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

510.5 PARTIAL HOSPITALIZATION SERVICES

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BACKGROUND

Partial Hospitalization Programs (PHP) provide a medically directed outpatient treatment program that offers intensive, coordinated, and structured services to medicaid members within a stable therapeutic milieu. Programs are designed to serve individuals with significant impairment resulting from a psychiatric, emotional, behavioral, and/or addiction/co-occurring disorders. The PHP is designed to provide member with direct access to direct psychiatric and medical services when needed and to provide daily monitoring of their mental illness, substance use disorder or a co-occurring disorder. The PHP primary purpose is for rehabilitation and not an adjunctive, maintanence service.The member continues to reside at home or in a supportive living environment, but commutes to a treatment center up to five days a week. Partial Hospitalization is designed to provide intensive treatment services for members who can be voluntarily diverted from inpatient psychiatric hospitalization or require intensive treatment after discharge from an acute inpatient psychiatric hospitalization stay. The treatment program must be under the general direction of a physician or psychiatrist employed by or contracted with the Partial Hospitalization Program. Adolescents and children will 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 ascertaining that the pharmacology and other medical, psychiatric and social needs of West Virginia Medicaid members are met. The PHP corresponds to the American Society of Addiction Medicine (ASAM) level of 2.5, and is a clinically more intensive and clinically oriented than intensive outpatient services or residential services. A PHP developed for the primary purpose of treating members with a substance use disorder will be responsible for providing a delivery system of addiction based treatments, monitoring and management of member with an appropriate diagnosis who is either being step-down from an inpatient, residential or withdrawal management services or who is being diverted from admission to a higher level of care. The PHP for substance abuse must encompass evidence-based practices for treating addiction disorders through therapy, health educational services, social and family intervention and proactive case management.

POLICY

510.5.1 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 Partial Hospitalization Programs pursue the goal of stabilization with the intention of diverting inpatient hospitalization or reducing the length of a hospital stay. They are also intended to have a positive clinical impact on the identified member's support system.

510.5.2 PROVIDER ENROLLMENT

Partial Hospitalization Programs can be operated by general acute care or critical access hospitals affiliated with a General Acute Care Hospital with a Medicare certified distinct part substance abuse and/or psychiatric unit, which are accredited by a nationally recognized accrediting organization. (Joint Commission, Healthcare Facilities Accreditation Program (American Osteopathic Association), De Norske Veritas (DNV)). Furthermore, a PHP can be operated through a Licensed Behavioral Health Center

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(LBHC) or through a university operated medical program as long as the Physician or Psychaitrist, overseeing the PHP, has admitting privledges at a hospital with a psychiatric unit and there is a clear memorandum of understanding detailing the responsibility of the Physician or Psychaitrist and the admitting hospital facility. This will insure the member has appropriate access medical, laboratory and toxicology services and that psychairic and other medical consultation is available within 8 hours by phone and 48 hours in person.

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' fiscal agent contract enrollment process **prior** to billing for any service.

Documentation regarding the program description, including, but not limited to, the targeted population to be served, a proposed daily schedule and staff names with their credentials (including per diem staff) must be included with the application. (See **Appendix 510.5 A** for Application Form). A description of direct service activities and time allocated providing billable services must also be provided. Any changes in the program content, target population or anything that was not previously reviewed and approved with the original application must be submitted to the fiscal agent at least 30 days prior to planned implementation for review, approval/denial **prior** to implementation. Changes in staff director, psychiatrist(s), psychologists, nursing director, or social worker must be reported within one week to BMS, Attention: Office Director, for Facility Based and Residential Care. Changes may be mailed to:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Attention: Facility Based and Residential Services Office Director
350 Capitol Street, Room 251
Charleston, West Virginia 25301

West Virginia does not enroll out-of-state Partial Hospitalization Programs.

510.5.3 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 addiction medicine, working with children and adolescents or specifically identified disorder 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's 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.

