The Commonwealth of Kentucky

Substance Use Disorder

Phase II: Residential Provider

Provisional Certification
Attestation Guide
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1 Introduction

Welcome to the SUD (Substance Use Disorder) Phase II: Residential Provider Provisional Certification Attestation Guide (Attestation Guide). This Attestation Guide contains information related to the provisional certification process in preparation for the American Society of Addiction Medicine (ASAM) certification, effective July 1, 2021.

Intended Audiences and Objectives

This document outlines the provisional certification attestation form for Substance Use Disorder Residential Providers in support of the implementation and requirement of the ASAM Certification on July 1, 2021.

Objectives:
By the end of guide, you should be able to:

- Self-Attest to the most accurate ASAM Level of Care
- Understand the supporting documents needed to self-attest
- Complete the Provisional Certification Attestation Form
- Submit the Provisional Certification Attestation Form and all applicable attachments to the Department of Medicaid Services at DMS.Issues@ky.gov

Icon Guide

<table>
<thead>
<tr>
<th>Icon</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>The ‘Important’ icon indicates important policy information.</td>
</tr>
<tr>
<td>Process</td>
<td>The ‘Star’ icon indicates important process information.</td>
</tr>
</tbody>
</table>
2 General Guidelines

- A separate form must be completed for each residential facility location that meets the specific level of care based on the criteria defined by the American Society of Addictions Medicine (ASAM) for the provision of substance use disorder treatment services. Should you provide more than one ASAM program or level of care within the same facility, a separate form must be completed for each program or level of care.

- Residential facility providers must have completed a provider enrollment application and locations must be uniquely identifiable when submitting claims according to data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

- Complete ALL items on the form unless otherwise instructed. Provisional Certifications will have an effective date beginning the next quarter.

- You should submit your DMS Attestation Form along with supporting documents to the DMS.Issues@ky.gov mailbox.

- When submitting, use the subject line “Facility Name: SUD Residential Provisional Certification Attestation.”
3 Section A: Legal Entity Information

1. **Legal Entity Name**: This is your Provider name registered in Partner Portal and used for billing purposes.

2. **Program Name** (if different than Legal Entity Name): This is the name used to identify unit or residential facility.

3. **Program Street Address**: The physical location/address where the program operates.
   a. **City**
   b. **State/Zip**

4. **Entity/Provider Website**: Provide the URL for the website used by the facility or practice. If not applicable, enter “N/A.”

5. **Mailing Address (if different than Program Address)**: The mailing address should be the address for the specific facility, not the legal entity. For example, if your corporate office is in Louisville, but your residential treatment facility is in Bardstown, make sure the Bardstown address is listed above. Location should be where the treatment provider can receive mail.
   a. **Mailing City**
   b. **Mailing State/Zip**
6. **Contact**: The contact should be the person responsible for filling out the form. This person will be responsible for ongoing correspondence with DMS throughout the provisional certification process. You may add additional contacts by attaching a supplemental list with the Contact Name, Title, Email, and Phone Number.
   
   a. **Title**: Contact job title/position. Ideally, the contact completing the form should be a Program Director or Program Manager.
   
   b. **Contact Email**: This email will be used for ongoing correspondence with DMS and should be monitored regularly. This will be the email used for future notifications regarding this provisional certification.
   
   c. **Contact Phone**: This phone number should be a direct line to the contact.

7. **National Provider Identifier (NPI)**: The NPI is a unique identification number for covered health care providers. Use the residential facility NPI - The NPI associated with this location.

8. **KY Medicaid ID**: Provider number associated with this facility or this facility’s ID.

9. **Tax ID**: Federal Tax Identification number associated with this provider for billing purposes.

10. **AODE Residential License #**: The AODE Residential License number associated to this location.

   a. **Current Bed Capacity**: Number of licensed beds for this program.
   
   b. **Expansion Bed Capacity**: If applicable, upon approval and with the waiver of the IMD exclusion, number of beds in which the program plans to expand beds.

11. **Are there multiple Facilities/Locations associated with this NPI**: List any facilities that are using the same billing NPI.

   a. **If yes, please list facilities and locations (attach list if necessary)**: Note that forms should be completed for individual facilities. If you have 3 facilities that use the same NPI, 3 separate forms should be completed. List should include name of facility, location, and contact.

