CHAPTER 521 BEHAVIORAL HEALTH OUTPATIENT SERVICES
APPENDIX B: DRUG FREE MOM AND BABY PROGRAMS

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BACKGROUND

The Drug Free Mom and Babies (DFMB) Program is a comprehensive maternity and behavioral health care program for pregnant and postpartum individuals with an opioid use disorder diagnosis or a history of opioid use. The program supports these individuals with opioid use disorder by coordinating treatment and recovery plans throughout pregnancy and up to one year postpartum. DFMB staff refer enrollees to services for any identified social service needs, including but not limited to the Women, Infant, and Children (WIC) program, housing assistance, food pantries, and transportation services. All DFMB sites must have access to Obstetrics and Gynecology (OB/GYN) care.

Care coordinators will do initial screening and development of treatment plan. They can also connect the member with services such as transportation, medication assisted treatment (MAT) services, and help enrolling the member in a home visitation program.

Community health workers (CHW) will act as a bridge between the mom/infant in the community and the care coordinator in the office setting. The CHW will assist the care coordinator with connecting the member with services such as transportation, medication assisted treatment (MAT) services, and help enrolling the member in a home visitation program.

Peer recovery support specialists play a supportive role to the member with life experience. The peer recovery support specialist must be in active recovery for a minimum of two years with lived experience of substance use during pregnancy post-partum periods. They must meet all Medicaid reimbursement requirements.

Obstetrics and gynecological providers perform all routine prenatal and post-partum care for the member. They also may provide MAT services at these locations. If a DFMB site does not have onsite MAT services, the DFMB provider will ensure access to a MAT provider and coordination of care between providers.

POLICY

521B.1 MEMBER ELIGIBILITY AND ENROLLMENT

In addition to meeting requirements in *Chapter 400, Member Eligibility*, members must meet all of the eligibility and enrollment requirements described below for DFMB Care Coordination:

1. Provide documentation from a physician, advanced practice registered nurse (APRN) or physician assistant (PA) indicating that the member is eligible for DFMB care coordination because the member is pregnant **OR** in the first year of postpartum.
2. Provide documentation indicating that the member has an opioid use disorder diagnosis as described in the current Diagnostic and Statistical Manual (DSM) **OR** a history of an opioid use disorder (OUD) through an evaluation and a completed Prenatal Risk Screening Instrument (PRSI).
3. Enrolled in a West Virginia Managed Care program (i.e., Mountain Health Trust)
4. If the individual is under the age of 18, the parent and/or guardian must consent to participation.

Exclusions

A member is not eligible for DFMB care coordination if they are currently receiving services through:

1. An acute psychiatric care facility,
2. A State-operated psychiatric facility,
3. A long-term care facility,
4. A psychiatric residential treatment facility (PRTF),
5. The Intellectual/Developmental Disabilities Waiver (IDDW) program,
6. Enrolled through the Assertive Community Treatment (ACT),
7. Child Residential Programs, or
8. Residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID),
9. Receiving Targeted Case Management Services through a licensed behavioral health center (LBHC).

521B.2 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

All Medicaid providers must meet the provider enrollment requirements in *Chapter 300, Provider Participation Requirements*.

DFMB providers must also complete an approval and readiness review that is processed with the West Virginia Perinatal Partnership and the Bureau for Medical Services (BMS) to be enrolled and deliver services.

DFMB providers must also enroll with the West Virginia Medicaid Managed Care Organizations (MCOs). See *Chapter 527, Section 527.9 Mountain Health Trust (Managed Care)*.

DFMB Provider Site Requirements

DFMB providers must promote effective operation of the various programs and agencies in a manner consistent with applicable State laws, regulations, and procedures. There must be clear policy guidelines for decision making, program operations, and provision for monitoring these activities. DFMB providers must maintain:

- Provisions for orientation, continuing education, and ongoing communication with MCO case manager.
- Policies and procedures to protect the rights of members.
- A comprehensive set of personnel policies and procedures.
- Job descriptions and qualifications, including licensure, for all staff employed either directly or by contract with the provider or with an agency contracting with the provider or program.
- Provisions for ensuring staff or contractors possess the skills and knowledge needed to perform job functions, and provisions for performing regular staff evaluations.
- Written definitions and procedures for use of all volunteers.
- A working knowledge of community providers.
- Current information regarding the types of resources and services offered by other community-based, local, and state human services agencies.

