

# Chapter 503

## LICENSED BEHAVIORAL HEALTH CENTERS

  

### Appendix 503 F

## RESIDENTIAL CHILDREN'S SERVICES

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**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.

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### BACKGROUND

Residential Children's Services are comprehensive programs for those children who, when professionally evaluated, demonstrate a combination of diagnostic, functional, behavioral, or social support conditions which indicate they must be served in residential settings outside their families, and in some instances outside a regular school setting. Services must include a comprehensive array of treatment/intervention modalities in accordance with the service description for which the provider is certified and must be clinically appropriate for the type of children receiving these services.

### PROVIDER ENROLLMENT

In order to participate in the West Virginia Medicaid Program and receive payment from the West Virginia Bureau for Medical Services (BMS) for covered services provided to West Virginia Medicaid members, providers of Residential Children's Services must be approved through BMS' fiscal agent enrollment process **prior** to billing for any services. Providers of Residential Children's Services must meet all enrollment criteria as described in [Chapter 300, Provider Participation Requirements](#). All Residential Child Care and Treatment Facilities and Child Placing Agencies must be issued a Child Care License or Certificate of Approval by the Bureau for Children and Families (BCF) Residential Child Care Licensing Unit to begin and continue operation in West Virginia. [WV Code 49-2B et.seq.](#) defines, directs, and authorizes the Child Care Licensing function. The rules under [78CSR3](#) for Residential Child Care and Treatment Facilities and Child Placing Agencies articulate the compliance requirements for licensure. The licensing process includes rulemaking, inspection, evaluation, and enforcement.

This service can only be reimbursed to agencies dually licensed as Licensed Behavioral Health Centers (LBHC) and as childcare group residential facilities, and only for those programs which meet the certification standards noted above.

In addition to the licensing and certification requirements, all Residential Children's Services providers must maintain good standing with the BMS, BCF, and the West Virginia Department of Education (DOE), in order to continue to participate as a West Virginia Medicaid provider. The BMS requires that all educational instruction for West Virginia Medicaid members meet West Virginia DOE standards. West Virginia is the final arbitrator of whether the treatment services or educational standards are sufficient for West Virginia Medicaid members. Failure to remain in good standing with the BCF and/or DOE resulting in admission restrictions by the BCF or if the state agency licensing the facility places admission restrictions on the facility as a result of a negative review of services, the BMS will place admission restrictions on the facility until the negative action is corrected and the BCF/BMS are notified by the licensing agency that the admission restrictions have been lifted.

In addition to the West Virginia Medicaid Provider Agreement, an agreement specific to Residential Treatment Services must be signed/dated by the Administrator. This agreement may be renewed at the BMS' discretion and is subject to the terms and conditions contained therein and all applicable state and federal law and regulations.

### EXCLUSION FOR BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE

While working in a Residential Children's facility, the Behavioral Health Counseling, Supportive (group and individual) can be credentialed from two separate processes:

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1. As defined in [Chapter 503 Licensed Behavioral Health Centers](#) “Individuals providing this service must have a *bachelor’s degree in a human services field or a high school diploma or GED with two years documented experience in mental health and/or substance abuse services. Staff must be properly supervised according to the BMS policy on clinical supervision. The service may be provided in a variety of settings by appropriately designated, trained, and supervised staff*”, **or**
2. Individuals providing this service must have a bachelor’s degree or a high school diploma or GED and complete the Residential Children’s Supportive Counseling Certification that was developed and maintained through the collaboration of the Residential Children’s Service providers and must be adopted by any residential provider that chooses to use this service under this provision. This includes core training modules, with a pre- and post-test, as well as 90 days of an on-the-job shadowing program. Core training modules include:
  - Away from Supervision (AFS) Training
  - Trauma Training
  - Diagnoses and Developmentally Appropriate Behavior
  - Confidentiality
  - Mandated Reporting
  - Policies and Procedures
  - Crisis Prevention and De-escalation (CPI/TCI)
  - Module Pre-Test Quiz
  - Module Post-Test Quiz

Training for core modules must be provided by a trained clinician within their scope of practice. Additional modules for training can be added (but are not mandatory) for facilities who have a specific population such as, but not limited to, children involved in human trafficking, children with substance use diagnosis, other specific mental health diagnosis, etc. After successful completion of core modules and shadowing, an employee must continue to be properly supervised according to the BMS policy on clinical supervision in [Chapter 503 Licensed Behavioral Health Centers](#). The personnel file must contain documentation for each of these certifications and pre-test and post-test quizzes with the appropriate correlating modules.

