WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Chapter 504

Substance Use Disorder Services

Appendix B

Application for Residential Adult Services

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.

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: ____

Contact Name: ____

Telephone Number: ____

Email Address: ____

Please indicate the ASAM® Level being applied for:

☐ 3.1 Clinically Managed Low Intensity (minimum clinical hours: 5)
☐ 3.3 Clinically Managed Population Specific High Intensity (minimum clinical hours:10)
☐ 3.5 Clinically Managed High Intensity (minimum clinical hours: 15)
☐ 3.7 Medically Monitored Intensive Inpatient Services (minimum clinical hours: 22)

☐ 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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BUREAU FOR MEDICAL SERVICES

SUPPORT SYSTEMS

Please attest to the following for adult residential services:

1) Telephone or in-person consultation with physician and emergency services available 24/7. ☐Yes
2) There direct affiliations with other levels of care and/or close coordination for referrals to other services. ☐Yes
3) You have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. ☐Yes
4) You can arrange for pharmacotherapy for medication services. ☐Yes
5) Psychiatric/psychological consultations available as needed. ☐Yes
6) Co-occuring disorders will be addressed in the program curriculum. ☐Yes

STAFF

1) There is staff (which include members such as BHT and other support staff) available on-site 24 hours a day? ☐ Yes
2) Treatment team consist of medical, addiction and mental health professionals? ☐Yes
3) One or more clinicians are available on site or by telephone 24 hours a day? ☐Yes

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All services listed below must adhere to the corresponding BMS manuals.

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-LIC	BA NON-LIC	BHT	PRSS
Medical RX Services	☐												
Medication Administration Services				☐									
Psychiatric Diagnostic Evaluation without medical services (90791)	☐	☐	☐		☐								
Psychiatric Diagnostic Evaluation with medical services (90792)	☐												
Mental Health Assessment by a Non-Physician (H0031)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Mental Health Service Plan Development by a Non-Physician (H0032)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Service Plan Development by a Psychologist (H0032AH)		☐											
Targeted Case Management (T1017)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Skills Training and Development by a Paraprofessional (H2014U1/H2014U4)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skills Training and Development by a Professional (H2014HNU1/H2014HNU4)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐			
Behavioral Health Counseling Supporitve (Individual/Group) (H0004/H0004HQ)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Behavioral Health Counseling Professional (Individual/Group) (H0004HO/H0004HOHQ)	☐	☐	☐		☐	☐	☐	☐	☐	☐			

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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-LIC	BA NON-LIC	BHT	PRSS
Crisis Intervention 24-hour Availability (H2011)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		
Peer Recovery Support (H0038)													☐
Therapeutic Behavioral Services Development Implementation (H2019HO/H2019)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physician Coordinated Care Oversight Services (G9008)	☐												
Psychological Testing with Interpretation and Report (96101)		☐											
Comprehensive Medication Services (H2010)	☐			☐									
Drug Screenings (Physician Order) (80305, 80306, 80307)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Any needed Evaluation/Management Services	☐												

MD/DO – Doctor of Medicine / Doctor of Osteopathic Medicine	AADC – Advanced Alcohol & Drug Counselor
LP/SP – Licensed Psychologist / Supervised Psychologist	ADC – Alcohol & Drug Counselor
LPC – Licensed Professional Counselor	MA Non-Lic – Master's Non-Licensed
RN/LPN – Registered Nurse/Licensed Practical Nurse	BA Non-Lic – Bachelor's Non-Licensed
LICSW – Licensed Independent Clinical Social Worker	BHT – Behavioral Health Technician
LCSW – Licensed Certified Social Worker	PRSS – Peer Recovery Support Specialist
LGSW – Licensed Graduate Social Worker	PA – Physician Assistant
LSW – Licensed Social Worker	APRN – Advance Practice Registered Nurse

- The CPT codes listed, which can be rendered by other providers, are included in the residential bundle rate services:
  - Family Psychotherapy without patient present (90846), Family Psychotherapy with patient present (90847)
  - Psychotherapy Patient and Family (90832, 90834, 90837)
  - Group Psychotherapy (90853)
  - Psychotherapy for Crisis (90839 and 90840)

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CLINICAL HOURS PER WEEK CURRICULUM

1) List planned clinical services per week. Clinical services are defined as evidenced-based, active treatment to directly assist with an individual's SUD treatment and any related co-occurring mental health issue(s) and correspond to the following codes. Not all services need to be checked.

Clinical Hour and Therapy Services.	**Number of Hours/ per Week**
Group Supportive Counseling (H0004HQ - Behavioral Health Counseling Supportive - Group)	
Individual Supportive Counseling (H0004 - Behavioral Health Counseling Support - Individual)	
Group Professional Therapy (H0004HOHQ - Behavioral Health Counseling Professional - Group)	
Individual Professional Therapy (H0004HO - Behavioral Health Counseling Professional - Individual)	
Skills Training and Development by a Paraprofessional (H2014U1/H2014U4)	
Skills Training and Development by a Professional (H2014HNU1/H2014HNU4)	
Mental Health Service Plan Development by a Non-Physician (H0032)	
Therapeutic Behavioral Services Development Implementation (H2019HO/H2019) **Note: Only to be used with ASAM Residential Level 3.3*	
Additional CPT codes, if applicable:	
Total Hours Per Week	

2) Detail any recovery support services available.

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3) Are family members and/or significant others involved in treatment? ☐Yes ☐No

4) Medication-Assisted Treatment (MAT) is available:

ONSITE ☐

OFFSITE ☐

- *Note: MAT must be arranged if the individual is assessed to need MAT service or is already receiving that service from another agency (with coordination of care documentation from that facility)*

5) Attest there will be monitoring of medication adherence (for behavioral health and physical health) ☐Yes

6) Attest that random drug screens will be used to monitor compliance. ☐Yes

7) Attest to an understanding of the residential service guidelines within the most current ASAM Criteria Manual Edition. ☐Yes

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 facility regulation for visitation guidelines and search/contraband protocol.

10) Please list the total program capacity and number of members in program weekly for each level of service provided.

11) With the exception of IDD, severe cognitive impairment or severe functional limitation (which are treated in the 3.3 ASAM residential population), please list any speciality groups to be served in the residential, such as mother and children, co-occurring, women who are pregnant or any specific age groups or gender.

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ASSESSMENT / TREATMENT PLAN AND REVIEW

Please indicate that your assessment and treatment plans includes the following:

1) There is an individualized, biopsychosocial-comprehensive assessment. ☐Yes

2) The individualized service plan is developed in collaboration with member reflecting the members' personal goals. ☐Yes

3) There is a daily assessment of progress and treatment changes. ☐Yes

4) A physical examination by MD/DO, PA, or APRN performed as part of the initial assessment and admission process. ☐Yes

5) There is an ongoing transition/continuing care planning. ☐Yes

6) The after-care plan includes specifies community resources and additional support services that the member is actively associated with. ☐Yes

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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:___________________________

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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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