TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Emergency Regulation

Titles of Regulations: **12VAC30-10. State Plan under Title XIX of the Social Security Act Medical Assistance Program; General Provisions (amending 12VAC30-10-540).**

12VAC30-50. Amount, Duration, and Scope of Medical and Remedial Care Services (amending 12VAC30-50-130).

12VAC30-60. Standards Established and Methods Used to Assure High Quality Care (amending 12VAC30-60-5, 12VAC30-60-50, 12VAC30-60-61).

12VAC30-130. Amount, Duration and Scope of Selected Services (amending 12VAC30-130-3000; repealing 12VAC30-130-850, 12VAC30-130-860, 12VAC30-130-870, 12VAC30-130-880, 12VAC30-130-890, 12VAC30-130-3020).

Statutory Authority: § 32.1-325 of the Code of Virginia; 42 USC § 1396 et seq.

Effective Dates: July 1, 2017, through December 31, 2018.

Agency Contact: Emily McClellan, Regulatory Supervisor, Policy Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4300, FAX (804) 786-1680, or email emily.mcclellan@dmas.virginia.gov.

Preamble:

The psychiatric residential treatment service was implemented in 2001. The existing regulations are not adequate to ensure successful treatment outcomes are attained for the individuals who receive high cost high intensity residential treatment services. Since moving behavioral health services to Magellan (the DMAS behavioral health service administrator or BHSA) there has been enhanced supervision of these services. The enhanced supervision has led to an increased awareness of some safety challenges and administrative challenges in this high level of care. The proposed revisions will serve to better clarify policy interpretations that revise program standards to allow for more evidence-based service delivery, allow DMAS to implement more effective utilization management in collaboration with the BHSA, enhance individualized coordination of care, implement standardized coordination of individualized aftercare resources by ensuring access to medical and behavioral health service providers in the individual's home community, and support DMAS audit practices. The changes will move toward a service model that will reduce lengths of stay for and facilitate an evidence-based treatment approach to better support the individual's discharge into his home environment.

The emergency action, pursuant to § 2.2-4011 of the Code of Virginia, includes changes to the following areas: (i) provider qualifications including acceptable licensing standards, (ii) preadmission assessment requirements, (iii) program requirements, (iv) new discharge planning and care coordination requirements, and (iv) language enhancements for utilization review requirements to clarify program requirements and help providers avoid payment retractions. These changes are part of a review of the services to ensure that they are effectively delivered and utilized for individuals who meet the medical necessity criteria. For each individual seeking residential treatment their treatment needs will be assessed with enhanced requirements by the current independent certification teams who must coordinate clinical assessment information and assess local resources for each person requesting residential care to determine an appropriate level of care. The certification teams will also be more able to coordinate referrals for care to determine, in accordance with Department of Justice requirements, whether or not the individual seeking services can be safely served using community-based services in the least restrictive setting. Independent team certifications will be conducted prior to the onset of specified services, as required by Centers for Medicare and Medicaid Services guidelines, by the DMAS behavioral health services administrator.

The proposal includes changes to program requirements that ensure that effective levels of care coordination and discharge planning occurs for each individual during his residential stay by enhancing program rules and utilization management principles that facilitate effective discharge planning and establish community-based services prior to the individual's discharge from residential care. The

proposal requires enhanced care coordination to provide the necessary, objective evaluations of treatment progress and to facilitate evidence-based practices during the treatment to reduce the length of stay by ensuring that medical necessity indicates the correct level of care and that appropriate and effective care is delivered in a person-centered manner. The proposal requires that service providers and local systems will use standardized preadmission and discharge processes to ensure effective services are delivered.

This emergency action is in compliance with provisions of Item 301 OO and Item 301 PP of Chapter 665 of the 2015 Acts of Assembly, as follows:

Item 301 OO c 7, 8, 9, 14, 15, 16, 17, and 18 directed that DMAS shall develop a blueprint for a care coordination model for individuals in need of behavioral health services that includes the following principles:

"7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.

