Chapter 503

LICENSED BEHAVIORAL HEALTH CENTERS

Appendix 503 F

RESIDENTIAL CHILDREN'S SERVICES

CHAPTER 503 LICENSED BEHAVIORAL HEALTH CENTERS (LBHC)

BACKGROUND

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

503F PROVIDER ENROLLMENT

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

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

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

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

503F EXCLUSION FOR BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE

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

1. As defined in *Chapter 503 Licensed Behavioral Health Centers* *"Individuals providing this service must have a bachelor's degree in a human services field or a high school diploma or GED with two years documented experience in mental health and/or substance abuse services. Staff must be properly supervised according to the BMS policy on clinical supervision. The service may be provided in a variety of settings by appropriately designated, trained, and supervised staff*", **or**

2. Individuals providing this service must have a bachelor's degree or a high school diploma or GED and complete the Residential Children's Supportive Counseling Certification that was developed and maintained through the collaboration of the Residential Children's Service providers and must be adopted by any residential provider that chooses to use this service under this provision. This includes core training modules, with a pre- and post-test, as well as 90 days of an on-the-job shadowing program. Core training modules include:

    - Away from Supervision (AFS) Training
    - Trauma Training
    - Diagnoses and Developmentally Appropriate Behavior
    - Confidentiality
    - Mandated Reporting
    - Policies and Procedures
    - Crisis Prevention and De-escalation (CPI/TCI)
    - Module Pre-Test Quiz
    - Module Post-Test Quiz

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

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

503F RESIDENTIAL CHILDREN'S SERVICES LEVEL I

Residential Children's Services, Level I is a structured 24-hour therapeutic group care setting targeting youth with a confirmed International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis that manifests itself through adjustment difficulties in school, home, and/or the community. This level of care is designed for children or youth whose needs can best be met in a community-based setting where the child can remain involved in community-based school and recreational activities. These youths usually can function in public school and in a group residential setting with a minimal amount of supportive services and behavioral interventions. The goal of supportive residential programs is to enable children to overcome their problems to the degree that they may move to a less restrictive community placement or independent living situation.

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

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

ADMISSION CRITERIA: The following admission criteria must be met:

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

Additional criteria to establish admission are:

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

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

CONTINUING STAY CRITERIA: The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in the West Virginia DoHS custody, and
- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and the child continues to exhibit symptoms and/or functional impairment such that treatment needs are best met in a community-based setting where the child can remain involved in the community, school and recreational activities, or
- The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, or
- The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child demonstrates new symptoms or functional impairment in adaptive and/or psychological functioning, and problem solving, which met the criteria for admission, or
- The child's symptoms have diminished, and functional impairment has improved, but there are continuing symptoms and functional impairment in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, or
- The child demonstrates an inability to sustain gains without the therapeutic service provided by the Residential Children's Services Level I program.

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

- The child has attained the age of 18 or 22 if the youth remained in DoHS custody.
- The child or family has attained goals as identified in the service plan or symptoms have decreased to the point where the child may be served in a less intensive treatment service.

- The child demonstrates functional impairment and symptoms, which cannot be treated safely and effectively at this level of treatment, and the child requires a higher level of care.
- The child has been on runaway status/away from supervision for a period of five days or more.
- Care appears to be custodial.

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

- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development (H0032)
- Targeted Case Management (T1017)
- Behavioral Health Counseling, Supportive, Individual (H0004)
- Behavioral Health Counseling, Supportive, Group (H0004HQ)
- Skills Training and Development (H2014U1, H2014U4, H2014HNU1, H2014HNU4)
- Therapeutic Behavioral Services – Implementation (H2019)

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

PROCEDURE CODE: H0019U1
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

503F RESIDENTIAL CHILDREN'S SERVICES LEVEL II

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

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

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

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

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

ADMISSION CRITERIA: The following admission criteria must be met:

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

Additional criteria to establish admission are:

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

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

CONTINUING STAY CRITERIA: The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in DoHS custody, and

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

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

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

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

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

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

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

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

503F RESIDENTIAL CHILDREN'S SERVICES LEVEL III

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

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

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

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

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

ADMISSION CRITERIA: The following admission criteria must be met:

- The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BSS to serve a child who does not meet the age requirements, and
- The child has a behavioral health diagnosis that meets medical necessity for Residential Children's Services Level III, and
- The child has severe symptoms and functional impairments which interfere with age-appropriate adaptive and psychological functioning and social problem solving, and
- The child's symptoms or functional impairments are such that the treatment cannot be successfully provided in a less intensive level of care, and
- The child's symptoms or functional impairments have existed for a duration of one year or longer and are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community.

Additional criteria to establish admission are:

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

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

CONTINUING STAY CRITERIA: The following criteria must be met:

- The child is under the age of 18 or 22 if the youth is in DoHS custody, and
- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and
- The child continues to exhibit an inability to sustain gains without the comprehensive program of therapeutic services provided by the Residential Children's Services Level III, or

- The child continues to exhibit symptoms and functional impairments so severe and complex that treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, or
- The child's symptoms and functional impairments which warranted admission to this level of service have been observed and documented, but treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, or
- The child demonstrates new symptoms or functional impairments which interfere with age-appropriate adaptive and/or psychological functioning, and problem solving, which meet the criteria for admission, or
- The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child's symptoms and functional impairments have diminished, but there are continuing disturbances/behaviors/symptoms in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions.

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

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

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

- Mental Health Assessment by a Non-Physician (H0031).
- Mental Health Service Plan Development (H0032)
- Mental Health Service Plan Development by Psychologist (H0032AH)
- Physician Coordinated Care Oversight Services (G9008)

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

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

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

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

503F RESIDENTIAL CHILDREN'S SERVICES LEVEL III.V

Residential Children's Services Level III.V provides comprehensive, highly structured, and intensively staffed care settings for children and adolescents with complex mental and behavioral health needs. Residential Children's Services Level III.V is divided into two specific services: Residential Diagnostic Services and Residential Intensive Behavioral Health Services.

