CHAPTER IV
COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS **PAGE**

Covered Services And Limitations 4

General Information 4

Behavioral Health Services Administrator (BHSA) 4

Medicaid Managed Care 4

Freedom Of Choice 5
Retroactive Billing 5
Transportation Benefits 5

Telehealth Services 6

Comprehensive Crisis Services 6
Definitions 6

Addiction And Recovery Treatment Services (ARTS) 17

Eligibility For Arts Benefits 18

Medical Necessity Criteria 19

Screenings And Assessments 20
Multidimensional Assessment 20
Co-Occurring Addictive And Mental Health Disorders 21

Individualized Service Plan (ISP) 22

Discharge Planning Within The ISP 22
Timeframes For The Development Of ISPS 23
ISP Specific Requirements For ASAM Levels 4.0/3.7/3.5/3.3/3.1/2.5/2.1 24
Comprehensive ISPS 26
ISP Reviews 26

ISP Specific Requirements For Asam Level 1.0 28
ISP Specific Requirements For Substance Use Case Management 28
Progress Notes 29
Covered Services And Limitations 29
ARTS Service Authorization And Registration 30
Managed Care And ASAM 32
Screening Brief Intervention And Referral To Treatment (ASAM Level 0.5) 33
Opioid Treatment Services (ASAM Level OTS) 34
Substance Use Case Management 35
Outpatient Services (ASAM Level 1) 37
Intensive Outpatient Services (ASAM Level 2.1) 39
Partial Hospitalization Services (ASAM Level 2.5) 42
Residential Levels Of Care 45
Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) 48
Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3) 51
Clinically Managed High-Intensity Residential Services (Adult) And Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5) 54
Medically Monitored Intensive Inpatient Services (Adult) And Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7) 58
Medically Managed Intensive Inpatient Services (ASAM Level 4.0) 62
Reporting Of Adverse Outcomes For Institution For Mental Diseases (IMDS) 65
Seclusion And Restraint 65
Peer Recovery Support Services 66
Patient Utilization Management Safety Program (PUMS) 66
Placement Into A PUMS Program 66
Temporary Change To PUMS Status 67
42 CFR Part 2 67

Client Medical Management (CMM) Program 68

Exhibits 69

CHAPTER IV
COVERED SERVICES AND LIMITATIONS

The Virginia Medicaid Program covers a variety of substance use disorder treatment services under the Addition and Recovery Treatment Services (ARTS) benefit for eligible members. This chapter describes these services and the requirements for the provision of those services.

All ARTS providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with DMAS, its Contractors (including the Medicaid Managed Care Organizations (MCOs)), and the Behavioral Health Services Administrator (BHSA) and state and federal regulations.

GENERAL INFORMATION

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the fee for service (FFS) behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving FFS Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

MEDICAID MANAGED CARE

Most individuals enrolled in Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) receive their Medicaid services through Medicaid MCOs. MCOs must adhere to all ARTS program requirements, service authorization criteria and reimbursement rates, and MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the individual's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. ARTS providers must contact the individual's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO. Refer to each managed care program's website for detailed information and the latest updates. Information on the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs is located at the websites below:

- Medallion 4.0:
  https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/

- Commonwealth Coordinated Care Plus (CCC Plus): https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/
- Program of All-Inclusive Care for the Elderly (PACE)
  Services for individuals enrolled in PACE are provided by the individual's PACE Program. For additional details see: https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care.

All ARTS providers are responsible for adhering to the ARTS regulations, this manual, their provider contracts with DMAS and its contractors, and state and federal regulations.

Freedom of Choice

According to federal requirements (Section 1902(a) (23) of Title XIX of the Social Security Act (the Act)), fee-for-service Medicaid (including FAMIS Plus and FAMIS) eligible members must be offered a choice of service provider(s) and this must be documented in the member's file. The MCOs do not have to offer a freedom of choice per this requirement however shall offer the member freedom of choice among network providers [42 CFR. 438.10(e)(2)(vi)].

Retroactive Billing

Service authorization is required prior to service delivery for most ARTS services. Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the individual. When retroactive eligibility is obtained, the request for authorization must be submitted to the appropriate DMAS contractor (the BHSA for fee-for-service members and the MCO for their enrolled members) no later than 30 days from the date that the individual's Medicaid was activated; if the request is submitted later than 30 days from the date of activation, the request will be authorized beginning on the date it was received.

Transportation Benefits

Non-Emergency Medical Transportation (NEMT) is transportation of a Medicaid member to a non-emergency Medicaid-covered service. NEMT is not transportation where emergency services are required. Members should dial 9-1-1 if immediate response is needed for emergencies or worsening conditions that threaten life or limb.

Medicaid covers non-emergency Medicaid transportation to ARTS covered services. Click here for the Virginia Medicaid FFS and MCOs' NEMT toll free contact telephone numbers. For specific questions and to coordinate transportation services for members enrolled in a MCO, please contact the specific MCO.

Telehealth Services

Coverage of services delivered by telehealth are described in the manual supplement "Telehealth Services." MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Comprehensive Crisis Services

Comprehensive Crisis Services are covered for both substance use disorder (SUD) and/or mental health crises as defined in the DMAS Mental Health Services Provider manual for all eligible members. Comprehensive Crisis Services are covered by the BHSA fee-for-service members and the MCOs for their enrolled members. Please refer to the Mental Health Services Provider manual for more information: www.virginiamedicaid.dmas.virginia.gov.

Definitions

"Abstinence" means the intentional and consistent restraint from the pathological pursuit of reward or relief, or both, that involves the use of substances.

"Addiction" means, as defined by the ASAM, a primary, chronic disease of brain reward, motivation, memory and related circuitry. Addiction is defined as the inability to consistently abstain, impairment in behavioral control, persistence of cravings, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

"Addiction-credentialed physician" means a physician who holds a board certification in addiction medicine from the American Board of Addiction Medicine, a subspecialty board certification in addition to certification in psychiatry from the American Board of Psychiatry and Neurology, or subspecialty board certification in addition medicine from the American Osteopathic Association. DMAS also recognizes physicians with the DATA 2000 Buprenorphine waiver and physicians treating addiction who have specialty training or experience in addiction medicine or addiction psychiatry. If treating adolescents, physicians shall have experience and specialty training with adolescent medicine.

"Adherence" means, as defined by ASAM, the member receiving treatment has demonstrated his ability to cooperate with, follow, and take personal responsibility for the implementation of his treatment plans.

"Adolescent" means a member from 12 to 20 years of age.

“Allied Health Professional" as defined in 12VAC35-105-1630 means a professional who is involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders, such as a certified substance abuse counselor, certified substance abuse counseling assistant, peer recovery support specialist, certified nurse aide, or occupational therapist.

"ARTS" means addiction and recovery treatment services.

"ARTS Care Coordinator" means an employee of DMAS, the BHSA, or MCO who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist, nurse practitioner or registered nurse with two years of clinical experience in the treatment of substance use disorders. The ARTS care coordinator performs independent assessments of requests for all ARTS intensive outpatient programs (ASAM Level 2.1); partial hospitalization programs (ASAM Level 2.5); residential treatment services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); and inpatient services (ASAM Levels 3.7 and 4.0).

"ASAM" means the American Society of Addiction Medicine.

"ASAM Criteria" means a single nationwide set of criteria that provide outcome-oriented, results-based care in the treatment of addiction. The ASAM Criteria is a set of guidelines for placement, continued stay and transfer of patients who suffer from addiction and its co-occurring conditions.

"Assertive Community Treatment (ACT)," means, long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community.

“Assessment” means using a standardized instrument that has been validated for defining the nature of a problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

“Biomedical Enhanced Services” means services that are delivered by appropriately credentialed medical staff, who are available to assess and treat co-occurring biomedical or physical disorders and to monitor the resident’s administration of medications in accordance with a physician’s prescription. The intensity of nursing care and observation is sufficient to meet the patient’s needs.

"Buprenorphine Waivered Practitioners" means health care providers licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain. Practitioners shall have obtained the buprenorphine waiver

through the Drug Addiction Treatment Act of 2000 (DATA 2000). Nurse Practitioners and physician assistants shall have obtained the buprenorphine waiver through DATA 2000. Practitioners shall meet all federal and state requirements and be supervised by or work in collaboration with a qualifying physician as required by the applicable regulatory board. In accordance with §54.1-2957 of the Code of Virginia, a nurse practitioner may practice without a written or electronic practice agreement with a qualifying physician. All buprenorphine-waivered practitioners shall have a DEA-X number to prescribe buprenorphine for the treatment of opioid use disorder.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with a member's health care to assist in improving the care of the individual. This includes e-consultations for primary care providers to specialists.

“Certified substance abuse counselor” or “CSAC” means the same as defined in 18VAC115-30-10 and in accordance with §54.1-3507.1.

“Certified substance abuse counseling-assistant” or “CSAC-A” means the same as defined in 18VAC115-30-10 and in accordance with §54.1-3507.2.

“Certified substance abuse counselor-supervisee” means an individual who has completed the educational requirements described in § 54.1-3507.1 C (i) of the Code of Virginia, but who has not completed the practice hours described in § 54.1-3507.1 C (ii) of the Code of Virginia.

"Child" means a member from birth up to 12 years of age.

"Clinical experience" means, for the purpose of these ARTS requirements, practical experience in providing direct services to members with diagnoses of substance use disorder. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

"Code" means the Code of Virginia.

"Collateral services" means services provided by therapists or counselors for the purpose of engaging persons who are significant to the member receiving substance use disorder services. The services are focused on the member’s treatment needs and support achievement of his recovery goals.

“Co-location” is the shared practice setting for the buprenorphine waivered practitioner and the CATP within an Office-Based Addiction Treatment or Opioid Treatment Program services. This can be the same office, facility, building complex or campus.

"Co-occurring disorders" means, as defined by ASAM, the presence of concurrent substance use disorder and mental illness without implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other. Other terms used to describe co-occurring disorders include ‘‘dual diagnosis’’. For purposes of coverage of co-occurring disorders through the ARTS benefit, the primary diagnosis and purpose for service must be substance use disorder. For primary mental health disorders, please see the Mental Health Services Provider Manual.

“Counseling” means the same as defined in §54.1-3500 of the Code of Virginia.

"Credentialed addiction treatment professionals" or “CATP” means an individual licensed or registered with the appropriate Board in the following roles: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) physician extenders with experience or training in addiction medicine; (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a registered psychiatric clinical nurse specialist; (viii) a licensed psychiatric nurse practitioner; (ix) a licensed marriage and family therapist; (x) a licensed substance abuse treatment practitioner; (xi) residents under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and registered with the Virginia Board of Counseling; (xii) residents in psychology under supervision of a licensed clinical psychologist and registered with the Virginia Board of Psychology (18VAC125-20-10); or (xiii) supervisees in social work under the supervision of a licensed clinical social worker and registered with the Virginia Board of Social Work (18VAC140-20-10).

"CSB" means community services board.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DHP" means the Department of Health Professions.

“Distinct case management” means a separate or independent service and/or activity as specified within this manual performed on separate days/visits.

"DMAS" or "the department" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

“Exempt settings” means a setting within the federal government, the Commonwealth, a locality, or of any agency established or funded, in whole or part, by any such governmental entity or of a private, nonprofit organization or agency sponsored or funded, in whole or part, by a community-based citizen group or organization.

"Evidence-based practice" means an empirically-supported clinical practice or intervention with a proven ability to produce positive outcomes.

“Face-to-face” means encounters that occur in person or through telehealth.

“Family counseling” means substance use disorder counseling services involving the individual’s family and significant others to advance the individual’s treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the individual, (2) the counseling is not aimed at addressing treatment needs of the individual’s family or significant others, and (3) the individual is present except when it is clinically appropriate for the individual to be absent in order to advance their treatment goals.

“Family Engagement” means family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for members and their families.

"FAMIS" means the Family Access to Medical Insurance Security as set out in 12 VAC 30-141 et seq.

"FQHC" means Federally Qualified Health Center.

“Group counseling” means substance use disorder counseling services for the direct benefit of the individual. Counseling, education group, and related services are aimed at addressing treatment needs of the individual, and the individual is present except when it is clinically appropriate for the individual to be absent in order to advance their treatment goals.

“Health Literacy Counseling” means patient counseling on mental health, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.

“IMD” means an institution for mental diseases such as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Individual" means the patient, client, beneficiary or member who receives services set out in 12 VAC 30-130-5000 et seq. These terms are used interchangeably.

"Individual service plan" or "ISP" means an initial and comprehensive treatment plan that is regularly updated and specific to an individual's unique treatment needs as identified in the assessment. An ISP contains an individual's treatment or training needs, the individual's goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. An individual is included in the development of the ISP, and the ISP is signed by the individual. If the individual is a minor, the ISP is also signed by the individual's parent or legal guardian. An ISP includes documentation if the individual is a minor child or an adult who lacks legal capacity and is unable or unwilling to sign the ISP (12VAC30-50-5020).

"Induction phase" means the medically monitored initiation of buprenorphine, buprenorphine/naloxone, naltrexone, or methadone treatment performed in a qualified practitioner's office or licensed OTP. The goal of the induction phase is to find the individual's ideal dose of buprenorphine, buprenorphine/naloxone, naltrexone, or methadone. The ideal dose minimizes both side effects and drug craving.

"In-person" means encounters that occur physically in-person and not via telehealth.

"Licensed practical nurse" or "LPN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing (18 VAC 90-20-10 et seq.).

