CHAPTER 504 SUBSTANCE USE DISORDER SERVICES

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BACKGROUND

On October 10, 2017, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid Section 1115 waiver application for the West Virginia Department of 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. On December 11, 2024, DoHS received the CMS approval for renewal and expansion of the 1115 SUD waiver. 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. Members must not be forced or coerced to choose a service 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 and other general Medicaid policy manual chapters.

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* pursuant to *Chapter 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 504.22, 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 504.22, 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 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 (JCAHO), 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. LICSWs and LPCs may also independently enroll, assuming criteria below are met.

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 calendar 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, , and Emergency Department

(ED) providers must follow Provider Review requirements, refer to *Appendix 521B, Drug-Free Mom and Baby Programs, and Chapter 510.4, Section 510.4.1.2, 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 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.

PRSS services are delivered by individuals who have lived 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 receive services billed by 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 Baby Program's bundled rate. Refer to *Chapter 521 Appendix B, Drug-Free Mom and Baby 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 Community 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(s) and objective(s) that pertain to their 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 calendar days. The PRSS shall perform and document a review of the recovery plan with the member at least every 30 calendar 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, Narcotics Anonymous (NA) 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 urine or blood 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 be used for oversight, supervision, or monitoring of individuals residing in a sober living residence or recovery home.
- 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. Providers may still bill an FQHC encounter rate on the same day as a PRSS-FQHC service.
    - Community PRSS services may be billed in addition to indirect (non-face-to-face) targeted case management services but should not duplicate services reimbursed by targeted case management 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. The BMS only recognizes certified PRSS who have direct, lived, personal experience with SUD and recovery.

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
- Have their rendering provider NPI included with their employer's claims documentation.

The PRSS must complete specific training within 30 calendar 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: The 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 service 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 service 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.
  - A description of the members' response to the PRSS activity or intervention

  - **NOTE:** More than one type of service and/or activity may be provided at any (one) meeting. Description of services provided should clearly pertain to the specific member and their individual goals. Descriptions that rely on boilerplate, standardized language, or that are limited to the service descriptions above (e.g., "Provided coaching, modeling, and mentoring to help member restore skills") will not be accepted as valid documentation.

Recovery Plan: A recovery plan is a flexible, dynamic document that is developed by the PRSS in close collaboration with the member. The recovery plan aligns with members' Service Plan, reflecting recovery goals and objectives, and the specific services and supports the PRSS will provide to support the member in achieving them. The recovery plan may be modified by the PRSS and the member informally; changes to the recovery plan should be discussed and coordinated with the members' treatment team. Changes to the recovery plan do not need to be reviewed and signed by the treatment team.

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 hospital-based ED setting; outpatient medical centers are not eligible settings for PRSS-ED services. 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;
- Have their rendering provider NPI included with their employer's claims documentation; and
- Complete specific training within 30 calendar 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
    - A description of the members' response to the PRSS activity or intervention:
    - 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. Description of services provided should clearly pertain to the specific member and their individual goals. Descriptions that rely on boilerplate, standardized language, or that are limited to the service descriptions above (e.g., "Provided engagement and support" will not be accepted as valid documentation.

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*.

504.17 PARTIAL HOSPITALIZATION PROGRAM

Refer to *Chapter 510.2, Partial Hospitalization Program* of the BMS Provider Manual.

504.18 RESIDENTIAL ADULT SERVICES

Residential adult services (RAS) are comprehensive, team-based services for adults ages 18 and older who have been diagnosed with a SUD and/or co-occurring SUD/mental health disorder. Individuals placed in these levels of care are unable to be treated effectively on an outpatient basis. The level of care that an individual is placed in is based upon medical necessity and the most recent ASAM® criteria.

Residential treatment provides members with a structured, therapeutic living environment as well as specific covered services provided pursuant to an individualized service plan.

This policy establishes residential treatment criteria in accordance with ASAM® guidelines, reflecting assessment, care planning, and treatment standards that are effective in promoting recovery for individuals receiving residential care.