503F RESIDENTIAL DIAGNOSTIC SERVICES

Residential Diagnostic Services provides a full range of observations, evaluations, testing, screening, and diagnostic assessments for youth with complex mental and behavioral health needs to ensure appropriate treatment needs are identified. The primary goal is to reduce placement disruptions due to inaccurate

identification of treatment needs and to shorten the length of stay for children and adolescents requiring residential mental health treatment. Within a period not to exceed 60 calendar days, the provider conducts 24/7 behavioral observations and completes a series of assessments. The resulting diagnostic evaluation report must provide a clear understanding of the child's needs and the most effective service interventions, leading to more informed and successful treatment outcomes.

ADMISSION CRITERIA: The following admission criteria must be met:

- The child's age must be between 10 and 17 years. In certain circumstances, younger children may be considered on a case-by-case basis, depending on the current population and dynamics of the program and with written approval from the BSS. The child must demonstrate a cognitive functioning level that is deemed appropriate for the program. This determination is made through a pre-admission interview conducted by the provider's staff, focusing on the child's ability to engage in the assessment process and benefit from the program's services.
- The child must have a documented history of complex mental and behavioral health needs that have not been successfully addressed through previous community-based, out-of-home and/or facility-based service interventions. This indicates a need for a more intensive and structured diagnostic evaluation to accurately identify the child's needs and develop an effective treatment plan.
- The child's previous inability to access or benefit from community services must not be solely due to the child or family's refusal to participate. This criterion ensures that Residential Diagnostic Services is utilized for children who genuinely require a higher level of care and assessment due to the complexity of their needs, rather than for cases where service refusal is the primary barrier to treatment.
- The provider must ensure any necessary psychological testing (e.g., developmental, neuropsychological) is completed and all reports are included in the full diagnostic evaluation.

CONTINUING STAY CRITERIA: To remain in Residential Diagnostic Services, the child must meet the following ongoing criteria:

- The child's comprehensive diagnostic assessment has not been completed within the initial 30 calendar day period due to factors such as:
    - The child's emotional or behavioral state has hindered their participation within the assessments or evaluations.
    - Documentation showing delays in scheduling necessary appointments with specialists or obtaining required testing and steps taken to alleviate those delays.
    - Documentation showing pending receipt of relevant records or information from external sources (e.g., previous providers, schools) and steps taken to alleviate the delays
    - The child's complex presentation requires additional time for thorough evaluation and observation. These complexities must be documented in the child's chart.
- The child demonstrates new symptoms or functional impairments which interfere with age-appropriate adaptive and/or psychological functioning, and problem solving that require further evaluation.

DISCHARGE CRITERIA: The following must be reviewed and met for discharge to occur:

- A comprehensive diagnostic evaluation report has been adequately developed, completed in full and shared with relevant parties.
- Based on the recommendations of the diagnostic evaluation report, the child is transitioned to the appropriate level of care or service, which may include residential treatment, community-based services, or a return to the family home with appropriate supports.
- The child or family demonstrates non-compliance with the evaluation process, including refusal to participate in assessments, evaluations, or therapeutic interventions. Documented attempts to engage the child and/or family have shown an inability to complete the diagnostic evaluation.
- It is determined that the child's needs cannot be met or are not appropriate for Residential Diagnostic Services, a more suitable placement or service is identified, and appropriate arrangements are made for those services to begin.

PROGRAM REQUIREMENTS: Residential Diagnostic Services will be comprised of several components, including referral, intake, evaluation, observation, and recommendations for services in a structured environment with the goal of identifying accurate treatment needs and developing a detailed evaluation/report that captures those needs. Providers will adhere to the following program requirements:

- To provide observation, evaluations, and a battery of assessments to determine the most beneficial and appropriate recommendations for treatment services. Assessments may include, but are not limited to:
    - CANS assessment
    - Psychological evaluations
    - Neuropsychological assessment
    - Psychiatric evaluation
    - Educational assessment
    - Additional assessments based on individual needs
- In small group unit, cottage, or homes with no more than six children assigned to one of these specific environments.
- Each unit, cottage, or home will offer individual bedrooms and create a homelike environment, including a designated recreational and family dining area.
- Individual bathing areas or private bathing times will be provided for all children.
- Have additional bed capacity to accommodate children transitioning between placements or awaiting in-home services.
- Maintain enrollment with BMS and be enrolled and credentialed with the managed care organization (MCO) to provide therapeutic diagnostic services and receive payment.
- Will accept any foster child who meets the program criteria if the provider has not met its maximum capacity.
- Not discharge any foster child in its program except as provided in the agreement. If the foster child does meet the provider's level and target population, the provider shall request an multidisciplinary team (MDT) and work toward alternative placement.
- If the child is in the state's custody, verbal and documented communication is required to take place with the child's worker in an effective and timely manner.
- The diagnostic evaluation report will be completed within 45 calendar days of admission in full.
- Staffing ratios of 1:3 at all times.

- Ensure the child is enrolled in on-grounds schooling immediately, consistent with the Fostering Connections to Success and Increasing Adoptions Act of 2008.

STAFFING REQUIREMENTS: Each Residential Diagnostic Services setting will maintain a 1:3 supervision ratio and employ sufficient staff with appropriate credentials, training, and experience to operate a safe and effective diagnostic program in accordance with state licensing regulations and the BMS Manual, *Chapter 503 Licensed Behavioral Health Centers*. Providers will ensure that employees and volunteers receive training as required by licensure rules, including organization-wide in-service training that incorporates the values and principles of a system of care framework. Supervision will be provided twenty-four (24) hours per day, seven (7) days per week. In addition to direct care staff, the provider must employ the following positions:

1. Director of Nursing: providers must have a director of nursing to work with the psychiatrist and on-site RN. Job responsibilities will include the following:
    a. Perform assessments of child medical needs at intake, and
    b. Schedule and coordinate medical appointments, and
    c. Manage the supply of prescription medications, and
    d. Provide supervision of staff medication administration, and
    e. Participate in care team meetings, and
    f. Coordinate medical areas of the discharge planning process, and
    g. Provide education to staff on medical needs of children served.

