Department for Medicaid Services
Division of Policy and Operation
275 East Main St. 6W-D
Frankfort KY 40621

Email: DMS.Issues@ky.gov
Phone: (502) 564-6890

Provisional Residential Certification / Attestation

GENERAL INSTRUCTIONS
• **A separate form must be completed for <u>each</u> 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 • 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. Issued Provisional Certifications will have an effective date beginning the next quarter. • You may 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***".

Additional information regarding ASAM:

- https://www.asam.org/
- https://www.asam.org/resources/level-of-care-certification
- https://www.asam.org/resources/level-of-care-certification/level-of-care-certification-faqs

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A. ENTITY INFORMATION	
1. Legal Entity Name / Provider Name:	
2. Program Name (If different than Legal Entity Name and used to identify unit or facility):	
3. Program Street Address (Physical location/address where the program operates):	
3a. City	3b. State/Zip
4. Entity/Provider Website	
5. Mailing Address (If different than Program Address)	
5a. Mailing City	5b. Mailing State/Zip
6. Contact	6a.Title
6b. Contact Email	6c. Contact Phone
7. National Provider Identifier (NPI) 8. KY Medicaid ID 9. Tax ID	
10. AODE Residential License # 10a. Current Bed Capacity 10b. Expansion Bed Capacity	

Additional Information:

11. Are there multiple Facilities / Locations associated with this NPI? Yes ☐ No ☐
    11a. If yes, please list facilities and locations. (attach list if neccessary)

12. Do you approve sharing attestation with our DMS contracted Managed Care Organizations (MCO)? Yes ☐ No ☐

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Program Types

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 complaint with all applicable State regulations for the LOC indicated.

Please Note: Certification from ASAM must be obtained by July 1, 2021.

B. Program Description	ASAM LOC	Provide Service
Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service per week. *Examples of service delivery: Halfway house, group home or other supportive living environment (SLE) with 24-hour staff and close integration with clinical services.*	3.1	☐
Clinically Managed Population-Specific High-Intensity Residential Services: Note: This level of care not designated for adolescent populations. 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. *Examples: Therapeutic rehabilitation facility or traumatic brain injury program*	3.3	*See note below*
Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu and therapeutic community. *Examples: Therapeutic community of variable length of stay with appropriately clinically trained staff; or a residential treatment center.*	3.5	☐

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.*

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C. ASSESSMENT / TREATMENT PLAN

Check all that apply

13. Bio-psychosocial assessment incorporates six dimensions and used to confirm the appropriateness of placement. ☐
14. Treatment plan is developed in collaboration with the recipient and reviewed by an interdisciplinary team knowledgeable about addiction treatment. ☐
15. Individualized treatment plan reflects recipient's clinical progress. ☐
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. ☐
17. Program provides discharge follow up. ☐
18. Plan includes ongoing transition and continuing care planning. (*required for ASAM level 3.3*) ☐

D. SUPPORT SYSTEMS

Check all that apply

19. Physician and emergency service consultation in-person or telephone 24/7. ☐
20. Program has direct affiliation or close coordination with other levels of care programs. ☐

21. Please indicate whether services are available on-site or coordinated closely off-site, include description of off-site coordination process:

	On-Site	Off-Site	If Off-Site, Describe or attach additional documentation
Medical	☐	☐	
Psychiatric	☐	☐	
Laboratory	☐	☐	
Toxicology	☐	☐	
Pharmacotherapy	☐	☐	
Anti-addiction meds	☐	☐	

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E. STAFF REQUIREMENTS

Check all that apply

22. Allied health professional staff on-site 24/7 able to provide supportive services. ☐
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. ☐

    25a. 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*) ☐
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*) ☐
28. Clinical staff with ability to explain purposes of psychotropic medications and interactions with SUD. (*required for ASAM level 3.5*) ☐
29. Do you have affiliation with DEA waivered MD or APRN? (please provide provider information) ☐

    Provider Name: NPI:

    Contact Info:

    License: Other:

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Additional Staffing / Programming Information:

