Chapter 504

Substance Use Disorder Services

Appendix B

Application for Residential Adult Services

Application for Residential Adult Services

The West Virginia Department of Health and Human Resources (WVDHHR), through the Bureau for Medical Services (BMS) is required to designate the ASAM® level of care for all licensed residential treatment facilities. To make this determination, the following application is required to be filled out for each licensed facility. The information provided and submitted with this application will allow WVDHHR to review information regarding the overall program integrity, description of population, treatment services, and qualification of staff, organizational structure, environment, and setting and to assign an ASAM® level for the program.

Facility Name: _____

Program Name: _____

Facility Address: _____

City/State/Zip: _____

NPI/Licensing Number: _____

Coodination of Care

Contact Name: _____

Telephone Number: _____

Email Address: _____

Please indicate the ASAM® Level being applied for:

- ☐ 3.1 Clinically Managed Low Intensity
- ☐ 3.3 Clinically Managed Population Specific High Intensity
- ☐ 3.5 Clinically Managed High Intensity
- ☐ 3.7 Medically Monitored Intensive Inpatient Services
  - ☐ 3.2 Withdrawal Management (*Note: Withdrawal Management Levels 1 and 2 are not Residential Services and are approved through another process outside of this document. Information about Level 1-WM Intensive Outpatient Services and Level 2-WM Community Psychiatric Supportive Treatment can be found in Chapter 503, Licensed Behavioral Health Center Services of the BMS Provider Manual.*)

SUPPORT SYSTEMS

1) Is telephone or in-person consultation with physician and emergency services available 24/7?	☐Yes	☐No
2) Are there direct affiliations with other levels of care and/or close coordination for referrals to other services?	☐Yes	☐No
3) Do you have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?	☐Yes	☐No
4) Can you arrange for pharmacotherapy for psychiatric or anti-addiction medications?	☐Yes	☐No
5) Are psychiatric/psychological consultations available as needed?	☐Yes	☐No

STAFF

1) Is professional staff available on-site 24 hours a day?	☐Yes	☐No
2) Does the treatment team consist of medical, addiction and mental health professionals?	☐Yes	☐No
3) Are one or more clinicians available on site or by telephone 24 hours a day?	☐Yes	☐No

Please indicate program staff conducting each service. Check all that apply on the following table:

License or Certification /Registration	MD/DO/ PA/APRN	LP/SP	LPC	RN/LPN	LICSW	LCSW	LGSW	LSW	AADC and ADC	MA NON-LISC	BA NON-LISC	BHT	PRSS
Medical RX Services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
COD Treatment Services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Diagnostic Evaluation without medical services (90791)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Diagnostic Evaluation with medical services (90792)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Assessment by a Non-Physician (H0031)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Service Plan Development by a Non-Physician (H0032)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Service Plan Development by a Psychologist (H0032AH)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Targeted Case Management (T1017)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skills Training and Development by a Paraprofessional (H2014U1/H2014U4)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skills Training and Development by a Professional (H2014HNU1/H2014HNU4)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Behavioral Health Counseling Supporitve (Individual/Group) (H0004/H004HQ)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Behavioral Health Counseling Professional (Individual/Group) (H0004HO/H0004HOHQ)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family Psychotheapy without patient present (90846)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

CHAPTER 504 SUBSTANCE USE DISORDER SERVICES

License or Certification /Registration	MD/DO/ PA/APRN	LP/SP	LPC	RN/LPN	LICSW	LCSW	LGSW	LSW	AADC and ADC	MA NON-LISC	BA NON-LISC	BHT	PRSS
Family Psychotheapy with patient present (90847)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crisis Intervention 24-hour Availability (H2011)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Group Psychotherapy (90853)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Recovery Support (H0038)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychotherapy Patient and Family (90832/90834/90837)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychotherapy for Crisis (90839/90840)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Therapeutic Behavioral Services Development Implementation (H2019HO/H2019)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physician Coordinated Care Oversight Services (G9008)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychological Testing with Interpretation and Report (96101)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comprehensive Medication Services (includes all Nursing) (H2010)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Screenings (80305, 80306, 80307)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Any needed Evaluation/Management Services	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MD/DO – Doctor of Medicine / Doctor of Osteopathic Medicine
LP/SP – Licensed Psychologist / Supervised Psychologist
LPC – Licensed Professional Counselor
RN/LPN – Registered Nurse/Licensed Practical Nurse
LICSW – Licensed Independent Clinical Social Worker
LCSW – Licensed Clinical Social Worker
LGSW – Licensed Graduate Social Worker
LSW – Licensed Social Worker