2. Psychiatrist: must be a board-certified or a board-eligible psychiatrist, able to prescribe all forms of Food and Drug Administration (FDA) approved medications and enrolled with West Virginia Medicaid. This could be an employee or contracted position. Job responsibilities will include the following:
    a. Conduct psychiatric evaluations with medical services, and
    b. Diagnose mental health disorders, and
    c. Develop and implement treatment plans, including medication management, and
    d. Prescribe and monitor psychotropic medications, and
    e. Collaborate with the treatment team, and
    f. Participate in team meetings, and
    g. Maintain accurate and timely documentation, and
    h. Provide consultation and education to staff, and
    i. Adhere to ethical guidelines and professional standards.

3. Psychologist: must be a licensed and/or supervised psychologist and enrolled with West Virginia Medicaid. This role could be directly employed or contracted, and services provided via telehealth. Job responsibilities will include the following:
    a. Conduct psychological evaluations without medical service, and
    b. Administer and interpret psychological tests, and
    c. Develop individualized treatment plans, and
    d. May provide individual/group therapy, and
    e. May facilitate family therapy sessions, and

f. Consult with staff on treatment strategies, and
g. Participate in Child and Family Team meetings.

4. Licensed Professional Counselor (LPC) or Licensed Independent Clinical Social Worker (LICSW): must be licensed and enrolled with West Virginia Medicaid. This role could be directly employed or contracted. Job responsibilities will include the following:

   a. Complete a psychiatric diagnostic evaluation without medical service, and
   b. Develop individualized treatment plans, and
   c. May provide individual/group therapy, and
   d. Facilitate family therapy sessions, and
   e. Consult with staff on treatment strategies, and
   f. Participate in Child and Family Team meetings, and
   g. Maintain accurate and timely documentation.

5. Licensed Registered Nurse: must be on-site and either directly employed or contracted.

   a. Conduct health assessments, and
   b. Administer medications, and
   c. Provide medical care and treatment, and
   d. Monitor vital signs and health status, and
   e. Educate youth and families on health-related issues, and
   f. Maintain medical records, and
   g. Collaborate with the treatment team, and
   h. Respond to medical emergencies.

6. Program Supervisor: must have at least a bachelor's degree in a human services field such as psychology, social work, counseling, or related discipline. Job responsibilities will include the following:

   a. Oversee daily operations, and
   b. Supervise and guide staff, and
   c. Collaborate with the treatment team, and
   d. Respond to crises, and
   e. Participate in meetings, and
   f. Maintain documentation, and
   g. Contribute to staff training.

7. Residential direct care staff: direct care staff will meet all applicable state licensing and program requirements:

   a. Meet all applicable state licensing requirements and adhere to age eligibility guidelines:
      i. Minimum 20 years of age for serving children aged 13 and older.
      ii. Minimum 18 years of age for serving children aged 12 and under.
   b. Maintain a minimum direct care staff-to-child ratio of 1:3, and
   c. Ensure two direct care staff are on-site, and

d. Possess the capability to increase the staff-to-child ratio in response to acuity, meeting the standards set forth in the agency's programming description, and
e. Supervise and facilitate activities of daily living, self-help, and socialization skills, and
f. Provide daily support and milieu intervention, including crisis response, co-facilitating group treatment and community meetings, and implementing individualized plans.

DIAGNOSTIC REQUIREMENTS: Diagnostic components will be delivered in a structured environment aimed at accurately identifying treatment needs and producing a detailed report that reflects these needs. Additionally, the program will provide intensive and high-quality mental and behavioral health services, offering a structured and effective approach to help children and families develop community strategies that support their emotional and behavioral well-being. Providers must adhere to the following diagnostic requirements:

- Upon referral, the provider will promptly schedule and conduct an interview with the child at the provider's facility, educational facility and/or through telehealth modality and gather necessary records, including the most recent Child and Adolescent Needs and Strengths (CANS) or CAPS, FAST assessment, medical, and educational records.
- Within 48 hours of placement, the provider will convene a meeting with the child and family, offering participation options (in-person, telephone, video chat) to engage the family in the evaluation process. This meeting should include the child's assigned worker, relevant provider staff, and individuals chosen by the child and family.
- Within 48 hours of the child's admission date, the provider must coordinate with the MCO to engage them in the process.
- A comprehensive assessment process will be conducted, which may include standardized tools (such as CANS, CAFAS, or other validated measures) and clinical observations, to identify the child's needs and inform treatment planning.
- Utilize a family-centered approach that emphasizes collaboration, strengths, and individualized planning when engaging the family in the assessment and treatment process.
- Provide documented program updates to the child's assigned worker at a minimum of one time per calendar week, including notable behaviors, assessment outcomes, and any known service needs.
- Deliver the comprehensive evaluation and recommendation to the child's assigned worker, the MCO and relevant MDT members within 30 calendar days or if needed a maximum of 45 calendar days.
- Maintain regular and frequent contact between the child and their family, utilizing a variety of methods (in-person, phone calls, video conferencing) based on the individual needs and circumstances. Contact must occur at least one time per calendar week from the date of admission. To complete the diagnostic evaluation, the provider must conduct at least 50% of the evaluation in the individual's home setting within 30 calendar days from the date of admission. If this is not possible, documentation must be provided explaining why.
- Identify and document parenting skills or needs to support the child's return home or transition to another placement and make referrals for services to address those skills.