This certification process for Behavioral Health Counseling, Supportive Exclusion can only be used while employed by a Residential Children’s Facility and cannot be transferred to different provider type. If this occurs, the criteria for Behavioral Health Counseling, Supportive reverts to the criteria defined in [Chapter 503 Licensed Behavioral Health Centers](#). An employee cannot bill for supportive counseling services until core modules and the 90 day shadowing period has been successfully completed.

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### RESIDENTIAL CHILDREN’S SERVICES LEVEL I

Residential Children’s Services, Level I is a structured 24-hour therapeutic group care setting targeting youth with a confirmed International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis that manifests itself through adjustment difficulties in school, home, and/or the community. This level of care is designed for children or youth whose needs can best be met in a community-based setting where the child can remain involved in community-based school and recreational activities. These youths usually can function in public school and in a group residential

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setting with a minimal amount of supportive services and behavioral interventions. The goal of supportive residential programs is to enable children to overcome their problems to the degree that they may move to a less restrictive community placement or independent living situation.

This level of care is appropriate for members whose relationship with their families or whose family situations, level of development, and social or emotional problems are such that family ties and relationships cannot be established and/or maintained in a less restrictive environment, or who are in transition from a more intensive form of care.

Members in need of this level of care display impaired abilities in the social, communication, or daily living skills domains. Life-threatening symptoms are generally absent. They generally are able to interact appropriately in social settings with a minimal amount of adjustment problems. Although they may display emotional problems such as anxiety, depression, avoidance, etc., these are not part of a persistent, long-term pattern, nor do they preclude normal social functioning in most school or community settings. If aggression is present, the behavior is not of a degree or at a frequency to require ongoing measures of control (restraint, hospitalization, and chemical interventions) and treatment generally occurs with logical/natural consequences and supportive counseling interventions.

**ADMISSION CRITERIA:** The following admission criteria must be met:

- The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to serve a child who does not meet the age requirements, and
- The child has a behavioral health diagnosis that meets medical necessity for Residential Children's Services Level I, and
- The child demonstrates low to moderate symptoms or functional impairment which interfere with age appropriate adaptive and psychological functioning and social problem solving that prohibit a relationship with a family, or whose family situation and functioning are such that the child cannot accept family ties or establish relationships in a less restrictive setting, and
- The child's symptoms and functional impairment are such that the treatment team needs are best met in a community-based structured setting where the client can remain involved in the community, school and recreational activities, and cannot be successfully provided in a less intensive level of care.

Additional criteria to establish admission are:

- The child will have a Children and Adolescent Functional Assessment of Strengths (CAFAS) score indicating a level of functioning in the mild to moderate range, which indicates that this is an appropriate level of service and a more appropriate living arrangement is not available, **or**
- The child is in need of a "step down" from a more restrictive level of care as part of a transitional discharge plan.

Admission solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary are not reimbursable by Medicaid.

**CONTINUING STAY CRITERIA:** The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in the West Virginia Department of Health

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and Human Resources' (DHHR) custody, and

- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and the child continues to exhibit symptoms and/or functional impairment such that treatment needs are best met in a community-based setting where the child can remain involved in the community, school and recreational activities, or
- The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, or
- The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child demonstrates new symptoms or functional impairment in adaptive and/or psychological functioning, and problem solving, which met the criteria for admission, or
- The child's symptoms have diminished and functional impairment has improved, but there are continuing symptoms and functional impairment in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, or
- The child demonstrates an inability to sustain gains without the therapeutic service provided by the Residential Children's Services Level I program.

**DISCHARGE CRITERIA:** Discharge planning begins during the intake and placement process. When the initial and/or ongoing service plans are being developed with the member and the family, social worker, child protective service workers, youth service worker, advocacy personnel and/or court liaisons, discharge plans are made, and continue as part of an ongoing treatment process. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, arranging for other levels of care, informing the member of the plan, or helping the member prepare for emancipation. Medicaid reimbursement for Residential Children's Services ends if one of the following has been met:

- The child has attained the age of 18 or 22 if the youth remained in DHHR custody.
- The child or family has attained goals as identified in the service plan or symptoms have decreased to the point where the child may be served in a less intensive treatment service.
- The child demonstrates functional impairment and symptoms, which cannot be treated safely and effectively at this level of treatment, and the child requires a higher level of care.
- The child has been on runaway status/away from supervision for a period of five days or more.
- Care appears to be custodial.

