



510.2 PARTIAL HOSPITALIZATION PROGRAM

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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

Partial Hospitalization Programs (PHP) provide a medically directed outpatient treatment program that offers intensive, coordinated, and structured services to adults, adolescent and children within a stable therapeutic environment. The member continues to reside at home or in a supportive living environment, but commutes to a treatment center, which may include daily operation. Partial hospitalization is designed to provide intensive treatment services for members who can be voluntarily diverted from inpatient psychiatric hospitalization, require intensive treatment after discharge from an acute inpatient psychiatric hospitalization stay or require more intensity of care than can be offered in an intensive outpatient setting. The treatment program must be under the general direction of a physician or psychiatrist employed by or contracted with the PHP. The program is designed to provide the member direct access to psychiatric and medical services as needed and to provide daily monitoring of their mental illness, substance use disorder, or a co-occurring disorder. Adolescents and children must have access to educational services if the program is designed to occur during school hours. The psychiatrist or physician must direct the program and is responsible for determining the pharmacology and other medical, psychiatric, and counseling needs of the Medicaid member.

The PHP corresponds to the American Society of Addiction Medicine (ASAM®) criteria level 2.5 and is a clinically more intensive and clinically oriented than intensive outpatient services or lower tiered residential services. A PHP developed for the primary purpose of treating members with a substance use disorder must provide a delivery system of addiction-based treatments, monitoring and management of member with an appropriate diagnosis who is either being stepped down from an inpatient, residential, or withdrawal management service or who is being diverted from admission to a higher level of care. The PHP for substance use disorder can also arise from a direct admission when a member meets specifications in the ASAM® dimensional criteria. The PHP for Substance Use Disorder (SUD) must encompass evidence-based practices for treating addiction disorders through therapy, health educational services, social and family intervention, and proactive case management.

For more information on Substance Use Disorder (SUD) Services, please see [Chapter 504, Substance Use Disorder Services](#).

POLICY

510.2.1 Program Coverage and Limitations

Partial Hospitalization is a general term embracing day, evening, night, and weekend treatment programs which provide an integrated, comprehensive, and complementary schedule of recognized treatment approaches. While specific program variables may differ, all PHPs pursue the goal of stabilization with the intention of diverting inpatient hospitalization, reducing the length of a hospital stay or offering more clinical services than an intensive outpatient program. Programs are designed to serve individuals with significant impairment resulting from a psychiatric, emotional, behavioral, and/or addictive/co-occurring disorders. They are also intended to have a positive clinical impact on the identified member's support system.

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510.2.2 Provider Enrollment

PHPs can be operated by an acute care or critical access hospital affiliated with an acute care or critical access hospital with a Medicare certified distinct part substance abuse and/or psychiatric unit, which are accredited by a nationally recognized accrediting organization. Furthermore, a PHP can be operated through a Licensed Behavioral Health Center (LBHC) or through a university operated medical program as long as the physician or psychiatrist overseeing the PHP has admitting privileges at a hospital with a psychiatric unit and there is a clear memorandum of understanding detailing the responsibility of the physician or psychiatrist and the admitting hospital facility. This ensures the member has appropriate access to medical, laboratory, and toxicology services and that psychiatric and other medical consultation is available within eight hours by phone and 48 hours in person. For SUD PHP, emergency services are available by telephone 24 hours a day, seven days a week when the treatment program is not in session. For more information on SUD Services, please see [Chapter 504, Substance Use Disorder Services](#).

In order to participate in the West Virginia Title XIX Medicaid program for reimbursement of covered services provided to West Virginia Medicaid members, providers of Partial Hospitalization Programs must be approved through the Bureau for Medical Services' (BMS) fiscal agent enrollment process **prior** to billing for any service.

NOTE: West Virginia does not enroll out-of-state PHPs.