Medical Necessity

Level of care and duration of treatment in RAS is based on medical necessity, which is documented through a person-centered assessment process pursuant to the most recent ASAM® guidelines. The BMS reimburses RAS providers for medically necessary services without regard to a predetermined program length. Members receiving services are not bound by predetermined length or duration of stay based on RAS programming. Members should remain in the RAS setting only while individually determined medical necessity is met. The length of stay for each member will vary.

Each member's level of care is determined based on an ASAM® assessment when prior authorization for RAS services is requested through the UMC or MCO. Please refer to Section 504.22, Prior Authorization of this chapter.

RAS providers are required to use an approved MCO utilization management tool, for authorization of admission and continued stay for managed care members.

RAS Program Requirements

Policies and Procedures: RAS providers must have written policies, procedures, and/or standards that describe:

- Processes to ensure that consistent use of ASAM® clinical assessment, service planning, and discharge planning occur throughout the length of stay, including discharge planning that:
    - Is based on an individual service plan
    - Supports an appropriate continuum of physical and behavioral health care for the individual post-discharge, including MAT, if applicable
    - Anticipates and addresses health-related social needs, including housing, employment, and transportation
    - Facilitates systematic coordination with members' MCO
    - Coordinates and shares necessary health information with community providers
    - Identifies discharge challenges and mitigation strategies, if applicable
- The facility's multidisciplinary team approach, the 24 hours a day, seven days a week (24/7) structured, therapeutic environment, specific evidence-based treatment models used at the facility and how these models are supported, and incorporation of trauma-informed care into service delivery and training.
- Staff qualifications, including education, licensure, expertise, and/or training that reflect and ensure service delivery standards and agency's ASAM® level(s) of care.

- Processes that describe for non-clinical staff when to contact medical personnel (i.e., physician/physician extender, addiction specialist physician, or psychiatrist).
- Processes to ensure assessment, triage, and treatment of co-occurring disorders.
- Processes to ensure medication review services are available to all members admitted to the service.
- Processes to encourage and facilitate family and support system involvement, where appropriate.
- Processes to ensure RAS can always provide behavioral health crisis services.
- If the RAS provider does not provide MAT directly, a description of how the program screens for, ensures, and facilitates access to all Food and Drug Administration (FDA) approved MAT for members, including continuation of MAT for individuals admitted who are already receiving these services.
- RAS withdrawal management protocol that is clinically and medically appropriate for the population served.
- Procedure for storage and access to overdose reversal medication on site.
- Processes for sharing protected health information in accordance with the OHFLAC, HIPAA, and 42 CFR part 2.
- Processes for ensuring availability of system supports, including:
    - Telephone or in-person consultation with a physician/physician extender 24 hours a day, seven days a week
    - Access to emergency services 24 hours a day, seven days a week
    - Ongoing coordination and referral to more and less intensive SUD levels of care
    - Ongoing coordination and referral to medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition
- Processes for ensuring coordination, referral, discharge planning, and follow up with community partners, including but not limited to:
    - Medical, dental, laboratory, and drug testing services
    - Licensed behavioral health centers
    - MAT providers
    - Housing, employment and transportation agencies
    - Probation/Parole
    - Family services and supports
    - Domestic violence resources
    - Other, depending on the needs of the RAS population
- Processes to ensure ongoing coordination with Medicaid MCOs, including:
    - Training applicable staff on working with MCOs, appropriately sharing information, and providing complete and accurate medical necessity and utilization review documentation (including clinical information) to the MCO in accordance with Medicaid and ASAM® guidelines
    - Notifying the member's MCO at intake
    - Consulting with the members' MCO as needed to ensure implementation of the service plan and discharge plan
    - Notifying the member's MCO of discharge no later than seven days prior to discharge.
- Processes for unplanned discharge including follow-up and necessary notifications.
- Processes to ensure care coordination and linkages to appropriate treatment if an individual is not admitted to the facility.
- RAS operations, including:
    - Safety procedures
    - Daily operations, including a written schedule of daily events
    - Visitation guidelines and/or restrictions
    - Standards for provision of room and board

  - Contraband guidelines and restrictions
- RAS reporting:
  - Processes for reporting quality measurement and other data per the BMS requirements