The following comprehensive array of services included in the per diem procedure code H0019U5 are:

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

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

PROCEDURE CODE: H0019U5
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

503F RESIDENTIAL INTENSIVE BEHAVIORAL HEALTH SERVICES

Residential Intensive Behavioral Health Services, Level III.V is a highly structured, intensively staffed, 24-hour group care intensive treatment setting targeting children with a confirmed ICD or DSM diagnosis which manifests itself in serious emotional or behavioral disorders or disturbances with severe and persistent challenges in social, emotional, behavioral, and/or psychiatric functioning. As a result, the child cannot function in multiple areas of their lives. Residential intensive treatment settings provide a highly organized nationally recognized evidence-based program that includes structured behavioral curriculums and clinical interventions designed to create a therapeutic environment. All planned activities and applied

interventions are designed with the goal of stabilizing the child's serious mental or behavioral health condition so the child can be served in a community/family setting.

Children in Residential Intensive Behavioral Health Services have a current ICD and/or DSM diagnoses that exhibit severe functional disturbance in some or all the following areas:

- Severe disturbances in behavior and/or emotions
- Severely impaired social functioning deficits
- Psychiatric or substance use
- Complex trauma needs
- Documented persistent and unpredictable aggression, which may include sexual acting out behaviors
- Documented patterns of disruptive behaviors that have not responded to less restrictive interventions

Substantial social, academic, and vocational functional limitations are additional characteristics of the population's behavior pattern, and as a result, the child requires environmental structure and controls including 24-hour awake supervision, crisis intervention, medical and medication management, and alternative learning environments. The key element is these children present with behaviors so intense, severe, and unpredictable it has been determined to be seriously detrimental to their growth, development, and welfare, or to the safety of themselves or others.

ADMISSION CRITERIA: The following admission criteria must be met for a child to be placed in a Level III.V setting:

- The child's age range is from seven years of age up to age 21 unless the provider has a specific contract or has received a waiver from the BSS to serve a child who does not meet the age requirements, and
- The child presents with a behavioral or mental health diagnosis consistent with the current DSM of Mental Disorders) diagnosis that meets medical necessity, and requires intensive out-of-home therapeutic intervention, and
- The child has severe symptoms and functional impairments which interfere with age-appropriate adaptive and psychological functioning and social problem solving, and
- The qualified independent assessment and other relevant clinical documentation indicates the child requires this intensity level of residential treatment services, and
- The child's CAFAS score indicates severe functional impairment, and this is the appropriate level of care, and
- The child's symptoms or functional impairments are such that treatment cannot be successfully provided in a less intensive environment and can only be safely and effectively treated with 24-hour supervision and with on-site behavioral and mental health programming, and
- The child's symptoms or functional impairments and maladaptive behaviors are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community and the child cannot be safely treated in these environments, and
- The child demonstrates a cognitive capacity to respond to rehabilitative programming and skill development within a structured setting.

Admission for this level of care is not for providing special education, housing, supervision, or meeting other needs that are not medically necessary and are not reimbursable by Medicaid.

EXCLUSION CRITERIA: If any of the following criteria is met, the child will be excluded from services:

- The child is at imminent risk of causing serious harm to self or others, and inpatient psychiatric hospitalization is clinically indicated.
- The child's presenting needs compromise the safety of the current therapeutic environment and cannot be controlled through other interventions.
- The child requires specialized treatment interventions that are beyond the scope of this program and cannot be effectively addressed within a residential setting.
- The child has medical conditions or physical health impairments that require a level of care that cannot be safely or effectively provided within a residential setting. Please note common medical conditions such as asthma, type 1 diabetes, allergies (including food allergies), and skin conditions are not conditions that should be excluded. If a provider is unsure about a medical condition or physical health impairment, they must contact BSS and BMS to ensure they are applying the appropriate guidelines concerning this requirement.
- The child's primary treatment needs pertain specifically to substance use and/or medical intervention, medical monitoring, or management is indicated prior to addressing behavioral health treatment needs.
- The child's trauma-related symptomology and/or other clinical needs cannot be adequately addressed and effectively treated within this intensity of mental health intervention services.
- If the child's intellectual/developmental disability includes one of the following and there are no co-occurring diagnoses, symptoms, or behaviors consistent with current DSM-5 behavioral health diagnosis:
    - The child has a sole diagnosis of Autism Spectrum Disorder (ASD).
    - The child has a sole diagnosis of an Intellectual/Developmental Disability.
    - The child has a diagnosis of ASD and Intellectual/Developmental Disability.

CONTINUING STAY CRITERIA: The following criteria must be met for a child to stay in a Level III.V setting:

- The child is under the age of 18 or 22 if the child is in DoHS custody, and
- The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and
- The emotional and behavioral disturbance's severity continues to meet the criteria for this treatment service intensity, and
- The 30-day CANS assessment and other relevant clinical information show the child continues to require the intensity of residential treatment services, and
- Progress in relation to specific treatment needs is clear and can be described in objective terms. However, some goals of treatment have not yet been achieved and are needed for the child to safely return to a less restrictive environment; adjustments in the treatment plan include strategies for achieving these unmet goals, or

- Intensity of residential intensive treatment services continue to be needed to support reintegration of the child into a less restrictive living environment, or
- The child continues to show symptoms and functional impairments so severe and complex that treatment goals have not been reached and a less intensive care setting would not adequately meet the child's needs, or
- The child's parent/guardian/caregiver has been documented to be actively engaged in the treatment planning process, as shown by regular attendance at treatment team meetings, participation in family therapy, routine visitation with their child, and active involvement with transition planning, or
- The child's symptoms and functional impairments which called for admission to this level of service have been observed and documented, but treatment goals have not been reached and a less intensive care setting would not adequately meet the child's needs, or
- The child shows new documented symptoms or functional impairments which interfere with age-appropriate adaptive and/or psychological functioning, and problem solving, which meet the criteria for admission, or
- The child has not shown any progress toward treatment goals, but the treatment plan has been modified to introduce further evaluation to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
- The child's symptoms and functional impairments have diminished, but there are continuing disturbances/behaviors/symptoms in the child's adaptive and/or psychological functioning or social problem solving or
- There is documented evidence of active individualized discharge planning.