Providers must provide other Bureaus within the West Virginia Department of Health and Human Resources (DHHR) with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services within the guidelines of HIPPA and 42 CFR Part 2.

521B.3 CRIMINAL BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for fingerprint-based background check requirements, which are required of all persons who have direct contact with members or access to member information. For additional information, please go the WV Clearance for Access: Registry & Employment Screening website.

521B.4 METHODS OF VERIFYING MEDICAID REQUIREMENTS

Enrollment and administrative requirements, as well as provision of services, are subject to review by the BMS and/or its contracted gents. The BMS-contracted agents may promulgate and update utilization management guidelines that the BMS has reviewed and approved. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information* and *Chapter 800, Program Integrity* and are subject to review by State and federal auditors.

521B.5 OTHER ADMINISTRATIVE REQUIREMENTS

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

- All documentation completed on a member must be recorded and maintained in the member's individual record, whether electronic or written, and must be legible.
- When a member is enrolled, the provider must notify the appropriate managed care organization (MCO) within 48 hours or the next business day.
- Staff must use uniform guidelines for case record organization, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- A Freedom of Choice form must be developed by the DFMB provider and signed by members to ensure there is no duplication of services.
- Copied or boilerplate language in documentation will not be reviewed and will cause dis-allowment.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports must be filed within 48 hours of case closure or on the next business day There must be on-going case record reviews to ensure that records contain current, accurate, and complete information.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.

- If requested, the providers must provide copies of Medicaid member records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- Providers must provide a point of contact throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements.*
- Services provided via Telehealth must align with requirements in *Chapter 519.17, Telehealth Services*.

521B.6 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services through Telehealth to allow easier access to services for Medicaid members. To utilize Telehealth, providers will need to document that the service was rendered under that modality. The provider is required to state in documentation if the service was rendered through the telehealth modality. Services provided through Telehealth must align with requirements in *Chapter 519.17, Telehealth Services*.

521B.7 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of BMS Provider Manual. Providers must also comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, history of OUD (provider must indicate instances of self-reported history), a current plan of care (POC) signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
    - Each case note must also:
        - Be dated and signed by the care coordinator along with a listing of the care coordinator's credentials, e.g., LSW, MA;
        - Have relevance to a goal or objective in the member's plan of service;
        - Include the purpose and content of the activity as well as the outcome achieved;
        - Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts);
        - Detail the DFMB component of the valid activity provided; (i.e., needs assessment and reassessment; development and revision of the DFMB

service plan; care coordination; health promotion and education; and monitoring and follow-up);
- List the location the activity occurred; and
- List the actual time spent providing each activity by itemizing the start and stop time.

- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel or BMS' contracted agent. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.
- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual to include:
  - Evidence in each clinical record that the member is shown to be in a targeted population as defined under the *Member Eligibility and Enrollment*, section 521B.1, of this policy.
  - An individualized service plan detailing the need for DFMB services which is updated as needed throughout the duration of treatment in a DFMB program.
  - A clinical record that must include documentation specific to services/activities reimbursed for the procedure codes T2023 HG and includes a specific note concerning the activities completed in connection to this service code.
  - If a member refuses to allow home visits to take place, then this should be documented in the patient's record.
- The BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy-based system. Regardless of the system the provider is using, providers using an electronic-based system will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Any document that is printed must have a handwritten signature and be dated.