510.2.3 Enrollment Requirement: Staff Qualifications

The multi-disciplinary team is central to the philosophy of staffing within a PHP setting. Staff characteristics will vary with the specific nature of the program. The program must be directed by a physician or a psychiatrist with appropriate academic credentials, administrative experience, and clinical experience in behavioral health settings as well as any specialty licenses or accreditation such as in addictive medicine, working with children and adolescents, or specifically identified disorders that would be the subjects of the program's targeted population. This individual's responsibilities will include fiscal and administrative support and ongoing assessment of the program effectiveness on a quarterly basis. A properly trained and certified Physician Assistant (PA) or a certified Advance Practice Registered Nurse (APRN) can oversee the day-to-day operation of the program if the psychiatrist or physician is available for the treatment team meetings and face-to-face assessments with the member. Regulations set forth in [WV Code, Chapter 30](#) Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed. The psychiatrist or physician is required to oversee the treatment team meeting and document findings related to treatment of the member in the member record.

A multidisciplinary treatment team is comprised, at a minimum, of the following:

- West Virginia Board-certified/board-eligible psychiatrist or physician. For children under age 14, the psychiatrist must be a board certified/board eligible child psychiatrist, or a pediatric certified physician. For SUD based programs, the psychiatrist or physician must be certified in addiction medicine or have the capacity to consult with an addiction psychiatrist or physician. A memorandum of understanding must accompany the application detailing the responsibility and capacity of the consulting addiction psychiatrist or physician.
- West Virginia registered nurse
- West Virginia licensed certified social worker (LCSW), licensed professional counselor (LPC), licensed independent clinical social worker (LICSW), or licensed psychologist/supervised

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psychologist. For SUD programs, these professions may have experienced with working with addiction disorders or for children and adolescent programs, experience working in child mental health services.

- West Virginia-Certified educator (in the case of a child/adolescent program)

Team members are required to have backgrounds from multi-disciplinary academic fields, including: medicine, psychology, social work, nursing, education, chemical dependency/addiction specialists, and recreational therapy. Staff providing service must have the necessary skills, qualifications, training, and supervision to provide the services specified in the individual plan of care. For co-occurring programs, staff must have education and experience in both addictive medicine and counseling as well as experience with mental health disorders. Documentation of educational qualifications/certifications must be verified prior to employment and updated as necessary. Annual verification of licensure/certification must be documented in the employee personnel file and readily available for review. Copies of documentation supporting personnel qualification/certification must be present in individual personnel files and readily available for review by all appropriate state entities upon request.

Services may be rendered to Medicaid members by a licensed psychologist or supervised psychologist under the supervision of a licensed psychologist. Documentation including required licenses, certifications, and proof of completion of training must be kept on file where the services are rendered. Services provided by a “psychologist under supervision for licensure” are limited to the extent that billing for these services is restricted to four individual supervised psychologists per Medicaid enrolled licensed psychologist.

510.2.4 Staff to Member Ratio

The program’s clinical staff to member ratio is dependent on several interrelated factors which include, but are not limited to: function of the program, acuity of illness, target population, type of programming offered, age, developmental factors, goals and objectives of the program itself, number of hours of structured treatment provided each day, average daily program attendance, and average length of stay. The minimum staff to member ratio is no more than 1:12, one full-time equivalent staff member for each 12 adult members, and 1:6, one full-time equivalent staff member to six children/youth services members present with the ability to increase staff to client ratio based on the acuity of the members.

510.2.5 Criminal Background Checks

Please see [Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening \(WV CARES\)](#) for Criminal Background Check requirements.

510.2.6 Training and Technical Assistance

The Utilization Management Contractor (UMC) develops and conducts training for Partial Hospitalization Programs 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.

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510.2.7 Other Administrative Requirements

The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review, including all of the following:

- 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 (when the PHP is SUD related, the comprehensive assessment must follow guidelines using the ASAM® criteria) 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 review.
- If requested, the providers must provide copies of Medicaid member 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, Partial Hospitalization Program providers must comply with the documentation and maintenance of records requirements described in [Chapter 100, 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.
- Telehealth services delivered in the Partial Hospitalization Programs must align with the Telehealth policy in [Chapter 503, Licensed Behavioral Health Center \(LBHC\) Services](#) unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.

510.2.8 Quality Assurance

The PHP must have a written plan of quality assurance and outcomes management which encompasses guidelines set forth by accrediting bodies, such as The Joint Commission, and regulatory agencies of local, state, and federal government. These activities are ongoing processes of the administration and staff of the program. They must address the program's mission as well as the needs of members and significant others. The results of quality assurance and outcomes management must be documented and incorporated into administrative, programmatic, and clinical decision making. Reviews of services must be conducted and documentation of the outcome of the review must be completed at least monthly.