8. Builds upon current best practices in the delivery of behavioral health services.

9. Accounts for local services and reflects familiarity with the community where services are provided.

…

14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.

15. Simplifies the administration of acute psychiatric, community and mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.

16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.

17. Provides actionable data and feedback to providers.

18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers."

Item 301 OO d states:

"The department may seek the necessary waiver(s) or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model … This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this act."

Item 301 PP states:

"The Department of Medical Assistance Services shall make programmatic changes in the provision of Residential Treatment Facility (Level C) and Levels A and B residential services (group homes) for children with serious emotional disturbances in order [to] ensure appropriate utilization and cost efficiency. The department shall consider all available options including, but not limited to, prior authorization, utilization review and provider qualifications. The department shall have authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act."

In response to Item 301 OO c 14, DMAS is proposing new requirements to ensure that comprehensive discharge planning begins at admission to a therapeutic group home or residential treatment facility so that the individual can return to the community setting with appropriate supports at the soonest possible time.

DMAS is responding to the legislative mandates in Item 301 OO c 7 through 9, 14, and 15 by sunsetting the Virginia Independent Assessment Program (VICAP) regulation at 12VAC30-130-3020. The VICAP program is no longer needed, as the BHSA is now conducting thorough reviews of medical necessity for each requested service, and the funds allocated to the VICAP program can be more effectively used elsewhere.

DMAS is responding to the legislative mandates in Item 301 OO c 16 through 18 by creating a single point of contact at the BHSA for families and caregivers who will increase timely access to residential behavioral health services, promote effective service delivery, and decrease wait times for medical necessity and placement decisions that previously have been managed by local family assessment and planning teams (FAPT). The FAPTs are not DMAS-enrolled service providers, and the individuals who must use the FAPT process to gain access to Medicaid covered residential treatment are not subject to the established Medicaid grievance process and choice options as mandated by CMS. The enhanced interaction of the families and the BHSA will enable more thorough data collection to ensure freedom of choice in service providers, and to measure locality trends, service provider trends, and population trends to facilitate evidence-based decisions in both the clinical service delivery and administration of the program. The enhanced family interaction will enable the BHSA to complete individual family surveys and monitor care more effectively after discharge from services to assess the family and individual perspective on service delivery and enable DMAS to more effectively manage evidence-based residential treatment services.

Since 2001, when residential treatment services were implemented by DMAS, individuals have not had access to standardized methods of effective care coordination upon entry into residential treatment due to locality influence and DMAS reimbursement limitations. This has resulted in a fragmented coordination approach for these individuals who are at risk for high levels of care and remain at risk of repeated placements at this level of care. The residential treatment prior authorization and utilization management structures require an enhanced care coordination model to support the individuals who receive this level of service to ensure an effective return to the family or caregiver home environment with follow-up services to facilitate ongoing treatment progress in the least restrictive environment. The added coordination is required to navigate a very complex service environment for the individual as the individual returns to a community setting to establish an effective aftercare environment that involves service providers who may be contracted with a variety of entities such as DMAS contracted managed care organizations (MCOs), BHSA enrolled providers, the local FAPT, local school divisions, and the local community services board (CSB). This regulation will allow DMAS to implement a contracted care coordination team that will focus on attaining specific clinical outcomes for all residential care episodes and provide a new single liaison who will ensure coordination of care in a complex service environment for individuals upon discharge from residential treatment and prior to the time when they will enroll in an MCO. During this transition period the individual is very vulnerable to repeated admissions to residential or inpatient care and must also be supported in the fee for service (FFS) environment with resources from the local CSB and BHSA enrolled services providers and requires ongoing support and coordination with the local FAPT to provide aftercare services consisting of post-discharge follow-up and transition services provided by the BHSA coordination team.