SERVICES

521B.8 CASE MANAGEMENT AND CARE COORDINATION ROLES AND RESPONSIBILITIES

DFMB Care Coordinator and MCO Case Manager Coordination

While actively enrolled in DFMB, Medicaid members rely on DFMB care coordinators for services defined in the table in *Service Coordination Definitions,* Section 521B.8.1 relating to their pregnancy, postpartum care, and OUD treatment. All other Medicaid covered, and referral services are managed by the member's MCO case manager as required by the State's contract with Medicaid MCOs and federal regulations codified in 42 CFR 438.208.

If the member is actively enrolled in Medicaid managed care at the time of DFMB enrollment, the DFMB care coordinators and MCO case manager will review the member assessment and existing plan of care together to identify any necessary revisions to the member's plan of care. DFMB Providers and MCOs are required to communicate on a calendar monthly basis for regular review of the plan of care.

The DFMB provider is responsible for ensuring that the release of information form is signed and forwarded to the appropriate MCO. The DFMB is required to notify the MCO within 48 hours or the next business day of a member consenting to treatment by the DFMB program.

The members plan must be updated at a minimum of every 90 days unless a critical juncture in care is identified by the DFMB or the MCO care coordinator then an update treatment team meeting should take place within seven days of the identified critical juncture.

If the member is not actively enrolled in Medicaid at the time of DFMB enrollment, the DFMB care coordinator will conduct an assessment and develop a plan of care under presumptive Medicaid eligibility as defined in the table in *Service Coordination Definitions,* Section 521B.8.1 and share those findings and materials with the MCO Case Manager after MCO enrollment to avoid duplication of services.

As part of care coordination services, DFMB care coordinators, DFMB CHW, and MCO case managers will work together as sources of referrals, partners to re-engage participants at risk for loss of engagement, and collaborators in addressing findings from health-related social needs screening. DFMB care coordinators and MCO case managers shall meet to coordinate across all Medicaid covered services no less than quarterly throughout the member's enrollment in the DFMB Program. The provider is responsible for ensuring that the release of information form is signed and forwarded to the appropriate MCO. The peer recovery support specialist should be informed of and invited to service plan meetings.

Transition of Care

DFMB services are limited to the duration of the member's pregnancy and one year postpartum. Approximately 30 days prior to the end of DFMB services, the member, DFMB care coordinator, and MCO Case Manager must begin the transition of care process. All transition of care activities must adhere to existing Medicaid policy and align with requirements as defined in the State's contracts with Medicaid MCOs to ensure a seamless transition and access to continuing care.

521B8.1 DFMB Service Coordination Definitions

Care Coordination Service	Definition
Comprehensive Needs Assessment and Re-assessment (as needed)	Comprehensive assessment and periodic re-assessment of expecting or new mother's current and potential strengths, resources, deficits, and needs, to determine the need for any medical, educational, social, or other services. These assessment activities include: • Conducting a Screening, Brief Intervention and Referral to Treatment (SBIRT) assessment; • Taking member history; • Identifying the expecting or new mother's needs and completing related documentation; and • Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible expecting or new mother; • Attempt to conduct a minimum of one home visit during the DFMB time period (i.e., during pregnancy and one-year postpartum) by the DFMB care coordinator or DFMB community health worker (CHW). The home visit is voluntary and the care coordinator or CHW must obtain written consent from the member or, if the member is a minor, a parent and / or guardian. If the member refuses to allow home visitation, documentation must reflect multiple such attempts by the provider.
Development and Update of Individualized Plan of Care	Within 30 days of entry into the program, development (and periodic revision) of a specific, comprehensive, individualized care (service) plan that is signed by all appropriate individuals and which is based on the information collected through the assessment that: • Specifies the goals and actions to address the medical, social, educational, and other services needed by the expecting or new mother. • Includes activities such as ensuring the active participation of the eligible expecting or new mother and working with the expecting or new mother (or the expecting or new mother's authorized health care decision maker) and others to develop those goals. • Is based on expecting or new mother's strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the expecting or new mother, her parent(s) or legal guardian (if applicable), the DFMB care coordinator, and as applicable, other members of the DFMB care team (e.g., the member's maternity care provider, behavioral health provider, substance use treatment provider, peer recovery coach, and CHW). • Identifies a course of action to respond to the assessed needs of the eligible expecting or new mother;

