenced in the individual's current, approved person-centered treatment plan
    - How the community PRSS service supports the goal or objective
    - A description of the specific activity or activities under one of the following categories:
        - Coaching, modeling, and mentoring to help member restore skills.
        - Providing guidance and support to the member in developing and implementing a recovery, crisis, and/or relapse plan.
        - Sharing and explaining information and resources about prevention, treatment, and recovery within the behavioral health system and in the community.
        - At individual's request, advocating for and/or amplifying the concerns of the individual related to medication or other treatment interventions.
        - Coordinating with the member's treatment team to enhance treatment and recovery goals, including goals for health-related social needs such as housing and employment.

NOTE: More than one type of service and/or activity may be provided at any (one) meeting.

Recovery Plan: A recovery plan/strategy shall be developed as part of the members' Service Plan to reflect recovery goals and objectives, and the specific services and supports the PRSS will provide to support the member in achieving them. If clinical services have been terminated but recovery services continue, a recovery plan/strategy is developed to reflect recovery goals and objectives. This should include determining wellness markers, the member's hopes and short and long-term recovery goals, recognizing triggers, determining warning signs and managing crisis. PRSS should be able to recognize signs of relapse and assist in making appropriate referrals to clinical services if a relapse occurs. This recovery plan should be reviewed at least every 30 days and must be signed and reviewed/ updated in conjunction with the member's Service Plan every 90 days.

504.15.2 Peer Recovery Support Specialist Emergency Department Services (PRSS-ED)

Procedure Code:	**H0038 ET billed on CMS 1500 Form**
Service Unit:	15 Minutes
Service Limits:	8 units per Calendar Day per member
Prior Authorization:	Not Required
Telehealth:	It is the expectation that PRSS-ED services should be via in-person, face-to-face encounters.
Limitations:	**Group and/or parent peer support services are not a covered service.**

Service Definition: PRSS-ED are nonclinical supports that assist members in their recovery from SUD. PRSS-ED are short-term services provided to an individual presenting at an ED with a SUD or suspected SUD. PRSS-ED Services are only billable within the ED setting. These services focus on engagement, outreach, and facilitating linkages, referrals, and warm or real-time hand-offs to community SUD providers, including community PRSS. PRSS-ED services are only provided in conjunction with the use of ED services and may not be billed for subsequent, non-emergency visits.

PRSS-ED Services include the following supports, as appropriate and necessary in the context of the short-term nature of this intervention:

- Engagement and Support: Engages, listens, and provides support.
- Information Sharing: Discusses the recovery process, provides information, offers options to encourage follow up and referral to services.
- Recovery Planning: Supports member in developing a brief plan and provides referrals, linkages and (when possible) warm hand-offs to identify services/supports.
- Self-Advocacy: Assists the individual in participating in and directing their immediate treatment and recovery needs.
- Advocacy: At the individual's request, advocates for and/or amplifies the concerns of the individual related to medication or other treatment interventions.

NOTE: More than one type of service and/or activity may be provided at any (one) meeting.

Service Eligibility Criteria: In order to receive PRSS-ED, individuals must be admitted to the ED, have a SUD or suspected SUD, and be referred to PRSS-ED by a qualified healthcare provider acting within the scope of their license.

SUD or suspected SUD may be verified by:

- Observing visible signs of intoxication and/or SUD withdrawal, and/or
- A drug screen; and
- A history of SUD based on one or more of the following:
  - Medical record,
  - Medical history, and/or
  - Physical exam

Role Description: The PRSS providing PRSS-ED services shall not perform services outside of the boundaries and scope of their expertise, shall be aware of the limits of their training and capabilities, and shall collaborate with other professionals and recovery support specialists to best meet the needs of the member.

Providers should ensure that services delivered are based upon the service definition of the procedure code that is being billed. The PRSS in this setting must ensure that linkages and referrals take place, including follow up to community providers.

Limitations:

- PRSS-ED Services are provided pursuant to a recommendation or referral from a qualified healthcare professional.
- PRSS-ED Services are only delivered within the ED of a hospital licensed pursuant to West Virginia Code Health and Human Resources Licensure Sec. 64-12-8.11.
- PRSS-ED Services may not be billed during transportation of a member or during other recovery services such as group recovery meetings.
- PRSS-ED Services may not be provided during the same time as any other direct support Medicaid service, except:
    - PRSS-ED Services may be billed in addition to services provided in Hospital EDs and shall not duplicate services reimbursed under those payments.

Staff Credentials: A PRSS providing PRSS-ED Services must have the qualifications, education, and established experience to perform PRSS tasks. The PRSS is qualified and trained to provide collaborative services to assist members in achieving sustained recovery from SUDs, to provide peer support as a self-identified individual successful in the recovery process with lived experience with SUD, or co-occurring mental health and SUD, and to offer support and assistance in helping others in the recovery and community-integration process. The BMS only recognizes PRSS who have direct, lived, and personal experience with SUD and recovery.

