

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 Health and Human Resources to develop a continuum of Substance Use Disorder (SUD) treatment benefits designed to address the immediate and long-term physical, mental, and social needs of individuals and to promote and sustain long-term recovery. The West Virginia Medicaid Program offers a comprehensive scope of medically necessary SUD services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal regulations. All Medicaid members, including those in managed care, will have these services available to them. West Virginia 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 Manual](#) 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 DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

SUD Medicaid enrolled providers must give priority to children ages 18 – 21 years that have been identified as being in the foster care system. Medicaid enrolled providers must make a good faith effort to complete assessments in a timely manner as well as work with the Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid members have the right to freedom of choice when choosing a provider for treatment. A Medicaid member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid members are in violation of their provider agreement.

All Medicaid enrolled providers should coordinate care if a Medicaid member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the member's treatment. Appropriate Releases of Information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

POLICY

504.1 MEMBER ELIGIBILITY

SUD Waiver Services are available to all Medicaid members with a known or suspected substance use disorder. 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 BMS to perform administrative review. The prior authorization process is explained in [Section 504.25](#) of this chapter.

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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:

1. appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and

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.

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

The level of care is determined based upon the levels of ASAM® criteria. [ASAM®](#) Dimensions include:

- Dimension 1: Acute Intoxication and/or Withdrawal Potential
- Dimension 2: Biomedical Condition and Complication
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery Environment

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. 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 504.25.1, Prior Authorization Procedures](#) and [Section 504.25.2, Prior Authorization Requirements](#).

504.3 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of SUD Waiver Services must meet all enrollment criteria as described in [Chapter 300, Provider Participation Requirements](#).

504.3.1 Enrollment Requirements: Agency Administration

Each participating provider must develop and maintain a Credentialing Committee composed of the clinical

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supervisor and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring the following activities:

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.
- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the employer. Based on this review, the employer must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

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

504.3.2 Enrollment Requirements: Staff Qualifications

Services may be rendered to Medicaid members by Physician's Assistants under the supervision of a psychiatrist. Services may also be rendered to Medicaid members by an Advanced Practice Registered Nurse (APRN) as defined below. An APRN without a psychiatric certification must function under the direct supervision of a WV Board of Medicine approved supervising physician/psychiatrist. An APRN with a psychiatric certification may practice without direct supervision by a psychiatrist.

An APRN must have a signed collaborative agreement for prescriptive authority with a psychiatrist/physician. The collaborative agreement must document the professional relationship between the APRN and the psychiatrist/physician. 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](#) must be followed. Physician's Assistants and/or APRNs will be referred to as physician extenders throughout the manual.

Board-approved supervisors may only bill for the four psychologists they are supervising. [Board Approved Supervisors](#) may not "trade" supervisees for billing Medicaid services.

Independent practitioners must be licensed to practice independently and must follow the internal regulations of their accrediting body and licensing board for their certification/credentials.

Documentation including required licenses, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between physician assistants/APRNs and physicians, proof of psychiatric certification as applicable, and any other materials

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substantiating an individual's eligibility to perform as a practitioner must be kept on file at the location where Behavioral Health 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 BMS or their contractors or state and federal auditors.

504.4 CRIMINAL BACKGROUND CHECKS

504.4.1 Pre-Screening

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through the WV DHHR designated website: [WV Clearance for Access: Registry & Employment Screening \(WV CARES\)](#).

"Direct access personnel" is defined as an individual who has direct access by 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.

If the applicant has a negative finding on any required registry or licensure database, the applicant will be notified, in writing, of such finding. Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Negative findings that would disqualify an applicant in the WV CARES Rule include:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Healthcare fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property
8. Sexual offenses;
9. Crimes against chastity, morality and decency; and
10. Crimes against public justice.

504.4.2 Fingerprinting

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record information check and may be employed as a provisional employee not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the State Police Criminal Identification Bureau and the Federal Bureau of Investigation to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

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Note: WV CARES can request a name based search when two federal or two state rejections have been received. Once the name based search results are received they will enter a fitness determination.