Care Coordination Service	Definition
	• Records the full range of services, treatment, and/or other support needs necessary to meet the expecting or new mother's goals; and • Describes the nature, frequency, and duration of the activities and assistance that meet the expecting or new mother's needs. The DFMB care coordinator is responsible for regular service planning reviews based on the member's needs at regularly scheduled intervals.
Care Coordination	Linkage, referral and related activities (such as scheduling appointments for the expecting or new mother) to help the eligible expecting or new mother obtain needed services including: • Identifying community resources and developing / maintaining collaborative relationships with community-based opioid use disorder and mental health providers; • Activities that help link the expecting or new mother and their child with medical, social, family support, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan. • Facilitating the expecting or new mother's access to and transition of care, services and resources through linkage, coordination, referral, consultation, and monitoring; • Coordinating care and services across multi-disciplinary care teams, with the MCO care coordinator, and other care coordinators, such as Child Protective Services (CPS), as needed; • Evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific expecting or new mother. • Acquainting the expecting or new mother, and her parent(s) or legal guardian (if applicable), with resources in the community and providing information. • Obtaining appropriate informed consent and release forms and tracking referrals Accomplished through in-person and telephone contacts with the expecting or new mother, and her parent(s) or legal guardian (if applicable), and with service providers and other collaterals on behalf of the expecting or new mother. This will occur as necessary, but at least monthly.
Health Education and Promotion	The DFMB care coordinator shall provide health education and promotion materials and linkages to preventative health services such as tobacco cessation and peer recovery support. Throughout the mother's pregnancy and post-partum period, the DFMB care coordinator will provide educational materials and referrals that help the expecting or new mother prepare for and

Care Coordination Service	Definition
	adjust to life as a parent. These educational materials and referrals may include topics such as: • Lactation support/counseling • Contraceptive counseling • Childbirth education • Mental health (e.g., postpartum depression) • Nutrition counseling • Infant care, including neonatal abstinence syndrome (NAS) symptoms / management • Parenting Education • Child development
Monitoring and Follow-up	The DFMB care coordinator or CHW shall conduct regular monitoring and follow-up activities with the expecting or new mother and her parent(s) or legal guardian, or with other related service providers, including the following: • Activities and contacts (either in-person or telephonic) that are necessary to ensure the care plan is implemented and adequately addresses the eligible expecting or new mother's needs. Contacts may be with the expecting or new mother, family members, service providers, or other entities or individuals assisting the eligible mother with implementation of their care plan. Contact is conducted as frequently as necessary, but at least monthly to determine whether the following conditions are met: ○ Services are being furnished in accordance with the expecting or new mother's care plan; ○ Services in the care plan are adequate, and of the appropriate quality, quantity, and effectiveness; and ○ Changes in the needs or status of the expecting or new mother are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. • Periodic review of the progress the expecting or new mother has made on the care plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. • Ensures appropriate quality, quantity, and effectiveness of services in accordance with the care plan.

521B8.2 DFMB Procedure Code

Procedure Code: T2023 HG
Service Unit: Per member/per calendar month
Service Limit: Maximum 1 Per Calendar Month

Caseload Limit: Maximum of 30 members per Care Coordinator and 30 members per Community Health Worker
Staff Credentials: Enrolled providers must provide a medical home which uses a team approach to providing health care and care management for DFMB eligible Medicaid members for the duration of their pregnancy and one year postpartum. The DFMB Care Coordinator is the primary contact for provision and coordination of a member's health care services and needs related to the individual's pregnancy and behavioral health services.