DISCHARGE CRITERIA: The following criteria must be reviewed and met for discharge to occur:

- The child has attained the age of 18 or 22 if the child remained in DoHS custody, or
- The child's documented treatment plan goals and objectives for this level of care have been met and the child can be expected to maintain these gains with community-based services and support, or
- The 30-day CANS assessment and other relevant clinical information indicate the child no longer requires the intensity of residential treatment services as determined by the treatment team (e.g. Physician, LPC, LICSW), or
- Support systems, which allow the child to be maintained in a less restrictive intensity of service, have been secured and established, or
- The child demonstrates symptoms or functional impairments which cannot be treated safely or effectively in this treatment setting and the child requires a different treatment option, or
- The child has been on runaway status/away from supervision for a period of five calendar days or more, or
- Care is custodial.

For children transitioning to a community setting, the wraparound facilitator must be engaged 30 calendar days before discharge.

PROGRAM REQUIREMENTS: Providers of Residential Intensive Behavioral Health Services must provide the highest level of nationally recognized evidence-based care along with a comprehensive array

of mental and behavioral health treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. The following is a list of requirements for providers at this level:

- Provide a nationally recognized, evidence-based, trauma-informed annual agency assessment, and
- Create and maintain policies and procedures that incorporate evidence-based, trauma-informed care into all levels of programming, and
- Offer a nationally recognized evidence-based, trauma-informed treatment model that provides a framework for a trauma-informed organizational structure applicable to the population of children served with suggested utilization of one of the following. If one of the models below is not chosen, the model selected must be submitted to BSS licensing for review and approval by the BMS and BSS prior to implementation. Current providers will have three calendar months to select a trauma-informed treatment model and up to one calendar year to fully implement:
    - Children and Residential Experiences (CARE)
    - The Sanctuary Model
    - Collaborative Problem Solving (CPS)
    - Attachment, Regulation and Competency (ARC) - System Level
    - Risking Connection
    - Restorative Approach
    - Trauma Systems Therapy
- Provide documentation upon request of training for all appropriate level employees, volunteers, interns, and independent contractors on the trauma-informed approach, completed within 90 calendar days of hire, updated as needed, and renewed annually, and provide use of treatment-level interventions rated by The California Evidence-Based Clearinghouse for Child Welfare as well-supported, supported, or promising to address trauma with suggested use of one of the following. If one of the models below is not chosen, the model selected must be submitted to BSS licensing for review and approval by the BMS and BSS prior to implementation. Current providers will have three calendar months to select a trauma-informed treatment model and up to one calendar year to fully implement:
    - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    - Eye-Movement and Desensitization Reprocessing (EMDR)
    - Prolonged Exposure Therapy for Adolescents (PE-A)
    - Seeking Safety
    - Cue-Centered Therapy
    - Risk Reduction Through Family Therapy
    - Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At Risk Treatment (SITCAP-ART)
    - I Feel Better Now! Trauma Intervention Program
- Each residential treatment setting will provide nationally recognized behavioral health sex trafficking prevention programming for all children in their care identified as victims of sex trafficking and will include the following:
    - Education about sex trafficking, including definition and prevalence, and
    - Understanding one's vulnerabilities and how to protect self from traffickers, and

  - Enhancement of existing support system (family, friends, community), and
  - Development of support system when one does not exist, and
  - Service linkage, as needed, for housing, homelessness prevention, educational support, and
  - Runaway prevention programming, and
- Providers must be accredited by Commission on Accreditations of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Health Organizations (JCAHO), Council on Accreditation (COA), or another independent Health and Human Services (HHS) approved organization. If a provider is not currently accredited, the provider must initiate the certification process within six calendar months. Currently enrolled providers must become fully certified no later than January 1, 2027. Newly enrolled providers must become fully accredited no later than two calendar years from provider enrollment date and comply by January 1, 2028, and
- All providers must ensure that each child has a comprehensive treatment, discharge, crisis, and aftercare plan. Each plan must include required components including family engagement and permanency that are **individualized** for each child, and
- If the child is admitted without an already submitted or approved Children with Serious Emotional Disorder (CSED) Waiver services application, the provider must ensure referral to the Pathway to Children's Mental Health Services, for the completion of a CSED Waiver services application within 30 calendar days of admission, and
- Ensure that each child has a completed qualified independent assessment (QIA) by a qualified independent assessor prior to admission that recommends short-term residential treatment intervention placement. For children that are admitted without a completed QIA, the provider must ensure a referral is completed for a QIA within 30 calendar days of admission, and
- Complete and submit written progress reports to the MCO at a minimum every 30 days from the date of admission, and at each subsequent service reauthorization on the child's progress and
- Always have one staff member on-site who is authorized to apply the reasonable and prudent parent standard to decisions involving appropriate developmental activities, and
- Provide ongoing quality review of policy and practices related to treatment, crisis, family engagement, permanency, discharge, and aftercare services plans, including monitoring, and tracking for individual and organizational outcomes.

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

If a provider is not in good standing with BMS and/or BSS reimbursement for services may stop at the discretion of DoHS.