504.4.3 Employee Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

504.4.4 Provisional Employees

Provisional basis employment for no more than 60 days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or
2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

504.4.5 Variance for Peer Support

The applicant, or the hiring entity may file on the applicant's behalf, a written request for a variance of the fitness determination with WV CARES within 30 days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

1. The passage of time;

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2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues;
3. A demonstration of rehabilitation such as character references, employment history, education, and training; and
4. The relevancy of the disqualifying information with respect to the type of employment sought.

Candidates for peer support should notify WV CARES at the time of admission and submit the request for a variance to the designated mailbox for peer support variances. If a variance is granted and the employee chooses to seek employment with another provider then they may resubmit the request for a variance.

The applicant and the hiring entity will receive written notification of the variance decision within 60 days of receipt of the request.

504.4.6 Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation for instructions.

If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process. The applicant reserves the right to reapply at any time.

504.4.7 Responsibility of the Hiring Entity

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine if the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees.

NOTE: The WV CARES Registry Recheck Report must be researched, printed and maintained on site for each month.

504.4.8 Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases;
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary, if applicable; and

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4. For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

504.4.9 Change in Employment

If an individual applies for employment at another long-term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

1. The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;
2. The prior criminal background check confirmed that the individual did not have a disqualifying offense;
3. The individual received prior approval from the DHHR Secretary to work for or with the health care facility or independent health contractor, if applicable; and
4. No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

504.5 CLINICAL SUPERVISION

The purpose of clinical supervision for comprehensive mental health centers and licensed behavioral health centers is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy, therefore the provider must have a policy for Clinical Supervision including guidelines for the following:

- the responsibilities of the supervisor;
- credentialing requirements of the supervisor, and;
- the minimum frequency for which supervision should occur.

Each agency shall have a chart demonstrating clinical chain of command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision structure.

The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals. This applies to all SUD services rendered.

504.6 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in [Chapter 100. General Administration and Information](#), of the

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Provider Manual and are subject to review by state and federal auditors.

504.7 SUD WAIVER PROVIDER REVIEWS

The primary means of monitoring the quality of SUD services is through provider reviews conducted by the Office of Health Facility Licensure and Certification (OHFLAC) and the contracted agents as determined by BMS as defined by their statement of work.

The contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site SUD provider reviews and/or desk reviews may be conducted by OHFLAC and/or the contracted agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

Upon completion of each provider review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the contracted agent will make available to the provider a draft exit report and a POC to be completed by the SUD service provider. If potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the SUD service provider and issue a final report to the SUD service provider's Executive Director. The final report reflects the service provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of SUD Services. A cover letter to the SUD service provider's Executive Director will outline the following options to effectuate repayment:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the SUD service provider disagrees with the final report, the SUD service provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in [Chapter 100, General Administration and Information](#) of the West Virginia Medicaid Provider Manual. The SUD service provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the contracted agent review, then the SUD service provider will receive a final letter and a final report from BMS.

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For information relating to additional audits that may be conducted for services contained in this chapter please see [Chapter 800, Program Integrity](#) of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

Plan of Correction (POC): In addition to the draft exit report sent to the SUD service providers, the contracted agent will also send a draft POC electronically. SUD service providers are required to complete the POC and electronically submit a POC to the contracted agent for approval within 30 calendar days of receipt of the draft POC from the contracted agent. BMS may place a pay hold on claims if an approved POC is not received by the contracted agent within the specified time frame. The POC must include the following:

1. How the deficient practice for the services cited in the report will be corrected;
2. What system will be put into place to prevent recurrence of the deficient practice;
3. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
4. The date the POC will be completed; and
5. Any provider-specific training requests related to the deficiencies.

504.8 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for SUD Waiver providers and other interested parties as approved by 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.