12. **Do you approve sharing attestation with our DMS contracted Managed Care Organizations (MCO)**: This question is optional. The answer you provide will **NOT** impact provisional certification.
4 Section B: Provisional Residential Certification/Attestation

• **Select the appropriate ASAM Level of Care (LOC) for the services offered at your facility,** by checking this LOC you attest that you have received the appropriate licensure and that you are compliant with all applicable State regulations for the LOC indicated. Note, should you provide more than one level of care or programming within the same facility, a separate attestation is required for each program provided.

- **NOTE:** The American Society of Addiction Medicine (ASAM) is not including level of care (LOC) 3.3 in the certification process at this time. IF ASAM makes this LOC certification available at a later time, the Department of Medicaid (DMS) will revise the attestation process as appropriate.

For more information about ASAM Levels of Care, visit the ASAM website at [https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/](https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/)
Section C: Assessment/Treatment Plan

13. Bio-psychosocial assessment incorporates six dimensions and used to confirm the appropriateness of placement: You must provide an attachment of the bio-psychosocial assessment incorporated by this facility (Attachment 5).

14. Treatment plan is developed in collaboration with the recipient and review by an interdisciplinary team knowledgeable about addiction treatment: An example treatment plan must be included (Attachment 6).

15. Individualized treatment plan reflects recipient’s clinical progress: An example treatment plan must be included (Attachment 6).

16. Treatment plan reflects care coordination conducted by on-site staff including coordination of related addiction treatment, health care, mental health, social, vocational, housing and integrated services at this level and other levels of care: If applicable, provide an example treatment plan or policy that reflects care coordination (Attachment 6 and/or Attachment 9).

17. Program provides discharge follow up: If applicable, an example or policy may include Attachment 6 and/or Attachment 9.

18. Plan includes ongoing transition and continuing care planning (required for ASAM level 3.3): If applicable, an example or policy of ongoing transition and continuing care planning may include Attachment 9.
## 6 Section D: Support Systems

<table>
<thead>
<tr>
<th></th>
<th>19. <strong>Physician and emergency service consultation in-person or telephone 24/7</strong>: You must provide documentation that shows 24/7 access to emergency services such as an individual on-call, a crisis line, etc. (Attachment 1 and/or Attachment 2).</th>
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<tbody>
<tr>
<td></td>
<td>20. <strong>Program has direct affiliation or close coordination with other levels of care programs</strong>: If applicable, an example or policy of direct affiliation or close coordination may include Attachment 1 and/or Attachment 9.</td>
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<td></td>
<td>21. <strong>Please indicate whether services are available on-site or coordinated closely off-site, include description of off-site coordination process</strong>: If applicable, an example may include linkage agreements with off-site or affiliated agency/providers (Attachment 1).</td>
</tr>
</tbody>
</table>
Section E: Staff Requirements

22. Allied health professional staff on-site 24/7 to provide supportive services: Professional staff employed to support the residential component of care.

23. Clinical staff with knowledge of biological and psychosocial dimensions of SUD treatment and able to identify signs and symptoms.

24. Team of licensed or credentialed medical, addiction and mental health clinicians who work with non-licensed professionals as an interdisciplinary team approach.

25. Clinical staff is able to assess and treat co-occurring mental health and SUD disorders.
   a. If not available, include provider referral process for mental health treatment.
26. **One or more clinician with substance use disorder competencies must be available onsite or by telephone 24/7. (required for ASAM level 3.3 and above):** Note this will be verified through the staffing schedule and staffing credentials you will provide in the attachments of Section G.

27. **Clinical staff able to recognize the signs and symptoms of acute psychiatric conditions including decompensation. Staff have specialized training in behavior management techniques. (required for ASAM level 3.3 and above):** Note this may be verified through documents you will provide in the attachments of Section G.

28. **Clinical staff with ability to explain purposes of psychotropic medications and interactions with SUD. (required for ASAM level 3.5):** Note this may be verified through the documents you will provide in the attachments of Section G.