**PROGRAM REQUIREMENTS:** Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. The following comprehensive array of services included in the per diem procedure code H0019U1 are:

- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development (H0032)
- Targeted Case Management (T1017)



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- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Skills Training and Development (H2014U1, H2014U4, H2014HNU1, H2014HNU4)
- Therapeutic Behavioral Services – Implementation (H2019)

These services must be provided and documented in accordance with the minimum standards established by the BMS in Appendix 503 F of the Provider Manual, [Chapter 503 Licensed Behavioral Health Centers](#), and with the certification standards established by [78CSR3](#).

**PROCEDURE CODE:** H0019U1

**SERVICE UNIT:** 24 hours

**SERVICE LIMITS:** One per day - All units must be prior authorized

### RESIDENTIAL CHILDREN'S SERVICES LEVEL II

Residential Children's Services, Level II is a structured 24-hour therapeutic group care setting targeting youth with a confirmed ICD or DSM diagnosis that manifests itself in the form of moderate to severe adjustment difficulties in school, home, and/or the community. These youths cannot function in a public-school setting without significant psychosocial and psychoeducational support. In the residential care setting they require substantial professional level treatment services and behavioral interventions that normally require a multidisciplinary team. The goals of intermediate residential treatment programs are to develop interpersonal skills and to remediate social skill deficits and disruptive behavior patterns that preclude living in a less restrictive environment.

Children served at this level are characterized by persistent patterns of disruptive behavior and exhibit disturbances in age-appropriate adaptive functioning and social problem solving. Disturbance in psychological functioning is common and may present some risk of causing harm to themselves or others.

This population generally displays emotional problems and/or persistent behavior patterns challenging enough to preclude socially appropriate functioning in family, school, and community contacts without behavior management and additional structure and support.

Most often the children display multi-agency needs that require interagency planning and interventions including behavioral health, education, child welfare, juvenile justice, and others. In this target population, children display a persistent pattern of challenging behavior that has been present for at least one year and is not a reaction to a single precipitating event.

Children in Level II have an ICD or DSM diagnosis usually in the disruptive behavior disorders, mood disorders, or in the psychoactive substance use disorder categories. Their social functioning limitations are significant to a degree that they require up to 24 hours of supervision, structure and support upon admission. Generally, they respond well to structure and treatment, and the level of supervision required initially can be gradually withdrawn. From time to time, they can present a danger to themselves or others, but this is not a routine issue in treatment. They possess cognitive capacity and can participate in academic and vocational education, but often require specialized instruction and a modified learning environment within a public or alternative secondary or primary school setting.

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**ADMISSION CRITERIA:** The following admission criteria must be met:

- The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to serve a child who does not meet the age requirements, and
- The child has a behavioral health diagnosis that meets medical necessity for Residential Children's Services Level II, and
- The child demonstrates low to moderate to severe symptoms or functional impairment which interfere with age-appropriate adaptive and psychological functioning and social problem solving that prohibits a relationship with a family, or whose family situation and functioning level are such that the child cannot accept family ties or establish relationships in a less restrictive setting, and
- The child's symptoms or functional impairments are such that the treatment cannot be successfully provided in a less intensive level of care, and
- The child's symptoms or functional impairments have existed for duration of six months or longer, and are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community.

Additional criteria to establish admission are:

- The child will have a CAFAS score indicating moderate to severe functional impairment and this is the appropriate level of service, **or**
- The child is in need of a "step down" from a more restrictive level of care as part of a transitional discharge plan (e.g., symptoms or functional impairments remain at a level that requires out-of-home treatment, but not at a level that would require continued psychiatric hospitalization).

Admission solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary are not reimbursable by Medicaid.

**CONTINUING STAY CRITERIA:** The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in DHHR custody, and
- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and
- The child continues to exhibit symptoms and functional impairment such that treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, or
- The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, or
- The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child demonstrates new symptoms or functional impairments in the child's adaptive and/or psychological functioning, and problem solving, which met the criteria for admission, or
- The child's symptoms and functional impairments have diminished, but there are continuing symptoms and functional impairment in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, or



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- The child demonstrates an inability to sustain gains without the therapeutic service provided by the Residential Children's Services Level II program.