504.9 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must assure implementation of BMS' policies and procedures pertaining to documentation and case record review, as well as the following:

- The provider must assure implementation of BMS' policies and procedures pertaining to documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid members records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, SUD Waiver Service providers must comply with the documentation and maintenance of records requirements described in [Chapter 100](#).

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[General Administration and Information](#), and [Chapter 300, Provider Participation Requirements](#) of the Provider Manual.

- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a provider and a member except for targeted case management services.
- SUD Waiver services provided via Telehealth must align with [Section 504.10, Telehealth Services](#) of this Chapter. Medicaid will reimburse according to the fee schedule for services provided.
- All residential treatment providers must be approved by BMS prior to providing services. No provider will be reimbursed for residential services unless the provider has been approved by BMS and the services have been prior authorized.
- MCOs may only utilize BMS-approved residential treatment providers.

504.10 TELEHEALTH SERVICES

BMS encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim, the Provider will bill the service code with a GT Modifier. 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.

- Minimum equipment standards are transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network) or proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths. Software that has been developed for the specific use of Telehealth may be used if the software is HIPAA Compliant and abides by a federal code pertaining to Telehealth.
- The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The provider at the distant site is responsible to maintain standards of care within the identified scope of practice.
- All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation that involves patient management.
- The health care agency or entity that has the ultimate responsibility for the care of the patient must be licensed in the State of West Virginia and enrolled as a WV Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.

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- All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- The operator of the Telehealth equipment must be an enrolled provider, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary. Member's consent to receive treatment via Telehealth shall be obtained, and may be included in the member's initial general consent for treatment.
- If the member (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.
- Telehealth services are available via web based applications and/or smartphone applications (apps) if they are HIPAA compliant and utilize a VPN.
- The health care practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:
 - The right to withdraw at any time;
 - A description of the risks, benefits and consequences of telemedicine;
 - Application of all existing confidentiality protections;
 - Right of the patient to documentation regarding all transmitted medical information;
 - Prohibition of dissemination of any patient images or information to other entities without further written consent.

504.11 DOCUMENTATION

BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation, the Bureau will accept both types of documentation. Electronic based systems will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice.

504.11.1 Confidentiality

A 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 West Virginia 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 West Virginia member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such 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 West Virginia 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, are prohibited. All West Virginia Medicaid member information is kept locked

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in a secure place.

504.11.2 HIPAA Regulations

Providers must comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all corresponding federal regulations and rules. The enrolled provider will provide, upon request of 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 BMS. Additional information on HIPAA may be found in [Chapter 300, Provider Participation Requirements](#).

504.12 SBIRT [ASAM®](#) LEVEL 0.5 EARLY INTERVENTION

The Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive, evidenced-based, integrated, public health approach for early identification and intervention with individuals whose patterns of alcohol and/or drug use puts their health at risk. This questionnaire is composed of three separate sections including the Screener (S); a series of brief question use to determine problematic alcohol and/or substance use and severity. The Brief Intervention (BI) focuses on education, increasing the individual's insight and awareness about risks related to unhealthy substance use, and enhances motivation towards healthy behavioral change. Finally, Referral to Treatment (RT) is used to help facilitate access to addiction assessment and treatment.

SBIRT is a required documentation component regardless of the suspected diagnosis of the following CPT and HCPS codes for ages 10 and up:

- 90791
- 90792
- H0031

The SBIRT is required for all initial evaluations under these codes.

504.12.1 Mental Health Assessment By Non-Physician

Procedure Code: H0031
Service Unit: Event
Service Limits: Prior Authorization Required
Telehealth: Available

Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required. See [Section 504.5 Clinical Supervision](#). Staff must be properly credentialed by the agency's internal credentialing committee.