Outcomes management processes must examine the impact of the program on the clinical status of the members served. Ongoing outcome studies must address:

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- Level of functioning
- Severity of symptoms
- Satisfaction with services
- Drop-out rate
- Discharge disposition
- Post discharge plan includes follow up appointments prior to discharge to link to community providers
- Readmission rates
- Measures of cost-effectiveness
- Substance Abuse Screening

For members receiving services from a substance use/addiction program or a co-occurring program, additional measure should be addressed:

- Risk of Relapse
- Sustained reductions in drug or alcohol use
- Improvement in overall health status
- Evidence of sustained abstinence
- Improvement in personal and public safety
- Ease and prompt transition to a different level of care
- Improvement and/or consistency in follow-up visits

Other quality assurance measurements must include, but are not limited to clinical peer review, negative incident reporting, and goal attainment of programmatic clinical and administrative quality indicators. It may also incorporate length of stay data and discharge practices (including transfer to a lower or higher level of care), concurrent and retrospective studies examining the distribution of services, as well as the necessity for treatment using agreed upon criteria as an internal program evaluation. All quality assurance measures will be monitored and reviewed by the UMC for compliance with documentation requirements for monthly reviews and analysis of outcomes and how this is incorporated into the program to improve program effectiveness and outcomes for individual members.

510.2.9 Target Population

PHPs treat a broad range of clinical behavioral health conditions. Programs may serve one or more of the following populations:

1. Individuals at risk for inpatient hospitalization. Without the ongoing, intensive services of this program, the member would require inpatient hospitalization; or
2. Individuals experiencing severe acute psychiatric or SUD symptoms or decompensating clinical conditions that severely impair their capacity to function adequately on a day-to-day basis; or
3. Individuals experiencing psychiatric or SUD symptoms or clinical conditions that severely and persistently impair their capacity to function adequately on a day-to-day basis, despite efforts to achieve clinical stability, symptoms reduction, and improved functioning in a less intensive level of care; or
4. Individuals at risk for a higher level of care or hospitalization or as a step down from a recent hospitalization or residential program due to a substance use disorder or a co-occurring disorder defined by the current Diagnostic and Statistical of Mental Disorders (DSM) or International

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Classification of Diseases and Related Health Problems (ICD). Individual with an addictive disorder or co-occurring diagnosis, have mild to moderate decompensation with psychiatric or SUD symptoms, impending risk of relapse, and/or insufficient coping skills to maintain safety without the assistance of the structured PHP.

510.2.10 Admission Criteria

Medical necessity prior authorization and/or continued stay authorization through the Bureau for Medical Services' UMC is required for all adults and children under the age of 21 being admitted to a psychiatric and/or substance abuse PHP. The Bureau for Medical Services will not reimburse for services provided to a member who is not prior authorized for admission or for continued stays treatment in the program by the UMC.

Members admitted to the PHP must be under the care of a psychiatrist or physician who certifies the need for admission to the PHP. The member must require comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized service plan, because of a substance use disorder, mental disorder, or co-occurring disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning.

All the following major criteria must be met for a member to be eligible for admission to a PHP:

1. Recent acute psychiatric or SUD symptoms including danger to self or others with current stability established although in jeopardy due to **one or more** of the following:
 - Insufficient behavioral care provider availability,
 - Inadequate member support system,
 - Member characteristics such as high impulsivity or unreliability,
 - High risk of relapse with imminent dangerous emotional behavior or cognitive consequences
 - Unable to receive effective treatment or maintain sobriety from a lower level of care or utilized as a step-down program from a higher level of care.
2. Psychiatric or SUD symptoms have resulted in impairment of psychosocial functioning and/or developmental progression from the individual's baseline due to a current DSM psychiatric or SUD disorder in one or more of the following:
 - education
 - vocation
 - family
 - social/peer relations
 - self-care deficits
 - personal safety
3. Risk status is appropriate for a partial hospital program as indicated by **ALL** the following:
 - Member is willing to participate in treatment voluntarily.
 - Clinical condition does not require 24-hour care.
 - No current attempt at self-harm or harm to others or has had sufficient relief from previous ideations or attempts.
 - Sufficient support network available for monitoring of member's condition.