"Maintenance treatment or treatments," means pharmacotherapy on a consistent schedule for members with addiction, usually with an agonist or partial agonist, which mitigates against the pathological pursuit of reward or relief, or both, and allows remission of overt addiction-related problems. Maintenance treatments of addiction are associated with the development of a pharmacological steady state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward or relief. Maintenance treatments of addiction are also designed to lessen the risk of overdose. Depending on the circumstances of a given case, an ISP including maintenance treatments can be time-limited or can remain in place for life as long as clinically indicated. Integration of pharmacotherapy via maintenance treatments with psychosocial treatment generally is associated with the best clinical results. Maintenance treatments can be part of a member's ISP in abstinence-based recovery activities or can be a part of harm reduction strategies.

"Managed Care Organization" or "MCO" means an organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange

for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

“Medication assisted treatment” or “MAT” means the use of medication in combination with behavioral health services to provide an individualized approach to the treatment of substance use disorder, including opioid use disorder (42 CFR 8.2).

“Medication for Opioid Use Disorder” or “MOUD” means U.S. Food and Drug Administration (FDA) approved medications for the treatment of opioid dependence: buprenorphine, methadone, and naltrexone.

"Multidimensional assessment" means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the member (including family members and significant others as needed) including: history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations. The ASAM Multidimensional Assessment is a theoretical framework for this individualized, person-centered assessment that includes the following dimensions: i) acute intoxication or likelihood of withdrawal; or both, ii) medical status and complications, both historical and current; iii) emotional, behavioral, or cognitive status and any issues ; iv) individual’s readiness to change; v) risks for relapse or continued use; and vi) recovery/living environment. The level of care determination, ISP, and recovery strategies development may be based upon this multidimensional assessment.

"Office-based opioid treatment" or "Preferred OBOT" means addiction treatment services for individuals with a primary opioid use disorder provided by buprenorphine-waivered practitioners working in collaboration with credentialed addiction treatment practitioners providing psychotherapy and substance use disorder counseling in public and private practice settings.

"Opiate" means, as defined by ASAM, one of a group of alkaloids derived from the opium poppy (*Papaver somniferum*) which has the ability to induce analgesia, euphoria, and, in higher doses, stupor, coma, and respiratory depression but excludes synthetic opioids.

"Opioid" means any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions.

"Opioid treatment program (OTP)" means a program certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engages in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of members who are addicted to opioids (42 CFR 8.2.).

"Opioid treatment services (OTS)" means, as defined by ASAM, office based opioid treatment (OBOT) and Opioid Treatment Programs (OTP) which encompass a variety of pharmacological and non-pharmacological treatment modalities.
"Overdose" means, as defined by ASAM, the inadvertent or deliberate consumption of a dose of a chemical substance much larger than either habitually used by the member or ordinarily used for treatment of an illness which is likely to result in a serious toxic reaction or death.
"Physician extenders" means licensed nurse practitioners as defined in § 54.1-3000 of the Code of Virginia and licensed physician assistants as defined in § 54.1-2900 of the Code of Virginia.

"Peer Recovery Specialist" or "PRS" as defined in 12VAC30-130-5160, means a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services (DBHDS) as set forth in 12VAC35-250-10 through 12VAC35-250-50 and who has received certification in good standing by a certifying body recognized by DBHDS as set forth in 12VAC35-250-40.

"Peer recovery support services" means the same as defined in 12VAC35-250-10. Collaborative nonclinical, peer-to-peer services that engage, educate, and support an individual's self-help efforts to improve his health, recovery, resiliency, and wellness to assist individuals in achieving sustained recovery from the effects of mental illness, addiction, or both.

"Professional Services" are services provided within a residential treatment center setting that are billed separate from the per diem rate. Those services include physician services, other medical and psychological services including those furnished by licensed mental health professionals and other licensed or certified health professionals. For a full list of services please see Chapter V of this manual.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment and progress that is also signed and dated during the same time period by the provider's professional staff who have prepared the notes and are of the minimum documentation requirements as set forth in 12VAC30-60-185.

"Psychoeducation" means (i) a specific form of education aimed at helping members who have a substance use disorder or mental illness and their family members or caregivers to access clear and

concise information about substance use disorders or mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective ISPs and recovery strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes a member's and his/her family's needs and focuses on increasing the member's and family's knowledge about substance use disorders and/or mental illness, recovery, communicating and facilitating problem solving and increasing coping skills.

“Psychotherapy” or “therapy” means the use of psychological methods in a professional relationship to assist a person or persons to acquire great human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive.

"Psychosocial treatment" means any non-pharmacological intervention carried out in a therapeutic context within a substance use disorder treatment program, at a member, family, or group level which may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (e.g., self-help groups or peer-facilitated activities).

“Patient Utilization Management Safety Program (PUMS)” means, a utilization control and case management program designed to promote proper medical management of essential health care.

"Recovery" means, as defined by ASAM, a process of sustained effort that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction and consistently pursues abstinence, behavior control, dealing with cravings, recognizing problems in one’s behaviors and interpersonal relationships, and more effective coping with emotional responses leading to reversal of negative, self-defeating internal processes and behaviors and allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as follows: A process of change through which members improve their health and wellness, live a self-directed life, and strive to reach their full potential.

“Register or registration” means notifying DMAS or its contractors that an individual will be receiving services that do not require service authorization such as substance use case management.

"Registered nurse" or "RN" means a professional who is either licensed by the Commonwealth or who holds a multi-state licensure privilege to practice nursing according to 18VAC90-19-80.

"Relapse" means, as defined by ASAM, a process in which a member who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward or relief through the use of substances and other behaviors often leading to disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

“Review of ISP” means that the service provider reads the ISP for any necessary changes, evaluates and updates the member's progress toward meeting the individualized service plan objectives, and documents the outcome of this review.

"RHC" means rural health clinic.

"SBIRT" means screening, brief intervention, and referral to treatment. SBIRT services are an evidence-and community-based practice designed to identify, reduce, and prevent problematic substance use disorders. Per CMS, SBIRT is an early intervention approach that targets members with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of members with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder.

“Screening” means using a standardized instrument that has been validated for evaluating the possible presence of a particular problem.

“Skills Restoration” means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual’s plan of care. Services include assisting the individual in restoring the following skills: self- management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by DMAS or its contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

“Substance use care coordinator” means staff in an OTP or Preferred-OBAT setting who has: 1) at least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and have one of the following qualifications: a) substance use related direct experience providing

services to individuals with a diagnosis of substance use disorder or b) clinical experience working with individual with co-occurring diagnoses of substance use disorder and mental illness; or 2) licensure by the Commonwealth as a registered nurse with a) substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or b) clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or 3) CSAC, CSAC-Supervisee or CSAC-A.

"Substance use case management" means the same as set out in 12VAC30-50-491.

"Substance use disorder" or "SUD" means substance-related addictive disorder, as defined in the DSM-5 with the exception of tobacco-related disorders and non-substance-related disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems.

“Substance use disorder counseling” means the same as substance abuse counseling as defined in 18VAC115-30-10.

“Telehealth” means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

"Telemedicine" means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

"Therapeutic passes" mean time at home or time with family consisting of partial or entire days of time away from the group home or treatment facility with identified goals as approved by the treating physician, psychiatrist, or the credential addiction treatment professional responsible for the overall supervision of the individual service plan and documented in the individual service plan that facilitate or measure treatment progress, facilitate aftercare designed to promote family/community engagement, connection and permanency, and provide for goal-directed family engagement.

"Tolerance or tolerate" means, a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug’s effects over time.

“Urine Drug Testing” or Urine Drug Screening means testing for drugs of substance use disorders using a structure of “screening” known as “presumptive” testing or “definitive” testing (Gas

Chromatography/Mass Spectrometry Combined (GC/MS)) that identifies the specific drug and quantity in the patient. Urine Drug Testing is used to monitor patients treated for substance use disorders. Their use should be supportive and non-punitive: providers are encouraged to consider both positive and negative Urine Drug Testing results in shaping and informing current and future treatment to best support their patients.

"Withdrawal management" means, as defined by ASAM, services to assist a member's withdrawal from the use of substances.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

DMAS worked in conjunction with the Department of Health Professions (DHP), the Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Health (VDH), MCOs and stakeholders, to design a transformed delivery system for addiction and recovery treatment which is based on the American Society of Addiction Medicine (ASAM) standards. These changes help to ensure the integration of high quality addiction treatment, physical health, and mental health services for Virginia's Medicaid and FAMIS enrolled members. ARTS covers the full spectrum of the ASAM levels of care for SUD including opioid use disorder (OUD), alcohol use disorder (AUD), stimulant use disorder and other drug addictions for adults and children.

DMAS is utilizing the treatment criteria for addictive, substance-related conditions as published by the **ASAM (third edition 2013)**. The ASAM Criteria provides criteria for a wide range of levels and types of care for addiction and substance-related conditions and establishes clinical guidelines for making the most appropriate treatment and placement recommendations for members who demonstrate specific signs, symptoms and behaviors of addiction. ASAM includes a comprehensive system of multidimensional assessment, broad and flexible continuum of care, interdisciplinary team approach to care; and clinical and outcome-driven treatment is expected to substantially reduce the consequences of addiction. It also includes the conceptual framework of Recovery-Oriented Systems of Care to facilitate understanding of addiction treatment services within a recovery-oriented "chronic disease management" continuum, rather than repeated and disconnected "acute episodes of treatment" for the acute complications of addiction; and/or repeated and disconnected readmissions to addiction or mental health programs that employ rigid lengths of stay into which members are "placed." The ASAM Criteria provides two distinct placement criteria for adults and adolescents.

Services listed below are covered under the ARTS benefit and are reimbursable by the MCOs for managed care enrolled members and through DMAS and the BHSA for fee-for-service members. The chart describes the ARTS service coverage by ASAM Level of Care.

ASAM Level of Care	ASAM Description
4.0	Medically Managed Intensive Inpatient
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
3.1	Clinically Managed Low-Intensity Residential Services
2.5	Partial Hospitalization Services
2.1	Intensive Outpatient Services
1.0	Outpatient Services
OTS	Opioid Treatment Program (OTP)
OTS	Office-Based Opioid Treatment (OBOT)
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)
n/a	Substance Use Case Management
n/a	Peers Recovery Support Services

The ARTS specific procedure codes and reimbursement structure are documented in Chapter V of this manual.

This provider manual serves as policy for providers of the DMAS reimbursable ARTS benefit. The Opioid Treatment Services (OTS) and Peer Recovery Support Services are described in the Supplemental chapters to this manual.

ELIGIBILITY FOR ARTS BENEFITS

Children and adults enrolled in Medicaid, FAMIS and FAMIS MOMS, whether in fee-for-service or enrolled in a MCO, who meet ASAM medical necessity criteria shall be eligible for ARTS. Effective July 1, 2021 (see 6/1/2021 Medicaid Bulletin) FAMIS MOMS enrollees are eligible for coverage for medically necessary services in an Institution for Mental Disease (IMD), equivalent to such benefits offered to pregnant women under the Medicaid state plan and Medicaid Section 1115 demonstration waiver. This coverage includes the following settings: American Society of Addiction Medicine (ASAM) Levels 3.3, 3.5, 3.7 and 4.0 in residential treatment settings, psychiatric units and free-standing psychiatric hospitals. FAMIS children are not eligible for this coverage in IMD settings.

MEDICAL NECESSITY CRITERIA

In order to receive reimbursement for ARTS services, the member shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria below:

1. The member shall demonstrate at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders with the exception of tobacco-related disorders, caffeine use disorder or dependence, and non-substance-related addictive disorders; or be assessed to be at risk for developing substance use disorder (for youth under the age of twenty-one using the ASAM multidimensional assessment).

2. The member shall be assessed by a CATP, as defined in 12VAC30-130-5020, acting within the scope of their practice, who will determine if he/she meets the severity and intensity of treatment requirements for each service level defined by the most current version of the ASAM Criteria Third Edition, 2013. Medical necessity for ASAM Levels of Care 1.0 to 4.0 (Outpatient, Intensive Outpatient, Partial Hospitalization Programs, Residential and Inpatient Services) shall be based on the outcome of the member's documented multidimensional assessment. Substance use case management services do not require a complete multidimensional assessment using the ASAM theoretical framework in but does require an assessment and development of a documented assessment and individualized service plan (ISP)developed by a substance use case manager provider.

3. For members younger than the age of 21 who do not meet the ASAM medical necessity criteria upon initial assessment, a second individualized review by a licensed physician shall be conducted to determine if the member needs medically necessary treatment under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions, including SUD, discovered by the screening.

ARTS shall integrate physical health and behavioral health services for a complete continuum of care for all Medicaid members meeting the medical necessity criteria. DMAS contracted MCOs and the BHSA shall apply the ASAM criteria to review and coordinate service needs when administering ARTS benefits. The MCOs and the BHSA shall use an ARTS Care Coordinator (a licensed mental health professional), a licensed physician or medical director employed by the MCO or the BHSA to perform an independent assessment of all requests for ARTS intensive outpatient and partial hospitalization programs (ASAM Level 2.1 and 2.5, residential treatment services (ASAM Levels 3.1, 3.3, 3.5, 3.7) and ARTS inpatient treatment services (ASAM Level 4.0). The length of treatment and service limits based on the written multidimensional assessment shall be determined by the ARTS Care Coordinator, a licensed physician or medical director employed by the MCO and the BHSA who must apply the ASAM criteria.

Screenings and Assessments

The Substance Abuse and Mental Health Services Administration (SAMHSA) describe the need for clinicians to use evidence-based screenings and assessments to appropriately and timely identify individuals at risk for SUD and mental illnesses and be able to engage in treatment[1].

The purpose of screenings for SUD are for individuals who do not have an established SUD diagnosis and to determine whether an individual needs further assessment. The purpose of assessments for SUD are to gather detailed information needed for defining or supporting a diagnosis and development of a treatment plan that is person-centered.