Definition: Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

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Approved Causes for Utilization:

1. Intake/Initial evaluation;
2. Alteration in level of care except for individuals being stepped down related to function of their behavioral health condition to a lesser level of care;
3. Critical treatment juncture, defined as the occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;
The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services;
5. No one under the age of three will have a Mental Health Assessment by Non-Physician conducted on them. The Medicaid member under the age of the three should be referred to the [Birth to Three Program](#). If the child is aging out of the Birth to Three Program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted.

Documentation:

1. Initial/intake (may include use of standardized screening tools):
 - A. Demographic data (name, age, date of birth, etc.);
 - B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
 - C. Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
 - D. History of behavioral health and health treatment (recent and remote);
 - E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
 - F. Medical problems and medications currently prescribed;
 - G. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
 - H. Analysis of available social support system at present;
 - I. Mental status examination;
 - J. Recommended treatment (initial);
 - K. Diagnostic impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
 - L. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator;
 - M. Efficacy of and compliance with past treatment (If past treatment is reported);
 - N. Past treatment history and medication compliance (If past treatment is reported);
 - O. Completed SBIRT is required.
2. Re-assessment:
 - A. Date of last comprehensive assessment;

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- B. Current demographic data;
- C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such).
- D. Changes in situation, behavior, functioning since prior evaluation;
- E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
- F. Mental status examination;
- G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
- H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and
- I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

Note: **H0031**, **T1023HE** and **90791** or **90792** are not to be billed at the same initial intake or re-assessment unless the **H0031** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using **90791** or **90792**.

504.12.2 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (Completed Evaluation)
Service Limits: Prior Authorization Required
Telehealth: Available

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, a physician, a physician extender, or a supervised psychologist who is supervised by a Board Approved Supervisor.

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date of service;
- Location of service;
- Purpose of evaluation;
- Psychiatrist's/Psychologist's signature with credentials;
- Presenting problem;
- History of Medicaid member's presenting illness;
- Duration and frequency of symptoms;
- Current and past medication efficacy and compliance;
- Psychiatric history up to present day;
- Medical history related to behavioral health condition;

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- Mental Status Exam - The Mental Status Exam must include the following elements:
 - Appearance
 - Behavior
 - Attitude
 - Level of consciousness
 - Orientation
 - Speech
 - Mood and affect
 - Thought process/form and thought content
 - Suicidality and homicidality
 - Insight and Judgment
- Members diagnosis per current DSM or ICD methodology;
- Rationale for diagnosis;
- Medicaid member's prognosis for treatment;
- Rationale for prognosis;
- Appropriate recommendations consistent with the findings of the evaluation;
- Completed SBIRT is required.

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

Procedure Code:	90792
Service Unit:	Event (Completed Evaluation)
Service Limits:	Prior Authorization Required
Telehealth:	Available

Staff Credentials: Must be completed by a physician or a physician extender

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other studies.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date of service;
- Location of service;
- Purpose of the evaluation;
- Psychiatrist's signature with credentials;
- Documentation that Medicaid member was present for the evaluation;
- Documentation that the medical evaluation was completed;
- Presenting problem;
- History of the Medicaid member's presenting illness;
- Duration and frequency of symptoms;
- Current and past medication including efficacy and compliance;
- Psychiatric history up to present day;

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- Medical history related to behavioral health condition;
- Mental Status Exam - The Mental Status Exam must include the following elements:
 - Appearance
 - Behavior
 - Attitude
 - Level of consciousness
 - Orientation
 - Speech
 - Mood and affect
 - Thought process/form and thought content
 - Suicidality and homicidality
 - Insight and judgment
- Medicaid member's diagnosis per current DSM and ICD methodology;
- Rationale for diagnosis;
- Medicaid member's prognosis for treatment;
- Rationale for prognosis;
- Appropriate recommendations consistent with the findings of the evaluation;
- Completed SBIRT is required.