Residential Intensive Behavioral Health Services will be provided in settings that adhere to the following program and structural expectations:

- Small group cottage structure, offering opportunities for relationship-building and family style interactions, and

- Capacity per license of up to 10 children unless with permission from BSS for expansion, with multiple cottages operating independently to provide consistency and foster small group units, and
- Preferred individual bedrooms for children, and
- Individualized clinical interventions, psychopharmacology services (when applicable), educational services, vocational, and medical services, and
- Staffing ratios of 1:4 at all times, and
- Case management ratios of 1:10, and
- Provide at least 10 hours per week of treatment service provision to the child and family. These services must be clearly logged, documented and verifiable. Treatment should include a combination of services, with an emphasis on professional therapies such as professional and supportive individual therapy, family therapy, and group therapy. Skills training and behavior management interventions may also be included.
- Documented weekly opportunities for family visits, calls, and engagement, and
- Have registered or licensed nursing and clinical staff on-site regularly and available 24/7 through telehealth modality, and
- Provide family engagement and permanency options that must include a continuous quality improvement component to ensure efficacy in providing appropriate family support.
- Please note family visits are not equal to family therapies.

STAFFING REQUIRMENTS: Each residential treatment setting must have qualified staff to meet the needs of children and families. The minimum direct care staff-to-child ratio is 1:4, with at least two staff on-site and the ability to increase staffing based on the needs of the children. Further staffing requirements include the following:

1. Director: the director will be a full-time employee with 24/7 on call availability and possess a minimum of a master's degree in the behavioral health field with three years of documented clinical experience, with one year being supervisory in a human service setting, or a bachelor's degree in the behavioral health field with six years of documented clinical experience, with three years being supervisory in a human service setting. Job responsibilities will include the following:
    a. Oversee operational programs to ensure achievement of stated programmatic goals and objectives, and
    b. Provide the supervision of assigned personnel, and
    c. Oversee the development and implementation of behavior plans and other assessments, and
    d. Ensure services are rendered in accordance with all federal and state regulations, and
    e. Maintain a clear plan for access to the physician.

2. Physician: either employed or contracted, is available to provide consultation and services 24/7. This may be utilized through the telehealth modality. Physicians or physician extenders serving within the residential program must be qualified as an M.D., D.O., APRN, Physician Assistant (PA) or Psych Nurse Practitioner (NP), Board-Certified or eligible, and licensed in the state of West Virginia. Job responsibilities will include the following:

a. Provide consultation to clinical and residential staff regarding medication targets, risks, side effects, and clinical needs, and
b. Contribute as needed to Continuous Quality Improvement (CQI) and risk management, and
c. Provide crisis responses, as needed, and
d. Perform observation and assessment on anyone on a psychotropic medication, and
e. Perform assessments to effectively coordinate all treatment, manage medication trials, or both, and
f. Provide medical management of all psychiatric and medical problems.

3. Nursing: either employed or contracted, there must be a licensed registered nurse that is available 24/7. Job responsibilities will include the following:

    a. Perform assessments of child medical needs at intake, and
    b. Schedule and coordinate medical appointments, and
    c. Manage the supply of prescription medications, and
    d. Provide supervision of staff medication administration, and
    e. Participate in care team meetings, and
    f. Coordinate medical areas of the discharge planning process, and
    g. Provide education to staff on medical needs of children served.

4. Clinical Staff: licensed mental health professionals such as LPC, LICSW, licensed psychologist or supervised psychologist, minimum of a master's degree in social work, counseling, or psychology, who are working toward licensure that have experience working with children. All clinical staff must meet state licensing rules for supervision and practice. Clinical staff must be available 24/7 to provide services and consultation to residential intensive treatment settings and staff. Clinical staff will maintain certifications necessary to adhere to all evidence-based models, assessments, and interventions utilized by the residential intensive treatment setting. Sufficient clinical staff is required to meet the needs of children being served, providing a minimum of 10 clinical treatment hours per week to each child, which could include individual, group, and/or family therapies. Job responsibilities will include the following:

    a. Complete family and individual assessments, and
    b. Provide psychotherapy, including face-to-face individual, family, and group therapy, and
    c. Assist with crisis de-escalation and crisis planning, and
    d. Participate in internal and external team meetings, and
    e. Contribute as needed to CQI and risk management initiatives, and
    f. Provide supervision and guidance to direct care in implementing treatment plans and evidence-based interventions.

5. Care Manager (CM) or Family Engagement Specialist (FES): the CM and/or FES must possess a bachelor's-level degree with one or more years of documented experience in the human services field. In residential intensive treatment settings, staff may fulfill both roles (CM and FES), providing services as stated in the plan, or separate the roles. Job responsibilities will include the following:

    a. Coordinate care planning, and

b. Develop and implement discharge planning, including but not limited to linkage, referral, advocacy and
c. Participate in internal and external team meetings, and
d. Identify and research family/kinship support resources for specific youth, and
e. Strengthen kinship/family relationships, and
f. Facilitate visits.

6. Residential direct care staff: residential setting direct care staff will meet state requirements and adhere to age eligibility guidelines and job responsibilities:

    a. The minimum age for serving children aged 13 and older shall be 20 years of age.
    b. The minimum age for serving children aged 12 years and under shall be 18 years.
    c. Supervise and facilitate activities of daily living, self-help, and socialization skills, and
    d. Provide daily support and milieu intervention, including crisis response, co-facilitating group treatment and community meetings, and implementing individualized plans.

7. CQI Manager: the CQI manager will possess a minimum of a master's-level degree with clinical knowledge and demonstrated experience with data analytics. These duties for the residential intensive treatment setting will constitute at least 50% of a full-time position, depending on size of organization and intervention models. There must be documentation that shows the 50% threshold has been met. Job responsibilities will include the following:

    a. Serve as a data manager, coordinating data collection and reporting activities, and
    b. Collect data related to intervention utilization, fidelity, outcomes, and compliance with state and federal policy and guidelines, and
    c. Review and manage data quality, and
    d. Compile and review data reports regularly to identify areas of need for improved compliance/quality and areas of strength in intervention implementation to better inform strategies for growth and improvement, and
    e. Monitor and report on fidelity requirements for all evidence-based models in use.