The DFMB Care Coordinator must meet one the following provider qualifications:

- A non-physician practitioner (NPP) e.g., registered nurse (RN), APRN, PA or equivalent; OR
- A licensed psychologist or supervised psychologist; OR
- A licensed independent clinical social worker (LICSW) or licensed professional counselor (LPC); OR
- A Licensed Certified Social Worker (LCSW) or Licensed Graduate Social Worker (LGSW), when affiliated with an enrolled West Virginia Medicaid provider, OR
- An individual with a four-year degree (BA or BS) in a human service field with at least two years or experience in care coordination and has completed all BMS required care coordination training.

DFMB care coordinators must hold an up-to-date license as applicable. Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to transcripts, licenses, and certificates.

Providers must train their staff by an internal curriculum specific to DFMB prior to the staff assuming their DFMB duties. Curriculum must include training including but not limited to the following:

- Overview of Mountain Health Trust and Mountain Health Promise programs
- Overview of MCOs and coordination with MCO case managers
- Best practices in case management
- Cultural awareness
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance
- Behavioral health with additional training on opioid use disorder
- Evidence-based pregnancy, infant care, trauma, and ethics

Providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance use, and related areas.

Federally Qualified Heath Centers (FQHCs) may bill the T2023 HG code as well as the encounter codes for DFMB Services. FQHC will be on the UB form, and the group practices will bill on a CMS 1500 form

DFMB Care Coordinators and MCO case managers will work collaboratively to develop plans of care, coordinate all healthcare and healthcare related needs through team meetings, collaborative care planning, and developing transition plans from the grant funded DFMB to Medicaid managed care

DFMB care coordinators are required to notify the MCO of impending discharge in known. If unknown the DFMB has 48 hours or next business day to inform MCO of discharge.

521B.9 BILLING PROCEDURES

Claims from providers must be submitted on the designated form or electronically transmitted to the fiscal agent and must comply with the following:

- Must include all information required to process the claim for payment
- The amount billed must represent the provider's usual and customary charge for the services delivered
- Claims must be accurately completed with required information
- By signing the Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures
- Claim must be filed on a timely basis and a separate claim must be completed for each individual member
- A DFMB unit of service is defined as a per member per month rate. Claims must not be processed for less than a full unit of service. The last date services were rendered must be billed as the date of service. The billing period cannot overlap calendar months.

521B.10 SERVICE LIMITATIONS AND EXCLUSIONS

General service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual.

In addition to the exclusions listed in *Chapter 100, General Administration and Information* of the BMS Provider Manual, members who receive case management services under the Home and Community Based Services Waivers granted under Section 1915(c) of the Social Security Act are excluded from receiving DFMB reimbursement through this service option.

Payment for DFMB services must not duplicate payments made to other entities for case management/service coordination services.

T1017 cannot be billed in conjunction with T2023.

Non-covered services are not eligible for a West Virginia DHHR Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Care Coordinator: DFMB care coordinators shall be employed by qualified DFMB sites as defined in the Provider Enrollment and Participation Requirements section of this policy and able to fulfill the in-person, virtual, and telephonic care coordination activities defined in this policy. DFMB care coordinators are specialists managing OUD and pregnancy related services for the member and conducting care

coordination in-person, including in-home visits and provide education to participants as further defined in the table in Service Coordination Definitions Section 521B.8.1.

Community Health Worker (CHW): The community health worker is an individual with specialized training (e.g., substance use disorder (SUD), treatment and recovery, healthy pregnancy, childbirth, lactation, infant bonding, and child development) who assists the DFMB Coordinator provide case management services to members in local communities where members reside.

Drug Free Mom and Babies (DFMB) Site: DFMB sites are approved by the Perinatal Partnership to offer uniform screening, integrated and comprehensive maternity and behavioral health care services, long-term follow-up, provider outreach, and program evaluation to individuals that meet the eligibility criteria for the program.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

- A Federally qualified Health Maintenance Organization (HMO) that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO.
- Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:
    - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area serviced by the entity
    - Meets the solvency standards of 42 CFR 438.116

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Appendix	Chapter 521 Behavioral Health Outpatient Services Appendix B: Drug Free Mom And Baby Programs	January 1, 2022