**DISCHARGE CRITERIA:** Discharge planning begins during the intake and placement process. When the initial and/or ongoing service plans are being developed with the member and the family, social worker, child protective service workers, youth service worker, advocacy personnel and/or court liaisons, discharge plans are made, and continue as part of an ongoing treatment process. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, arranging for other levels of care, informing the member of the plan, or helping the member prepare for emancipation.

- The child has attained the age of 18 or 22 if the youth remained in DHHR custody.
- The child or family has attained goals as identified in the service plan or symptoms and functional impairment have decreased to the point where the child may be served in a less intensive treatment service.
- The child demonstrates functional impairment and symptoms, which cannot be treated safely and effectively at this level of treatment, and the child requires a higher level of care.
- The child has been on runaway status/away from supervision for a period of five days or more.
- Care appears to be custodial.

**PROGRAM REQUIREMENTS:** Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. The following comprehensive array of services included in the per diem procedure code H0019U2 are:

- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development (H0032)
- Targeted Case Management (T1017)
- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO)
- Behavioral Health Counseling, Professional, Group (H0004HOHQ)
- Skills Training and Development (H2014U1, H2014U4, H2014HNU1, H2014HNU4)
- Therapeutic Behavioral Services – Implementation (H2019)
- Therapeutic Behavioral Services – Development (H2019HO)
- Crisis Intervention 24-hour availability (H2011)
- Psychotherapy (90832, 90834, 90837)
- Psychotherapy for Crisis (90839, 90840)
- Family Psychotherapy (90846, 90847)
- Group Psychotherapy (90853)

These services must be provided and documented in accordance with the minimum standards established by the BMS in Appendix 503 F of the Provider Manual, [Chapter 503 Licensed Behavioral Health Centers](#), and with the certification standards established by [78CSR3](#).

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**PROCEDURE CODE:** H0019U2  
**SERVICE UNIT:** 24 hours  
**SERVICE LIMITS:** One per day - All units must be prior authorized

### RESIDENTIAL CHILDREN'S SERVICES LEVEL III

Residential Children's Services, Level III is a highly-structured, intensively-staffed, 24-hour group care setting targeting youth with a confirmed ICD or DSM diagnosis which manifests itself in severe disturbances in conduct and emotions. As a result, they are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment. All planned activities and applied interventions are designed with the goal of stabilizing the child's serious mental condition.

The service plan is implemented in all aspects of the child's daily living routine. The focus of intensive residential treatment is on psychosocial rehabilitation aimed at returning the child to an adequate level of functioning. In the case of children and adolescents, this includes rehabilitation in instances where psychiatric or substance abuse disorders have significantly disrupted the achievement of the expected development level.

This level of care is comprised of children who display seriously disordered behaviors with sufficient frequency to be considered an established pattern of long duration, or are so intense that they preclude social interaction in school, family, or community environments. Often, they exhibit persistent or unpredictable aggression, serious sexual acting out behavior, and marked withdrawal and depression. Symptoms of thought disorder are often present. They routinely present a significant danger to themselves or others.

Children in Level III have ICD or DSM diagnoses that include major depression, bipolar disorders, post-traumatic stress disorders, other anxiety disorders, thought disorders, and personality disorders. Where the focus of care has been on antisocial and dangerous behavior patterns, an initial diagnosis of Conduct Disorder, Severe, may be present. However, in many of these cases, underlying significant psychiatric disturbance will reveal itself during the course of treatment.

Substantial social, academic, and vocational functional limitations are characteristics of the population's behavior pattern, and as a result, they require substantial environmental structure and controls including 24-hour awake supervision, verbal crisis response, medical management, chemical interventions, physical restraint, and alternative learning environments. The key element is that these children present behaviors so intense, severe, and unpredictable to be seriously detrimental to their growth, development and welfare, or to the safety of others.

**ADMISSION CRITERIA:** The following admission criteria must be met:

- The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to serve a child who does not meet the age requirements, and
- The child has a behavioral health diagnosis that meets medical necessity for Residential Children's Services Level III, and

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- The child has severe symptoms and functional impairments which interfere with age-appropriate adaptive and psychological functioning and social problem solving, and
- The child's symptoms or functional impairments are such that the treatment cannot be successfully provided in a less intensive level of care, and
- The child's symptoms or functional impairments have existed for a duration of one year or longer, and are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community.