504.13 METHADONE ASAM® LEVEL MEDICATION ASSISTED TREATMENT

Procedure Code:	H0020 (Bundle Code)
Service Unit:	Weekly
Service Limits:	Per Calendar Week
Telehealth:	Professional Therapy And Physician Services Only

504.13.1 Staff Credentials

The following are the minimum supervision requirements per degree/credential type:

- **Bachelors' Degree in Human Services without Alcohol and Drug Counselor Credential:** Indirect supervision required by Clinical Supervisor, Advanced Alcohol and Drug Counselor
- **Masters' Degree Only, includes Licensed Clinical Social Worker and Licensed Graduate Social Worker:** Must be supervised (can be indirect by Advanced Alcohol and Drug Counselor)
- **Doctoral Level, Non-Licensed:** Must be supervised by Alcohol and Drug Counselor or Advanced Alcohol and Drug Counselor (can be indirect)

The following providers do not require supervision:

- Licensed Independent Clinical Social Worker
- Licensed Psychologist
- Board Supervised Psychologist
- Licensed Professional Counselor
- National Certified Addiction Counselor II
- Masters Addiction Counselor
- BA/BS in Human Services with Alcohol and Drug Counselor Credential

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504.13.2 Assessing a Patient for Opioid Treatment Program Initiation

There are several important areas on which to concentrate regarding a patient history for this population of patients.

1. Ensure the patient has a DSM-5 diagnosis of moderate to severe opioid use disorder;
2. Complete a medical history which should include:
 - Potential risks for methadone toxicity prior to opioid treatment program initiation (benzodiazepine) use, age, etc.;
 - Patterns of use of all major drug classes (including tobacco, alcohol and caffeine);
 - Previous addiction treatment history and response;
 - High risk behavior such as needle sharing and exchanging sex for drugs;
 - Legal history;
 - Psychiatric history and current mental status including suicidal ideation;
 - Social-economic situation including, employment, housing, supports, child custody, and partner's drug-use history;
 - Details regarding chronic or recurrent pain; and
 - A list of current medications.

This information should be included when using H0031, 90791 and 90792 for assessment and evaluations. See [Section 504.12 SBIRT ASAM® Level 0.5 Early Intervention](#).

<u>Phase of Treatment</u>	<u>Missed Doses</u>	<u>Action</u>	<u>Dose Change</u>
Early Stabilization	24 hours missed	No dose increase	No change
Early Stabilization	48 hours	Reevaluate patient	Start from initial dose
Late Stabilization/ Maintenance	1-2 days	If patient not intoxicated, continue current dose.	No change
Late Stabilization/ Maintenance	3 days	Reassess Patient Urine Drug Screen	Restart at 50% of dose, then increase dose to no more than 10 mg daily for a maximum of 3 days
Late Stabilization/ Maintenance	4 or more days	Reassess Patient Urine Drug Screen	Restart at 30 mg or less and titrate per usual

504.13.3 Therapy and Phases

Medicaid members receiving the medication methadone must meet the minimum therapy requirements to continue this Medication Assisted Treatment (MAT) Program.

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Phase 1: During their first 12 months of MAT, a member is required to have at least four hours of therapy per month from their date of intake. A minimum of three of these therapies must be in a group setting. The fourth therapy can be a choice of individual, group, or family as based on the member's service plan and assessed need.

Phase 2: A member who has completed 12 months of MAT and shown compliance with urine drug screens and therapy requirements is required to have a minimum of one hour of therapy per calendar month. This therapy may be a group, individual or family session based on the member's service plan.

The physician/physician extender who is responsible for the member's MAT is required to move a member from phase 2 to phase 1 if there is non-compliance with therapy or urine drug screens. As part of this process, the physician/physician extender must request a review of the therapeutic component in terms of effectiveness, relationship to medication adherence, the need for treatment adjustments, etc. The physician/physician extender and the treating clinician will consult on revisions to the treatment plan and therapeutic approach that will be made to potentially improve adherence to the medication regimen.

Urine drug screen requirements: Phase 1 members are required to have two random urine drug screens per calendar month. Phase 2 member are required to have one random drug screen per month. In addition to urine screens, the physician/physician extender is responsible for monitoring alcohol use during treatment and assessing patients for alcohol use disorders as appropriate.