An APRN must have a signed collaborative agreement for prescriptive authority with a psychiatrist/physician. The collaborative agreement must document the professional relationship between the APRN and the psychiatrist/physician. Regulations set forth in **WV Code, Chapter 30 Legislative Rules – Board of Examiners for Registered Professional Nurses** must be followed. Physician's

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Assistants and/or APRNs will be referred to as physician extenders throughout the manual. The psychiatrist or physician would still be 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:

- 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 program, the psychiatrist or physician needs to be certified in addiction medicine or have the capacity to consult with an addiction psychiatrist or physician. A memoriandum of understanding must accompany the application detailing the responsibility and capacity of the consulting addiction psychiatrist or physician.
- Registered Nurse (BA level or certified psychiatric nurse or for SUD certified as an addiction specialist),
- Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), (Licensed Independent Clinical Social Worker (LICSW), or Licensed Psychologist/Supervised 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.
- WV Licensed Education specialist in the case of a child/adolescent program.
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Team members are required to have backgrounds from various 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 addiction medicine and counseling as well has 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 at the psychological practice 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 (4) individual supervised psychologists per Medicaid enrolled licensed psychologist.

510.5.4 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

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twelve 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.

510.5.5 FINGERPRINT-BASED BACKGROUND CHECK REQUIREMENTS, RESTRICTIONS, AND MEDICAID EXCLUSION LIST

A thorough Fingerprint-Based Background Check and review of a Federal Registry is required with results of an on-line preliminary check available for review **PRIOR** to employment of any individual (including volunteers) who will be working in a facility providing treatment or care for **all** West Virginia Medicaid members the on-line preliminary results may be used for a period of three months (90 days) while awaiting the results of fingerprinting. During that time period the individual may **not** work unsupervised. Results of the Fingerprint-Based Background check must be documented in the personnel file **within three months (90 days)** of hiring the employee. (Refer to requirements listed below regarding exclusions/sex offender registries lists which must be completed with a negative result prior to hiring or allowing to volunteer.) An applicant must complete a DHHR Statement of Criminal Record every two years after the initial submission to the respective agency or department. A subsequent Fingerprint-Based Background Check must be completed at least every five years, but may be submitted at any point if there is an indication that the Fingerprint-Based Background Check information may have changed.

The applicant shall not be approved, employed, utilized, nor considered for employment if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault or battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Misdemeanor domestic battery or domestic assault;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure; and
- Health care fraud.

The applicant shall not be approved or employed if on parole or probation for a felony conviction.

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It is the responsibility of the employer to check the list of excluded individuals/entities (LEIE) monthly at:

- (LEIE) at: http://exclusions.oig.hhs.gov/;
- (Formerly EPLS) https://www.sam.gov/;

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry upon hiring. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

510.5.6 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent 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.

510.5.7 OTHER ADMINISTRATIVE REQUIREMENTS

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

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- 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, Behavioral Health Rehabilitation Services* unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.

510.5.8 QUALITY ASSURANCE

Partial Hospitalization Programs 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:

- 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
- Indices of cost-effectiveness
- Substance Abuse Screening

For members being serviced with 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

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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.

510.5.9 TARGET POPULATION

Partial Hospitalization Programs possess an inherent capacity to effectively 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 symptoms or de-compensating clinical conditions that severely impair their capacity to function adequately on a day-to-day basis. The member's characteristic level of functioning is judged to have significantly declined as evidenced by the nature and degree of the presenting symptoms and impairments compared to baseline symptoms and impairments. Such acute states frequently follow a serious crisis situational stressor. A less intensive level of care is judged to be insufficient to provide the medically necessary treatment the individual requires, and there is a reasonable expectation that the member is likely to make timely and practical improvement; or
3. Individuals experiencing psychiatric 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. Treatment in a less intensive level of care has been ineffective, a more intensive level of care is medically necessary to reduce severe symptoms and impairments, and the member is determined by a physician to have the capacity to make timely and practical improvement.
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 Manual of Mental Disorders (*DSM) or International Classification of Diseases (ICD*). Individual with an addiction disorder or co-occurring diagnosis, have mild to moderate decompensation with psychiatric symptoms, impending risk of relapse, and/or insufficient coping skills to maintain safety without the assistance of the structured PHP. The member has adequate community, social and/or family support to reside and remain behaviorally stable but without the PHP has high risk regression. Supportive living environment can be used in conjunction with a PHP if the member can remain relatively stable in the living environment, but continually needs the intensive treatment offered by a PHP

510.5.10 ADMISSION CRITERIA

All Partial Hospitalization Programs require initial medical necessity prior authorization review and continued stay authorization review through the Bureau for Medical Services' UMC. Prior authorizations are required for all adults and children under the age of 21 being admitted to a psychiatric and/or substance abuse Partial Hospitalization Program.