The care coordination team will (i) provide increased standardization of preadmission assessment activity, (ii) provide facilitation of an effective independent certification team process, (iii) ensure that MCO and medical home resources are used to provide accurate psychosocial assessment and clinical/medical history to the certification team and BHSA, (iv) facilitate accurate authorization decisions and consider community-based service options prior to any out-of-home placement, (v) facilitate high levels of family involvement, (vi) provide aggressive discharge planning that ensures smooth transition into community-based services and MCO-funded health services, and (vii) provide meaningful, coordinated post-discharge follow-up for up to 90 days after discharge with the youth and family.

The residential care coordination team will ensure meaningful communication across all parts of the Comprehensive Services Act, Department of Behavioral Health and Developmental Services, MCO, and FFS service systems to maximize efficiency of activities, eliminate duplicative or conflicting efforts, and ensure established timelines are met (e.g., regular assessment of progress).

These enclosed proposed utilization control requirements are recommended consistent with the federal requirements at 42 CFR Part 456 Utilization Control. Specifically, 42 CFR 456.3, "Statewide surveillance and utilization control program" provides: "The Medicaid agency must implement a statewide surveillance and utilization control program that—

(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

(b) Assesses the quality of those services;

(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part, and

(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."

The Code of Federal Regulations also provides, at 42 CFR 430.10, "...The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program." FFP is the federal matching funds that DMAS receives from the Centers for Medicare and Medicaid Services. Not performing utilization control of the services affected by these proposed regulations, as well as all Medicaid covered services, could subject DMAS' federal matching funds to a CMS recovery action.

Purpose. This regulatory action is essential to protect the health, safety, or welfare of individuals with Medicaid who require behavioral health services. In addition, these proposed changes are intended to promote improved quality of Medicaid-covered behavioral health services provided to individuals.

This regulatory action is also essential to ensure that Medicaid individuals and their families are well informed about their behavioral health condition and service options prior to receiving these services. This ensures the services are medically necessary for the individual and are rendered by providers who use evidence-based treatment approaches.

While residential treatment is not a service that should be approved with great frequency for a large number of individuals, it is a service that should be accessible to the families and individuals who require that level of care. The current service model has significant operational layers that must be navigated to access residential services. The current program processes involve coordination of care by local FAPT teams who have, over time, demonstrated some influence on determining an individual's eligibility for FAPT funded services. The local influence on the program's administration causes limitations on individualized freedom of provider choice and inconsistent authorization of funding for persons deemed to need psychiatric care out of the home setting. This local administration of the primary referral source for residential treatment lies outside the purview of DMAS and this situation produces outcomes that are inadequate to meet CMS requirements on ensuring the individual freedom of choice of providers. In addition, local FAPT administrators do not enforce the Department of Justice settlement requirements in a uniform manner.

DMAS has added content to program requirements and covered services portions of the regulations to better clarify the benefit coverage and utilization criteria. The emergency regulations allow the use of additional information collection to better assess ways to reduce the average length of stay for individuals in residential care, and to better coordinate educational funding for those who require medically necessary services in a psychiatric treatment setting by using enhanced Medicaid supports.

The goal is that individuals receive the correct level of service at the correct time for the treatment (service) needs related to the individual's medical/psychiatric condition. Residential treatment services consist of behavioral health interventions and are intended to provide high intensity clinical treatment that should be provided for a short duration. Stakeholder feedback supported DMAS observations of lengthy durations of stay for many individuals. Residential treatment services will benefit from clarification of the service definition and eligibility requirements to ensure that residential treatment does not evolve into a long-term level of support instead of the high intensity psychiatric treatment modality that defines this level of care.

Substance. The sections of the State Plan for Medical Assistance that are affected by this action are 12VAC30-10-540 (Inspection of care in intermediate care facilities); 12VAC30-50-130 (Skilled nursing facility services, EPSDT, school health services, and family planning); 12VAC30-60-5 (Applicability of utilization review requirements); 12VAC30-60-50 (Utilization control: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD); 12VAC30-60-61 (Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children). The state-only regulations that are affected by this action are 12VAC30-130-850 through 12VAC30-130-890 (Part XIV - Residential Psychiatric Treatment for Children and Adolescents).