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- Member is agreeable to contacting provider or support system if symptoms increase.
 - No active signs of psychosis or breaks or psychosis is managed with medication
 - No significant signs or symptoms of withdrawal or intoxication through the program (if suspected, may be monitored with drug screens)
 - Any physical health problems are minimal and do not interfere with treatment.
4. The individual has failed to make sufficient clinical gains within a community setting, through intensive outpatient services or has not attempted such outpatient treatment and the severity of presenting symptoms is such that prognosis of intensive outpatient treatment success is poor. Or the individual has progressed in treatment through a higher level of care and documentation indicates symptoms severe enough to warrant a PHP.

510.2.11 Medical Necessity

All PHP Services covered in this chapter are subject to a determination of medical necessity. Medical Necessity must be demonstrated throughout the provision of services.

Consideration of medical necessity in the service planning process must be documented and re-evaluated at regular service plan updates per utilization guidelines. The provider may perform one assessment per calendar year to update medical necessity. 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 of care and type of service provided.

Providers rendering services that require prior authorization must register with the BMS UMC and receive authorization before rendering such services. Prior Authorization does not guarantee payment for services rendered. See [Section 510.2.10 Admission Criteria](#) for additional Prior Authorization information.

510.2.12 Assessment

Upon admission to the PHP, a certification by the psychiatrist or physician is required for the member to be admitted to the PHP. The certification must include the current DSM/ICD diagnosis and psychiatric need for the PHP.

At the time of admission to a PHP, all members must undergo a formal comprehensive biopsychosocial assessment by the psychiatrist or physician certifying the required treatment which draws upon documented assessments made during the current episode of care and must summarize all prior psychiatric hospitalizations, residential program admissions, intensive ambulatory mental health services, medication trials, and other mental health/psychosocial interventions, including an assessment of their degree of success or failure. If a member has just been discharged from an inpatient psychiatric admission to a partial hospitalization program, the psychiatric evaluation, medical history, and physical examination from that admission with appropriate update is acceptable.

All assessments must be documented in the medical record and must address medical, emotional, behavioral, social, self-care, leisure, vocational, level of functioning, legal, nutritional needs, and resources. The assessment should also document any abuse/neglect/trauma history, Traumatic Brain Injury (TBI) history or difficulty with pain or pain management. PHPs involving only mental health,

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Screening, Brief Intervention, and Referral to Treatment (SBIRT) should be used as a screener to determine any potential substance abuse/addiction issue. Conversely, programs that are primarily for substance use disorders must continually assess for co-occurring mental health symptoms. For co-occurring diagnoses, it should be documented that there is a relationship between the mental health disorder and the substance use disorder. Also, the evaluation should indicate the individual's readiness to change. A review of the member's current and past school, work or other social role and family interactions should be reported with deficits. There must be a review of the member's psychiatric and withdrawal management, chemical abuse, and dependency history (if present), presenting symptoms, results of a mental status exam, and a diagnostic impression based on the current DSM or ICD. Furthermore, a member's cognitive ability must be considered with determining admission into a PHP.

The assessment must be carried out in a manner that is sensitive to cultural and ethnic factors. The initial assessment must serve to document the medical necessity of admission to the PHP and be in the medical record within two treatment days following the date of admission.

510.2.13 Service Planning

Partial Hospitalization is active treatment pursuant to an individualized service plan, prescribed and signed by a psychiatrist or physician, which identifies treatment goals, describes a coordination of services, is structured to meet the particular needs of the member, and includes a multidisciplinary team with collaboration from the member. The treatment goals described in the treatment plan must directly address the presenting symptoms and are the basis for evaluating the member's response to treatment. Treatment goals must be designed to measure the member's response to active treatment. The plan must document ongoing efforts to restore the individual member to a higher level of functioning that would promote discharge from the program or reflect continued need for the intensity of the active therapy to maintain the member's condition and functional level and to prevent relapse or hospitalization. Activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms placing the member at risk, do not qualify as PHP services.