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The Bureau for Medical Services uses the UMC to certify member medical necessity for admission and continued stays through the prior authorization process in all Partial Hospitalization Programs. The Bureau for Medical Services is not financially responsible for reimbursement for services provided to a member who is not prior authorized for admission or for continued stays treatment in the program by this 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 West Virginia Medicaid 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 symptoms including danger to self or others with current stability established although in jeopardy due to **1 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 symptoms have resulted in impairment of psychosocial functioning and/or developmental progression from the individual's baseline due to a current DSM psychiatric 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.
   - 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.

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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 though a higher level of care and documentation indicates symptoms severe enough to warrant a PHP.

510.5.11 MEDICAL NECESSITY

All Partial Hospitalization Program Services covered in this chapter are subject to a determination of medical necessity defined as follows in the managed care position paper published in 1999 by the State of WV:

Services and Supplies that are:

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

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

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

Consideration of these factors 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 BMS's Utilization Management Contractor (UMC) and receive authorization before rendering such services. Prior Authorization does not guarantee payment for services rendered. See *Section 531.2.22.1, Prior Authorization Procedures* and *Section 531.2.22.2, Prior Authorization Requirements*.

510.5.12 ASSESSMENT

Upon admission to the Partial Hospitalization Program a certification by the psychiatrist or physician is required for the member to be admitted to the PHP. The certification must indicate the member would require inpatient psychiatric hospitalization or a higher level residential program if this program were not

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provided. The certification must include the appropriate DSM/ICD diagnosis and psychiatric need for the Partial Hospitalization Program.

At the time of admission to a Partial Hospitalization Program 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 and/or failure. If the WV Medicaid 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. For program subscribing to mental health only, the Screening, Brief Intervention and Referral to Treatment (SBIRT) should be used as a screener to determine any potential substance abuse/addiction issue. Conversely, program 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 Partial Hospitalization Program and be in the medical record within two treatment days following the date of admission.

510.5.13 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 Partial Hospitalization Program services.

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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 five (5) 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 five (5) 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 pre-morbid functioning;
- 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.

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510.5.14 PROGRAM REQUIREMENTS

Partial Hospitalization Programs which make up a program of active treatment must be evidenced-based, vigorous, proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. 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 the services of the Partial Hospitalization Program. The therapies, services, and treatment provided by the Partial Hospitalization Program must take into consideration the members intellectual and developmental level in developing a structured program milieu.
At a minimum, seventy-five percent (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
- 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 the Substance Use Disorder Educational Health Service Section):
  - 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, 7 days a week. Adolescent programs have access to educational services if they occur during school hours or make arrangement for educational proliferation. 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 Partial Hospitalization Program (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 that provides these services:

1. Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;

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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.

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 member and family/social support.

510.5.15 SUBSTANCE USE DISORDER EDUCATIONAL HEALTH SERVICE

The medical and psychiatric consequences of substance use are ubiquitous and includes 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, weaken 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 in 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 as in pregnancy and during perinatal and neonatal development. Additional problems commonly occur during infant care regarding issues with breast feeding, coping with children developmental and mental health disorders from drug exposure and the higher potential for sudden unexpected infant death (SUID). As part of the overall PHP agenda, facilities and 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:

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- STI information primarily focusing on Hepatitis B and C and 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 contraceptive (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, caring for a NAS baby, issue involving substance use and breast feeding, safe sleep, purple crying, shaken baby syndrome and sentinel injuries in infants will be provided all members who are parents or potential parents.

If during this educational service, any female of birthing age, who request to have additional information concerning LARC or request to have a LARC procedure, will be provided the opportunity receive the LARC, in a timely manner 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.

510.5.16 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.