12VAC30-10-540. Inspection of care in intermediate care facilities for ~~the mentally retarded~~ persons with intellectual and developmental disabilities, facilities providing inpatient psychiatric services for individuals under 21, and mental hospitals.

All applicable requirements of 42 CFR 456, Subpart I, are met with respect to periodic inspections of care and services.~~*~~

~~Inpatient psychiatric services for individuals under age 21 are not provided under this plan.~~

~~*~~Inspection of ~~Care~~ care (IOC) in ~~Intermediate Care Facilities~~ intermediate care facilities for ~~the Mentally Retarded and Institutions for Mental Diseases are~~ persons with intellectual and developmental disabilities is completed through contractual arrangements with the Virginia Department of Health.

12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services, and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

B. Early and periodic screening ~~and,~~ diagnosis, and treatment (EPSDT) of individuals under 21 years of age, and treatment of conditions found - general provisions.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

~~5. Community~~ C. Early and periodic screening diagnosis and treatment (EPSDT) of individuals younger than 21 years of age - community mental health services. These services in order to be covered (i) shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and (ii) are reflected in provider records and on ~~providers'~~ provider claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

~~a.~~ 1. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

~~"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.~~

"Adolescent ~~or child~~" means the individual receiving the services described in this section. For the purpose of the use of ~~these terms~~ this term, adolescent means an individual 12-20 years of age~~; a child means an individual from birth up to 12 years of age~~.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

~~"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.~~

~~"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.~~

"Child" means the individual receiving the services described in this section; an individual from birth up to 12 years of age.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

~~"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.~~

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means ~~a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist~~ the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. ~~For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.~~

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. ~~For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.~~

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

~~"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 contemporaneously~~

~~dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.~~

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

~~"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.~~

"Qualified mental health professional-child" or "QMHP-C" means the same as the term is defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

~~"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.~~

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

~~b.~~ 2. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

~~(1) These services shall be limited annually to 26 weeks.~~ a. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

~~(2)~~ b. Service authorization shall be required for services to continue beyond the initial 26 weeks.

~~(3)~~ c. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

~~(4)~~ d. These services ~~may~~ shall only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

~~c.~~ 3. Therapeutic day treatment (TDT) shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units~~,~~ (a unit is defined in 12VAC30-60-61 D 11) provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family counseling.

~~(1)~~ a. Service authorization shall be required for Medicaid reimbursement.

~~(2)~~ b. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

~~(3)~~ c. These services ~~may~~ shall be rendered only by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E.

~~d. Community-based services for children and adolescents under 21 years of age (Level A).~~

~~(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.~~

~~(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.~~

~~(3) Individuals shall be discharged from this service when other less intensive services may achieve stabilization.~~

~~(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.~~

~~(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.~~

~~(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), or Regulations for Children's Residential Facilities (12VAC35-46).~~

~~(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.~~

~~(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.~~

~~(9) Service specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service specific provider intakes or ISPs shall be denied reimbursement. Requirements for intakes and ISPs are set out in 12VAC30-60-61.~~

~~(10) These services may only be rendered by an LMHP, LMHP supervisee, LMHP resident, LMHP-RP, a QMHP-C, a QMHP-E, or a QPPMH.~~

D. Early and periodic screening diagnosis and treatment (EPSDT) of individuals younger than 21 years of age - therapeutic group home services and residential treatment services.

1. Definitions. The following words and terms when used in this subsection shall have the following meanings:

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC. Each plan of care shall be designed to improve the individual's condition and to achieve the individual's safe discharge from residential care at the earliest possible time.

"Assessment" means a service conducted within seven calendar days of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S utilizing a tool or series of tools to provide a comprehensive evaluation and review of an individual's current mental health status in order to make recommendations; provide diagnosis; identify strengths, needs, and risk level; and describe the severity of symptoms.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a residential treatment facility are or were needed.