TREATMENT REQUIREMENTS: The Residential Intensive Behavioral Health Services setting will provide intensive and high-quality mental and behavioral health services that will offer a structured and sound approach to helping children and families find translatable community strategies that will meet their emotional and behavioral well-being. Each program will have a comprehensive array of nationally recognized evidence-based, trauma-informed treatment options, including those that are socially and culturally responsive that can be tailored to meet the individual needs of children and their families and that can be evaluated for outcomes and improved functioning. The time frame in which treatment should occur should be short in duration; typically, three to four months.

TREATMENT PLAN: The treatment plan is a collaborative, detailed, and structured plan created by the MDT to address the child's specific needs and goals and. It will:

- Be evidence-based and trauma-informed, person-centered and
- Allows for input from the child, family/guardian, and other MDT members to share the child's strengths, understand their goals for treatment, and provide a path for them to achieve success, and

- Have a medically identified behavioral or mental health diagnosis required for placement, and
- Complete a child and family strength-based assessment related to specific needs, including cultural preferences, and
- Provide a summary of assessments completed or needed for diagnostic and treatment recommendations, and
- Complete an initial plan of care within 72 hours of admission and provide a complete plan of care within 30 calendar days of admission, and
- Specify **individualized/person-centered** goals to be achieved during treatment that includes the following:
    - Measurable objectives for each individual goal, and
    - Identified techniques to be used to achieve goals and objective, and
    - Time frame in which each goal and objective will be completed, and
    - Criteria to be utilized in determining when a goal is complete, and
- Identify list of educational needs and strategies to achieve them, and
- Provide list of identified medical, dietary, vocational, cultural, and socially necessary needs and strategies to achieve them, and
- Provide a schedule of purposeful daily activities that are individualized to give the child a way to contribute and a sense of purpose, and
- Ensure cultural, language, and social needs are identified and strategies to meet those needs are incorporated into the plan, and
- Provide an opportunity for choice and decision-making and ensure that the child feels safe, secure, and supported, and
- Establish a plan for routine family involvement, including but not limited to, site visits, home visits, phone calls, involvement in treatment and crisis planning and discharge processes, and
- Specify short-term individual and group interventions to be utilized, and
- Develop a crisis prevention and relapse plan that includes identified triggers, coping strategies, and emergency supports, and
- Develop a discharge plan that identifies how, when, and what going home or to the community will look like or be needed for the child to return successfully to their home and/or community, and
- Develop a behavior plan including completion of functional behavior assessment, individualized strategies, and data collection on effectiveness of interventions provided, and
- Provide peer support options for children and families to share experiences, build on their resilience, and foster a sense of community and belonging, and
- Ensure plan is shared as updated with appropriate parties.

CRISIS PREVENTION AND RELAPSE PLAN: The purpose of the crisis prevention and relapse plan is to guide staff and others by clearly assigning roles and responsibilities, outlining necessary actions, ensuring everyone's safety, minimizing damage, and restoring the environment to normalcy. The plan will:

- Be developed at the time of admission, and
- Be evidenced based with crisis de-escalation skills to aid youth in developing regulation and alternatives to pain-based behaviors such as self-harm, physical aggression, defiance and running away, and

- Be a collaborative effort that allows for input by the child, family/guardian, and other members of the MDT, and
- Identify triggers and early warning signs, such as specific behaviors, situations, or environmental factors that may precede an impending crisis, and
- Provide documented detailed and individualized strategies that will help to de-escalate a situation and help the youth with regulating their emotions, including but not limited to offering choices, utilization of calming techniques, and verbal de-escalation, and
- Ensure cultural, language, and social needs are identified and strategies to meet those needs are incorporated into the plan, and
- Identify crisis prevention, verbal de-escalation, and self-calming/soothing techniques tried, and which ones were helpful, and
- Provide documented defined roles and responsibilities for each staff member during a crisis, including but not limited to communication protocols, decision-making processes, and implementation of de-escalation techniques, and
- Identify potential challenges or setbacks that may or have occurred during the treatment process, transition and discharge process and contingencies to address them, and
- Will include documentation of de-escalation techniques utilized, notification and reporting to required parties, i.e., family/guardian, BSS licensing, etc., and
- Develop and implement a standard format for documenting and reporting crisis incidents, including events leading up to crisis, interventions utilized, outcomes, and utilizing objective and detailed information.
- Be added to or imbedded in the discharge plan.

DISCHARGE PLAN: The discharge plan is a comprehensive strategy developed to ensure a smooth transition for the child and their family to their home, community, or other location. Discharge plans should utilize a nationally recognized evidence-based practice and outline the care and support needed after leaving the residential facility to ensure the greatest opportunity for success: Each discharge plan should:

- Be developed within 7 calendar days of the child's admission and will be reviewed and discussed at each treatment review and on an ongoing basis, and will be updated monthly from the date of admission and
- Shared with the appropriate parties, and
- Be collaborative and detailed in structure and requiring input from the child, family/guardian, and other MDT members, and
- Identify a discharge location, and if one is not identified to begin family finding activities, and
- Provide education to the child and family/guardian on the purpose of the discharge plan and to gain their input, and
- Ensure the child and family/guardian's understanding of all aspects of the discharge plan including but not limited to medications and medical needs, and behavioral and social needs, and
- Ensure the discharge plan, along with the child's planned discharge date, is included in each child's treatment plan, and
- Ensure that medications and a medication plan have been explained and there is a clear understanding of what needs to occur, including timely administration of medication, attending follow up appointments, and watching for side effects, and

