# Chapter 504

# Substance Use Disorder Services

# Appendix B

# Application for Residential Adult Services

# Application for Residential Adult Services (RAS)

The West Virginia Department of Health and Human Resources (DHHR), 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 must be completed for each level of residential adult services programming in a licensed facility.

**Provider Name:** _____

**Provider's Address/Zip Code:** _____

**Name of RAS Program:** _____

**RAS Program Physical Address/Zip Code:** _____

**LBHC Certificate #:** _____ **NPI #:** _____

**Member Capacity:** _____ **Flexible Capacity* (if applicable):** _____
*(*Note: Flexible capacity is only available between RAS Levels 3.1 and 3.5. Please refer to Chapter 504, Section 504.18.)*

**Target Population: MALE** ____ **FEMALE** ____ **COED** ____

**Specialized Population: (If not applicable, put N/A)** _____
*(Examples: Traumatic Brain Injury (TBI), mothers and infants, pregnant women, etc.)*

**Contact Name:** _____

**Contact Phone Number:** _____

**Contact Email:** _____

**Medical Director/Physician:** _____

**Please indicate the ASAM® Level being applied for:** *(Note: A new application is required for **each** program level.)*

☐ 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: Only check if you will offer 3.2 Withdrawal Management within a 3.7 Medically Monitored Intensive Inpatient Services program.)*

***By checking the boxes below, you attest that you have read and understand the following policies, guidelines, and criteria listed below:***

☐ ***Chapter 504, Substance Use Disorder (SUD) Services***

- Sections 504.15 and 504.18 describes the criteria for Peer Recovery Support Specialist (PRSS) and Residential Adult Services (RAS) as well as definition and documentation requirements.
- **Please note:** The PRSS services are not considered clinical services but are supportive-recovery services.
- https://dhhr.wv.gov/bms/Pages/Manuals.aspx

☐ ***Chapter 503, Licensed Behavioral Health Centers (LBHC)***

- Sections 503.12 through 503.23 describe the criteria for the clinical services which are rendered through SUD RAS. These sections describe the definition of each service, staff credentials for completing each services and documentation requirements.
- https://dhhr.wv.gov/bms/Pages/Manuals.aspx

☐ ***Chapter 521, Behavioral Health Outpatient Services***

- Sections 521.11 through 521.13 describe the Current Procedural Terminology (CPT) codes, service definitions, and staffing credentials for codes that can be used within the array of SUD treatment services. These include:
  - Family Psychotherapy without patient present (90846),
  - Family Psychotherapy with patient present (90847)
  - Psychotherapy Patient and Family (90832, 90834, and 90837)
  - Group Psychotherapy (90853)
  - Psychotherapy for Crisis (90839 and 90840) ***Note:*** *Crisis services cannot be used as scheduled clinical hours.*
  - https://dhhr.wv.gov/bms/Pages/Manuals.aspx

☐ **I understand that the facility must be appropriately licensed as an LBHC through the West Virginia Office of Health Facility Licensure and Certification (OHFLAC) prior to completing this application.**

- https://ohflac.wvdhhr.org/

☐ **I understand the current ASAM (American Society of Addiction Medicine) criteria including the differences between each level of residential care, withdraw management, dimensional concepts and interaction, settings, support systems, staff credentials, assessment, and therapies.**

☐ **I understand commonly used, evidenced-based SUD treatment and practices including Medication Assisted Treatment (MAT) and the difference between treatment and recovery services.**

## SUPPORT SYSTEMS

*Please attest to the following for adult residential services:*

1) Telephone or in-person consultation with physician and emergency services are available 24/7. ☐ Yes

2) There are direct affiliations with other levels of care and/or close coordination for referrals to other services. ☐ Yes

3) You can 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 are available as needed. ☐ Yes

6) Co-occurring disorders will be addressed in the program curriculum. ☐ Yes

## STAFF

1) Staff is 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

| Program Staff | Number of staff employed for this ASAM® level of care | Please check if staff is AADC or ADC certified* |
|---|---|---|
| Doctor of Medicine (MD) / Osteopathic Medicine (DO), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) | | |
| Licensed Psychologist (LP), Supervised Psychologist (SP) | | |
| Registered Nurse (RN), Licensed Practical Nurse (LPN) | | |
| Licensed Independent Clinical Social Worker (LICSW) | | |
| Licensed Certified Social Worker (LCSW) | | |
| Licensed Graduate Social Worker (LGSW) | | |
| Licensed Social Worker (LSW) | | |
| Licensed Professional Counselor (LPC) | | |
| Master's level Non-Licensed | | |
| Bachelor's level Non-Licensed | | |
| Behavioral Health Technician (BHT) | | |
| Peer Recovery Support Specialist (PRSS) | | |

*AADC – Advanced Alcohol & Drug Counselor, ADC – Alcohol & Drug Counselor

**Note:** *Chapter 503, Licensed Behavioral Health Centers* and *Chapter 521, Behavioral Health Outpatient Services* describe service definitions, staff credentialing, and documentation that must be followed for each service rendered in the SUD array. You must have enough staff to provide the services listed on your schedule if your program is at full capacity.