- *Screening* means using a standardized instrument that has been validated for evaluating the possible presence of a particular problem. The screening determines the likelihood that an individual has SUD or co-occurring mental disorders and establishes the need if a further in-depth assessment is warranted. Screening is a formal process that typically is brief and occurs soon after the individual presents for services. See the SBIRT section of this chapter for more information.

- *Assessment* means using a standardized instrument that has been validated for defining the nature of a problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. The assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. The assessment gathers information and engages in a process with the individual that enables the practitioner to establish (or rule out) the presence or absence of a SUD or co-occurring disorder. Outcomes of the standardized instrument also helps to address dimensions in the multidimensional assessment to determine the most appropriate level of care.

Multidimensional Assessment

DMAS requires a multidimensional assessment to be completed and documented by a CATP or CSAC/CSAC-Supervisee, acting within the scope of their practice, as defined in 12VAC30-130-5020, for ASAM Levels of Care as described in the table earlier in this chapter. This includes gathering diagnostic and multidimensional assessment data relevant to the six ASAM criteria dimensions, however interpretation of this information must be within the scope of the assessor's scope of practice. (Note: CSACs and CSAC-supervisees are not allowed to do a diagnostic assessment per the Board of Counseling Guidance Document 115-11.) The multidimensional assessment, risk/severity rating, and an immediate need profile shall be maintained in the member's medical record by the provider as these contribute to a profile of the member, organized by the six

[1] https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004

specific ASAM criteria assessment dimensions. The ASAM level of care shall be determined based on the outcome of these assessment elements in addition to the member meeting the diagnostic criteria for a substance-related and/or addiction disorder of the DSM-5. Initiation of member services must take place within 30 days of the completion of the multidimensional assessment; if not then the assessment should be redone in order to ensure it is current.

The multidimensional assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions:

- Dimension 1: Acute intoxication or withdrawal potential, or both;
- Dimension 2: Biomedical conditions and complications;
- Dimension 3: Emotional, behavioral, or cognitive conditions and complications;
- Dimension 4: Readiness to change;
- Dimension 5: Relapse, continued use, or continued problem potential; and
- Dimension 6: Recovery/living environment.

The level of care determination, Individual Service Plan (ISP) and recovery strategies development shall be based upon this multidimensional assessment.

Co-occurring Addictive and Mental Health Disorders

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Members who are experiencing a co-occurring substance use and mental health disorders may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with members with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained in treatment of both substance use and mental health disorders, they should refer the member to an appropriate service provider. With a current signed consent and authorization to exchange/disclose personal health information, both providers should collaborate to coordinate effective treatment.

For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance use disorder services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented.

Providers shall incorporate in their multidimensional assessment of members the goal of identifying independent co-occurring disorders (both substance use and mental health disorders) for all members entering treatment. Providers shall use the ASAM Criteria to determine the

appropriate levels of care for ARTS services. ARTS covers members with a primary SUD diagnosis and when the purpose of the service is to primarily treat their SUD. Members who have a primary diagnosis related to mental health and the primary purpose of the service is to treat their mental health diagnosis, should follow the DMAS Mental Health Services Provider Manual.

INDIVIDUALIZED SERVICE PLAN (ISP)

The ISP is person-centered, recovery oriented, outcomes based and includes all planned interventions, aligns with the member's identified needs and recovery goals, care coordination needs, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment. The written ISP contains, but is not limited to, the member's treatment or training needs, the member's goals, measurable objectives and recovery strategies to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized written discharge plan that describes transition to other appropriate services. For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's ISP.

The adult member shall sign his or her own ISP and if unwilling or unable to sign the ISP, then the service provider shall document the reasons why the member was not able or willing to sign the ISP. The child's or adolescent's ISP shall be signed by the parent/legal guardian except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per §54.1-2969.

Documentation of the ISP review must be added to the member's medical record no later than 7 days from the calendar date of the review as evidenced by the dated signatures of the CATP as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting §54.1-2969).

If a member is transitioning between levels of care, the ASAM multidimensional assessment based on the criteria above, must also reflect the need for that level of care. If the transition is taking place within the same organization, an amended ISP is required to reflect all planned interventions, alignment with the member's identified needs, recovery goals, and care coordination needs. If the member is transitioning to a new service provider within a new organization that provider must develop a new ISP. Providers are encouraged to work with the transitioning provider to discuss previous interventions utilized and goals outlined in the members previous ISP.

Discharge Planning within the ISP

All ISPs for all levels of care shall include an individualized written discharge plan. Anticipated discharge plans are documented at the start of treatment. The discharge plan describes the discharge planning activities, summarizes an estimated timetable to achieving the goals and

objectives in the service plan, and includes discharge plans that are kept current and specific to the needs of the member.

Discharges shall be warranted when one of the below criteria is met:

A. Service documentation does not demonstrate that services meet the level of care service definition. Discharge is required when the individual has achieved maximal benefit from that level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted.

B. If there is a lapse in ASAM Level 1.0, 2.1 or 2.5 services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual.

C. If within the past 31 calendar days, the provider has not provided any ARTS services as recommended by the multidimensional assessment or no ARTS related billable activity has been conducted during that timeframe.

D. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days if in an ASAM Level 3.3/3.5/3.7 or 10 days in an ASAM Level 3.1, for Medicaid purposes, the authorization will be end-dated and addressed as a discharge. Any subsequent admission to an ASAM Level 3.1/3.3/3.5/3.7 is considered a new admission. If an individual requires acute psychiatric or inpatient admission, the authorization will be end-dated and addressed as a discharge. Any subsequent admission to an ASAM Level 3.1/3.3/3.5/3.7 would also be considered a new admission.

E. DMAS requires the co-prescribing of the overdose reversal agent naloxone with MOUD since individuals with OUD are at elevated risk for overdose. DMAS also strongly recommends co-prescribing of naloxone for individuals with any SUD as the risks of polysubstance use, whether intentional opioid use or unintentional use if drugs are contaminated with synthetic opioids, increases risk factors for overdose. When possible, family members and significant others should also be trained in the use of naloxone. This must be part of the discharge planning process for all Levels of Care.

Timeframes for the Development of ISPs

The ISP consists of two stages:

- Initial ISP; and
- Comprehensive ISP.

The initial ISP shall be developed and documented within 24 hours of admission to services based on the ASAM multidimensional assessment to address the immediate service needs, health, and safety needs of the member at the initial point of contact.

The comprehensive ISP shall be developed and documented within 30 calendar days of the initiation of services to address needs specific to the member's unique treatment as identified in the multidimensional assessment as applicable to the ASAM Level of Care. The initiation of services may be associated with the date the assessment was completed. If members are discharged from the service prior to the initial 30 calendar days, the provider is still required to have the ISP documented in the member's medical record.

The ISPs shall be contemporaneously signed and dated by the CATP(s) and the physician and/or physician extender, as necessary, preparing the ISP.

ISP Specific Requirements for ASAM Levels 4.0/3.7/3.5/3.3/3.1/2.5/2.1

In the settings below there are specific requirements that shall be followed for the ISP:

- Medically managed intensive inpatient services (ASAM 4.0);
- Substance use residential/inpatient services (ASAM levels 3.1, 3.3, 3.5, and 3.7); and
- Substance use intensive outpatient and partial hospitalization programs (ASAM levels 2.1 and 2.5).

The initial ISP shall be developed and documented by the stated professionals within the following levels of care:

- **ASAM Level 4.0**: The physician or the physician extender along with the other interdisciplinary staff or CATPs shall develop and document the initial ISP for inpatient services.

- **ASAM Level 3.7**: CATP, as well as CSACs and CSAC-supervisees (under supervision) in collaboration with interdisciplinary team shall complete and document the initial ISP. The CATPs must sign off on the ISP developed by a CSAC or CSAC-supervisee within three business days.

- **ASAM Level 3.5 to 3.1**: CATPs as well as CSACs and CSAC-supervisees (under supervision) in collaboration with interdisciplinary team. The CATPs must sign off on the ISP developed by a CSAC or CSAC-supervisee within three business days.

  If Dimension 1 and/or 2 indicates medical concerns or symptoms, the physician or physician extender shall be consulted in the ISP development as well as document the name of the physician or physician extender on the service authorization form. If Dimension 3

indicates mental health history, concerns or symptoms, the CATPs must be consulted in the development of the ISP. A psychiatrist or psychiatric nurse practitioner shall be consulted with as clinically necessary. The service authorization shall include the name of the consulting psychiatrist or psychiatric nurse practitioner and their credentials.

- **ASAM Level 2.5 to 2.1**: CATPs as well as CSACs and CSAC-supervisees (under supervision) in collaboration with interdisciplinary team shall develop and document the initial ISP. The CATPs must sign off on the ISP developed by a CSAC or CSAC-supervisee within three business days.

  If Dimension 1 and/or 2 indicates medical concerns or symptoms, the physician or physician extender shall be consulted in the ISP development and document the name of the physician or physician extender on the service authorization form. If Dimension 3 indicates mental health history, concerns or symptoms, the psychiatrist or psychiatric nurse practitioner shall be consulted with as clinically necessary. The service authorization shall include the name of the consulting psychiatrist or psychiatric nurse practitioner and their credentials.

The initial ISP shall include the plan for assessing and offering (as appropriate) medication for opioid use disorder (MOUD) for members with an OUD or medications for the treatment of alcohol use disorder.

In cases where the member is not able to participate in the assessment process due to an acute medical condition and/or acute intoxication or impairment, the provider should note this in the member's record and include the member as soon as they are able to participate. The provider shall include the member and the family/caregiver, as appropriate, in the development of the ISP. To the extent that the member's condition requires assistance for participation, assistance shall be provided.

To effectively implement the ASAM Criteria in programs that offer multiple levels of care, the ISP should clearly document the level(s) of care that a member is in at a given time. If the member is concurrently receiving treatment at another level of care (e.g., withdrawal management or MOUD), it should be clearly documented in the medical record. The medical record should clearly articulate the member's individualized treatment plan and reflect implementation of that plan. Progress notes should document the member's response to the therapeutic services provided and how the member's treatment plan has been modified over time based on their response to treatment, including changes to the types or frequency of services and changes to the level of care.

Please reference the chart in this chapter's appendix for a summary of ARTS Provider Qualifications for the development of the ISPs.

Comprehensive ISPs

The Comprehensive ISP shall be documented by the provider types listed above in the Initial ISP requirements and meet all of the following criteria:

- Be developed by staff by ASAM Level of Care as noted above in the Initial ISP section, in consultation with the member, as well as collateral contacts or the member as appropriate such as family members or legally authorized representative, or appropriate others into whose care the member will be released after discharge;
- Be based on the multidimensional assessment addressing all Dimensions 1-6 to support the level of care;
- Be based on a diagnostic clinical evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and must reflect the need for the ASAM Level of Care;
- The member's SUD diagnosis is based on the DSM-5 supported by valid and reliable assessment tools to gather clinical information to help in defining the nature of the issue, determining or supporting a SUD or co-occurring diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis;
- Describe any prior treatment information and testing that the member has received;
- Shall state treatment objectives that includes the member's goals that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities (as appropriate), and the design of community-based aftercare with target dates for achievement;
- For members with an OUD or AUD, describe how the member was assessed for the need of and offered pharmacotherapy including prescribing of the overdose reversal agent naloxone;
- Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the member's treatment needs; and
- Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

ISP Reviews

If the ISP review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems. The ISP shall include the signature and date from the member, parent, or legally authorized representative, CATP(s), CSAC/CSAC-supervisee and the physician and/or physician extender, as appropriate.

Individual, group, family psychotherapy and SUD counseling shall be provided in accordance to the ASAM Criteria for the specific level of care, as directed by the member's ISP and based on the member's treatment needs as identified in the multidimensional assessment. These services shall be provided by CATPs, CSACs and CSAC Supervisees within the scope of their practice according to their appropriate regulatory Board at the Department of Health Professions, and shall be documented in the ISP and progress notes in accordance with the requirements in this section. A week is defined as Sunday through Saturday.

Family engagement, for the benefit of the member, shall be provided in addition to family therapy/counseling as appropriate and outlined in the ISP. The family or legally authorized representative shall be part of the family engagement strategies in the ISP. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the ISP. Any deviation from the ISP shall be documented along with a clinical or medical justification for the deviation based on the needs of the member.

ASAM Level 4.0/3.7/3.5/3.3/3.1/2.5: The ISP shall be reviewed with the member at least every 30 calendar days in these ASAM Levels by the CATP(s) to determine that services being provided are or were required at the specific ASAM Level of Care and to recommend changes in the plan as indicated by the member's overall adjustment during the placement. CSACs and CSAC-supervisees, within their scope of practice, may complete this review, with the exception of ASAM Level 4.0 settings due to the acute medical needs of individuals requiring this level of care. The CATPs must sign off on the ISP developed by a CSAC or CSAC-supervisee within three business days. For settings that are medically managed versus clinically managed, the physician and/or physician extender should also review the ISP. The ISP shall be updated at least every 30 calendar days and as the member's needs and progress change. An ISP that is not updated either every 30 calendar days or as the member's needs and progress change shall be considered outdated. For services that require a 30 calendar day ISP review, the 30 calendar day ISP review requirements can be met through a progress note that documents the following:

- The treatment plan, including goals and progress towards them has been discussed with the team and the individual;
- Any alterations to the ISP;
- The review and any necessary changes have been discussed with the individual and the individual's response. The individual's signature is not required.

During months where a quarterly review is conducted, no additional documentation is necessary to meet 30 day ISP review requirements.