- Provide documented clear criteria for discharge that should be discussed with the child and family/guardian, in addition to discussing expectations around the discharge and transition process, and
- Start the transition prior to discharge, with opportunities for the child and family to rehearse and practice strategies and routines and to process and adjust with residential treatment setting guidance. Barriers to a successful discharge will be assessed on an ongoing basis, and
- Include crisis prevention and relapse planning, based on the developed crisis prevention and relapse plan and the strategies that have worked during placement, community outings, and home visits. The plan should be tailored for the proposed discharge setting and anticipated experience, and
- Ensure cultural, language, and social needs are identified and strategies to meet those needs are incorporated into the plan, and
- Identify and develop a plan to address social determinants of health, including but not limited to, food insecurity, housing instability, utility needs, and financial strain, and
- Contain the following written information:
    - Contact information and steps to access each community provider, and
    - Contact information for the residential treatment setting and its role in continued supports, and
    - Recognition of the child and family's efforts, family strengths, and progress that has been made, and
    - Challenges the family may face, and a finalized version of the safety/crisis support prevention and relapse plan developed during residential treatment placement, and
- Ensure that all required referrals as identified through assessments and treatment plan have been made, documented and
- Schedule all follow-up appointments as needed and identified with child and family/guardian input and including but not limited to the following:
    - Medical – physical/well child check
    - Dental – routine checkups or identified follow up needs
    - Therapy – speech, OT, PT, etc.
    - Behavioral and/or mental health – counseling, medication management
    - Education – IEP and/or 504, or other support meetings, including sports or extracurricular activities
- Define and develop a documented transition timeline and steps involved in the transition process, including roles and responsibilities of the child, family/guardian, and MDT team members, and
- Develop and implement a standard format for the discharge plan that can be individualized based on each child's unique needs, and
- Provide ongoing quality review of policy and practices related to crisis planning, monitoring and tracking for individual children and outcomes.

The following comprehensive array of services included in the per diem procedure code H0019U5 are:

- Mental Health Assessment by a Non-Physician (H0031)
- Mental Health Service Plan Development (H0032)
- Mental Health Service Plan Development by Psychologist (H0032AH)

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

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

PROCEDURE CODE: H0019U5
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized

503F BEHAVIORAL HEALTH: SHORT-TERM RESIDENTIAL (LEVEL IV)

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

ADMISSION CRITERIA: The following admission criteria must be met:

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

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

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

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

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

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

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

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

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

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

503F DOCUMENTATION

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

- Behavioral observations of the child.
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start/stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs from the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503F REIMBURSEMENT METHODOLOGIES

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

Prospective means that the rates of reimbursement are established in advance of the rate period and are considered to be fixed for the rate period. No retrospective adjustments are made except for identified

errors in rate calculation; audit findings; errors or misrepresentations in financial reporting; or recaptures resulting from penalties or non-provision of reported services. Rate periods are for six months, with recalculation of rates occurring on April 1 and October 1 of each year. Additionally, the prospective nature of rates means that the calculated level of payment is the limit of cost experience which the DoHS will recognize for the period.

Cost related means that the provider specific rates are related to the actual cost of the provider, relative to limits derived from the actual cost experience of all providers in a peer group. These peer groups correspond to the identified level of the facility. The governing principle is that of "reasonable cost" reimbursement. Under such an approach, rates of reimbursement cannot exceed those of an "efficiently and economically operated" facility. The determination and test of "reasonableness" is contained in the rate setting system itself and established objectively by formula. Separate limits (ceilings) are established by component with peer groupings varying by component. This serves to simulate the workings of a market system for the covered services.
There are three primary components of the braided rate system: room and board, supervision, and treatment services. The treatment services and costs represent the residual after accounting for expenditures in the previous components. Facilities are categorized into levels based upon the array of services to be available and/or provided to residential children. Within each Level, a ceiling is derived from the weighted average Medicaid patient day costs of all providers in that peer group. Facility costs are reimbursed up to the amount of this ceiling. Reimbursement criteria are stated below.

- Reimbursement begins on the day of admission (regardless of the time of admission) prior to 12:00 AM. The admission date requires services provided as outlined in this policy which is in the per diem rate, to be billed but does not require the eight continuous hour criteria (see criteria below).
- Reimbursement then occurs for each 24-hour period provided by the following definition. A member's day is defined as eight continuous hours in residence in the facility in a 24-hour period. Since the daily census time starts at 12:00 AM, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive at least one unit of a service as outlined in this policy which is in the facility's per diem rate.
- If services outlined in this policy are within the per diem rate but are billed through outside agencies/contractors/providers, within a 24-hour census period, the facility receiving the per diem rate is responsible for payment to the outside agencies/contractors/providers and this service can be counted as an itemized service. There must be a contract or Memorandum of Understanding (MOU) with the outside agency/contractor/provider identifying services to be rendered and record maintenance of those services.
- Since the discharge date does not qualify as 24-hour duration, this date cannot be reimbursed.
- Claims must be itemized in the billing system to reflect all Medicaid billable services by the facility under the per diem rate that is provided for a child on a daily basis.

REFERENCES

West Virginia State Plan references reimbursement for Residential Children's Services at 4.19-B(4)(b)(iii).
The West Virginia Bureau for Social Services' Foster Care Policy

West Virginia State Plan references *Chapter 503 Licensed Behavioral Health Centers*
West Virginia State Plan references 78CSR3

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Appendix	Residential Children's Services	April 25, 2016
Entire Appendix	Reformatted appendix to include an effective date and to remove references to the specific Utilization Management contractor. Per provider request, Targeted Case Management, Procedure Code T1017, was added to the services that are included in the per diem payment for Behavioral Health: Short-Term Residential (For Children) H0019UA.	January 1, 2018
Entire Appendix	Services included in the per diem rate was added to each Residential level. Reimbursement Methodologies were added Guidelines for Behavioral Health Counseling, Supportive were clarified	February 21, 2019
Entire Appendix	Section numbers added to the table of contents. Section added for Residential Children's Services Level III.V with two subsections, Residential Diagnostic Services and Residential Intensive Behavioral Health Services. Changed Department of Health and Human Resources (DHHR) to Department of Human Services (DoHS) and Bureau for Children and Families (BCF) to Bureau for Social Services (BSS).	January 1, 2025