The clinical assessment must be translated into a formalized and documented service plan. An initial service plan will be completed within two treatment days following the date of admission and will document minimally one primary treatment goal/problem, the member's treatment schedule, and preliminary treatment objectives. A more formalized, comprehensive service plan must be developed within seven days of admission to the program. This plan must comprehensively cover all aspects of treatment for the member while in the PHP. The service plan must be developed and reviewed by the multidisciplinary team every seven treatment days for the duration of the member's PHP treatment. The initial treatment plan and subsequent reviews of the plan must include a review of all the following:

- Assessments of individual, family, social and community strengths/resources;
- Short-term measurable objectives as well as long term goals;
- Specific, multidisciplinary treatment recommendations targeting specific factors that precipitated the admission;
- Developmental milestones and course for adolescents and children;
- Member support system dynamics, including, if applicable recovery support and supportive living
- Member's ability to interact appropriately (including peer relationships) in work, school, and social environment, based on previous difficulties and premorbid functioning;

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- Ongoing mental status examination for mental health and co-occurring disorders;
- Substance use/abuse;
- Ongoing withdrawal monitoring should be used if members are suspected to have continuing withdrawal problems;
- Ongoing relapse risk assessment for SUD and co-occurring based programs;
- Collaboration with any Medication Assisted Treatment (MAT) program (if applicable).

Overall structure of the service plan should contain the following:

- Date of development of the plan;
- Participants in the development of the plan;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the service providers and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (intervention) that are nationally recognized evidenced based practices for the treatment of SUD to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives;
- Discharge criteria;
- A date for review of the plan, times in consideration of the expected duration of the program or service;
- Start and Stop Times; and credentials of staff.

Appropriate time frames must be identified with each goal and objective and each review must include the date and signature of all multidisciplinary treatment team members on the treatment plan.

510.2.14 Program Requirements

PHPs that make up active treatment programs, must be evidenced-based, vigorous, and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. The therapies, services, and treatment provided by the Partial Hospitalization Program must take into consideration the member's intellectual and developmental level in developing a structured program environment.

At a minimum, 75% of scheduled program hours must consist of active treatment that specifically addresses the presenting problems of the population served. Examples of active treatment include, but are not limited to the following:

- Individual, group and family psychotherapy (family therapy should be extended to anyone in the member's support system),
- Medication evaluation and therapy,
- Specific therapy groups such as:
 - communication skills;
 - assertiveness training;
 - stress management and/or relaxation training;
 - motivational interviewing

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- Chemical dependency counseling and prevention;
 - motivational enhancement and engagement strategies
 - contingency management
 - Transtheoretical model of change
 - Adolescent Community Reinforcement Approach (ACRA)
- Educational groups involving (See [Section 510.2.15 Substance Use Disorder Educational Health Service](#)):
 - symptom recognition
 - problem solving
 - medication and MAT information
 - addiction and drug use effects on health, pregnancy, and newborns

Emergency Services are available 24 hours a day, seven days a week. Adolescent programs must have access to educational services if they occur during school hours or make arrangement for educational requirements. The type of therapeutic involvement offered is dependent upon the nature of the member's target population and the overall goals of the individual treatment program. Group therapy or counseling must have no more than 12 members, regardless of payer source, however group sessions can be conducted consecutively if the 12-member limit is maintained and staff ratios are present. PHP can work in conjunction with external medicated assisted treatment if treatment services are coordinated by both agencies and there is a memorandum of understanding between the two agencies.

West Virginia Medicaid defines the PHP ([42 CFR §410.2](#) and [42 CFR §410.43](#)) as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and provides services that:

1. Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;
2. Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization;
3. Include any of the following:
 - Individual and group therapy with physicians or psychologists or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, nurse specialists, certified alcohol and addiction counselors);
 - Services of other staff (social workers, addiction specialist, trained psychiatric nurses, and others trained to work with psychiatric patients or co-occurring disorders);
 - Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in [42 CFR §410.29](#));
 - Individualized activity therapies that are not primarily recreational or diversionary (not to be billed as individual or group psychotherapies). These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
 - Family counseling, the primary purpose of which is treatment of the patient's condition;
 - Patient training and education, to the extent that training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition or substance use disorder/co-occurring disorder and;
 - Care coordination services to additional supplemental, adjunctive, or supportive systems; and
 - Medically necessary diagnostic services.