These requirements are in addition to any requirements that can be found in the Legislative Rule [69 CSR 11](#) as governed by OHFLAC.

504.13.3.1 Induction Phase

The physician/physician extender should base the initial methadone dose on the patient's underlying risk for methadone toxicity. Sedating drugs, including over-the-counter medications such as diphenhydramine, prescribed medications such as antipsychotics, sedating antidepressants and therapeutic doses of benzodiazepines, or drugs of abuse, such as medical grade marijuana, can increase the risk of methadone toxicity and lead to an overdose. The physician/physician extender prescribing methadone should look for benzodiazepine use in the initial drug screen.

Opioid tolerance is difficult to establish by history, so it is safer to initiate methadone therapy at a lower dose. Lowered tolerance is likely in patients who report non-daily opioid use, daily use of codeine, or daily use of oral opioids at moderate doses. Typically, patients who use opioids intra-nasally have a lower tolerance than patients who inject opioids. Tolerance is lower in patients who have been abstinent for more than a few days, e.g., patients who have been recently discharged from a correctional facility, detox center or treatment center.

504.13.3.2 Early Stabilization Phase (0 – 2 Weeks)

Dosage increases during the early stabilization phase should take place only after an in-person opioid treatment program physician/physician extender assessment and for patients who are experiencing cravings, ongoing opioid use, and/or several opioid withdrawal symptoms. Physicians or physician extenders in consultation with the physician should assess patients at least once a week during this phase.

During the early stabilization phase, patients should be on the same dose for at least three consecutive days with no missed doses before an increase. If two consecutive doses are missed during the early stabilization phase, the physician/physician extender should cancel the prescription until the patient can be reassessed. The patient must

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be reassessed in person by the physician or physician extender in consultation with the physician and restarted at 30 mg or less.

504.13.3.3 Late Stabilization Phase (2 – 6 Weeks)

Dose increases during the late stabilization phase should be the same as during the early stabilization phase until a dose of 80 mg is reached. Dose increases during the late stabilization phase should take place with an in-person opioid treatment program clinician discussion with patients who are experiencing cravings, ongoing opioid use, and/or signs of multiple opioid withdrawal symptoms. Opioid treatment program clinical staff should assess patients at least once weekly during this phase.

504.13.3.4 Maintenance Phase (6+ Weeks)

The physician/physician extender can reach the maintenance dose for most their patients within 2-8 weeks of initiating methadone. However, all patients must be treated on an individualized basis and some may not reach their optimal dose until up to 12 weeks. The optimal dose range for most opioid treatment program patients is 60-120 mg. During the maintenance phase (when the dose is 80 mg or more), the physician/physician extender should increase the dose by no more than 5-10 mg every 5-7 days. Dose increases during the maintenance phase should take place with an in-person opioid treatment program physician assessment or physician extender in consultation with the physician for patients who are experiencing cravings, ongoing opioid use, and/or several opioid withdrawal symptoms. Opioid treatment program clinical staff should assess patients once weekly when ongoing dose adjustments are occurring and less frequently thereafter as required.

504.13.4 Dosing Requirements

The following dosing requirements must be followed by the Medication Assisted Treatment (MAT) program.

504.13.4.1 Patient Factors to Determine Initial Dose Parameters

1. Recent abstinence from opioids = 10 mg or less
2. Higher risk for methadone toxicity = 20 mg or less
3. No risk factors and recent abstinence = 30 mg or less

504.13.4.2 Dosing Adjustments During Early and Late Stabilization Phases

1. Recent abstinence from opioids = 5 mg or less every five days or more
2. Higher risk for methadone toxicity = 5-10 mg every 3-5 days
3. No risk factors and recent abstinence = 10-15 mg every 3-5 days

504.13.4.3 Missed Doses

If three or more consecutive doses are missed during the late stabilization phase, the physician or physician extender after consultation with the physician should cancel the prescription until the patient can be reassessed by the physician or physician extender in consultation with the physician. The patient must be reassessed in person by the physician or physician extender in consultation with the physician. After three consecutive days missed, the dose should be decreased to 30 mg or 50% of the current dose. After four or more consecutive days missed, the

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dose should be decreased to 30 mg or less. Missed doses during maintenance should be treated the same as those for late stabilization.