ASAM Level 2.1: The ISP shall be reviewed with the member at least every 90 calendar days in ASAM Level 2.1 by the CATP(s) to determine that services were medically necessary at ASAM Level 2.1 and to recommend changes in the plan as indicated by the member's overall adjustment during the placement. CSACs and CSAC-supervisees, within their scope of practice, may complete this review. The CATPs must sign off on the ISP developed by a CSAC or CSAC-supervisee within three business days. The ISP in ASAM Level 2.1 shall be updated at least every 90 calendar days and as the member's needs and progress change. An ISP that is not updated either every 90 calendar days or as the member's needs and progress change shall be considered outdated.

ISP Specific Requirements for ASAM Level 1.0

The initial ISPs shall be developed at the first appointment to address the immediate service, health, and safety needs for ASAM level 1.0 settings based on the multidimensional assessment, risk severity rating and immediate need profile to support the level of care.

The comprehensive ISP shall be fully developed and documented within 30 calendar days of the initiation of services and contemporaneously signed and dated by the CATP preparing the ISP. In these settings above, the ISP shall be reviewed at least every 90 calendar days and shall be modified as the needs and progress of the member changes. If the review identifies any changes in the member’s progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

Documentation of the ISP review shall include the dated signature of the CATP and the response of the member. The provider shall include the member and the family/caregiver, as appropriate, in the development of the ISP or treatment plan. To the extent that the member's condition requires assistance for participation, assistance shall be provided.

The ISP shall be updated in writing at least annually and as the member's needs and progress change. An ISP that is not updated either annually or as the member's needs and progress change shall be considered outdated. The outcome of the review shall be documented. If the review identifies any changes in the member’s progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

ISP Specific Requirements for Substance Use Case Management

The substance use case management ISP shall be developed with the member, in consultation with the member’s family, as appropriate as defined in 12VAC30-130-5020. The ISP shall be completed within 30 calendar days of initiation of this service with the member in a person-centered manner and shall document the need for active substance use case management before such case management services can be billed. The ISP shall require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum

of one face-to-face client contact, which is separate from the required monthly activities, at least every 90 calendar days. These required face-to-face contacts can be delivered via telehealth.

The substance use case manager shall review the ISP with the member at least every 90 calendar days for the purpose of evaluating and updating the member's progress toward meeting the ISP objectives. The review will be due by the 90th calendar day following the date the last review was completed. The reviews shall be documented in the member's medical record. DMAS will allow a grace period to be granted up to the 120th calendar day following the date of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the date the review was initially due and not the date of actual review.
The ISP shall be reviewed with the member present, and the outcome of the review documented in the member's medical record. The ISP shall be updated and documented in the member's medical record at least annually and as a member's needs change.

PROGRESS NOTES

Progress notes shall disclose the extent of services provided and corroborate the units billed. Each progress note shall demonstrate unique differences particular to individuals' circumstances, treatment and progress. Progress notes shall be individualized and based on the individual's treatment and ISP goals.

Daily progress notes do not require co-signature but shall be completed and signed by the appropriate CATP or CSAC performing the billable service. While co-signatures are not required, progress notes should be reviewed by supervising staff to ensure they are clinically written. Progress notes should meet all requirements as stated within the utilization and review portion of the ARTS manual chapter VI.

COVERED SERVICES AND LIMITATIONS

In order to be covered, ARTS Services (as defined in 12VAC30-130-5000 et al) shall meet medical necessity criteria based upon the multidimensional assessment, risk/severity rating and immediate need profile completed by a CATP or CSAC/CSAC-Supervisee as defined in this manual, and within the scope of their practice. ARTS Services shall be accurately reflected in provider medical record documentation and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

These ARTS services, with their service definitions, shall be covered:

- Medically Managed Intensive Inpatient Services (ASAM Level 4.0);
- Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7);
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);

- Opioid Treatment Programs (OTP) and Preferred Office-Based Opioid Treatment (OBOT);
- Substance Use Outpatient Services (ASAM Level 1);
- Early Intervention Services/SBIRT (ASAM 0.5);
- Substance Use Care Coordination;
- Substance Use Case Management Services and
- ARTS Peer Support Services and Family Support Partners.

The ARTS covered Opioid Treatment Services and ARTS Peer Support Services are documented in separate supplements to this manual.

Withdrawal Management services shall be covered when medically necessary as a component of the following:

- Medically Managed Inpatient Services (ASAM Level 4);
- Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7);
- Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5);
- OTP and Preferred OBOT;
- Substance Use Outpatient Services (ASAM Level 1).

ARTS Service Authorization and Registration

Service authorization is the process to determine medical necessity for specific ARTS services for an enrolled Medicaid/FAMIS member by the MCOs or the BHSA prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and the ASAM criteria for authorization. Service authorization does not guarantee payment for the service. Providers need to verify the member's benefit eligibility prior to initiating services to ensure the service being requested is covered under the particular benefit. This is required as FAMIS members are not eligible for all of the ARTS benefits as noted earlier in this Chapter under "Eligibility for ARTS Benefits" as well as some members have limited Medicaid benefits such as Plan First and Qualified Medicare Benefit (QMB)-Only, which does not cover ARTS. The medical record content shall corroborate the information provided to the DMAS contracted MCO or the BHSA. Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the individual. When retroactive eligibility is obtained, the request for authorization must be submitted to the appropriate DMAS contractor (the BHSA for fee-for-service members and the MCO for their enrolled members) no later than thirty (30) days from the date that the individual's Medicaid was activated; if the request is submitted later than thirty (30) days from the date of activation, the request will be authorized beginning on the date it was received.

The ARTS Service Authorization Review Form for initial requests as well as the ARTS Service Authorization Extension Review Form for requests for extensions for the same ASAM level are located online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/authorization-and-registration/ . Providers should submit to the MCOs via the fax number listed for the appropriate MCO on the service authorization form, and contact the BHSA via telephone for fee-for-service members. Providers are encouraged to submit the completed service authorizations prior to or at initiation of services however must follow the timeframe listed below. Requests for service authorizations shall include a current multidimensional assessment and address the six dimensions of the ASAM Criteria. Requests for service authorizations that do not meet the ASAM requirements for the requested level of care will not be approved.

ARTS Service Authorization Requirements:

ASAM Level of Care	**ASAM Description**	**Service Authorization Required?**
4.0	Medically Managed Intensive Inpatient	Yes
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Yes
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)	Yes
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Yes
3.1	Clinically Managed Low-Intensity Residential Services	Yes
2.5	Partial Hospitalization Services	Yes
2.1	Intensive Outpatient Services	Yes
1.0	Outpatient Services	No
n/a	Opioid Treatment Program (OTP)	No
n/a	Preferred Office-Based Opioid Treatment (OBOT)	No
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
n/a	Substance Use Case Management	Registration Required
n/a	ARTS Peer Recovery Support Services	Registration Required

The BHSA utilizes the "Virginia DMAS Registration" form available: https://www.magellanofvirginia.com/for-providers/provider-tools/forms/.

The MCOs utilize the "ARTS and MHS Registration Form" form available: https://www.dmas.virginia.gov/media/4077/arts-and-mhs-registration-form-december-2021.pdf

DMAS Recommended Timeframes for Submission of the Service Authorization or Registration*:

Service	**Time Frame for Submission for Initial Requests**	**Timeframe for Submission for Continuation Requests**	**Form**
Substance Use Case Management	MCO: 2 business days from service initiation. FFS: Request must be submitted within 2 business days of the requested start date but no earlier than 30 calendar days prior to the start date.	MCO: Within 7 days of expiration of preceding registration period FFS: Request must be submitted within 2 business days of the requested start date but no earlier than 30 calendar days prior to the date the initial approval ends.	**MCOs**: ARTS and MHS Registration Form **FFS**: Virginia DMAS Registration Form
ASAM 2.1 to 4.0	1 business day from service initiation but no greater than 5 calendar days prior to service initiation.	Submitted prior to current service authorization ending but no greater than 5 calendar days prior to service authorization end date. If submitted after the current service authorizations ends, the begin date of extension will be based on the day of receipt.	ARTS Service Authorization Request ARTS Service Authorization Request for Extensions
ARTS Peer Services	Prior to service delivery but no greater than 30 days from documented assessment by CATP		ARTS and MHS Registration Form **FFS**: Virginia DMAS Registration Form

* The BHSA will follow these specific DMAS recommendations. The MCOs will follow the requirement of the National Committee for Quality Assurance (NCQA).

Managed Care and ASAM

The ASAM Criteria provides principles on how to work effectively in a managed care environment (beginning on page 119 of the ASAM Criteria). ASAM states that all practitioners as well as

MCOs are responsible for "managing care" and utilizing resources appropriately. ASAM Criteria provides the following guidance for working with managed care:

- Diagnostic and multidimensional assessment data relevant to the six ASAM criteria dimensions performed by the treatment team shall encompass factual, biopsychosocial data;
- A case presentation format can be used to document the biopsychosocial data following the multidimensional assessment (same format in ASAM Criteria page 125);
- Use the decisional flow process to match the assessment and treatment/placement assignment to guide the clinical discussion (ASAM Criteria page 124);
- If the provider and the ARTS Care Coordinator/Physician disagrees with the treatment/placement discussion, identify the specific area of disagreement; and
- If no agreement is reached, providers may utilize the MCO/BHSA appeal process that will be documented in the authorization denial.

Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5)

Early intervention (ASAM Level 0.5) / Screening, Brief Intervention, and Referral to Treatment (SBIRT) services may be provided in a variety of settings including: local health departments, FQHCs, rural health clinics (RHCs), Community Services Boards (CSBs)/ Behavioral Health Authorities (BHAs), health systems, emergency departments of hospitals, pharmacies, physician's offices, and private and group outpatient practices. The individual practitioners conducting the screenings shall include CATPs contracted and credentialed by the MCOs or the BHSA to perform this level of care, or employed by organizations that are contracted by the MCOs or the BHSA.

- **Screening** — a healthcare professional assesses a member for risky substance use behaviors using standardized screening tools. See the Screening section noted earlier in this manual. Screenings may occur in any healthcare setting.

- **Brief Intervention** — a healthcare professional engages a member showing risky substance use behaviors in a short conversation, providing feedback and advice.

- **Referral to Treatment** — a healthcare professional provides brief therapy or a referral for an additional assessment to determine need of additional services.

Early intervention/SBIRT (ASAM Level 0.5) service components shall include (as defined in 12VAC30-130-5070):

- Identifying members who may have alcohol or other substance use problems using an evidence-based screening tool. The Substance Abuse and Mental Health Services Administration (SAMHSA) has SBIRT resources available: https://www.samhsa.gov/sbirt.

- Following the evidence-based screening tool, a brief intervention by a CATP acting within the scope of their practice, shall be provided to educate members about substance use, alert these members to possible consequences and, if needed, begin to motivate members to take steps to change their behaviors.
- Physicians, pharmacists, and CATPs shall administer the evidence-based screening tool. The licensed providers may delegate administration of the evidence-based screening tool to other clinical staff as allowed by their scope of practice, such as to CSACs/CSAC-supervisees or physicians delegating administration of the tool to a licensed registered nurse or licensed practical nurse. The physician may also delegate providing the counseling and intervention to these individuals as well but should be available for review as needed.

Service Units and Limitations

CPT Code	**Description**
99408	SBIRT - Alcohol and/or substance use structured screening: 15 - 30 minutes
99409	SBIRT - Alcohol and/or substance use structured screening: greater than 30 minutes

SBIRT services do not require service authorization. Members with an identified SUD diagnosis do not require additional SUD screenings. There are no annual service limits.

Opioid Treatment Services (ASAM Level OTS)

Opioid Treatment Services and Medication Assisted Treatment (MAT) are allowable and can be billed separately in community-based settings. Please refer to the Opioid Treatment Services Supplement for more detailed information.

Preferred Office Based Opioid Treatment (OBOT)

Preferred Office-Based Opioid Treatment (OBOT), as defined in 12VAC30-130-5060, shall be provided by a buprenorphine-waivered practitioner in collaboration with co-located licensed mental health professional and may be provided in a variety of practice settings. Opioid treatment services are allowable in ASAM Levels 1.0 through 3.7 excluding inpatient services. Please reference the Opioid Treatment Services Supplement to this provider manual for more detailed information and a crosswalk table in the exhibits.

Opioid Treatment Programs (OTPs)

OTPs services, as defined in 12VAC30-130-5050, shall be licensed by DBHDS. OTP services are allowable in ASAM Levels 1.0 through 3.7 excluding inpatient services. OTPs shall meet the requirements as set forth in the Opioid Treatment Services Supplement to this provider manual.

Substance Use Case Management

Substance use case management services assist members and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the member's basic needs. Substance use case management services are to be person-centered, individualized, culturally and linguistically appropriate to meet the member's and family member's needs. The Medicaid eligible member shall meet the DSM-5 diagnostic criteria for SUD. Tobacco-related disorders, caffeine related disorders and non-substance-related disorders shall not be covered. If a member has co-occurring mental health and SUD, the case manager shall include activities to address both the mental health and SUD.

Substance use case management shall include an active ISP which requires:

- A minimum of two substance use case management service activities each month, that consist of two separate and distinct case management activities occurring on different days with the member, and
- At least one face-to-face contact, separate from the two distinct activities per month minimum, with the member at least every 90 calendar days. The face-to-face contacts may be met delivered via telehealth.

Substance use case management is reimbursable on a monthly basis only when the minimum substance use case management service activities are met as noted later in this section. Only one type of case management may be billed at one time. Please see the Limitations section. Substance use case management can be provided as a stand-alone service, without the condition that the member shall be receiving another Medicaid covered service, including Medicaid-covered ARTS service.

Substance use case management services are intended to be an individualized person-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one member at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more members was person-specific. For example, the case manager needs to work with two members, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both members simultaneously for the purpose of helping each member obtain a financial entitlement and subsequently follow-up with each member to ensure he or she has proceeded correctly.