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Involvement of the member's family and/or support system (as available) must be clearly addressed in the individualized treatment plan and reflected in the individual programming offered. Members diagnosed with a substance use disorder or a co-occurring disorder and has an invested support system should have a review of the recovery environment with the patient and family/social support.

510.2.15 Substance Use Disorder Educational Health Service

The medical and psychiatric consequences of substance use are numerous and include higher rates of psychological problems such as depression and anxiety, increased sexually transmitted infections (STI) such as Hepatitis, HIV/AIDS, and other communicable diseases and escalation in direct health issues such as cardiovascular disease, weakened immune system, liver failure, stroke, cancer, and lung disease. Women face unique challenges when it comes to coping with a substance use disorder including problems with reproductive health, fertility, menopause, unexpected pregnancy, and higher than average rate of premature births, miscarriage, and low birth weight infants. The impact of substance use can be far reaching with pregnancy, perinatal, and neonatal development. Additional problems commonly occur during infant care regarding issues with breast feeding, coping with children having developmental delays and mental health issues from drug exposure, and the higher potential for sudden unexpected infant death. As part of the overall PHP agenda, facilities must provide a medically accurate, comprehensive educational service containing substance use disorder and its related health issues and extended difficulties. This is to be provided in a non-judgmental, non-coercive manner and, at the minimum, must include:

- STI information primarily focusing on Hepatitis B and C and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). Information should include current treatment for STI, effects and duration of these illnesses, and information on harm reduction programs such as needle exchange.
- General health information on the short and long-term effects of using illicit and non-prescribed substance focusing on organ damage, cardiovascular disease, and immune system issues. Healthy alternatives should be identified that counteract health problems related to substance use disorder. General pain management information and techniques should be presented.
- Women's reproductive information including the effects of substance use and pregnancy, neonatal development, and neonatal abstinence syndrome. Long acting, reversible contraception (LARC), including both intrauterine device (IUD) and birth control implants including basic procedure, length of action, possible side effects and removal. Additional information on pregnancy and withdrawal and information on elective termination should be presented.
- Developmental and mental health issues of neonatal abstinence syndrome (NAS), caring for a baby with NAS, issues involving substance use and breast feeding, safe sleep, purple crying, shaken baby syndrome and sentinel injuries in infants will be provided to all members who are parents or potential parents.

If during this educational service, any eligible woman requesting additional information concerning LARC or requesting to have a LARC procedure, will be provided the opportunity to receive the LARC, in a timely manner, as medically necessary from a facility that provide LARC procedures. As part of case management, arrangement will be made including transportation to provide a comfortable transition to these facilities. Programs, agencies, and facilities that provide substance use disorder treatment must have memorandums of understandings (MOUs) with facilities and hospitals that provide LARC.

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510.2.16 Family And Support System Involvement

Family and support system involvement is an important piece to the recovery process as long as the treatment team does not feel that having the family involved in the treatment process would have a detrimental effect on the member's outcomes during treatment. The member should be:

- Encouraged to maintain contact with the family and provided with support in making such arrangements, unless specifically contraindicated because of the member's treatment;
- Provided information about activities and progress toward the goals of stepping down to outpatient services when the appropriate releases of information are completed;
- Provided with assistance in maintaining the relationship with the family or support system through visits and shared activities;
- Prepared for the return to home, recovery housing, or other safe residences to continue the rehabilitation process.