A PRSS providing PRSS-ED Services must have an NPI. The PRSS must have a valid and active WVCBAPP Peer Recovery Certification and must maintain all requirements for continuation of that certification. Additional information and the application for the Peer Recovery Certification can be found on the WVCBAPP website. Additionally, a PRSS providing PRSS-ED Services must:

- Possess a current CPR/First Aid card;
- Complete a Fingerprint-Based Background Check. See Section 504.4, Fingerprint-Based Background Checks for more information;
- Be employed by a licensed hospital;
- Be enrolled with the fiscal agent through their employer and claims must include their NPI as the rendering provider; and
- Complete specific training within 30 days of employment, and prior to billing PRSS Services.

Training includes, but is not limited to:

- Member rights
- Confidentiality/HIPAA
- Crisis Intervention

Documentation of staff credential requirements, including certification, must be maintained in the PRSS personnel files by the applicable PRSS employer.

Supervision: A PRSS providing PRSS-ED services must receive supervision from qualified supervisory staff in accordance with certification board supervision requirements. Refer to the WVCBAPP for supervision

requirements. The employer may have a memorandum of understanding or contract with a local community provider to provide additional supervision as necessary to meet this standard.

Service Documentation: Documentation of PRSS-ED Services must be maintained in the member's medical record and contain the following:

- Member name, date of birth, and contact information;
- Date, location, and start/stop time of service/meeting;
- Signature and credentials of the staff providing the service;
- Facility where the provider is employed;
- Activity note. For each service, describe:
    - A description of the activity or activities:
      Engagement and Support
        - Information Sharing
        - Recovery Planning
        - Self-Advocacy
        - Advocacy
    - Documentation of referral, linkage, or next step identified as a result of the intervention, if any.

NOTE: More than one type of service and/or activity may be provided at any (one) meeting.

Discharge Criteria: PRSS-ED Services are provided as a short-term intervention that terminates when the member is deemed to no longer be receiving a benefit from the service; when the member no longer wishes to receive the service, or upon discharge/release/transfer from the facility, whichever is first.

504.16 INTENSIVE OUTPATIENT SERVICES

Refer to *Chapter 503, Licensed Behavioral Health Centers (LBHC).*

504.17 PARTIAL HOSPITALIZATION PROGRAM

Refer to *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. Duration of residential services are based on medical necessity. Individuals placed in these levels of care are unable to be treated on an outpatient basis effectively. The level of care that an 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 it is 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:

- Delivering services in accordance with an evidence-based treatment modality;
- Visitation guidelines and/or restrictions;
- Facility responsibility for working with the family;
- Providing for basic needs while a member resides there;
- Ensuring appropriate linkage and transportation if to appropriate care and/or housing if the residential setting is determined not appropriate.
- Contraband guidelines and restrictions; and
- Any other appropriate issues.

To be reimbursed, the provider must be licensed by OHFLAC as an LBHC or hospital, 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 or hospital 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.

Providers must adhere to the approved schedule of staffing and clinical hours as submitted to the BMS. If a provider chooses to change the clinical hours they have previously been approved to provide, they must submit a written notice to the BMS no less than 30 days in advance of the change. The written notice must describe the impact, if any, to the level of care and/or treatment plans of individuals currently receiving treatment at the facility, how impact will be addressed, and the impact, if any, on the facility's ability to continue offering the applicable level of care.

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. **Residential Provider Change in Operations**: If facilities experience an emergency and must temporarily or permanently disband and/or end

operations, the provider facility must notify and provide a list of affected members to the BMS, OHFLAC, and MCOs. The provider must document and share discharge plans as applicable with the entities. Providers must also adhere to any processes and requirements in OHFLAC regulation 11.1, related to emergency planning and response. This applies to all levels of SUD RAS.

No less than 30 days prior to purchase, merger, or other change of ownership or authority of a residential facility, whether to an individual, partnership, corporation, nonprofit corporation, or other entity, the provider must notify the BMS in writing of the planned change. The BMS will review the change to determine whether or not the facility will need to submit a new application for review to the BMS.

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

- A 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 and level of care;
- 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 members' participation in the services. The attending staff must sign, list their credentials, and date this summary;
- Medication administration records;
- Urine drug screen records: refer to *Chapter 529.2, Drug Screenings*.
- 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 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.
- Providers must receive and document verbal physician's orders if an individual is transitioned to a different level of RAS care in-house, and written permission if the individual is being transitioned to another RAS.

Each member's level of care will be determined, based on ASAM® assessment, 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 receiving RAS may not receive day treatment, crisis stabilization, assertive community treatment and/or CCBHC services on the same day as RAS 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, there must be no more than 12 members per group, and they must maintain all levels of approved programming based on the member's assessed need.