Substance Use Case Management Service Activities

Substance use case management service activities include the following:

1. Assessing needs and planning services to include developing a substance use case management ISP developed with the member, in consultation with the member’s family, as appropriate as

defined in 12VAC30-130-5020. The ISP shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service.

2. Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;

3. Making collateral contacts with the member's significant others with properly authorized releases to promote implementation of the member's ISP and their community adjustment;

4. Linking the member to those community supports that are most likely to promote the personal or rehabilitative, recovery, and life goals of the member as developed in the ISP;

5. Assisting the member directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;

6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

7. Monitoring service delivery through contacts with members receiving services and service providers including site and home visits to assess the quality of care and satisfaction of the member;

8. Providing follow-up instruction, education, and counseling to guide the member and develop a supportive relationship that promotes the ISP;

9. Advocating for members in response to their changing needs, based on changes in the ISP;

10. Planning for transitions in the member's life;

11. Knowing and monitoring the member's health status, any medical conditions, medications and potential side effects, and assisting the member in accessing primary care and other medical services, as needed; and

12. Understanding the capabilities of services to meet the member's identified needs and preferences and to serve the member without placing the member, other participants, or staff at risk of serious harm.

Service Units and Limitations

- The billing unit for case management is per month (1 unit = 1 month).
- The MCOs will register a service request for a maximum of ***up to*** 6 units/6 months.
- The BHSA may register a service request for a maximum of ***up to*** 12 units/12 months.

- In accordance to 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.
    - For individuals ages 22 - 64, services rendered during the same month as the admission to the IMD is reimbursable as long as the service was rendered prior to the date of the admission.
    - Two conditions must be met to bill for case management services for individuals who are in institutions and who do not meet the exclusions noted in bullet one. The case management services may not duplicate other services provided by the institution, and the case management services are provided to the individual 30 calendar days prior to discharge.
- No other type of case management may be billed concurrently with substance use case management including mental health, treatment foster care, or services that include case management activities, including Intensive Community Treatment.
- Substance use case management may not be billed concurrently with substance use care coordination in a Preferred OBAT or OTP setting.
- Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking members to determine potential service needs that do not meet the requirements for the monthly billing.
- Substance use case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible member has been referred.
- Contact with the MCO ARTS Care Coordinator or other health plan care coordination staff do not count towards the monthly case management service activities.

Substance use case management does not include activities for which a member may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c)of the Social Security Act.

Outpatient Services (ASAM Level 1)

Outpatient services (ASAM Level 1) as defined in 12VAC30-130-5080 shall be provided by CATP who is contracted by the MCOs and the BHSA to perform these services in the following community based settings: primary care clinics, outpatient health system clinics, psychiatry clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) Community

Service Boards (CSBs)/Behavioral Health Authorities (BHAs), local health departments, physician and provider offices in private or group practices.

Reimbursement for substance use outpatient services shall be made for medically necessary services provided in accordance with an ISP or the treatment plan and include withdrawal management as necessary. Services can be provided face-to-face or by telehealth according to DMAS Telehealth Supplemental manual.

Outpatient services (ASAM Level 1) shall include the following service components as medically necessary and indicated in the member's ISP:

- Professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.
- An ISP as defined earlier in this Chapter shall be used and documented to determine that a member meets the medical necessity criteria and shall include the evaluation or analysis of substance use disorders; the diagnosis of SUD; and the assessment of treatment needs to provide medically necessary services.
- If Dimension 1 and/or 2 indicates medical concerns or symptoms, must consult with physician or physician extender to determine if a physical examination and laboratory testing is necessary. For members who have not been screened for infectious diseases within previous 12 months, screening on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.
- Individual psychotherapy between the member and a CATP. Services provided face-to-face or by telemedicine shall qualify as reimbursable.
- Group psychotherapy by a CATP, with a focus on the needs of the members served.
- Family psychotherapy to facilitate the members' recovery and support for the family's recovery provided by a CATP.
- Evidenced-based member education on addiction, treatment, recovery and associated health risks.
- Medication services including the prescription of or administration of medication related to substance use treatment, or the assessment of the side effects or results of that medication. Medication services shall be provided by staff lawfully authorized to provide such services and they shall order laboratory testing within their scope of practice or licensure.
- Collateral services as defined under the definition section in the beginning of this chapter.

- To ensure continuity of care, members who are transitioning to Level 1.0 from a higher Level of Care, the initial outpatient appointment should be provided within 7 business days of discharge.
- Outpatient services may be provided on site or through referral to an outside provider.

Co-Occurring Enhanced Programs

In addition to all of the above, outpatient services (ASAM Level 1) co-occurring enhanced programs shall include:

- Ongoing substance use case management for highly crisis prone members with co-occurring disorders. Outpatient service providers may coordinate the substance use case management services with the DBHDS licensed substance use case management provider.
- CATPs who are trained in severe and chronic mental health and psychiatric disorders and are able to assess, monitor and manage members who have a co-occurring mental health disorder.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for outpatient services: is available online: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .
- Substance use outpatient services shall be provided fewer than 9 hours per week.
- Group psychotherapy by a CATP shall have a maximum limit of 12 individuals in the group. CSACs/CSAC-supervisees by scope of practice are not able to perform psychotherapy, thus are not considered a provider of outpatient services.
- Outpatient substance use disorder treatment services do not require service authorization.
- Opioid Treatment Services/Medication Assisted Treatment including medications, labs, and urine drug screens may be billed separately in community-based settings. See the Opioid Treatment Services Supplement to this Provider Manual.

Intensive Outpatient Services (ASAM Level 2.1)

Intensive outpatient services (ASAM Level 2.1) as defined in 12VAC30-130-5090 and 12VAC35-105-1730 to 1770 shall be provided by an interdisciplinary team of CATPs, which may include generalist physicians or physicians with experience in addiction medicine Intensive outpatient services (ASAM Level 2.1) shall be a structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three service hours per service day for adults to achieve an average of nine to 19 hours of services per week and a minimum of two service hours per service day for children and adolescents to achieve an average of six to 19 hours of services

per week. This service is provided to members who do not require the intensive level of care of inpatient, residential, or partial hospitalization services, but requires more intensive services than outpatient services.

If hours consistently exceed the standard weekly hours, then the member should be evaluated for a more appropriate level of care.

Intensive outpatient service providers shall meet the ASAM Level 2.1 service components. The following service components shall be assessed and monitored weekly and shall be provided in accordance to the ASAM Criteria, as directed by the member's ISP and based on the member's treatment needs identified in the multidimensional assessment. The provider must demonstrate the following service components in the member's ISP as medically necessary, through provision of services or through referral:

- Psychiatric and other individualized treatment planning;
- Individual, family and/or group counseling and or psychotherapy;
- Medication management;
- Health literacy counseling and psychoeducational activities;
- Skill restoration / development;
- Requests for a psychiatric or a medical consultation shall be available within 24 hours of the requested consult by telephone and preferably within 72 hours of the requested consult in person or via telemedicine. Referrals to external resources are allowed in this setting;
- Psychopharmacological consultation;
- Addiction medication management provided on-site or through referral;
- 24-hour emergency services available seven days per week when the treatment program is not in session;
- Occupational and recreational therapies, motivational interviewing, enhancement, and engagement strategies to inspire a member's motivation to change behaviors;
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral, as indicated in the member's ISP. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation;
- Withdrawal management services may be provided as necessary by qualified staff either on site or through referral. Providers should refer to the ASAM Criteria text for Intoxication/Withdrawal Management guidelines; and

- Ensure members with OUD or AUD admitted to the program have access to appropriate pharmacotherapy, including buprenorphine, methadone or naltrexone.

Co-Occurring Enhanced Programs

In addition to the above, Intensive Outpatient Services (ASAM Level 2.1) co-occurring enhanced programs offer these therapies and support systems in intensive outpatient services to members with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a planned program of therapies. Members who are not able to benefit from a full program of therapies, will be offered and provided services or a referral made to enhanced program services to match the intensity of hours in ASAM Level 2.1, including substance use case management, intensive community treatment, medication management and psychotherapy.

Service Units and Limitations

- Intensive outpatient services require service authorization. The MCOs and the BHSA will respond within 72 hours to the service authorization request. If approved, the MCOs and the BHSA may reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member ceases to participate or the member demonstrates need for a higher level of care. Discharge planning shall document realistic plans for the continuity of MOUD services with an in-network Medicaid provider.
- Intensive Outpatient Services may not be authorized concurrently with ASAM Level 2.5, 3.3, 3.5, 3.7 or 4.0; Mental Health Services including Mental Health Intensive Outpatient Services, Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or inpatient admission. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.
- Intensive Outpatient Services may be provided concurrently with the pharmacotherapy component of Preferred OBOT or OTP services for access to MOUD. Collaboration between the Intensive Outpatient provider and the buprenorphine-waivered practitioner is required and shall be documented. Preferred OBOT and OTP services including physician visits and medications, labs, and urine drug screens may be billed separately except for the counseling component which is part of the ASAM Level 2.1 per diem. Please see the Opioid Treatment Services Supplement to this Provider Manual.
- Staff travel time is excluded and not reimbursable.

- One unit of service is one day with a minimum of 3 service hours per service day to achieve an average of 9 to 19 hours of services per week for adults and an average of 6 to 19 hours of services per week for children and adolescents, with regards to the first and last week of treatment. A maximum average of 19 hours shall be billed per week. In cases that a member does not complete the minimum of 3 service hours per service day, the provider should document any deviation from the ISP in the member's medical record and reason for the deviation and notify the MCO or the BHSA (based on member's benefit) weekly when the minimum sessions have not been provided. If the member consistently deviates from the required services in the ISP, the provider should work with the MCO or the BHSA ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the member's needs.
- ASAM Criteria allows for less than an average of 9 hours per week for adults and an average of 6 hours per week for adolescents as a transition step down in intensity for 1 to 2 weeks prior to transitioning to Level 1 to avoid relapse. The transition step down needs to be approved by the MCO or the BHSA (based on the member's benefit), and documented and supported by the member's ISP.
- Group substance use counseling by CATPs, CSACs and CSAC supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the clinical determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees, by scope of practice, are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- There are no maximum annual limits.

Partial Hospitalization Services (ASAM Level 2.5)

Substance use partial hospitalization services (ASAM Level 2.5) shall be provided by an interdisciplinary team comprised of CATPs, CSAC and CSAC-supervisees. Substance use disorder partial hospitalization services, as defined in 12VAC30-130-5100 and 12VAC35-105-1680 to 1720, are structured programs of skilled treatment services for adults, children and adolescents delivering the minimum number of service hours per week of 20 hours with at least five service hours per service day of skilled treatment services.

Partial hospitalization (ASAM Level 2.5) service components shall include the following provided at least once weekly or as directed by the ISP and based on the member's treatment needs identified in the multidimensional assessment:

- Individualized treatment planning;
- Withdrawal management services may be provided as necessary. Providers should refer to the ASAM Criteria text for Intoxication/Withdrawal Management guidelines;

- Daily individual, group and family therapies involving family members, guardians, or significant other in the assessment, treatment, and continuing care of the member;
- Motivational interviewing, enhancement, and engagement strategies;
- Health literacy counseling and psychoeducational activities;
- Skill restoration / development;
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available by consult or referral;
- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation;
- Psychiatric and medical formal agreements to provide medical consult within 8 hours of the requested consult by telephone, or within 48 hours in person or via telemedicine. Referrals to external resources are allowed in this setting;
- Emergency services available 24-hours a day and seven days a week;
- Close coordination through referrals to higher and lower levels of care and supportive housing services such as in a Clinically Managed Low Intensity Residential Services (ASAM Level 3.1); and
- Ensure members with OUD or AUD admitted to the program have access to appropriate pharmacotherapy, including buprenorphine, methadone or naltrexone.

The following service components shall be provided a minimum of once each day the member is in attendance or more as the treatment needs identified in the multidimensional assessment require:

- Skilled treatment services with a planned format including member and group psychotherapy;
- Medication management;
- Education groups; and
- Occupational, recreational therapy, and/or other therapies.

Co-Occurring Enhanced Programs

In addition to the above, Partial Hospitalization Services (ASAM Level 2.5) co-occurring enhanced programs shall offer the following:

- Therapies and support systems as described above to members with co-occurring addictive and psychiatric disorders who are able to tolerate and benefit from a full program of therapies. Other members who are not able to benefit from a full program of therapies (who

are severely or chronically mentally ill) will be offered/referred/linked to enhanced program services to constitute intensity of hours in Level 2.5, including substance use case management, intensive community treatment, medication management, and psychotherapy.

- Psychiatric services as appropriate to meet the member's mental health condition. Services may be available by telephone and on site, or closely coordinated off site, or via telemedicine.
- Clinical leadership and oversight and, at a minimum, capacity to consult with an addiction psychiatrist via telephone, telemedicine, or in person.
- CATPs with experience assessing and treating co-occurring mental illness.
- Ensure members with OUD or AUD admitted to the program have access to appropriate pharmacotherapy, including buprenorphine, methadone or naltrexone.

Service Units and Limitations

- Partial Hospitalization services require service authorization. The MCOs and the BHSA will respond within 72 hours to the service authorization request. If approved, the MCOs and the BHSA may reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member ceases to participate, or the member demonstrates a need for a higher level of care. Discharge planning shall document realistic plans for the continuity of MOUD services with an in-network Medicaid provider.
- Partial Hospitalization Services may not be authorized concurrently with ASAM Level 2.1, 3.3, 3.5, 3.7 or 4.0; Mental Health Services including Mental Health Intensive Outpatient Services, Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or inpatient admission. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.
- Partial Hospitalization services may be provided concurrently with the pharmacotherapy component of Preferred OBOT or OTP services for access to MOUD. Counseling is part of the ASAM Level 2.5 per diem. Collaboration between the Partial Hospitalization provider and the buprenorphine-waivered practitioner is required and shall be documented.