Additional criteria to establish admission are:

- The child will have a CAFAS score indicating severe functional impairment and this is the appropriate level of care, **or**
- The child is in need of a "step down" from a more restrictive level of care as part of a transitional discharge plan (e.g., symptoms or functional impairments remain at a level that requires out-of-home treatment, but not at a level that would require continued psychiatric hospitalization).

Admission is not solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary are not reimbursable by Medicaid.

**CONTINUING STAY CRITERIA:** The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in DHHR custody, and
- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and
- The child continues to exhibit an inability to sustain gains without the comprehensive program of therapeutic services provided by the Residential Children's Services Level III, or
- The child continues to exhibit symptoms and functional impairments so severe and complex that treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, or
- The child's symptoms and functional impairments which warranted admission to this level of service have been observed and documented, but treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, or
- The child demonstrates new symptoms or functional impairments which interfere with age-appropriate adaptive and/or psychological functioning, and problem solving, which meet the criteria for admission, or
- The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child's symptoms and functional impairments have diminished, but there are continuing disturbances/behaviors/symptoms in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions.

**DISCHARGE CRITERIA:** Discharge planning begins during the intake and placement process. When the initial and/or ongoing service plans are being developed with the member and the family, social worker, child protective service workers, youth service worker, advocacy personnel and/or court liaisons, discharge plans are made, and continue as part of an ongoing treatment process. After determining a

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tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, arranging for other levels of care, informing the member of the plan, or helping the member prepare for emancipation.

- The child has attained the age of 18 or 22 if the youth remained in DHHR custody, or
- The child or family has attained goals as identified in the service plan or symptoms and functional impairments have decreased to the point where the child may be served in a less intensive treatment service, or
- The child demonstrates symptoms or functional impairments which cannot be treated safely or effectively at this level of treatment, and the child requires a higher level of care, or
- The child has been on runaway status/away from supervision for a period of five days or more, or
- Care appears to be custodial.

**PROGRAM REQUIREMENTS:** Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. The following comprehensive array of services included in the per diem procedure code H0019U3 are:

- Mental Health Assessment by a Non-Physician (H0031).
- Mental Health Service Plan Development (H0032)
- Mental Health Service Plan Development by Psychologist (H0032AH)
- Physician Coordinated Care Oversight Services (G9008)
- Targeted Case Management (T1017)
- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO)
- Behavioral Health Counseling, Professional, Group (H0004HOHQ)
- Skills Training and Development (H2014U1, H2014U4, H2014HNU1, H2014HNU4)
- Therapeutic Behavioral Services – Implementation (H2019)
- Therapeutic Behavioral Services – Development (H2019HO)
- Crisis Intervention 24-hour availability (H2011)
- Psychotherapy (90832, 90834, 90837)
- Psychotherapy for Crisis (90839, 90840)
- Family Psychotherapy (90846, 90847)
- Group Psychotherapy (90853)
- Comprehensive Medication Services (Clozaril, Lithium, Depakote) (H2010)
- Injection Haldol (J1630)
- Injection Prolixin (J2680)
- Psychological Testing with Interpretation and Report (96130, 96131, 96136, 96137)
- Psychiatric Diagnostic Evaluation (90791, 90792)
- Screening by Licensed Psychologist (T1023HE)
- Developmental Testing: Limited and Extended (96110, 96111)
- Any needed Behavioral Health Service including psychiatric evaluation and management services

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All Residential Children's Services Level III providers must provide on-campus schooling.

These services must be provided and documented in accordance with the minimum standards established by the BMS in Appendix 503 F of the Provider Manual, [Chapter 503 Licensed Behavioral Health Centers](#), and with the certification standards established by [78CSR3](#).

**PROCEDURE CODE:** H0019U3  
**SERVICE UNIT:** 24 hours  
**SERVICE LIMITS:** One per day - All units must be prior authorized

### BEHAVIORAL HEALTH: SHORT-TERM RESIDENTIAL (LEVEL IV)

Short-Term Residential (Level IV) is a highly-structured, intensively-staffed, 24-hour group crisis residential care setting. It must be provided in a site licensed as a Children's Emergency Shelter by the DHHR. The service is delivered in an environment that is safe, supportive, and therapeutic. The purpose of this service is to provide a supportive environment designed to minimize stress and emotional instability which may have resulted from family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of a child from a failed placement or other current living situation.