Staffing: The RAS provider must ensure that the following minimum staffing requirements are met:

- The RAS provider must employ a full-time program director with at least two years' direct and documented experience in SUD treatment/service settings.
  - If a program is unable (through reasonable and documented efforts) to identify a program director who meets these qualifications after reasonable effort, a clinician with at least five years of documented clinical and supervisory experience in addiction treatment who meets the competencies may serve as the program director.
- The RAS provider must employ or contract with licensed behavioral health clinicians sufficient to provide clinical services to the RAS population, supervise non-clinical staff, and ensure adequacy of the 24 hours a day, seven days a week-structured therapeutic environment.
- The RAS provider must employ sufficient case managers to ensure caseloads of no more than 25 members. The RAS must ensure that a designated case manager is assigned to a member within 72 hours of admission.
- The RAS provider must ensure sufficient supervision, with at least one staff person physically on site and available to residents 24 hours per day, seven days per week, including holidays. For facilities that serve more than 25 members, a minimum of one staff person per 25 members is physically on site and available to residents 24 hours per day, seven days per week, including holidays.
- All staff providing Medicaid services permitted within the BMS-approved level of care must meet the credentials and qualifications for each service as described in the applicable BMS chapter, including:
  - *Chapter 503, Licensed Behavioral Health Centers*
  - *Chapter 504, Substance Use Disorder Services*
  - *Chapter 519, Practitioner Services*
  - *Chapter 521, Behavioral Health Outpatient Services*
  - *Chapter 523, Targeted Case Management*
- The RAS provider shall document that all direct service RAS staff, not otherwise licensed or qualified under these rules receive an orientation that complies with West Virginia licensing standards and any additional training as described in the RAS provider's written policies, including training that reflects service delivery standards and the agency's ASAM® level(s) of care.

Service Delivery: The RAS provider must ensure that ASAM®-aligned clinical assessment, service planning, and discharge planning are provided at appropriate intervals throughout the entire length of stay.

- Clinical Assessment: LBHCs, CCBHCs, and CBHCs must follow clinical assessment requirements as described in *Chapter 503, Licensed Behavioral Health Centers, Section, 503.14 Assessment Services*. Additional RAS requirements include:
  - The full clinical assessment must be completed within 72 hours of admission and reviewed as needed throughout the members' stay in the RAS.
  - The clinical assessment must align with latest ASAM® criteria, identify key problem areas, barriers to transition, and member priorities.
  - The clinical assessment shall be reviewed and approved by a licensed clinical supervisor as evidenced by date and signature.

- Service planning: LBHCs, CCBHCs, and CBHCs must follow service planning requirements as described in *Chapter 503, Licensed Behavioral Health Centers 503.16 Service Planning Requirements*. Additional RAS service planning requirements include:
    - The service plan must be completed within 72 hours of admission and reviewed weekly thereafter.
    - The service plan must align with the most recent ASAM® guidance and address applicable dimensions identified in the member's clinical assessment.
    - Service plans must be reviewed and approved by a licensed clinical supervisor as evidenced by date and signature.
    - The service plan must document discharge planning, including:
        - Role of family and natural supports.
        - Appropriate continuum of physical and behavioral health care for the individual post-discharge, including MAT, if applicable.
        - Health-related social needs, including housing, employment, and transportation.
        - Coordination with member's MCO.
        - Coordination with and linkages to specific community providers.
        - Any discharge challenges and mitigation strategies, if applicable.
    - Service plans may be modified by the team as necessary and clinically appropriate. When an intervention proves to be ineffective, the service plan must reflect consideration by the team of changes in the intervention strategy.
    - Service plans must be revisited at critical treatment junctures, including changes in member service level.
    - Weekly service plan review summary: The member's designated case manager must coordinate with the RAS multidisciplinary team weekly to review the service plan with the member. The case manager, in coordination with the member and team shall document services received, progress member has made toward individual goals, any new issues or concerns, service plan updates, and current discharge plan.