- Preferred OBOT and OTP services including physician visits and medications, labs, and urine drug screens may be billed separately. For more information, please see the Opioid Treatment Services Supplement to this Provider Manual.
- Staff travel time is excluded and therefore not reimbursable.
- One unit of service is equivalent to one day. The minimum number of service hours per week is 20 hours with at least five service hours per service day of skilled treatment services, with regards to the first and last week of treatment. In cases that a member does not complete the minimum of five clinical service hours per service day, the provider should document any deviation from the ISP in the member's medical record and reason for the deviation and notify the MCO or the BHSA (depending on the member's benefit) weekly when the minimum sessions have not been provided. If the member consistently deviates from the required services in the ISP, the provider should work with the MCO or the BHSA ARTS Care Coordinator to reassess for another ASAM Level of Care or model to better meet the member's needs. Medicaid allows as a transition step down in intensity for 1 to 2 weeks prior to transitioning to Level 2.1 or 1 to avoid relapse. The transition step down needs to be approved by the MCO or the BHSA (depending on the member's benefit) and documented and supported by the member's ISP.
- Group substance use counseling by CATPs, CSACs and CSAC-supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Time not spent in skilled, clinically intensive treatment is not billable.
- There are no maximum annual limits.

Residential Levels of Care

Residential Services Length of Stay

The Centers for Medicare and Medicaid Services (CMS) requires that any member receiving residential substance use disorder services pursuant to the ARTS demonstration, regardless of the length of stay or the bed size of the facility, be a "short-term resident" of the residential or inpatient facility in which they are receiving the services. **Short-term residential treatment is defined as a statewide average length of stay of 30 days.** CMS further stated residential treatment services should be provided **as medically necessary as determined by an independent party and the level of care consistent with the ASAM multidimensional assessment,** detailed in the "Service Authorization for Residential Services" section in this Chapter.

Residential Treatment Service Medicaid providers shall ensure that Medicaid and FAMIS enrolled members with OUD or AUD admitted to the program have access to appropriate pharmacotherapy, including buprenorphine, methadone or naltrexone.

Discharge Planning

Since CMS requires "short term" residential stays, providers **shall begin planning for the member's discharge at time of their admission**. Thus, all comprehensive ISPs for residential levels of care shall include an individualized discharge plan to the most appropriate ASAM Level of Care based on the multidimensional assessment. Anticipated discharge plans are documented at the start of treatment. The discharge plan describes the discharge planning activities, summarizes an estimated timetable to achieving the goals and objectives in the service plan, and includes discharge plans that are kept current and specific to the needs of the member. The discharge plan shall address the plan for transitioning from an appropriate residential ASAM Levels of Care to a lower ASAM Levels of Care. DMAS requires that discharge planning shall also document realistic plans for the continuity of MOUD services with an in-network Medicaid provider.

Service Authorization for Residential Treatment Services

CMS requires an independent third party to review all requests for residential levels of care to determine if members meet medical necessity based on ASAM Criteria 3rd Edition. CMS requires DMAS to contract with each of the MCOs and the BHSA for ARTS Care Coordinators, physician reviewers and medical directors to perform these independent reviews. Practitioners reviewing these service authorization requests must determine the appropriate level of care and length of **stay** recommendations based upon the ASAM Criteria *3rd Edition* and the multidimensional assessment to match severity and level of function with type and intensity of service for adults and adolescents. Additional information may be requested as part of the review process. DMAS requires the MCO and the BHSA ARTS Care Coordinators, physician reviewers or medical directors to document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services based on the ARTS Service Authorization form.

Please note that for dually enrolled Medicare / Medicaid members who are not enrolled in a CCC Plus program, the BHSA requires submission on provider letterhead with each claim submitted for fee-for-service members that states SUD residential treatment services are not a Medicare covered benefit in order to process through the system.

ASAM specifies that once admission for a given level of care has met the Criteria, there are specific requirements for continued service, discharge or transfer from that particular level of care. Providers, MCOs and the BHSA shall apply the ASAM Criteria as specified below:

<u>Continued Service Criteria</u>: ASAM Criteria states it is appropriate to retain the member at the present level of care if:

1. The member is making progress, but has not yet achieved the goals articulated in the ISP. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work towards treatment goals; or

2. The member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the ISP. Continued treatment at the present level of care is assessed as medically necessary to permit the member to continue to work toward his or her treatment goals; and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive and or restrictive at which the member's new problems can be addressed effectively.

The provider shall document and communicate the member's readiness for discharge or need for transfer to another level of care based on each of the six dimensions of the ASAM Multidimensional Assessment. If the assessment reflects that the member's problems continue to exist or new problem(s) are identified, the member should continue in treatment at the present level of care. If not, the member shall be discharged/transferred to another ASAM Level of Care or other services as indicated below.

Discharge/Transfer Criteria: It is appropriate to transfer or discharge the member from the present level of care if he or she meets the following criteria:

1. The member has achieved the goals articulated in the ISP, thus resolving the problem(s) that justified admission to the current level of care; or

2. The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the ISP. Treatment at another level of care or type of service therefore is indicated; or

3. The member has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

4. The member has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Case Management and Institutions of Mental Diseases

In accordance with 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- For individuals ages 22-64, services rendered during the same month as the admission to the IMD are reimbursable as long as the service was rendered prior to the date of the admission.
- Two conditions must be met to bill for case management services for individuals who are in institutions and who do not meet the exclusions as stated in subdivision 2 of this subsection. The case management services may not duplicate other services provided by the institution, and the case management services are provided to the individual 30 calendar days prior to discharge.

Clinically Managed Low Intensity Residential Services (ASAM Level 3.1)

Clinically managed low intensity residential services (ASAM Level 3.1) as defined in 12VAC30-130-5110 and 12VAC35-105-1630 to 1670, provides a minimum of at least five hours of professionally directed program activities per week. This service shall not include settings such as sober houses, boarding houses or group homes where clinical treatment services are not provided.

Staff shall provide awake 24-hour onsite supervision.

Clinically managed low intensity residential services (ASAM Level 3.1) required service components include:

- Services for the member's family and significant others, as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Weekly face-to-face meetings with the member and the treatment team will be required to review, discuss and document treatment progress and progress toward discharge. A week is defined as Sunday through Saturday.
- Clinically directed program activities by CATPs, CSACS/CSAC-supervisee within scope of practice, constituting at least five hours per week of professionally directed treatment designed to stabilize and maintain substance use disorder symptoms, and to develop and apply recovery skills, utilizing motivational enhancement and engagement strategies.
- Psychotherapy, substance use disorder counseling and clinical monitoring to support initial or re-involvement in regular productive daily activity and reintegration into family or community living with health education.
- Relapse prevention, emotional coping strategies, interpersonal choice exploration, and development of social networks in support of recovery. Services shall promote personal responsibility and re-integration of the member into the network systems of work, education, and family and community life.
- Physician consultation and emergency services shall be available 24 hours a day and seven days per week.

- Arrangements for medically necessary procedures including laboratory and toxicology tests, which are appropriate to the severity and urgency of a member's condition.
- Arrangements for pharmacotherapy for psychiatric or anti-addiction medications and drug screenings.
- Arrangements for higher and lower levels of care and other services. Direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as intensive outpatient, vocational assessment and placement, literacy training, and adult education.
- Regular monitoring of the member's medication adherence.
- Education on benefits and potential side effects of pharmacotherapy for OUD and AUD including referral to treatment as necessary. Opportunities for member to be introduced to the potential benefits of addiction pharmacotherapies as a long term tool to manage addiction.
- Biomedical enhanced services are delivered by appropriately credentialed medical staff who are available to assess and treat co-occurring biomedical disorders and to monitor the member's administration of medications in accordance with a physician's prescription.
- Coordination with community physicians to review treatment as needed.
- Appropriate arrangements or referrals to all service providers identified in the discharge plan prior to the member's scheduled discharge date.
- Follow-up and monitoring of members immediately after discharge to ensure continuity of engagement.

Co-Occurring Enhanced Programs

In addition to the Level 3.1 service components listed in this section, Clinically Managed Low Intensity Residential Services (ASAM Level 3.1) co-occurring enhanced programs shall offer the following:

- Programs for members who have both unstable substance use and psychiatric disorders including appropriate psychiatric services, medication evaluation and laboratory services. Such services are provided either on-site, via telemedicine, or closely coordinated with an off-site provider, as appropriate to the severity and urgency of the member's mental health condition. In addition to the Level 3.1 support systems listed above, Level 3.1 co-occurring enhanced programs offer appropriate psychiatric services, including medication evaluation and laboratory services. Such services are provided on-site or closely coordinated off-site, as appropriate to the severity and urgency of the member's mental condition.
- Level 3.1 co-occurring capable programs shall offer the therapies described above as well as planned clinical activities (either directly or through affiliated providers) that are designed to stabilize the member's mental health program and psychiatric symptoms and

to maintain such stabilization. Goals of therapy shall apply to both the substance use disorder and any co-occurring mental illness.

- Medication education and management shall be provided. Such services are provided either on-site or closely coordinated with an off-site provider.

Discharge planning

Discharge planning should take place at the start of admission of the member and should continue throughout the member's placement., The member or legally authorized representative and either the MCO or the BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least 15 calendar days prior to discharge, the provider shall document in members records active written discharge plan.

Service Units and Limitations

- ASAM Level 3.1 services require service authorization. The MCOs and the BHSA will respond within 72 hours to the service authorization request. If approved, the MCOs and BHSA may reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member moves out of the facility or a higher level of care is needed for the member.
- ASAM Level 3.1 services may be provided concurrently with Preferred OBOT/OTP, partial hospitalization services, intensive outpatient services and outpatient services.
- Preferred OBOT and OTP services including medications, labs, and urine drug screens may be billed separately in community-based settings.
- Group substance use counseling by CATPs, CSACs and CSAC supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Staff travel time is excluded.
- Medicaid does not pay for room and board.
- One unit of service is one day.
- There are no maximum annual limits but shall meet ASAM Criteria for the level of care.

Clinically Managed Population-Specific High Intensity Residential Service (ASAM Level 3.3)

Clinically managed population-specific high intensity residential services (ASAM Level 3.3) as defined in 12VAC30-130-5120 and 12VAC35-105-1590 to 1620, must have all the following service components through service provision or through referral:

- Access to consulting physician or physician extender and emergency services 24 hours a day and seven days a week via telephone and in person.
- Arrangements for higher and lower levels of care, including direct affiliations or close coordination through referral to more and less intensive levels of care and other services such as IOP, vocational assessment and placement, literacy training, and adult education.
- Arrangements for laboratory and toxicology services appropriate to the severity of need. Arrangements for addiction pharmacotherapy including pharmacotherapy for psychiatric or anti-addiction medications including drug screenings. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Regular monitoring and documentation of the member's medication adherence.
- Weekly face-to-face meetings with the member and the treatment team or CATP who prepared the ISP will be required to document treatment progress and progress toward discharge.
- Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the member into the network systems of work, education, and family life. Daily clinical services shall be provided to improve organization, daily living skills, recovery, personal responsibility, personal appearance and punctuality.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the member in initial involvement or re-engagement in regular productive daily activity.
- Recreational therapy, art, music, physical therapy and vocational rehabilitation. These services do not constitute the primary mode of treatment.
- Clinical and didactical motivational interventions to address readiness to change and understanding of disorder life impacts.
- Substance use disorder counseling and psychoeducation activities provided individually and or in group and family settings to promote recovery.
- Services for the member's family and significant others, as appropriate to advance the member's treatment goals and objectives identified in the ISP.

- Education on benefits of medication assisted treatment and arrangements for addiction pharmacotherapy provided on-site or thorough referral as necessary.
- Withdrawal management services may be provided as necessary. Providers should refer to the ASAM Criteria for Intoxication/Withdrawal Management guidelines.

Co-Occurring Enhanced Programs

Clinically managed population-specific high intensity residential service co-occurring enhanced programs, shall include the Level 3.3 service components listed in this section, including appropriate psychiatric services, medication evaluation and laboratory services which shall be provided on-site or through a closely coordinated off-site provider, as appropriate to the severity and urgency of the member's mental condition. Level 3.3 co-occurring enhanced programs offer planned clinical activities designed to stabilize the member's mental health programs and psychiatric symptoms, and to maintain stabilization

Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or two consecutive days of passes 8 hours or more shall require service authorization. Providers shall consult with the MCO or BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Discharge planning should take place at the start of admission of the member and should continue throughout the member's placement, the member or legally authorized representative and either the MCO or the BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least seven calendar days prior to discharge, the provider shall document in the member's record an active written discharge plan. Once a member has been discharged from ASAM levels of care 3.1/3.3/3.5/3.7, any subsequent admission to an ASAM Level 3.1/3.3/3.5/3.7 would be considered a new admission.

Service Units and Limitations

- ASAM Level 3.3 requires service authorization. The MCOs and the BHSA will respond within 72 hours of the request to the service authorization request. If approved, the MCOs and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.

- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member discontinues services, or a higher level of care is needed for the member.
- ASAM Level 3.3 services may be provided concurrently with Preferred OBOT or OTP services.
- Preferred OBOT or OTP services including medications, labs, and urine drug screens may be billed separately in community-based settings. For more information, please refer to the Opioid Treatment Services Supplement to this Provider Manual.
- One unit of service is one day.
- There are no maximum annual limits but shall meet ASAM Criteria.
- Group substance use counseling by CATPs, CSACs and CSAC-supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- Some examples of non-reimbursable services include:
    - Remedial education (tutoring, mentoring)
    - Evaluation for educational placement or long-term placement
    - Day care
    - Psychological testing for educational diagnosis, school, or institutional admission and/or placement
    - Mental Health and ARTS Partial Hospitalization Programs/ Intensive Outpatient Programs
    - Case management for therapy services
    - Team meetings
    - Documentation/record keeping

Clinically Managed High-Intensity Residential Services (Adult) and Clinically Managed Medium-Intensity Residential Services (Adolescent) (ASAM Level 3.5)

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) as defined in 12VAC30-130-5130 and 12VAC35-105-1530 to 1570, are residential treatment services which shall include through service provision or through referral:

- Telephone or in-person consultation with a physician or physician-extender who shall be available to perform required physician services. Emergency services shall be available 24 hours per day and seven days per week.
- Arrangements for more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.
- Arrangements for needed procedures including medical, psychiatric, psychological, lab and toxicology services appropriate to the severity of need. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Arrangements for addiction pharmacotherapy.
- Random drug screening to monitor and reinforce recovery.
- Clinically directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the member into the network systems of work, education, and family life.
- Program activities shall be designed to stabilize and maintain substance use disorder symptoms and apply recovery skills and may include relapse prevention, interpersonal choice exploration, and development of social networks in support of recovery.
- Daily clinical services to improve organization, daily living skills, recovery, personal responsibility, personal appearance and punctuality. Development and practice of prosocial behaviors.
- Range of cognitive and behavioral therapies administered individually and in family and group settings to assist the member in initial involvement or re-engagement in regular productive daily activities including education on medication management, addiction pharmacotherapy, and education skill building groups to enhance the member's understanding of substance use and mental illness.
- Clinically directed program activities designed to stabilize and maintain substance use disorder symptoms, and apply recovery skills. Relapse prevention, interpersonal choice exploration, development of social networks in support of recovery.

- Counseling and clinical interventions to facilitate teaching the member skills needed for productive living and successful reintegration into family living to include health education.
- Monitoring of the adherence to prescribed medications and over-the-counter medications and supplements.
- Daily treatments to manage acute symptoms of biomedical substance use or mental health disorder
- Planned clinical interventions to enhance the members understanding of substance use and mental health disorders.
- Daily scheduled professional services, interdisciplinary assessments and treatment, designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of social network supportive of recovery. Such services would include member and group counseling, psychotherapy, family therapy, recreational therapy, art, music, physical therapy, vocational rehabilitation, educational and skill building groups,
- Planned community reinforcement designed to foster improved community living skills.
- Motivational enhancements and engagement strategies appropriate to the members' stage of readiness and desire to change.
- Psychotherapy, substance use disorder counseling and clinical monitoring assist the member in initial involvement or re-involvement in regular productive daily activity such as work or school, with successful re-integration into family living with health education.
- Services for family and significant others, as appropriate, to advance the member's treatment goals and objectives identified in the ISP.
- Education on benefits of and arrangements for addiction pharmacotherapy provided on-site or thorough referral as necessary
- Withdrawal management services may be provided as necessary. Providers should consult the ASAM Criteria for Intoxication/Withdrawal Management requirements.

Co-Occurring Enhanced Programs

Clinically managed high-intensity residential services (adult) and clinically managed medium-intensity residential services (adolescent) (ASAM Level 3.5) co-occurring enhanced programs shall include the services listed in this section in addition to psychiatric services (psychiatric evaluation and/or therapy individual, group, family), medication evaluation, and laboratory services which shall be available by telephone within eight hours of requested service and on-site or via telemedicine, or closely coordinated with an off-site provider within 24 hours of requested service, as appropriate to the severity and urgency of the member's mental and physical condition. Level 3.5 co-occurring enhanced programs offer planned clinical activities designed to stabilize

the member's mental health problems and psychiatric symptoms, and to maintain such stabilization. Planned clinical activities shall be required and shall be designed to stabilize and maintain the member's mental health problems and psychiatric symptoms.

Family engagement shall be provided in addition to family therapy/counseling as appropriate. Family engagement shall be provided as outlined in the ISP and the family or legally authorized representative shall be part of the family engagement strategies in the ISP. Family engagement activities are considered to be an intervention consisting of family psycho-educational training or coaching; transition planning with the family; family and independent living skills; and training on access using community supports as defined in the ISP. Family engagement activity shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the ISP. Any deviation from the ISP shall be documented along with a clinical or medical justification for the deviation based on the needs of the member.

Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or two consecutive days of passes eight hours or more shall require service authorization. Providers shall consult with the MCO or the BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Discharge planning should take place at the start of admission of the member and should continue throughout the member's placement. The member or legally authorized representative and either the MCO or the BHSA ARTS Care Coordinator shall be involved in treatment planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. At least seven calendar days prior to discharge, the provider shall submit an active discharge plan to the MCO, or the BHSA for review based on the member's benefit. Once the MCO or the BHSA approves the discharge plan, the provider shall begin collaborating with the member or legally authorized representative and the treatment team to prepare the member for referral into another level of care, post treatment returns or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO or the BHSA of all scheduled appointments within seven calendar

days of discharge, and shall notify the MCO or the BHSA within one business day of the member's discharge date from their facility.

Once a member has been discharged from ASAM levels of care 3.1/3.3/3.5/3.7, any subsequent admission to an ASAM Level 3.1/3.3/3.5/3.7 would be considered a new admission.

Service Units and Limitations

- ASAM Level 3.5 requires service authorization. The MCOs and the BHSA will respond within 72 hours to the service authorization request. If approved, the provider may be reimbursed retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member leaves the facility or a higher level of care is needed for the member.
- ASAM Level 3.5 services may be provided concurrently with Preferred OBOT or OTP services.
- Preferred OBOT and OTP services including medications, labs, and urine drug screens may be billed separately in community-based settings. For more information, please refer to the Opioid Treatment Services Supplement to this Provider Manual.
- One unit of service is one day.
- There are no maximum annual limits but shall meet ASAM Criteria.
- Group substance use counseling by CATPs, CSACs and CSAC supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.
- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- Some examples of non-reimbursable services include:
    - Remedial education (tutoring, mentoring)
    - Evaluation for educational placement or long-term placement
    - Day care

- Psychological testing for educational diagnosis, school, or institutional admission and/or placement
- Mental Health and ARTS Partial Hospitalization Programs / Intensive Outpatient Programs
- Case management for therapy services
- Team meetings
- Documentation/record keeping

Medically Monitored Intensive Inpatient Services (Adult) and Medically Monitored High Intensity Inpatient Services (Adolescent) (ASAM Level 3.7)

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) as defined in 12VAC30-130-5140 and 12VAC35-105-1480 to 1520, and shall meet the following service components through service provision or through referral:

- Clinical staff shall be able to provide a planned regimen of 24 hour professionally directed evaluation, care and treatment including the administration of prescribed medications.
- Addiction-credentialed physician or physician with experience in addiction medicine shall oversee the treatment process and assure quality of care. Licensed physicians or physician extenders shall perform physical examinations for all members who are admitted; except in cases where a member is admitted to Level 3.7 as a step-down from Level 4.0 within the same facility, in which case the physician/physician extender shall review the physical exam that was performed within the previous seven days. Staff shall supervise addiction pharmacotherapy, integrated with psychosocial therapies. The professional may be a physician or psychiatrist, or physician extender as defined in 12VAC30-130-5020 if knowledgeable about addiction treatment. Physician monitoring, nursing care and observation shall be available. A physician shall assess the member in person within 24 hours of admission and thereafter as medically necessary.
- A registered nurse (RN) under direction of a Physician Medical Director, shall conduct an alcohol or other drug focused nursing assessment upon admission. The RN shall have the competencies and experience in conducting an alcohol or other drug focused nursing assessment. The RN performing the alcohol or other drug focused nursing assessment shall report the results to the attending physician, who then directs initiation of the medical-monitored protocol based on the results of the focused assessment. A RN or licensed practical nurse (LPN) shall be responsible for monitoring the member's progress and for medication administration duties.
- Daily clinical services provided by an interdisciplinary team to involve appropriate medical and nursing services, as well as individual, group and family therapy services. Activities may include pharmacological, withdrawal management, cognitive-behavioral, and other

therapies administered on an individual or group basis and modified to meet the member's level of understanding and assist in the member's recovery.

- Planned clinical activities to enhance understanding of substance use disorders. Planned clinical program activities to stabilize acute addictive or psychiatric symptoms. Activities may include pharmacological, cognitive-behavioral, and other therapies administered on an individual or group basis and adapted to the member’s level of comprehension.
- Psychotherapy, substance use disorder counseling and clinical monitoring to facilitate re-involvement in regular productive daily activities and successful re-integration into family living if applicable. Counseling and clinical monitoring to promote re-involvement in or skill building in regular productive daily activities such as work or school and successful re-integration into family living if applicable.
- Random drug screens to monitor use and strengthen recovery and treatment gains.
- Regular medication monitoring.
- Health education associated with the course of addiction and other potential health related risk factors including Tuberculosis, HIV, Hepatitis B and C, and other sexually transmitted infections.
- Evidence based practices such as motivational interviewing to address the members readiness to change, designed to facilitate understanding of the relationship between SUD and life impacts.
- Daily treatments to manage acute biomedical symptoms of substance use or mental illness.
- Services to family and significant others as appropriate to advance the member's treatment goals and objectives identified in the ISP.
- Additional medical specialty consultation, psychological, laboratory and toxicology services shall be available on site, either through consultation or referral. For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.
- Coordination of necessary services shall be available on-site or through referral to a closely coordinated off-site provider to transition the member to lower levels of care.
- Psychiatric services are available onsite, through consultation or referral when a presenting problem could be attended to at a later time. Such services are available within eight hours by telephone and 24 hours in-person.
- Psychoeducation along with medication education and management shall be offered.

Co-Occurring Enhanced Programs

Medically monitored intensive inpatient services (adult) and medically monitored high intensity inpatient services (adolescent) (ASAM Level 3.7) co-occurring enhanced programs shall include the services listed in this section in addition to appropriate psychiatric services, medication evaluation, and laboratory services. A psychiatric assessment of the member shall occur within four hours of admission by telephone and within 24 hours following admission in person or via telemedicine, or sooner, as appropriate to the member's behavioral health condition, and thereafter as medically necessary. A behavioral health-focused assessment at the time of admission shall be performed by a registered nurse or licensed mental health clinician. A licensed registered nurse or licensed practical nurse supervised by a registered nurse shall be responsible for monitoring the member's progress and administering or monitoring the member's self-administration of medications.

Planned clinical activities shall be offered and designed to promote stabilization and maintenance of the member's behavioral health needs, recovery, and psychiatric symptoms. Evidence based practices such as motivational enhancement strategies and interventions appropriate to address the members' readiness to change, designed to facilitate understanding of relationship of the substance use disorder and life impacts.

Therapeutic Passes

Therapeutic passes mean time away from the treatment facility with identified goals as clinically indicated by the treating credential addiction treatment professional and documented in the ISP. Therapeutic passes are paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Therapeutic leave passes of 24 hours or more, or two consecutive days of passes eight hours or more shall require service authorization. Providers shall consult with the MCO or the BHSA regarding the service authorization process for therapeutic passes. Any unauthorized therapeutic passes shall result in retraction for those days of service.

Discharge planning

Discharge planning should take place at the start of admission of the member and should continue throughout the member's placement, the member or legally authorized representative and either the MCO or BHSA ARTS Care Coordinator shall be involved in treatment/discharge planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. The provider shall submit an active written discharge plan to the MCO or the BHSA depending on the member's benefit, for review prior to the member's discharge. Once the MCO or the BHSA approves the discharge plan, the residential treatment service provider shall begin collaborating with the member or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments as needed. Once the MCO or the BHSA approves the discharge plan, the provider

shall begin collaborating with the member or legally authorized representative and the treatment team to prepare the member for referral into another level of care, post treatment returns or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The provider shall request information from post-discharge providers to establish that the planning of services and activities has begun. The provider shall inform the MCO or the BHSA depending on the member's benefit of all scheduled appointments post discharge, and shall notify the MCO or the BHSA within one business day of the member's discharge date from their facility to help facilitate the post discharge care.

Once a member has been discharged from ASAM levels of care 3.1/3.3/3.5/3.7, any subsequent admission to an ASAM Level 3.1/3.3/3.5/3.7 would be considered a new admission.

Service Units and Limitations

- ASAM Level 3.7 requires service authorization. The MCOs and the BHSA will respond within 72 hours to the service authorization request. If approved, the MCOs and the BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.
- Members shall be discharged from this service when other less intensive services may achieve stabilization, the member requests discharge, the member leaves the facility or a higher level of care is needed for the member.
- ASAM Level 3.7 may be provided concurrently with Preferred OBOT or OTP services. Preferred OBOT and OTP services including medications, labs, and urine drug screens may be billed separately in community-based settings but not inpatient settings. For more information, refer to the Opioid Treatment Services Supplement to this Provider Manual.
- One unit of service is one day.
- There are no maximum annual limits but shall meet ASAM Criteria.
- Group substance use counseling by CATPs, CSACs and CSAC supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Providers may not bill another payer source for any supervisory services.
- Daily supervision, including one-on-one, is included in the Medicaid per diem reimbursement.

- Residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.
- Some examples of non-reimbursable services include:
  - Remedial education (tutoring, mentoring);
  - Evaluation for educational placement or long-term placement;
  - Day care;
  - Psychological testing for educational diagnosis, school, or institutional admission and/or placement;
  - Mental Health and ARTS Partial Hospitalization Programs / Intensive Outpatient Programs;
  - Case management for therapy services;
  - Team meetings; and
  - Documentation/record keeping.