510.2.17 Continued Stay Criteria

An individual's length of stay in a PHP is dependent upon the nature of presenting problems and an ongoing authorization of the medical necessity for continued stay in the program. The necessity of and rationale for continued stay must be documented in the medical record and treatment plan review. Globally, a program's average length of stay must reflect the member population and primary program function. Medicaid members must meet the following criteria for continued stay:

1. Risk status continues to be appropriate for this level of care.
2. Emergence of new and/or previously unidentified symptoms consistent with a current ICD/DSM diagnosis.
3. Limited progress has been made and a modification in the treatment plan and/or discharge goals has been made specifically to address lack of expected treatment progress.
4. Progress toward treatment goals has occurred, as evidenced by measurable reductions in signs, symptoms, and/or behaviors to the degree that indicate continued responsiveness to treatment; and/or:
 - a. Member is currently involved and cooperating with the treatment process.
 - b. The family/support system is involved and cooperating with the treatment process (except where clinically counterproductive or legally prohibited).

The [Association for Ambulatory Behavioral Healthcare](#) in its Standards and Guidelines for Partial Hospitalization recognizes that there is a regulatory presumption against the appropriateness of Partial Hospitalization Program services in excess of 30 days. While this is the recognized standard for care, West Virginia Medicaid will allow the 30-day limit to be waived by the UMC for up to 10 additional days of service in certain circumstances.

Consideration may be given for 10 additional days of PHP services in situations in which the care plan and treatment documentation supports the need for additional services as follows:

- Additional days/sessions are necessary to complete essential elements of the treatment prior to discharge from the Partial Hospitalization Program.
- The member exhibits well documented **new** symptoms or maladaptive behaviors.

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There must be documentation of a reassessment that reasonably can be accomplished within the time frame of the additional 10 days/sessions or less of coverage requested under the waiver provisions.

The physician responsible for the member's care is responsible for documenting the need for additional days/sessions and must establish an estimated length of service beyond the date of the 30-day/session limit up to the ten days/sessions. The waiver must be requested prior to the end date of the authorization for the 30-day/session limit.

510.2.18 Discharge Planning

To ensure a smooth transition to a lower level of service, or, if unsuccessful to a higher level of care, discharge planning must begin at the time of admission to the program. The program must have in place standardized policy and procedures for ongoing informal and periodic formal assessment of the member's readiness for discharge (see [Section 510.2.8, Quality Assurance](#)). Intensive case management, care coordination and systematic follow-up is required for members diagnosed with substance use disorder or co-occurring disorder. Smooth transitions through engaging the member's support system is crucial so that all parties are aware of treatment plans, discharge arrangement and the overall comprehensive need of the member at their next level of care (except where clinically counterproductive or legally prohibited).

The following medical and psychological indicators must be evidenced in the discharge plan from a PHP:

- Goals for treatment have been substantially met as evidenced by abatement of admission symptoms and the member has returned to a level of functioning that allows reintegration into their previous or newly acquired living arrangement and/or use of a less intensive outpatient service.
 - Risk status and/or relapse can be managed at a lower level of care and sobriety continues to be maintained.
 - Functional impairments are more manageable or have diminished, indicating services are appropriate at a less intensive level of care.
 - An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place.
- OR**
- The member exhibits symptoms and functional impairment that requires a higher level of care.
 - The member becomes medically unstable and requires treatment related to their physical health condition.

510.2.19 Non-Covered Services

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a PHP. Psychosocial programs which provide only a structured environment, socialization, and/or vocational rehabilitation are not covered. A program that only provides medical management of medication for members whose psychiatric condition is otherwise stable is not the combination, structure, and intensity of services required in a PHP. It is the need for intensive, active treatment of his/her condition to maintain a functional level and to prevent relapse or hospitalization which qualifies the member to receive PHP services.

The items listed below are **not** included for coverage under the PHP benefit:

510.2 PARTIAL HOSPITALIZATION PROGRAM

- Meals for individuals while participating under the PHP benefit;
- Primarily recreational or diversional activities (i.e., activities primarily social in nature) not documented in the treatment plan;
- Self-administered drugs;
- Training that is designed for the purpose of fostering vocational skills.

510.2.20 Documentation

The medical record is an essential tool in treatment. It is the central repository of all pertinent information about each member. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. There must be a permanent medical record maintained in a manner consistent with applicable state and federal licensing regulations and agency record keeping policies. Documentation must include:

1. The psychiatrist/physician's certification of the need for services,
2. A comprehensive treatment plan,
3. Physician progress notes (completed at least once weekly)
4. Date of service, amount of time, type of service, focus/content of service, level of member participation, symptoms/impairments, interventions, member's response, and progress made toward attainment of objectives outlined in the individualized treatment plan, and signature/credentials of services provider.
5. Negative incident occurrence where applicable.
6. Educational plan with specific recommendations based on the individual's presenting behaviors,
7. Discharge plan.