RAS Provider Requirements

The RAS provider must meet the following requirements:

- Be licensed by OHFLAC as an LBHC or hospital,
- Effective January 1, 2026, be accredited by one of the following entities: the Commission on Accreditation of Rehabilitative Facilities (CARF), Joint Commission (JCAHO), or Det Norske Veritas (DNV),
- Be an enrolled Medicaid provider, and
- Be issued an approval certification by the BMS before rendering services:
    - Approval certification by BMS is provided upon completion and approval of *Chapter 504, Appendix B Application for Residential Adult Services*. Organizations interested in becoming an RAS provider must submit the application with a copy of their organization's LBHC or hospital licensure from OHFLAC, which includes the physical address of the site(s) providing both residential and clinical services, and any other supporting documentation as required in the RAS application, to the designated mailbox BMSSUDWaiver@wv.gov.
    - The BMS will review the application and will notify the provider within 30 days of receipt of approval, disapproval, or request more information if needed to complete the certification review request.
    - RAS certification is valid 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.

RAS Provider Change in Operations: RAS providers must submit a written notice to the BMS of any material changes to provider operations no less than 30 days in advance of the change. Material changes to provider operations include:

- Changes in primary contact person name and/or contact information.
- Changes to NPI, provider name and address, and/or program locations.
- Modifications to provider staffing schedule, bed count, and/or clinical hours.
- 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 written notice of the provider change in operations must describe the impact, if any, to the level of care and/or service 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.

Discontinuation or Closure: Prior to discontinuing services or closing an RAS facility, the RAS provider must submit a written notice to the BMS no less than 30 days in advance of discontinuation or closure. Along with the 30-day written notice to the BMS and in accordance with HIPAA and 42 CFR part 2, the RAS provider must document and submit discharge plans for each of the members currently served in the program to the BMS. The RAS provider must also document that it has contacted applicable MCOs on behalf of individual members to ensure coordination of care.

Emergency Discontinuation or Closure: If an RAS provider experiences an emergency that requires the provider to temporarily or permanently discontinue services or end operations, the RAS provider must notify the BMS as soon as feasible but no later than 24 hours after the emergent event. In accordance with HIPAA and 42 CFR part 2, the RAS provider must submit a list of affected members in writing to the BMS and OHFLAC. The RAS provider must document that it has contacted applicable MCOs on behalf of individual members to ensure coordination of care. The RAS provider must submit discharge plans for each of the members currently served in the program to the BMS. Providers must adhere to any processes and requirements in OHFLAC regulation 11.1, related to emergency planning and response. This applies to all levels of RAS.

Recertification: Providers shall submit information to the BMS for re-certification and documentation review every two years, as dated from their most recent certification date. RAS providers must submit relevant information at least 60 days in advance of the expiration date of their current certification. There will be an on-site re-certification process conducted.

RAS Documentation Requirements

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

- A clinical record for each member must be maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies.
- The record for each member must contain the following:
  - A written physician's/physician extender's order authorizing RAS at the specified appropriate level of care and the member's individual service plan. The order must be completed within 24 hours of admission to the RAS program.

- A physician's/physician extender's order communicated verbally must be documented in the medical record by the receiving practitioner's signature and credentials, identified as "verbal orders," and authenticated promptly by the ordering physician/physician extender or by another practitioner who is responsible for the care of the member.
- A physician/physician extender's order to transfer a member to a different level of care within the same facility may be communicated verbally, documented in the medical record by the receiving practitioner's signature and credentials, identified as "verbal orders," and authenticated by the ordering physician/physician extender or by another practitioner who is responsible for the care of the member. If a 'verbal order' is given, the ordering individual must sign within 72 hours.
- A physician/physician extender order to transfer a member to a different RAS facility requires a written order.
- A physician/physician extender order to discharge a member from the RAS facility.