- 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

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510.5.17 CONTINUED STAY CRITERIA

An individual's length of stay in a Partial Hospitalization Program is dependent upon 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. West Virginia 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 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
   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, WV 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 Partial Hospitalization Program 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.

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.

510.5.18 DISCHARGE PLANNING

To ensure a smooth transition to a lower level of service, or, if unsuccessful 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

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readiness for discharge (see 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.

The following medical and psychological indicators must be in evidence in the discharge plan from a Partial Hospitalization Program:

- 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 services in a more restrictive setting.
- The member becomes medically unstable and requires treatment related to their physical health condition.

510.5.19 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.

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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 treatment, the member's response to the therapeutic intervention and the relation to the goals developed in the treatment plan.

510.5.20 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, delivered in sessions of four hours' duration and extending over a minimum of five days per week; or
2. Evening PHP, which must provide a minimum of 16 hours of scheduled treatment, delivered in sessions of four hours' duration and 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 6 to 10 hours of group therapy per week, delivered in two hour 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 one hour service unit may be billed for individuals who have been approved for either a four-hour day or evening program or the two-hour program in instances when the patient is unable to complete the full four hour or two-hour treatment session. This abbreviated treatment session is **not** intended to replace either the four-hour day or evening program, or the two-hour program. It is intended only for use in those instances when the patient is unable to complete either a four-hour day or evening program, or a two-hour session. It may not be billed in addition to or with either the evening/day program or the intensive outpatient procedure code. 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 West Virginia Medicaid member.

Both the 20 hour per week day program, and the 16 hour per week evening program (H0035), will be reimbursed on a per diem basis, at the rate of TBD per day.

The PHP session which consists of three to five, two-hour group psychotherapy sessions (units) per week (90853), will be reimbursed at the rate of TBD per session.

The abbreviated treatment session (H0015) one hour service unit will be reimbursed at the rate of $25.00 per one hour unit, to a maximum of three units for a date of service. Services must be reported using CPT/HCPCS codes as follows:

Partial Hospitalization 4 Hour Session

Procedure Code: H0035
Service Unit: One (1) Unit per day
Service Limit: One (1) per day (Minimum of four hours)
Prior Authorization Required: Yes
MAT: Available to members in conjunction with PHP treatment

Partial Hospitalization 2 Hour Session

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Procedure Code: 90853
Service Unit: One (1) Unit per day
Service Limit: One (1) per day (Minimum of two hours)
Prior Authorization Required: Yes
MAT: Available to members in conjunction with PHP treatment

Partial Hosp. Abbreviated Treatment Session
Procedure Code: H0015
Service Unit: One (1) Unit = 1 hour
Service Limit: Three (3) Per Day if Enrolled in H0035
One (1) Per Day if Enrolled in 90853
MAT: Available to members in conjunction with PHP treatment

Prior Authorization Required: Yes (Retroactive Authorization will be considered)

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.

510.5.21 NON-COVERED SERVICES

A program comprised primarily of diversionary activity, social, or recreational therapy does not constitute a Partial Hospitalization Program. 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 Partial Hospitalization Program. The items listed below are **not** included for coverage under the Partial Hospitalization Program benefit:

- Meals for individuals while participating under the Partial Hospitalization Program 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;

510.5.22 MEDICATION ASSISTED TREATMENT

Members should have available to them in PHP medication assisted treatment. Please see Chapter 503 Behavioral Health Rehabilitation 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 as stated in Chapter 503. PHP must have a Memorandum of Understanding with other facility to collaborate with MAT.

GLOSSARY

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510.5 PARTIAL HOSPITALIZATION SERVICES

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): is 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.

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 milieu. 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.

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

Therapeutic Milieu: 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 milieu provides an idealized setting for group members to work through their psychological issues. The keys to a successful therapeutic milieu are support, structure, repetition and consistent expectations.

Traumatic Brain Injury (TBI): is a nondegenerative noncongential brain injury from an external mechanical force, possible leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD

POLICY INTENT

There is no policy intent worksheet for this policy. Hospital services vary depending on the type of service.

Contact BMS UMC for prior authorization information on hospital services.

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CONFIGURATION OVERVIEW

There is no MMIS Configuration worksheet for this policy.

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