**ADMISSION CRITERIA:** The following admission criteria must be met:

- The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to serve a child who does not meet the age requirements, and
- The child is experiencing a crisis due to a mental condition or impairment in functioning due to a problematic family setting. The child may be displaying behaviors and/or impairments ranging from impaired abilities in the social, communication, or daily living skills domains to severe disturbances in conduct and emotion. The crisis results in emotional instability which may be caused by family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of the child from a failed placement or other current living situation, **and**
- The child is in need of 24-hour treatment intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the child's needs based on the documented response to prior treatment and/or intervention, or
- The child is in need of 24-hour treatment/intervention to prevent hospitalization (e.g., the child engages in self-injurious behavior, but not at a level of severity that would require psychiatric hospitalization, or the child is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization), or
- The child is in need of step-down from a more restrictive level of care as part of a transitional discharge plan (e.g., behaviors/symptoms remain at a level which requires out of home care, but the placement plan has not been fully implemented).

**CONTINUING STAY CRITERIA:** For those cases in which it is considered necessary to continue a child's participation in the program, a physician's order and appropriate justification with related documentation are required. Short-term residential services may be extended in those cases where appropriate clinical criteria for continued service are met, and the extension has prior authorization approval by the BMS'



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contracted agent. The child must meet one of the following criteria to receive approval for a continued care extension:

- The child is under the age of 18 or 22 if the youth is in DHHR custody, and
- Symptoms, behaviors, or conditions persist at the level documented upon admission and the projected time frame for accessing long-term placement has not been reached, or
- Relevant member and family progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to this level of care have been observed and documented, but treatment goals have not been reached and/or an appropriate level of care is not available, or
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement, but the treatment/placement plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and placement options, or
- New symptoms or maladaptive behaviors have appeared which have been incorporated into the service plan and modified the service plan for the member, or
- These new symptoms and maladaptive behaviors may be treated safely in the short-term residential setting and a less intensive level of care would not adequately meet the child's needs.

**DISCHARGE CRITERIA:** Discharge planning begins during the intake and placement process. When the initial and/or ongoing service plans are being developed with the member and the family, social worker, child protective service workers, youth service worker, advocacy personnel and/or court liaisons, discharge plans are made, and continue as part of an ongoing treatment process. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, arranging for other levels of care, informing the member of the plan, or helping the member prepare for emancipation.

It is expected that in most cases, a child's short-term residential needs will be met prior to discharge. In order to be discharged, the child must meet one of the following criteria:

- The child has attained the age of 18 or 22 if the youth remained in DHHR custody, or
- Appropriate placement has been located which meets the child's treatment and care needs as outlined in the service plan, or
- The crisis that necessitated placement has decreased, and the child has returned to a level of functioning that allows reintegration into a previous care setting, or
- The child exhibits new symptoms or maladaptive behaviors that cannot be treated safely and effectively in the short-term residential setting and which necessitate more restrictive care (e.g. inpatient).

**PROGRAM REQUIREMENTS:** Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. The following comprehensive array of services included in the per diem procedure code H0019U4 are:

- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development (H0032)



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- Mental Health Service Plan Development by Psychologist (H0032AH)
- Physician Coordinated Care Oversight Services (G9008)
- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Behavioral Health Counseling, Professional, Individual (H0004HO)
- Behavioral Health Counseling, Professional, Group (H0004HOHQ)
- Skills Training and Development (H2014U1, H2014U4, H2014HNU1, H2014HNU4)
- Therapeutic Behavioral Services – Implementation (H2019)
- Therapeutic Behavioral Services – Development (H2019HO)
- Crisis Intervention 24-hour availability (H2011)
- Psychotherapy (90832, 90834, 90837)
- Psychotherapy for Crisis (90839, 90840)
- Family Psychotherapy (90846, 90847)
- Group Psychotherapy (90853)
- Comprehensive Medication Services (Clozaril, Lithium, Depakote) (H2010)
- Injection Haldol (J1630)
- Injection Prolixin (J2680)
- Psychological Testing with Interpretation and Report (96130, 96131, 96136, 96137)
- Psychiatric Diagnostic Evaluation (90791, 90792)
- Screening by Licensed Psychologist (T1023HE)
- Developmental Testing: Limited and Extended (96110, 96111)
- Targeted Case Management (T1017)
- Any needed Behavioral Health Service including psychiatric evaluation and management services

These services must be provided and documented in accordance with the minimum standards established by the BMS in Appendix 503 F of the Provider Manual, [Chapter 503 Licensed Behavioral Health Centers](#), and with the certification standards established by [78CSR3](#).