- Diagnosis(es).
- Documentation of the member's medical clearance to participate in RAS services.
- Documentation of a physical exam within the time frame required per specific ASAM® level of care as described in this chapter.
  - Individuals transferring from a different level of RAS treatment are not required to receive an additional physical exam if one was completed as part of admission to the previous service.
- Medication administration records.
- Urine drug screen records: refer to *Chapter 529.2, Drug Screenings*.
- Sign-in/sign-out sheet that is filled out when the member leaves the residential site. The sheet must note the actual time the individual leaves the site and returns to the site, as well as the reason for their absence. Each entry must be signed and dated by the agency staff.
- Service plan weekly review summary that is concise, person-centered and individualized. Boilerplate, standard, or non-individualized summaries are not acceptable documentation. Compiled summaries or documents from across the treatment team that are not synthesized and summarized are not acceptable documentation. Summaries that do not provide updates on individual treatment goals are not acceptable documentation. Summaries shall include:
  - Name of member's designated case manager.
  - Names/credentials/titles of multidisciplinary team members.
  - Person-centered and individualized summary of services received, progress member has made toward individual goals, any new issues or concerns, service plan updates, and a summary of discharge planning status, including:
    - Planning, coordination, referral and other activities to ensure continuity of physical and behavioral health care, including MAT if applicable.
    - Planning, coordination, referral, and other activities to address housing, employment, transportation and/or other health-related needs
    - Current discharge planning challenges and mitigation strategies identified.
  - Date and signature of supervising clinician.
- All documentation required in accordance with standards established by WV State Code §64-CSR-11.
- All documentation required for the delivery of permitted RAS services, in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and in the following chapters:
  - *Chapter 503, Licensed Behavioral Health Centers*
  - *Chapter 504, Substance Use Disorder Services*

- *Chapter 519, Practitioner Services*
- *Chapter 521, Behavioral Health Outpatient Services*
- *Chapter 523, Targeted Case Management*

Minimum Clinically Directed Hours

The RAS provider must ensure that residents receive at least the minimum required hours of clinically-directed services per the applicable ASAM® level of care as described in this chapter.

- Clinically-directed services are services delivered in a comprehensive, individualized service plan that has been reviewed and approved by a licensed clinician as evidenced by date and signature.
- Services and supports received by the member while in the RAS facility and documented in the member's service plan, including but not limited to primary and obstetrician-gynecologist (OB/GYN) care, nursing care, management of chronic health conditions, dental care, and MAT, may be counted toward minimum clinically directed service requirements.
- Services delivered by a PRSS may be used to satisfy no more than 25% per week of the minimum required clinical-directed service hours.

Service Limitations

Medicaid members receiving RAS may not receive day treatment, crisis stabilization, assertive community treatment, comprehensive community support services, and/or CCBHC services on the same day as RAS services.

RAS clinical hours may not include the following activities:

- Alcoholics Anonymous, Narcotics Anonymous or similar self-help meetings. While these meetings cannot be counted toward clinical hours in an RAS, these activities may be a part of the member's service plan and treatment strategy, and the member may engage in these activities while receiving RAS services.
- Services that do not support individual treatment goals.
- Services that are inappropriate due to members' specific needs and considerations, such as a history of trauma, co-occurring conditions, physical or cognitive limitations, or other individual factors that may limit efficacy of specific treatment or member's ability to participate in treatment.

The RAS provider cannot require or coerce the member to attend religious services or activities.

Program Flexibility

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.

Flexible capacity between 3.5 and 3.7 levels of care: Community facilities approved to operate both a 3.5 and 3.7 level program at the same site may utilize flexible capacity in a 3.7 RAS site to deliver Level 3.5 services. The member must still receive services according to the member's assessed level of need. **Note**: ASAM® Level 3.7 hospital-based 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 as appropriate and identified in a member's individual service plan. 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.

Note: No residential treatment beds, at any level of care, may be flexed with or integrated with a recovery residence or sober living environment.

504.18.1 Residential Adult Services ASAM® Level 3.1

RAS Level 3.1 is a structured 24-hour adult SUD residential treatment setting serving 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.

Services in 3.1 are clinically managed and directed by an interdisciplinary team of nonphysician professionals. In addition to a structured therapeutic environment available seven days per week, 24 hours per day, members in RAS Level 3.1 must receive between nine and 19 hours of documented, clinically-driven services per week.

These services are directed toward managing withdrawal, maintaining SUD medication therapies, applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the domains 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.

