



Chapter 504

Substance Use Disorder Services

Appendix B

Application for Residential Adult Services



CHAPTER 504 SUBSTANCE USE DISORDER SERVICES

Application for Residential Adult Services

The West Virginia Department of Health and Human Resources (WVDHHR), through the Bureau for Medical Services (BMS) is required to designate the ASAM® level of care for all licensed residential treatment facilities. To make this determination, the following application is required to be filled out for each licensed facility. The information provided and submitted with this application will allow WVDHHR to review information regarding the overall program integrity, description of population, treatment services, and qualification of staff, organizational structure, environment, and setting and to assign an ASAM® level for the program.

Facility Name: _____

Program Name: _____

Facility Address: _____

City/State/Zip: _____

NPI/Licensing Number: _____

Coordination of Care

Contact Name: _____

Telephone Number: _____

Email Address: _____

Please indicate the ASAM® Level being applied for:

- 3.1 Clinically Managed Low Intensity
- 3.3 Clinically Managed Population Specific High Intensity
- 3.5 Clinically Managed High Intensity
- 3.7 Medically Monitored Intensive Inpatient Services
- 3.2 Withdrawal Management (*Note: Withdrawal Management Levels 1 and 2 are not Residential Services and are approved through another process outside of this document. Information about Level 1-WM Intensive Outpatient Services and Level 2-WM Community Psychiatric Supportive Treatment can be found in [Chapter 503, Licensed Behavioral Health Center Services](#) of the BMS Provider Manual.*)



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SUPPORT SYSTEMS

- | | | |
|---|------------------------------|-----------------------------|
| 1) Is telephone or in-person consultation with physician and emergency services available 24/7? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Are there direct affiliations with other levels of care and/or close coordination for referrals to other services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Do you have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Can you arrange for pharmacotherapy for psychiatric or anti-addiction medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Are psychiatric/psychological consultations available as needed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

STAFF

- | | | |
|---|------------------------------|-----------------------------|
| 1) Is professional staff available on-site 24 hours a day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Does the treatment team consist of medical, addiction and mental health professionals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Are one or more clinicians available on site or by telephone 24 hours a day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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Please indicate program staff conducting each service. Check all that apply on the following table:

License or Certification /Registration	MD/DO/PA/APRN	LP/SP	LPC	RN/LPN	LICSW	LCSW	LGSW	LSW	AADC and ADC	MA NON-LISC	BA NON-LISC	BHT	PRSS
Medical RX Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COD Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Diagnostic Evaluation without medical services (90791)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Diagnostic Evaluation with medical services (90792)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Assessment by a Non-Physician (H0031)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Service Plan Development by a Non-Physician (H0032)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Service Plan Development by a Psychologist (H0032AH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Targeted Case Management (T1017)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skills Training and Development by a Paraprofessional (H2014U1/H2014U4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skills Training and Development by a Professional (H2014HNU1/H2014HNU4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Counseling Supportive (Individual/Group) (H0004/H004HQ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health Counseling Professional (Individual/Group) (H0004HO/H0004HOHQ)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Psychotherapy without patient present (90846)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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License or Certification /Registration	MD/DO/ PA/APRN	LP/SP	LPC	RN/LPN	LICSW	LCSW	LGSW	LSW	AADC and ADC	MA NON- LISC	BA NON- LISC	BHT	PRSS
Family Psychotherapy with patient present (90847)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis Intervention 24-hour Availability (H2011)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Psychotherapy (90853)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer Recovery Support (H0038)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy Patient and Family (90832/90834/90837)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy for Crisis (90839/90840)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Behavioral Services Development Implementation (H2019HO/H2019)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Coordinated Care Oversight Services (G9008)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Testing with Interpretation and Report (96101)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive Medication Services (includes all Nursing) (H2010)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Screenings (80305, 80306, 80307)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any needed Evaluation/Management Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MD/DO – Doctor of Medicine / Doctor of Osteopathic Medicine LP/SP – Licensed Psychologist / Supervised Psychologist LPC – Licensed Professional Counselor RN/LPN – Registered Nurse/Licensed Practical Nurse LICSW – Licensed Independent Clinical Social Worker LCSW – Licensed Clinical Social Worker LGSW – Licensed Graduate Social Worker LSW – Licensed Social Worker									AADC – Advanced Alcohol & Drug Counselor ADC – Alcohol & Drug Counselor MA Non-Lisc – Master’s Non-Licensed BA Non-Lisc – Bachelor’s Non-Licensed BHT – Behavioral Health Technician PRSS – Peer Recovery Support Specialist PA – Physician Assistant APRN – Advance Practice Registered Nurse				

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

THERAPIES AND SERVICES

1) List planned clinical programs/activities and hours per week. List others on additional sheet if needed.

Therapy/Service	Number of Hours
1.	
2.	
3.	
4.	
5.	

2) List counseling and curriculum programs and hours per week.

Counseling/Curriculum Programs	Number of Hours
1.	
2.	
3.	
4.	
5.	

3) Detail any recovery support services available.

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- 4) Are family members and/or significant others involved in treatment? Yes No
- 5) Is Medication-Assisted Treatment (MAT) available?
- ONSITE Yes No
- OFFSITE Yes No
- 6) Is there monitoring of medication adherence (for behavioral health and physical health)? Yes No
- 7) Do you use random drug screens to monitor compliance? Yes No
- 8) Please attach a weekly schedule of services with the individual, group, educational and/or other treatment services labeled, to validate the service hours listed above.
- 9) Please attach other programmatic documentation that will support the ASAM® Level for which approval is being sought.
- 10) Please attach facility regulation for visitation guidelines and search/contraband protocol.
- 11) Please list the total program capacity and number of members in program weekly for each level of service provided.

Service	# Total Program Capacity	# Members in Program Weekly
ASAM® 3.1		
ASAM® 3.3		
ASAM® 3.5		
ASAM® 3.7		
ASAM® 3.2 WM		

ASSESSMENT / TREATMENT PLAN AND REVIEW

Does the program's assessment & treatment plan review include:

- 1) Utilizing an individualized, comprehensive assessment? Yes No
- 2) An individualized service plan developed in collaboration with member reflecting the members' personal goals? Yes No
- 3) A daily assessment of progress and treatment changes? Yes No
- 4) A physical examination by MD/DO, PA, or APRN performed as part of the initial assessment and admission process? Yes No
- 5) Ongoing transition/continuing care planning? Yes No
- 6) An after-care plan that specifies community resources and additional support services that the member is actively associated with? Yes No

SATELLITE LOCATIONS

A program that operates in more than one location (site) must list the names and address of all sites operating under the same governing authority in the space provided below as well as the services categories at each site. The Master Site is the location which provides direct substance abuse services. If the administrative office does not provide services, this location should be indicated below.

MASTER SITE: License/NPI# _____ Telephone # _____

Program Name: _____ Program Director: _____

Name of Program: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Telephone #: _____ Site Director: _____

Name of Program: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Telephone #: _____ Site Director: _____

Name of Program: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Telephone #: _____ Site Director: _____

Name of Program: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Telephone #: _____ Site Director: _____

Name of Program: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Telephone #: _____ Site Director: _____

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

List the contact information of the person that can be reached for follow-up if needed.

NAME	TITLE	EMAIL	TELEPHONE

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