**PROCEDURE CODE:** H0019U4  
**SERVICE UNIT:** 24 hours  
**SERVICE LIMITS:** One per day - All units must be prior authorized

### DOCUMENTATION

All documentation for BMS services must comply with the [Chapter 503 Licensed Behavioral Health Centers](#) service criteria. There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. Documentation must also include:

- Behavioral observations of the child.
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start/stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.

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- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

### REIMBURSEMENT METHODOLOGIES

The DHHR has fully implemented facility-specific prospective rate system for Residential Child Care Facilities. This is a cost-related system that encompasses payments to be made for traditional Social Services payments (i.e., State-only dollars) and for services covered by Medicaid (i.e., state and federal match) under the Rehabilitation Option. The blend of payment sources, resulting in a single, total per diem payment rate per facility, is comprehensive for the covered services, and represents payment in full for the covered residential services to children.

Prospective means that the rates of reimbursement are established in advance of the rate period, and are considered to be fixed for the rate period. No retrospective adjustments are made except for: identified errors in rate calculation; audit findings; errors or misrepresentations in financial reporting; or recaptures resulting from penalties or non-provision of reported services. Rate periods are for six months, with recalculation of rates occurring on April 1 and October 1 of each year. Additionally, the prospective nature of rates means that the calculated level of payment is the limit of cost experience which the DHHR will recognize for the period.

Cost related means that the provider specific rates are related to the actual cost of the provider, relative to limits derived from the actual cost experience of all providers in a peer group. These peer groups correspond to the identified level of the facility. The governing principle is that of “reasonable cost” reimbursement. Under such an approach, rates of reimbursement cannot exceed those of an “efficiently and economically operated” facility. The determination and test of “reasonableness” is contained in the rate setting system itself, and established objectively by formula. Separate limits (ceilings) are established by component with peer groupings varying by component. This serves to simulate the workings of a market system for the covered services.

There are three primary components of the braided rate system: room and board, supervision, and treatment services. The treatment services and costs represent the residual after accounting for expenditures in the previous components. Facilities are categorized into levels based upon the array of services to be available and/or provided to residential children. Within each Level, a ceiling is derived from the weighted average Medicaid patient day costs of all providers in that peer group. Facility costs are reimbursed up to the amount of this ceiling. Reimbursement criteria are stated below.

- Reimbursement begins on the day of admission (regardless of the time of admission) prior to 12:00 AM. The admission date requires services provided as outlined in this policy which is in the per-diem rate, to be billed but does not require the eight continuous hour criteria (see criteria below).
- Reimbursement then occurs for each 24-hour period provided by the following definition. A member’s day is defined as eight continuous hours in residence in the facility in a 24-hour period. Since the daily census time starts at 12:00 AM, the eight continuous hours must occur between the start and end of the census period. On each day of the member’s residence, he/she must receive at least one unit of a service as outlined in this policy which is in the facility’s per-diem rate.

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- If services outlined in this policy are within the per-diem rate but are billed through outside agencies/contractors/providers, within a 24-hour census period, the facility receiving the per-diem rate is responsible for payment to the outside agencies/contractors/providers and this service can be counted as an itemized service. There must be a contract or Memorandum of Understanding (MOU) with the outside agency/contractor/provider identifying services to be rendered and record maintenance of those services.
- Since the discharge date does not qualify as 24-hour duration, this date cannot be reimbursed.
- Claims must be itemized in the billing system to reflect all Medicaid billable services by the facility under the per-diem rate that is provided for a child on a daily basis.

### REFERENCES

West Virginia State Plan references reimbursement for Residential Children's Services at [4.19-B\(4\)\(b\)\(iii\)](#). The West Virginia Bureau for Children and Families' [Foster Care Policy](#)

### CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Appendix	Residential Children's Services	April 25, 2016
Entire Appendix	Reformatted appendix to include an effective date and to remove references to the specific Utilization Management contractor. Per provider request, Targeted Case Management, Procedure Code T1017, was added to the services that are included in the per-diem payment for Behavioral Health: Short-Term Residential (For Children) H0019UA.	January 1, 2018
Entire Appendix	Services included in the per diem rate was added to each Residential level.  Reimbursement Methodologies were added  Guidelines for Behavioral Health Counseling, Supportive were clarified	February 21, 2019