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 list of services is 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)
- Crisis Psychotherapy 60 minutes (90839) and 30 minutes add-on (90840)
- Group Psychotherapy (90853)
- Peer Recovery Support Specialist services (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
- Therapeutic Behavioral Services Development (H2019HO); Implementation (H2019)

MAT must be available to members in conjunction with residential treatment. Please see *Chapter 503 Licensed Behavioral Health Centers (LBHC)* and *Policy 519.22, Mental Health Counseling and Substance Abuse Treatment* for MAT in the residential setting. If a member is receiving RAS, they must still meet the criteria and policy requirements stated in *Chapters 503, Licensed Behavioral Health Centers* and *Policy 519.22, Mental Health Counseling and Substance Abuse Treatment.*

Admission Criteria for RAS Level 3.1 Facilities: The following admission criteria must be met:

- Referral is received by physician, physician extender, or provider of services at the RAS facility.
- A physician/physician extender has completed, signed, and dated the physician order form for the referral. The physician/physician extender order form must specify the level of care and be completed within 24 hours of admission.
- A physician/physician extender must provide medical clearance for the member prior to admission.
    - Medical clearance may be completed by the referring physician/physician extender, the member's primary care provider, emergency room, or other referring physician/physician extender with sufficient medical knowledge of the individual.
- The individual must have a documented SUD diagnosis completed within the last 12 months based on the current ICD or DSM.
- A level of care assessment is conducted prior to admission. Within one business day, a comprehensive assessment including ASAM dimensions is conducted and clearly documents medical necessity for the service, that the member is unable to be treated in an outpatient setting and that 3.1 is the appropriate level of care. A previous assessment may be used if conducted in the past 30 calendar days.
- Members in level 3.1 RAS may be employed up to 20 hours per calendar week, to the extent that employment does not interfere with or present barriers to treatment. The member and the member's treatment team will discuss employment and determine if the member is therapeutically ready for employment. The members' service plan must describe how the individual will continue to benefit from services and the therapeutic milieu, and how the treatment team supports the individual in prioritizing treatment goals while managing employment. Members must continue to clearly meet medical necessity as documented in the weekly service plan review. Members cannot be forced to work if they choose not to.

Continuing Stay Criteria: The member continues to meet medical necessity for this level of care as documented by the RAS multidisciplinary team weekly service plan review summary and clinical documentation that describe members' continuing treatment needs.

Member's continuing stay is not contingent on RAS pre-set program design or a customary length of stay. Evidence that the member continues to meet medical necessity for this level of care, and that the member's goals and needs are being addressed successfully by program services, is required.

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

1. Member has addressed the individual goals and objectives identified in their service plan and can be safely discharged to an outpatient setting in the member's documented discharge plan; or
2. Member is unable to complete goals and objectives and need to be transferred to an appropriate level of care; or
3. Member's medical issues are not able to be managed, and the member needs to be transferred to an appropriate level of care; or
4. Member refuses to engage in treatment.

Additional 3.1 Program Requirements

- Level 3.1 facilities must provide at least nine to 19 hours of clinically-directed services per week.
- Level 3.1 facilities must be able to admit members receiving MAT, support referral to MAT providers, and facilitate continuity of pharmacotherapy through admission and other care transitions.
- Level 3.1 providers must be able to provide clinically managed withdrawal management.
- Medication review services must be made available to all members at this level of care.

504.18.2 Residential Adult Services ASAM® Level 3.5

RAS Level 3.5 is a structured 24-hour adult substance use residential treatment setting serving 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 or less intensive residential level of care.

Services in 3.5 are high intensity, clinically-managed, and directed by an interdisciplinary team of nonphysician professionals. In addition to a structured therapeutic environment available seven days per week, 24 hours per day, members in RAS Level 3.5 must receive at least 20 hours of documented, clinically-driven services per week.

These services are directed toward managing withdrawal, maintaining SUD medication therapies, applying recovery skills, preventing relapses, counseling and therapeutic intervention, improving emotional functioning, promoting personal responsibility, and rebuilding pro-social relationships with family and friends. Treatment services focus on improving the individual's functioning and coping skills in accordance with the ASAM® criteria while maintaining a safe environment for individuals with significant recovery needs.