29. **Do you have affiliation with DEA waivered MD or APRN? (please provide provider information below):** If applicable, please provide provider name, NPI, contact info, and license.
7.1 Additional Staffing

**Please indicate programs staff/clinician discipline per service provided. Check all that apply.**

<table>
<thead>
<tr>
<th>Program Clinician/Staff</th>
<th>Behavior Therapy</th>
<th>Group Therapy</th>
<th>Family Therapy</th>
<th>Occupational Therapy</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Medical Doctor (MD)</td>
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<td>Advanced Practice Registered Nurse (APRN)</td>
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<td>Physician’s Assistant (PA)</td>
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<td>Registered Nurse (RN)</td>
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<td>Psychiatrist (PSY)</td>
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<tr>
<td>Licensed Psychological Practitioner (LPP)</td>
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<tr>
<td>Certified Psychologist (CP)</td>
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<td>Licensed Clinical Social Worker (LCSW)</td>
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<td>Licensed Professional Clinical Counselor (LPC)</td>
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<td>Licensed Marriage &amp; Family Therapies (LMFT)</td>
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<td>Licensed Clinical Alcohol &amp; Drug Counselor (LCADC)</td>
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<td>Licensed Psychological Associate (LPA)</td>
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<td>Certified Social Worker (CSW)</td>
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<td>Licensed Professional Counselor Associate (LPCA)</td>
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<td>Licensed Marriage &amp; Family Therapist Associate (LMFTA)</td>
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<td>Licensed Clinical Alcohol &amp; Drug Counselor Associate (LCADCA)</td>
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<tr>
<td>Certified Alcohol &amp; Drug Abuse Counselor (CADC)</td>
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<td>Peer Support Specialist (PSS)</td>
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<tr>
<td>Targeted Case Management (TCM)</td>
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30. Planned clinical program activities at least 5 hours per week designed to stabilize SUD symptoms, maintenance and relapse prevention: Note that you must provide a detailed weekly program schedule (Attachment 3).

31. Does this program provide withdrawal management services? (If yes, provide more information): Select if yes. More information includes levels of withdrawal management, specific interventions, and assessment tools used.

32. Do you offer Medication Assisted Treatment (MAT) on-site? (If no, explain how programs affiliates off-site): If unselected, off-site affiliates may be included in Attachment 1.

33. Motivational enhancements and engagement strategies appropriate to the individual's stage or readiness and desire to change.

34. Program offers recovery support services: May include examples of evidence-based practices/therapies utilized in Attachment 3 and/or Attachment 11.

35. Regular monitoring of the recipient’s medication adherence: May include example in Attachment 4 and/or Attachment 6.

36. Program offers services for patient’s family and significant others: May include example in Attachment 3 and/or Attachment 6.

37. Family services designed to accommodate the cognitive limitation(s) frequently seen in this population: May include example in Attachment 3 and/or Attachment 6.

38. For recipients with significant cognitive deficits, therapies are delivered in a manner that is slower-paced, more concrete and repetitive. (required by ASAM level 3.3): May include example in Attachment 3 and/or Attachment 6.
39. **Random drug screening as appropriate to the recipient’s treatment plan:** Note, this will be verified by the drug screening policy provided in attachment 10.

40. **Program offers health educational services:** May include examples in Attachment 3.

41. **Program offers a range of cognitive, behavioral and other therapies adapted to the recipient’s developmental stage, level of comprehension, understanding and physical abilities.** (required by ASAM level 3.3 and above): May include examples in Attachment 3 and/or Attachment 6.

42. **Program offers planned community reinforcement fostering community living skills** (required by ASAM level 3.5): May include examples in Attachment 3 and/or Attachment 6.

43. **Support system components include evidenced based clinical services.** (required by ASAM level 3.5): May include examples in Attachment 11.
9 Section G: Attachments

- List of attachments required with this request for provisional certification. Please keep the attestation and all attachments in order: Attachments should include operating procedures, tools, and policies specific to this facility or programming attesting.
  
1. Attachment 1: Linkage agreement(s) with off-site or affiliated agency/providers (if applicable)
2. Attachment 2: Documentation supporting access to 24/7 emergency services
3. Attachment 3: Detailed weekly program schedule
4. Attachment 4: Weekly staffing schedule including staffing credentials
5. Attachment 5: Assessment Tool(s)
6. Attachment 6: Example of Treatment Plan and Discharge Summary
7. Attachment 7: Yearly staff education/training requirements
8. Attachment 8: Certifications for Non-Licensed/Non-Credentialed staff
9. Attachment 9: Policy for care coordination, discharge planning and referrals (if applicable)
10. Attachment 10: Drug screening policy
11. Attachment 11: Description of evidence-based practices/therapies utilized
12. Attachment 12: Kentucky Alcohol and Other Drug Entity (AODE) Residential License