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

Program Clinician/Staff	Number of Staff	Individual Therapy	Group Therapy	Family Therapy	Educational Session	Other
Medical Doctor (MD)		☐	☐	☐	☐	☐
Advanced Practice Registered Nurse (APRN)		☐	☐	☐	☐	☐
Physician's Assistant (PA)		☐	☐	☐	☐	☐
Registered Nurse (RN)		☐	☐	☐	☐	☐
Psychiatrist (PSY)		☐	☐	☐	☐	☐
Licensed Psychological Practitioner (LPP)		☐	☐	☐	☐	☐
Certified Psychologist (CP)		☐	☐	☐	☐	☐
Licensed Clinical Social Worker (LCSW)		☐	☐	☐	☐	☐
Licensed Professional Clinical Counselor (LPCC)		☐	☐	☐	☐	☐
Licensed Marriage & Family Therapies (LMFT)		☐	☐	☐	☐	☐
Licensed Clinical Alcohol & Drug Counselor (LCADC)		☐	☐	☐	☐	☐
Licensed Psychological Associate (LPA)		☐	☐	☐	☐	☐
Certified Social Worker (CSW)		☐	☐	☐	☐	☐
Licensed Professional Counselor Associate (LPCA)		☐	☐	☐	☐	☐
Licensed Marriage & Family Therapist Associate (LMFTA)		☐	☐	☐	☐	☐
Licensed Clinical Alcohol & Drug Counselor Associate (LCADCA)		☐	☐	☐	☐	☐
Certified Alcohol & Drug Abuse Counselor (CADC)		☐	☐	☐	☐	☐
Peer Support Specialist (PSS)		☐	☐	☐	☐	☐
Targeted Case Management (TCM)		☐	☐	☐	☐	☐

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F.THERAPIES

Check all that apply

30. Planned clinical program activities at least 5 hours per week designed to stabilize SUD symptoms, maintenance and relapse prevention. ☐
31. Does this program provide withdrawal management services? (If yes, provide more information:) ☐
32. Do you offer Medication Assisted Treatment (MAT) on-site? (If no, explain how programs affiliates off-site) ☐
    Off-site information:
33. Motivational enhancements and engagement strategies appropriate to the individual's stage of readiness and desire to change. ☐
34. Program offers recovery support services. ☐
35. Regular monitoring of the recipient's medication adherence. ☐
36. Program offers services for patient's family and significant others. ☐
37. Family services designed to accommodate the cognitive limitation(s) frequently seen in this population. ☐
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*) ☐
39. Random drug screening as appropriate to the recipient's treatment plan. (*required by ASAM level 3.1 and above*) ☐
40. Program offers health educational services.(*required for ASAM level 3.1 and above*) ☐
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*) ☐
42. Program offers planned community reinforcement fostering community living skills. (*required by ASAM level 3.5*) ☐
43. Support system components include evidenced based clinical services. (*required by ASAM level 3.5*) ☐

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Check if attached	G. ATTACHMENTS
	List of attachments required with this request for provisional certification. Please keep the attestation and all attachments in order.

- ☐ Attachment 1: Linkage agreement(s) with off-site or affiliated agency/providers (if applicable)
- ☐ Attachment 2: Documentation supporting access to 24/7 emergency services
- ☐ Attachment 3: Detailed weekly program schedule
- ☐ Attachment 4: Weekly staffing schedule including staff credentials
- ☐ Attachment 5: Assessment Tool(s)
- ☐ Attachment 6: Example of Treatment Plan and Discharge Summary
- ☐ Attachment 7: Yearly staff education/training requirements
- ☐ Attachment 8: Certifications for Non-Licensed/Non-Credentialed staff
- ☐ Attachment 9: Policy for care coordination, discharge planning and referrals (if applicable)
- ☐ Attachment 10: Drug screening policy
- ☐ Attachment 11: Description of evidence-based practices/therapies utilized
- ☐ Attachment 12: Kentucky Alcohol and Other Drug Entity (AODE) Residential License

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I hereby certify that all information contained in this document and the supporting document is true and accurate. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreements that the facility has or may enter into with DMS and/or its contractors.

In compliance with the DMS Provisional Residential Certification/Attestation Form, the Facility attests that it will permit only staff members who are fully licensed and/or meet DMS program requirements to see and treat Medicaid eligible members.

I hereby give permission and consent for DMS and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to DMS and/or its contractors, of all information relevant to the evaluation of the facility's ability to render addiction recovery and treatment services in a cost-effective manner and agree to hold harmless any such person or organization from any cause or action based on the release of such information to DMS and/or its contractors.

By signing this attestation, I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement.

Printed Name: _____

Title: _____ **Phone (if different)** _____

Signature: _____ **Date:** _____