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 list of services is 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)
- Crisis Psychotherapy 60 minutes (90839) and 30 minutes add-on (90840)
- Group Psychotherapy (90853)
- Peer Recovery Support Specialist services (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
- Therapeutic Behavioral Services Development (H2019HO); Implementation (H2019)

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

Admission Criteria for RAS Level 3.5 Facilities: The following admission criteria must be met:

- Referral received by physician, physician extender, or provider of services.
- A physician/physician extender has completed, signed, and dated the physician order form for the referral. The physician/physician extender order form must specify level of care and be completed within 24 hours of admission.
- A physician/physician extender must provide medical clearance for the member prior to admission.
    - Medical clearance may be completed by the referring physician/physician extender, the member's primary care provider, emergency room or other referring physician/physician extender with sufficient medical knowledge of the individual.
- The individual must have a documented SUD diagnosis completed within the last 12 months based on the current ICD or DSM.
- A level of care assessment is conducted prior to admission. Within one business day, a comprehensive assessment including ASAM® dimensions is conducted and clearly documents medical necessity for the service, that the member is unable to be treated in an outpatient or less intensive residential setting, and that 3.5 is the appropriate level of care. A previous assessment may be used if conducted in the past 30 calendar days.
- A physical exam is completed within 72 hours of admission to the Level 3.5 program.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by the RAS multidisciplinary team weekly service plan review summary and supporting clinical documentation that describes members' continuing treatment needs.

Members' continuing stay is not contingent on a pre-set program design or customary length of stay. Evidence that the members' individual goals and needs are being addressed successfully by the services provided is required.

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

1. Member has addressed the individual goals and objectives identified in their service plan and can be safely discharged to an outpatient setting in the member's documented discharge plan; or
2. Member is unable to complete goals and objectives and need to be transferred to an appropriate level of care; or
3. Member's medical and/or psychiatric issues cannot be adequately managed, and the member needs to be transferred to an appropriate level of care; or
4. Member refuses to engage in treatment.

Additional Level 3.5 Program Requirements: In addition to the minimum staffing requirements in Section 504.18, Residential Adult Services that apply to all levels of care, Level 3.5 RAS providers must comply with the following:

- Level 3.5 facilities must provide at least 20 hours of clinically-directed services per week to each individual member.
- Level 3.5 providers must 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.
- Level 3.5 providers must be able to provide clinically-managed withdrawal management services.
- Level 3.5 providers must have processes in place to provide integrated treatment of co-occurring emotional, behavioral, or cognitive conditions.
- Level 3.5 providers must 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.
- Level 3.5 providers must employ or contract with a medical director who is a physician/physician extender with expertise in addiction medicine.
- Level 3.5 providers must ensure 24/7 access either in-person or via telehealth to consultation with a physician/physician extender and emergency services.

504.18.3 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 a residential setting. 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. Level 3.7 residential facilities must have a separate therapeutic schedule from other levels of SUD residential care.

RAS 3.7 services are medically managed and provided by an interdisciplinary team. Services in RAS Level 3.7 are available 24 hours per day, 7 days per week. In addition to a structured therapeutic environment available seven days per week, 24 hours per day, members in RAS Level 3.7 must receive at least 22 hours of documented, clinically-driven services per week.

Requirements for admission to a Level 3.7 program include meeting medical necessity in accordance with ASAM® criteria. The focus of treatment is specific to SUD. The skills of this team and their availability can accommodate MAT, medically managed withdrawal services, intensive individual treatment of addiction, and integrated treatment of co-occurring subacute biomedical, emotional, behavioral, and/or cognitive conditions.