504.13.4.4 Managing Missed Doses

Missed doses may indicate a variety of problems, including relapse to alcohol or other drug use. Therefore, the physician or physician extender in consultation with the physician should reassess the patient's clinical stability. As part of this process, the physician/physician extender must request a review of the therapeutic component in terms of effectiveness, relationship to medication adherence, the need for treatment adjustments, etc. The physician/physician extender and the treating clinician will consult on revisions to the treatment plan and therapeutic approach that will be made to potentially improve adherence to the medication regimen.

Dosing personnel should report missed doses to the opiate treatment program physician/physician extender in a timely fashion. A clinically significant loss of tolerance to opioids may occur within as little as three days without methadone; therefore, the opioid treatment clinician should reduce the methadone dose in patients who have missed three consecutive days. The dose can be rapidly increased once the response to the lower dose is assessed.

504.13.4.5 Doses Below 60 mg

There is evidence that methadone doses of 60–100 mg are more effective than doses below 60 mg for reducing heroin use and retaining patients in treatment. However, maintenance doses below 60 mg are justified for patients who have no unauthorized opioid use, report no significant withdrawal symptoms or cravings, are at high-risk for methadone toxicity, or are on a tapering protocol.

504.13.4.6 Doses Above 120 mg

Opioids such as methadone have several side effects that may be dose related, including sedation, overdose leading to death, sleep apnea and sexual dysfunction. High methadone doses are also associated with a prolonged QT interval which can cause Torsades de Pointes, a ventricular arrhythmia.

504.13.4.7 Assessment, Monitoring and Management On High Doses

A trial of tapering is indicated for patients who report sedation when on high doses. While tapering is based on the clinical assessment by the physician/physician extender clinical experience suggests that tapering by an overall decrease of 20-40 mg is tolerated well, and patients often report that they feel more alert and energetic.

504.13.4.8 Ongoing Withdrawal Symptoms in Patients with High Doses

Patients with ongoing withdrawal symptoms despite high methadone doses require ongoing assessment by the physician/physician extender. Possible causes include the rapid metabolism of methadone. The use of medications that increase the metabolism of methadone such as phenytoin, chronic alcohol use, or the ongoing use of cocaine (a methadone inducer) in large doses may result in the patient complaining of the need for a dose increase. Although controversial, peak and trough levels might be useful in patients who continue to report withdrawal symptoms despite doses of 120 mg or higher.

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Additional reasons for ongoing withdrawal symptoms may include the increased tolerance caused by ongoing opioid use and then opioid cessation or dose diversion, such as consuming partial amounts of the take-home dose and selling the rest.

“Pseudo-normalization” can occur after a methadone dose increase and some patients experience very mild mood elevation. They develop tolerance to this effect after a few weeks, prompting them to seek another dose increase. Insomnia, anxiety, fatigue and other psychiatric symptoms are such a prominent feature of opioid withdrawal that patients may incorrectly attribute these symptoms to withdrawal.

504.13.5 Variance

While it is common practice to provide group therapy as a standard model for substance abuse treatment, individualized treatment plans may contraindicate group therapy, in lieu of individual therapy, as a standard treatment practice. A provider may request a variance per member, by supplying a copy of the member's service plan to the designated employees of BMS, including the documented clinical reason why group therapy is not needed. BMS will be responsible for providing a letter of acceptance or denial within ten calendar days of the request for variance being received. At minimum, the required therapy must be completed as required during this review period. See [Section 504.13.3 Therapy and Phases](#).