Medically Managed Intensive Inpatient Services (ASAM Level 4.0)

Medically managed intensive inpatient services (ASAM Level 4.0) as defined in 12VAC30-130-5150 and 12VAC35-105-1430 to 1470 may be acute care hospitals, inpatient psychiatric units of an acute care hospital or a freestanding psychiatric facility, and shall be the designated setting for medically managed intensive inpatient treatment. Medically managed intensive inpatient services shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, a member's use of alcohol and other drugs. Such service settings shall offer medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress, or all of these, resulting from, or co-occurring with, a member's use of alcohol or other drugs with the exception of tobacco-related disorders, caffeine abuse or dependence, or non-substance-related disorders.

ASAM Level 4.0 providers shall meet the service components as noted in this section.

Medically managed intensive inpatient services (ASAM Level 4.0) include:

- An evaluation or analysis of substance use disorders shall be provided, including the diagnosis of substance use disorders and the assessment of treatment needs for medically necessary services.
- Observation and monitoring the member’s course of withdrawal shall be provided. This shall be conducted as frequently as deemed appropriate for the member and the level of

care the member is receiving. This may include, for example, observation of the member's health status.

- Medication services including the prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by appropriate licensed staff who provide such services within their scope of practice or license.
- For members who have not been screened for infectious diseases within previous 12 months, screening provided on-site or referral for screening of infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation.

The following therapies are reimbursable based on individual member's needs:

- Daily clinical services provided by an interdisciplinary team to stabilize acute addictive or psychiatric symptoms. Activities shall include pharmacological, cognitive-behavioral, and other psychotherapies or substance use disorder counseling administered on an individual or group basis and modified to meet the member's level of understanding. For members with a severe biomedical disorder, physical health interventions are available to supplement addiction treatment. For the member who has less stable psychiatric symptoms, Level 4 co-occurring capable programs offer individualized treatment activities designed to monitor the member's mental health and to address the interaction of the mental health programs and substance use disorders.
- Health education services.
- Planned clinical interventions that are designed to enhance the member's understanding and acceptance of illness of addiction and the recovery process.
- Services for the member's family, guardian, or significant other, as appropriate, to advance the member's treatment and recovery goals and objectives identified in the ISP.
- This level of care offers 24-hour nursing care and daily physician care for severe, unstable problems in any of the following ASAM dimensions: i) acute intoxication or withdrawal potential; ii) biomedical conditions and complications; iii) emotional, behavioral, or cognitive conditions and complications.

Discharge planning

Discharge planning should take place at the start of admission of the member and should continue throughout the member's inpatient stay the member or legally authorized representative and the ARTS Care Coordinator of the MCO or the BHSA shall be involved in treatment/discharge planning and shall identify the anticipated needs of the member and family upon discharge and identify the available services in the community. Prior to discharge, the inpatient services provider shall submit an active written discharge plan to the MCO or the BHSA depending on the member's benefit, for review. Once the MCO or the BHSA approves the discharge plan, the inpatient services provider shall begin collaborating with the member or legally authorized

representative and the treatment team to prepare the member for referral into another level of care, post treatment returns or reentry into the community, or the linkage of the member to essential community treatment, housing, recovery, and human services. The inpatient services provider shall request written permission from the member or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The inpatient services provider shall notify the MCO or the BHSA depending on the member's benefit within one business day of the member's discharge date from their facility.

Once a member has been discharged from ASAM levels of care 4.0, any subsequent admission to an ASAM Level 4.0 would be considered a new admission.

Medically managed intensive inpatient services (ASAM Level 4.0) co-occurring enhanced programs. These programs shall be provided by appropriately credentialed mental health professionals who assess and treat the member's co-occurring mental illness and are knowledgeable about the biological and psychosocial dimensions of psychiatric disorders and their treatment.

Service Units and Limitations

- Members shall be discharged from this service when other less intensive services may achieve stabilization.
- One unit of service is one day.
- There are no maximum annual limits.
- Group substance use counseling by CATPs, CSACs and CSAC-supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Group size may exceed this limit based on the determination of the CATP. Such counseling shall focus on the needs of the members served.
- CSACs and CSAC-supervisees by scope of practice are able to perform group substance use counseling, thus could provide counseling and psychoeducational services in this level of care.
- Some examples of non-reimbursable services include:
    - Behavior modification;
    - Remedial education;
    - Day care; and
    - Psychological testing done for any or all of the following purposes: educational diagnosis, school recommendations, institution admission or institutional placement.

Medically managed intensive inpatient services (ASAM Level 4.0) require service authorization. On admission, the member must meet severity of illness and intensity of service criteria for inpatient hospitalization and have a treatment plan in place that requires an inpatient level of care.

The MCOs and the BHSA will responds within 72 hours to the service authorization request. If approved, the MCOs and BHSA will reimburse providers retroactively for this service to allow members to immediately enter treatment.

REPORTING OF ADVERSE OUTCOMES FOR INSTITUTION FOR MENTAL DISEASES (IMDS)

Seclusion and Restraint

Psychiatric residential treatment facilities must comply with federal requirements regarding restraint and seclusion. Providers should refer to 42 CFR §§ 483.350 – 483.376 for detailed information regarding definitions, the protection of individuals; orders for the use of restraint or seclusion; consultation with the treatment team physician; monitoring of the individual in and immediately after restraint or seclusion; notification of the individual's parent or legal guardian; application of time out; post intervention debriefings; medical treatment for injuries resulting from an emergency safety intervention; facility reporting; and, education and training of staff.

Each psychiatric residential treatment facility must submit an attestation of facility compliance if the facility provides inpatient psychiatric services to individuals under age 21 in writing that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

The use of Seclusion and Restraint in an IMD shall be in accordance with the Virginia State Regulations 12VAC30-60-50 as defined in 42 CFR § 483.350 through 42 CFR § 483.376.

Each use of a seclusion or restraint, as defined in 42 CFR § 483.350 through 42 CFR § 483.376, shall be reported by the service provider to Magellan and the Medicaid members MCOs or within one calendar day of the incident.

Facilities must report any serious incident involving a resident to Magellan and MCOs within **one business day** of the occurrence.

Facilities must report each instance of restraint or seclusion involving a resident to Magellan and MCOs within **one calendar day** of the occurrence.

At minimum, the following information must be included:

- Member's name and Medicaid number;
- Facility name, address, and NPI number;
- Detailed description of the incident, including the dates and location of the incident;
- Name(s) of staff involved;
- Outcome, including the persons notified; and
- Current location of the member.

In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no later than 24 hours after the serious occurrence.

Staff must document in the resident's record that the serious occurrence was reported to the appropriate person.

PEER RECOVERY SUPPORT SERVICES

Peer Recovery Support Services includes Peer Support Services and Family Support Partners; which are non-clinical services including peer-to-peer activities that engage, educate, and support an individual's self-help efforts to improve health recovery resiliency and wellness.

Information about Peer Support Services and Family Support Partners and detailed program requirements are available in the Peer Recovery Support Services Supplement to the following DMAS Provider Manuals:

- Addiction and Recovery Treatment Services (ARTS) Manual
- Residential Services Manual
- Mental Health Services (MHS) Manual
- Psychiatric Services Manual
- Mental Health Clinic Manual and
- Hospital Manual

PATIENT UTILIZATION MANAGEMENT SAFETY PROGRAM (PUMS)

All contracted Medicaid MCOs are required to have a Patient Utilization Management Safety Program (PUMS). The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS Program, the MCO must refer members to appropriate services based upon the member's unique situation and service needs.

<u>Placement into a PUMS Program</u>

Members may be placed into a PUMS program for a period of twelve (12) months when either of the following trigger events occurs:

- (PUMS1) Opioid Use Disorder (OUD) Case Management: The MCO may review any Members receiving OUD and provide case management. o Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three (3) years; pregnant women with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate; o Clinical expertise and judgment shall be used to identify and manage any Members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").

- (PUMS2) High Average Daily Dose: > ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,
- (PUMS3) Opioids and Benzodiazepines concurrent use – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order),
- (PUMS4) Doctor and/or Pharmacy Shopping: > three (3) prescribers OR > three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,
- (PUMS5) Use of a Controlled Substance with a History of Dependence, Misuse, or Poisoning/Overdose: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Misuse or Dependence in the past three hundred and sixty-five (365) days,
  (PUMS6) History of Substance Use, Use or Dependence or Poisoning/Overdose: Any Member with a diagnosis of substance use, substance misuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

Medical providers or social service agencies provide direct referrals to the Department or the Medicaid MCOs.

Members identified for placement in the PUMS program may also be evaluated for referral to ARTS.

Temporary Change to PUMS Status

Members that are in PUMS will be limited to utilizing one particular pharmacy of their choice. If they are referred to an ARTS Residential Treatment Services facility, and need to continue medication management via a single pharmacy, the Residential provider shall contact the MCO to request the pharmacy be updated to one that the Residential provider utilizes, so that the member may continue the current medical regimen. Provider may contact the health plans and Magellan of Virginia to update the preferred pharmacy while member is in the residential treatment program. The health plan contacts are posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/credentialing/ .

Upon discharge from the Residential Treatment Facility, the provider needs to notify the member's MCO of the discharge so that the member's pharmacy provider may be updated based on the member's choice and proximity to their place of discharge. This task shall be included on the discharge planning process.

42 CFR PART 2

42 CFR Part 2 (http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2) applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). The

regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser …" (42 CFR §2.12(a) (1)). In laymen's terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies a member directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.

With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing. Providers should consult with their own legal counsel for questions about 42 CFR Part 2.

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

As described in Chapters I and VI, the Medicaid Program may designate certain members to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the member's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these members only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

EXHIBITS

	Page
Provider Qualification Table	1

Appendix 1: ARTS Provider Qualification Requirements for ASAM Level of Care Assessments, Development of ISP and Service Authorization

Service	ASAM LOC	Multidimensional Assessment	Individual Service Plan	Service Authorization	Additional requirements as indicated
SUD IOP	**2.1**	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee.	If Dimension 1 and/or 2 indicates medical concerns or symptoms, **must consult with physician or physician extender** and document on service auth the name of the physician/physician extender. If Dimension 3 indicates mental health history, concerns or symptoms, **must consult with psychiatrist or psychiatric nurse practitioner as clinically indicated**, and document on service authorization the name of the Licensed Provider and Title.
SUD Partial Hospitalization	**2.5**	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee.	If Dimension 1 and/or 2 indicates medical concerns or symptoms, **must consult with physician or physician extender** and document on service auth the name of the

		CSAC and CSAC-supervisee.			physician/physician extender. If Dimension 3 indicates mental health history, concerns or symptoms, **must consult with psychiatrist or psychiatric nurse practitioner as clinically indicated**, and document on service authorization the name of the Licensed Provider and Title.
SUD Group Home	**3.1**	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee.	If Dimension 1 and/or 2 indicates medical concerns or symptoms, **must consult with physician or physician extender** and document on service auth the name of the physician/physician extender. If Dimension 3 indicates mental health history, concerns or symptoms, **must consult with CATP as well as including psychiatrist or psychiatric nurse practitioner as clinically indicated**, and document on service

					authorization the name of the Licensed Provider and Title.
Clinically Managed Population with Cognitive Impairments – High Intensity - RTS	**3.3**	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee.	If Dimension 1 and/or 2 indicates medical concerns or symptoms, **must consult with physician or physician extender** and document on service auth the name of the physician/physician extender. If Dimension 3 indicates mental health history, concerns or symptoms, **must consult with CATP, including psychiatrist or psychiatric nurse practitioner as clinically indicated**, and document on service authorization the name of the Licensed Provider and Title.
Clinically Managed All Population – High Intensity	**3.5**	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee.	If Dimension 1 and/or 2 indicates medical concerns or symptoms, **must consult with physician or physician extender** and document on service auth the name of the physician/physician extender.

					If Dimension 3 indicates mental health history, concerns or symptoms, **must consult with Licensed Behavioral Health Provider, including psychiatrist or psychiatric nurse practitioner as clinically indicated**, and document on service authorization the name of the Licensed Provider and Title.
Medically Monitored Intensive Inpt	**3.7**	CATP, CSAC and CSAC-supervisee, in consultation with Credentialed Addiction Physician or Physician Extender.	CATP, CSAC and CSAC-supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.	CATP, CSAC and CSAC-supervisee **with documentation of consulting physician or physician extender.**	
Medically Managed Inpt	**4.0**	Inpatient psychiatric units/Free standing psychiatric units: CATP in consultation with Credentialed Addiction Physician or Physician Extender. Acute care: Admitting Physician	Inpatient psychiatric units/Free standing psychiatric units: CATP, in collaboration with interdisciplinary team Acute care: An interdisciplinary staff of appropriately credentialed clinical staff including, addiction-credentialed	Inpatient psychiatric units/Free standing psychiatric units: CATP with documentation of consulting physician or physician extender.	

			physicians or physicians with experience in addiction medicine, licensed nurse practitioners, licensed physician assistants, registered nurses, licensed professional counselors, licensed clinical psychologists, or licensed clinical social workers	Acute care: Credentialed Addiction Physician or Physician Extender – including designee such as authorization or utilization review staff.	

*"**CATPs**" means (i) an addiction-credentialed physician or physician or physician extender with experience or training in addiction medicine; (ii) a licensed psychiatrist; (iii) a licensed clinical psychologist; (iv) a licensed clinical social worker; (v) a licensed professional counselor; (vi) a certified psychiatric clinical nurse specialist; (vii) a licensed psychiatric nurse practitioner; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) residents under supervision of a licensed professional counselor, licensed marriage and family therapist, or licensed substance abuse treatment practitioner who is registered with the Virginia Board of Counseling; (xi) a resident in psychology under supervision of a licensed clinical psychologist who is registered with the Virginia Board of Psychology; (xii) a supervisee in social work under the supervision of a licensed clinical social worker who is registered with the Virginia Board of Social Work.