Additional Level 3.7 Requirements: In addition to the minimum requirements in Section 504.18, Residential Adult Services, that apply to all levels of care, Level 3.7 RAS providers must comply with the following:

- The Level 3.7 RAS provider must employ or contract with a medical director who is a physician/physician extender with expertise in addiction medicine and is available for consultation.
- A physician/physician extender must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary.
- A registered nurse must be available 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.
- Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site through consultation or referral.
- 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.
- The Level 3.7 RAS provider must ensure capacity to provide:
    - Medically managed withdrawal services
    - Medication Assisted Treatment
    - 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 list of services is 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)
- Crisis Psychotherapy 60 minutes (90839) and 30 minutes add-on (90840)
- Group Psychotherapy (90853)

- Peer Recovery Support Specialist services (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.
- Medically necessary Evaluation/Management Services
- Therapeutic Behavioral Services Development (H2019HO); Implementation (H2019)

MAT must be available to members in conjunction with their residential treatment. Please see *Chapters 503, Licensed Behavioral Health Centers* and *Policy 519.22, Mental Health Counselling and Substance Abuse 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 *Chapters 503, Licensed Behavioral Health Centers* and *Policy 519.22, Mental Health Counseling and Substance Abuse Treatment*.

Admission Criteria for RAS Level 3.7 Facilities: 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.
- A physician or physician extender has completed, signed, and dated the physician order form for the referral. The physician order form must specify the level of care and be completed within 24 hours of admission.
- A physician or physician extender has provided medical clearance for the member prior to admission. This may be completed by the referring physician/physician extender, the member's primary care provider, emergency room or other referring physician or physician extender with sufficient knowledge of the individual.
- The individual must have a documented SUD diagnosis completed within the last 12 months based on the current International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).
- A level of care assessment is conducted prior to admission. Within one business day, a comprehensive assessment including ASAM® dimensions is conducted and clearly documents medical necessity for the service, that the member is unable to be treated in an outpatient or less intensive residential setting, and that 3.7 is the appropriate level of care. A previous assessment may be used if conducted in the past 30 calendar days.

- ASAM® assessment documents that the member meets level of care criteria and is in need of level 3.7 Medically Managed Residential Treatment.
- A physical exam is completed within 24 hours of admission to the program.

Continuing Stay Criteria: Member continues to meet medical necessity for this level of care as documented by

the RAS multidisciplinary team weekly summary and clinical documentation that describe members' continuing treatment needs.

Continuing stay criteria may include ongoing medical complexity that presents a risk to recovery if not addressed at the 3.7 level of care. Members with medically complex needs may seek prior authorization for stays of longer than 30 days when clinical documentation indicates that stepping down to a lower level of care may disrupt progress in behavioral and/or physical treatment.

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 are not able to be managed, and the member needs to be transferred to an appropriate level of care; or
4. Member refuses to engage with treatment.

504.19 TRANSPORTATION

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

504.20 SERVICE LIMITATIONS

Service limitations leading to the provision of all West Virginia Medicaid services can be found in *Chapter 100, General Information* of the Provider Manual.

504.21 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 or individual 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.

504.22 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply, refer 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, community psychiatric supportive treatment services, and Partial Hospital Program's services. Prior authorization must be obtained from the UMC or MCO and requests must be submitted within the timelines and in the manner required by the 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 UMC or MCO.

504.23 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply, refer 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 the BMS upon request; and
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

504.24 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 their 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 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 West Virginia Department of Human Services 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: 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 Intensive Outpatient Services Program and prior

authorization for members admitted to an Intensive Outpatient Services 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 (LICSW): 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 West Virginia 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 West Virginia 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 the FDA-approved medications in combination with evidence-based behavioral therapies to provide a whole-member approach to treating SUD.

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.

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.

Peer Recovery Support Specialist (PRSS): A trained and certified individual with lived SUD experience, who has been successful in their own recovery process.

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 their 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. 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 MAT 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 as well as clarifications were made to existing policy in other areas. The following changes were made 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. • 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.	February 1, 2025

	• 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 Chapter 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 519.22. Added a definition for LPC.	
RAS Section 504.18, including subsections Removal of Prior Section 504.19 Withdrawal Management	• Updated RAS policy, including the overview section as well as requirements at levels of care 3.1, 3.5, and 3.7. RAS Level 3.3 subsection has been removed. These changes align with the 4th edition criteria from ASAM®. • In alignment with 4th ASAM® criteria, removed withdrawal management as a distinct subsection and incorporated withdrawal management capacity into each RAS level of care. • With the removal of the distinct Withdrawal Management section 504.19, each of the following subsections in this have been renumbered accordingly. • Glossary: Added PRSS definition.	March 1, 2026