# 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/or any related co-occurring mental health issue(s) and correspond to the following codes. Only report the services you are providing. Not all services need to be checked.
    - **Note:** Skills Training and Development is a service provided after a member has been assessed to have a skills deficit due to a SUD or mental health difficulty. Not all members receiving RAS will need Skills Training and Development and although these are considered clinical hours, they **cannot** be added to the cumulated clinical hours needed for each ASAM level.
    - Confirm that the clinical hours listed reflect the same clinical hours in your weekly schedule.

| Service Codes for ASAM® Clinical Hours | Clinical Hours Per Week/Per Member |
|---|---|
| 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) | |
| Mental Health Service Plan Development by a Non-Physician (H0032) | |
| Skills Training and Development by a Professional (H2014HNU1/H2014HNU4)* | |
| Skills Training and Development by a Paraprofessional (H2014U1/H2014U4)* | |
| Therapeutic Behavioral Services Development Implementation (H2019HO/H2019) ***Note:*** *Only to be used with ASAM® Level 3.3* | |
| CPT Codes: 90846, 90847, 90832, 90834, 90837 and 90853 ***Note:*** *Crisis services cannot be a scheduled event.* | |
| **Total Hours Per Week:** ***Note:****The total clinical hours must match the hours provided in the weekly schedule.* | |

*Please refer to *Chapter 503, Licensed Behavioral Health Center Services*, Section 503.18.

2) Family members and/or significant others are involved in treatment, if not contraindicated. ☐ Yes

3) There is monitoring of medication adherence for behavioral health and physical health. ☐ Yes

4) Random drug screens will be used to monitor compliance. ☐ Yes

5) Services are provided according to the residential service guidelines within the most current edition of the ASAM® Criteria manual, as well as medical necessity as defined by BMS. ☐ Yes

6) Please attach a weekly schedule of services including:

- Treatment services identified by the Medicaid service code.
- Non-clinical activities (to present a comprehensive view of the program operation.)
- The total number of clinical hours on the schedule which must match the total of clinical hours listed on page six of this application.
- Details of any recovery support services available (such as Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or other support or 12-step groups, etc.).

***Note:*** *You must have enough staff to provide the services listed on your schedule if your program is at full capacity and you must allow enough time for the services to be delivered to all members of your program.*

7) Please attach facility regulations for visitation guidelines and search/contraband protocol.

8) All forms of MAT must be made available in all residential services. The MAT may be assessed as a needed service while receiving residential treatment or an individual may be receiving MAT prior to admission. *(Note: Only Opioid Treatment Programs (OTP) can offer methadone. Other forms of MAT can be offered through residential services or an outside agency. The RAS facilities must have a Memorandum of Understanding (MOU) with an existing OTP to provide these services, and if applicable, with other MAT providers).*

Please indicate where MAT is available: ☐ ONSITE ☐ OFFSITE

List the MAT facility(s) with whom your program has MOU/Coordination of Care agreements:

1._____

2._____

3._____

4._____

5._____

# ASSESSMENT/TREATMENT PLAN AND REVIEW

Please attest that your assessment and treatment plans include the following:

1) An individualized, biopsychosocial comprehensive assessment. ☐ Yes

2) The individualized service plan is developed in collaboration with member reflecting the member's personal goals. Please note in the description how services are individualized. ☐ Yes

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

4) A physical examination by MD/DO, PA, or APRN is performed as part of the initial assessment/admission process or a review of a previous physical examination by the provider's MD/DO, PA, or APRN. ☐ Yes

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

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

7) If an individual is assessed for your residential level and does not meet the criteria for your level of care, or if ongoing assessment indicates a need for a different level of care, please list other facilities (and their level of care) with whom you have referral potential, MOUs, or care coordination agreements.

1._____

2._____

3._____

4._____

5._____

***Please include additional pages as needed.***

# SATELLITE LOCATIONS

A program that operates in more than one location/site, must list the names and addresses 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:_____

**I certify that the information provided in this application 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 |
|---|---|---|---|
| | | | |