504.14 – 504.22 Reserved For Future Use

This manual will include additional sections providing information regarding Naloxone, Peer Recovery Support Specialists, and all levels of Short-Term Residential Treatment as determined by ASAM® levels including Withdrawal Management, Intensive Outpatient, and Partial Hospitalizations Programs. These changes will be released in a future update.

504.23 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services apply pursuant to [Chapter 100, General Administration and Information](#) of the Provider Manual.

504.24 SERVICE EXCLUSIONS

In addition to the exclusions listed in [Chapter 100, General Administration and Information](#), reimbursement is not allowed for the following services:

- Telephone consultations;
- Meeting with the Medicaid member or Medicaid 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 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.

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504.25 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Intensive Outpatient Program (IOP) Services described in this chapter.

- BMS requires that providers register and receive prior authorization for **all** IOP Services and Partial Hospitalization Program (PHP) services. Prior authorization must be obtained from BMS' UMC.
- Prior authorization requests must be submitted within the timelines and in the manner required by BMS' UMC

General information on prior authorization requirements for additional services and contact information for submitting a request may be obtained by contacting BMS' UMC.

504.26 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to [Chapter 100, General Administration and 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 WV Medicaid 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 BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request;
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

504.27 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 BMS to process the claim for payment;
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered;
- Claims must be accurately completed with 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

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- 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](#): A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse 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.

ASAM® Criteria: The ASAM® (American Society of Addiction Medicine) 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 patients or patients' families

Clinical Supervisor (CS): 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. The occurrence constitutes a change in the member's needs that require services, treatment, or

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interventions to be decreased, increased or changed. The member's needs affected would be related to their behavioral health, physical health, change in setting or crisis.

Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

Direct Access Personnel: An individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel do not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

Direct Supervision: Supervision that is provided by a licensed individual who monitors OTP 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 IOP Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Freedom of Choice: The guaranteed right of a member to select a participating provider of their choice.

Foster Child: The West Virginia DHHR 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, child care institutions, and pre-adoptive homes.

Human Services Degree: A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

- 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 OTP providers, but is not required to be present, in the setting when services are being rendered.

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Intensive Outpatient Program (IOP): 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 IOP program and prior authorization for members admitted to an IOP 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 WV State Board of Examiners for Licensed Practical Nurses.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the WV Board of Examiners of Psychologist and is in current good standing with the board.

Masters Addiction Counselor (MAC): 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): is the use of FDA-approved medications in combination with evidence-based behavioral therapies to provide a whole-patient approach to treating SUDs.

Methadone: A synthetic opiate. The most common medical use for methadone is as a legal substitute for heroin in treatment programs for drug addiction.

Naloxone: A drug that antagonizes morphine and other opiates. Naloxone is a pure opiate antagonist and prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension. Sold under the brand name of Narcan and in combination with buprenorphine as Suboxone.

National Certified Addiction Counselor (NCAC): 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 West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Physician: As defined in [West Virginia Code Annotated §30-3-10](#), an individual who has been issued a license to practice medicine in the state of WV by the WV Board of Medicine and is in good standing with the board; or an individual licensed by the WV Board of Osteopathy in accordance with [West Virginia Code Annotated 30-14-6](#).

Physician's Assistant: 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

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attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Physician Extender: A medical professional including an advanced practice registered nurse or a Physician's Assistant 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.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Substance Use Disorder (SUD) Services: Services that are medical or remedial that recommended by a physician, physician extender, licensed psychologist, or supervised psychologist for the purpose of reducing a physical or mental disability and restoration of a member to his/her pre-morbid functioning level. These services are designed for all members with conditions associated with substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. SUDs occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the current DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. SUD Services may be provided to members in a variety of settings, including in the home, community, or a residential program, but do not include services provided in an inpatient setting.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D, or Ed.D. and has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Utilization Management Contractor (UMC): The contracted agent of BMS.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Substance Use Disorder Services	January 1, 2018