Service Planning: LBHCs, CCBHCs, and CBHCs must follow Service Planning requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section 503.16, Service Planning Requirements*.

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. Refer to *Chapter 503, Licensed Behavioral Health Centers, Section 503.16 Service Planning Requirements* for additional service planning requirements.

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. Service Plan reviews must be conducted by the treatment team, and include a review of goals, progress made, and continued barriers to discharge or step down to another level 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. Provider re-certification and documentation reviews must happen every two years.

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*.

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 International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (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 accordance with 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 am/midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: Codes within the bundled rate may not be billed outside of the bundle. 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 Specialist (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) - see *Chapter 529.2, Drug Screenings* for additional information.

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503, Licensed Behavioral Health Centers* and *Chapter 519.22, Mental Health Counseling and Substance Use Treatment* for MAT in the residential setting. If a member is in a Residential Setting, they must still meet the criteria and policy requirements stated in *Chapter 503, Licensed Behavioral Health Centers* *and* *Chapter 519.22, Mental Health Counseling and Substance Use Treatment*.

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 indicating appropriate level of care (using the ASAM® criteria or another evidence-based, nationally recognized SUD assessment) include:
    - Inability to apply recovery skills.
    - Lack of personal responsibility in relation to diagnosis.

- Inability to maintain employment and/or able to work part-time (to a maximum of 20 hours per week) outside the facility while receiving treatment, gaining 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. Individuals receiving RAS Level 3.1 are permitted to work no more than 20 hours a week.

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. Clinical services must meet service definition and service documentation 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. 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 members' level of impairment is more severe at

this level, requiring services to 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 am/midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: Codes within the bundled rate may not be billed outside of the bundle. The following comprehensive array of services are included in procedure code **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 Specialist (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); additional 30 minutes (90840) each
- 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) - please see the BMS drug screening policy for additional information

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503, Licensed Behavioral Health Centers* and *Chapter 519.22, Mental Health Counseling and Substance Use Treatment* 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* *and* *Chapter 519.22, Mental Health Counseling and Substance Use Treatment*.

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 indicating appropriate level of care (using the ASAM® criteria or another evidence-based, nationally recognized SUD assessment) 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 relationships, 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. Clinical services must meet service definition and service documentation requirements.

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 function 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 am/midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: Codes within the bundled rate may not be billed outside of the bundle. The following comprehensive array of services are included in procedure code **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 Specialist (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); additional 30 minutes (90840) each
- Physician Coordinated Care Oversight Services (G9008)
- Comprehensive Medication Services (includes all nursing) (H2010)
- Drug Screenings (80305, 80306, 80307) - See BMS drug screening policy for additional information

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503 Licensed Behavioral Health Centers* and *Chapter 519.22, Mental Health Counseling and Substance Use Treatment* 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 *Chapters 503, Licensed Behavioral Health Centers and 519.22, Mental Health Counseling and Substance Use Treatment*.

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 indicating appropriate level of care (using the ASAM® criteria or another evidence-based, nationally recognized SUD assessment) include:
    - Member's impairment is considered more severe due to substance use issues;
    - Members' 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 an outpatient level of care. Clinical services must meet service definition and service documentation requirements.

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. Level 3.7 residential facilities must be separate from other levels of SUD residential care, both programmatically and physically, such as in a separate building or wing.

Requirements for admission to a Level 3.7 program include meeting medical necessity in accordance with ASAM® criteria. 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 SUD. 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 12:00 am/midnight), reimbursement then occurs for each calendar day except for the day of discharge.

Payment Limits: Codes within the bundled rate may not be billed outside of the bundle. The following comprehensive array of services are included in procedure code **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 Specialist (H0038)
- Psychotherapy Patient and Family, 30 minutes (90832); 45 minutes (90834); 60 minutes (90837)
- Psychotherapy for Crisis, Initial 60 minutes (90839); additional 30 minutes (90840) each
- 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) - See *Chapter 529.2, Drug Screenings* policy for additional information. Any needed evaluation/management services

MAT is available to members in conjunction with their residential treatment. Please see *Chapter 503, Licensed Behavioral Health Centers* and *Chapter 519.22, Mental Health Counseling and Substance Use Treatment* for 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* and *Chapter 519.22, Mental Health Counseling and Substance Use Treatment*.

Admission Criteria: The following admission criteria must be met, in alignment with ASAM® criteria used for assessing appropriate levels of care:

- 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 indicating appropriate level of care (using the ASAM® criteria or another evidence-based, nationally recognized SUD assessment) 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. Clinical services must meet service definition and documentation requirements.

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 that 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* 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* 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:

- 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 Information of the Provider Manual.