AADC – Advanced Alcohol & Drug Counselor
ADC – Alcohol & Drug Counselor
MA Non-Lisc – Master's Non-Licensed
BA Non-Lisc – Bachelor's Non-Licensed
BHT – Behavioral Health Technician
PRSS – Peer Recovery Support Specialist
PA – Physician Assistant
APRN – Advance Practice Registered Nurse

THERAPIES AND SERVICES

1) List planned clinical programs/activities and hours per week. List others on additional sheet if needed.

Therapy/Service	Number of Hours
1.	
2.	
3.	
4.	
5.	

2) List counseling and curriculum programs and hours per week.

Counseling/Curriculum Programs	Number of Hours
1.	
2.	
3.	
4.	
5.	

3) Detail any recovery support services available.

_____

_____

_____

4) Are family members and/or significant others involved in treatment? ☐Yes ☐No

5) Is Medication-Assisted Treatment (MAT) available?

ONSITE ☐Yes ☐No

OFFSITE ☐Yes ☐No

6) Is there monitoring of medication adherence (for behavioral health and physical health)? ☐Yes ☐No

7) Do you use random drug screens to monitor compliance? ☐Yes ☐No

8) Please attach a weekly schedule of services with the individual, group, educational and/or other treatment services labeled, to validate the service hours listed above.

9) Please attach other programmatic documentation that will support the ASAM® Level for which approval is being sought.

10) Please attach facility regulation for visitation guidelines and search/contraband protocol.

11) Please list the total program capacity and number of members in program weekly for each level of service provided.

Service	# Total Program Capacity	# Members in Program Weekly
ASAM® 3.1		
ASAM® 3.3		
ASAM® 3.5		
ASAM® 3.7		
ASAM® 3.2 WM		

ASSESSMENT / TREATMENT PLAN AND REVIEW

Does the program's assessment & treatment plan review include:

1) Utilizing an individualized, comprehensive assessment?	☐Yes	☐No
2) An individualized service plan developed in collaboration with member reflecting the members' personal goals?	☐Yes	☐No
3) A daily assessment of progress and treatment changes?	☐Yes	☐No
4) A physical examination by MD/DO, PA, or APRN performed as part of the initial assessment and admission process?	☐Yes	☐No
5) Ongoing transition/continuing care planning?	☐Yes	☐No
6) An after-care plan that specifies community resources and additional support services that the member is actively associated with?	☐Yes	☐No

SATELLITE LOCATIONS

A program that operates in more than one location (site) must list the names and address of all sites operating under the same governing authority in the space provided below as well as the services categories at each site. The Master Site is the location which provides direct substance abuse services. If the administrative office does not provide services, this location should be indicated below.

MASTER SITE: License/NPI#_____ Telephone #_____

Program Name: _____ Program Director:_____

Name of Program:_____
Street Address:_____
City:_____Zip:_____County:_____
Telephone #:_____Site Director:_____

Name of Program:_____
Street Address:_____
City:_____Zip:_____County:_____
Telephone #:_____Site Director:_____

Name of Program:_____
Street Address:_____
City:_____Zip:_____County:_____
Telephone #:_____Site Director:_____

Name of Program:_____
Street Address:_____
City:_____Zip:_____County:_____
Telephone #:_____Site Director:_____

Name of Program:_____
Street Address:_____
City:_____Zip:_____County:_____
Telephone #:_____Site Director:_____

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

List the contact information of the person that can be reached for follow-up if needed.

NAME	TITLE	EMAIL	TELEPHONE