Medical records must be complete, accurate, accessible, legible, signed and dated by the professional providing the service, and organized. Documentation must support claims submitted for reimbursement. The progress notes must include a description of the nature of the treatment the Medicaid member's response to the therapeutic intervention, and the relation to the goals developed in the treatment plan.

510.2.21 Covered Services

The interdisciplinary program of medical therapeutic services may be delivered through any one of the following program formats (services may not be provided under multiple PHP formats concurrently):

1. Day PHP, which must provide a minimum of 20 hours of scheduled treatment, extending over a minimum of five days per week; or
2. Evening PHP, which must provide a minimum of 16 hours of scheduled treatment, extending over a minimum of four days per week; or
3. A shortened PHP for those individuals whose needs can be met through group psychotherapy consisting of six to 10 hours of group therapy per week, delivered in two hours per day group therapy sessions.

The abbreviated treatment session (H0015) is a one-hour unit of service limited to a maximum of three units per date of service. This abbreviated treatment session is **not** intended to replace the regular scheduled program formats. Use of the abbreviated code for more than five sessions during a treatment course will result in a review by the UMC to determine if PHP services are appropriate for the member.

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Prior authorization is required for the following services and MAT must be available to members in conjunction with PHP services. Services must be reported using Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes as follows:

Partial Hospitalization Four Hour Session

Procedure Code: H0035
Service Unit: One (1) Unit = Minimum of four hours
Service Limit: One (1) per day

Partial Hospitalization Two Hour Session

Procedure Code: 90853
Service Unit: One (1) Unit = Minimum of two hours
Service Limit: One (1) per day

Partial Hospitalization Abbreviated Treatment Session

Procedure Code: H0015
Service Unit: One (1) Unit = 1 hour
Service Limit: Three (3) Units Per Day if Enrolled in H0035
One (1) Unit Per Day if Enrolled in 90853
If H0015 is used more than five times in a 30-day period, a UMC review will be required

The Medicaid Program will not be responsible for reimbursement of any services provided prior to issuance of an authorization, nor for any dates of service which exceed the authorization, unless Retroactive Authorization is approved by the UMC.

510.2.22 Medication Assisted Treatment

Members should have MAT available to them in PHP. This can occur through the PHP itself or through additional services. Please see [Chapter 503 Behavioral Health Rehabilitation Services](#) or [Chapter 504 Substance Use Disorder Services](#) for the policy on medication assisted treatment. If a member is in a Partial Hospitalization Program, they must still meet the criteria and policy requirements the medication assisted treatment policies. The PHP must have a Memorandum of Understanding with the other facility to collaborate with MAT.

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.

Medication Assisted Treatment (MAT): The use of medication with counseling and behavioral therapies to treat substance use disorders.

Multimodal Treatment: This treatment often includes interventions such as medical treatment, educational interventions, behavior modification programs, and psychological treatment and is recommended by the National Institute of Mental Health for the provision of behavioral health services.

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Partial Hospitalization Program (PHP): Is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. While specific program variables may differ, all Partial Hospitalization Programs pursue the goal of stabilization with the intention of averting inpatient hospitalization or reducing the length of a hospital stay.

Premorbid functioning: refers to the state of functionality prior to the onset of a disease or illness.

Substance Use Disorder (SUD): A condition in which the use of one or more substances leads to clinically significant impairment or distress.

Therapeutic Environment: A structured group setting in which the existence of the group is a key force in the outcome of treatment. Using the combined elements of positive peer pressure, trust, safety and repetition, the therapeutic environment provides an idealized setting for group members to work through their psychological issues. The keys to a successful therapeutic environment are support, structure, repetition, and consistent expectations.

Traumatic Brain Injury (TBI): A nondegenerative non-congenital brain injury from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

CHANGE LOG

SECTION	TITLE	EFFECTIVE DATE
New Chapter	Partial Hospitalization Program	January 1, 2024