504.22 SERVICE EXCLUSIONS

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

- Telephone consultations- telehealth is permissible in instances specified above, and in accordance with the BMS telehealth policy;
- 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 the medical report when the agency paid for the original service;
- Experimental services or drugs;
- Any activity provided for leisure or recreation;
- Services rendered outside the scope of a provider's license; or
- Group psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, motion therapy, and non-directional play therapy.

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, the BMS requires that providers register and receive prior authorization for **all** Behavioral Health Intensive Outpatient Services (IOS), Community Psychiatric Supportive Treatment Services, and Partial Hospital Program (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 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 the 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: 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. This occurrence constitutes a change in the members' needs that require services, treatment, or interventions to be decreased, increased, or changed. The members' needs affected would be related to their behavioral health, physical health, change in setting or crisis.

Designated Legal Representative: 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 is provided by a licensed individual who monitors Opioid Treatment Program 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 Intensive Outpatient Program (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 DoHS 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, childcare 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 fields of human services:

- 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 Opioid Treatment Program 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 Professional Counselor (LPC): An individual who has completed the education and training requirements to be an LPC as defined by the West Virginia Board of Examiners in Counseling.

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 currently in 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.

National Certified Addiction Counselor: 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 DoHS 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.

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 is 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
Methadone Medication Assisted Treatment Section 504.13	Added First Day Service section allowing 90791 to be billable on the first day and removed 90791 from Methadone bundle.	August 12, 2020
PRSS Section 504.15.1	Updated PRSS definition, role definition, certification process, ethics, and appeals.	October 1, 2020
PRSS Section 504.15.1	Termination of the BMS PRSS certification process on September 30, 2022. Extension for the (WVCBAPP) Peer Recovery certification and National Provider Identifier Standard (NPI) to December 31, 2022. Continued reimbursement for both PRSS certification (BMS and WVCBAPP) through December 31, 2022.	October 1, 2022
PRSS Section 504.15.1	Updated credentials for PRSS to include West Virginia Certification Board for Addiction & Prevention Professional (WVCBAPP) Peer Recovery certification and National Provider Identifier Standard (NPI). Omission of the BMS PRSS Ethical Investigation.	January 1, 2023
Entire Chapter	PRSS services have been expanded upon within this policy update. The BMS has also updated policy language to make clarifications to existing policy in other areas. Specifically, BMS has made the following changes with this update: • Policy: Added clarifying language for how this 504 Chapter relates to and should be considered in conjunction with other BMS policy manual Chapters • 504.2 Medical Necessity: Updated to remove specific ASAM dimensions and requires medical necessity in alignment with ASAM criteria more broadly.	February 1, 2025

	• 504.3.1 Enrollment Requirements: CBHC and LBHC Administration: Updated to refer to Chapter 503 requirements. • 504.5 Clinical Supervision: Updated to refer to Chapter 503 requirements. • 504.7 Provider Reviews: Updated to refer to other policy Chapters, as applicable to relevant provider types. • 504.9 Other Administrative Requirements: Updated to refer to requirements in Chapter 503. • 504.10 Telehealth: Removed outdated coding information. • 504.11 Documentation: Updated to refer to requirements in Chapter 503. • 504.12 SBIRT Early Intervention; 504.12.1 Mental Health Assessment; 504.12.2, Psychiatric Diagnostic Evaluation: 504.12.3, Psychiatric Diagnostic Evaluation (with medical services): Updated to refer to requirements in Chapter 503. • 504.13 Methadone MAT: Methadone policy has been transferred to Chapter 519.22, Mental Health and Substance Use Treatment as of February 2025. • 504.14 Naloxone: Naloxone policy has been transferred to Chapter 519.22, Mental Health and Substance Use Treatment as of February 2025. • 504.15 PRSS: Created subsections 504.15.1 for Community PRSS and 504.15.2 for PRSS-ED. Expanded provider types able to provide Community PRSS and updated previous policy in areas such as allowable service limits, activities, limitation/ exclusions, and documentation requirements. 504.15.2 for PRSS-ED is a new subsection of PRSS policy as of February 2025. Adjustments have been made to each subsection of 504.15 following public comment, to clarify documentation requirements, recovery plans, the applicability of primary peers, and medical necessity. Certain references to 503 policy have been updated. • 504.16 Intensive Outpatient Services: Updated to refer to policy in Chapter 503. • 504.17 Partial Hospitalization Program: Updated to refer to policy in Chapter 503. • 504.18 RAS: Added clarification about coding in the bundled rate, and medical necessity, as well as policy references for available MAT. • 504.22 Service Exclusions: Added detail regarding certain exclusions, namely as related to telehealth and group psychotherapy services. • Glossary: Removed SBIRT, Methadone, and Naloxone definitions, as policy for these services will now be housed in *Chapter 519.22, Mental Health Counseling and Substance Use Treatment* policy manual. Added a definition for LPC.	