"Combined treatment services" means a structured, therapeutic milieu and planned interventions that promote (i) the development or restoration of adaptive functioning, self-care, and social skills; (ii) community integrated activities and community living skills that each individual requires to live in less restrictive environments; (iii) behavioral consultation; (iv) individual and group therapy; (v) recreation therapy, (vi) family education and family therapy; and (vii) individualized treatment planning.

"Comprehensive individual plan of care" or "CIPOC" means a person-centered plan of care that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation, often developing suddenly that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis.

"Daily supervision" means the supervision provided in a residential treatment facility through a resident-to-staff ratio approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services with documented supervision checks every 15 minutes throughout the 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a residential treatment facility or therapeutic group home with the goal of transitioning the individual out of the residential treatment facility or therapeutic group home to a less restrictive care setting with continued, clinically-appropriate, and possibly intensive, services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of the CIPOC and shall be approved by the BHSA.

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

"Emergency admissions" means those admissions that are made when, pending a review for the certificate of need, it appears that the individual is in need of an immediate admission to group home or residential treatment and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization, or acute psychiatric inpatient services.

"Emergency services" means unscheduled and sometimes scheduled crisis intervention, stabilization, acute psychiatric inpatient services, and referral assistance provided over the telephone or face-to-face if indicated, and available 24 hours a day, seven days per week.

"Family engagement" means a 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 children, youth, and families. Family engagement requires ongoing opportunities for an individual to build and maintain meaningful relationships with family members, for example, frequent, unscheduled, and noncontingent phone calls and visits between an individual and family members. Family engagement may also include enhancing or facilitating the development of the individual's relationship with other family members and supportive adults responsible for the individual's care and well-being upon discharge.

"Family engagement activity" means an intervention consisting of family psychoeducational training or coaching, transition planning with the family, family and independent living skills, and training on accessing community supports as identified in the IPOC and CIPOC. Family engagement activity does not include and is not the same as family therapy.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; has knowledge of the individual's situation; and is composed of at least one physician and one LMHP. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members.

"Individual" means the child or adolescent younger than 21 years of age who is receiving therapeutic group home or residential treatment facility services.

"Initial plan of care" or "IPOC" means a person-centered plan of care established at admission that meets all of the requirements of this subsection and is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; psychoeducational activities with specific topics focused to address individualized needs; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the youth's ability to acquire coping and functional or self-regulating behavior skills; day and overnight passes; and family engagement activities. Interventions shall not include individual, group, and family therapy, medical, or dental appointments, physician services, medication evaluation or management provided by a licensed clinician or physician and shall not include school attendance. Interventions shall be provided in the therapeutic group home or residential treatment facility and, when clinically necessary, in a community setting or as part of a therapeutic leave activity. All interventions and settings of the intervention shall be established in the CIPOC.

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in § 54.1-2900 of the Code of Virginia.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving, and increasing coping skills.

"Recertification" means a certification for each applicant or recipient for whom residential treatment facility services are needed.

"Residential case management" means providing care coordination, maintaining records, making calls, sending emails, compiling monthly reports, scheduling meetings, and performing other administrative tasks related to the individual. Residential case management is a component of the combined treatment services provided in a group home setting or residential treatment facility.

"Residential medical supervision" means around-the-clock nursing and medical care through onsite nurses and onsite or on-call physicians, as well as nurse and physician attendance at each treatment planning meeting. Residential medical supervision is a component of the combined treatment services provided in a congregate residential care facility and is included in the reimbursement for residential services.

"Residential supplemental therapies" means a specified minimum of daily interventions and other professional therapies. Residential supplemental therapies are a component of the combined treatment services provided in a congregate residential care facility and are included in the reimbursement for residential services. Residential providers shall not bill other payment sources in addition to DMAS for these covered services as part of a residential stay.

"Residential treatment facility" means the same as defined in 42 CFR 483.352 and is a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to

provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive inpatient treatment.

"Room and board" means a component of the total daily cost for placement in a licensed residential treatment facility. Residential room and board costs are maintenance costs associated with placement in a licensed residential treatment facility and include a semi-private room, three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for residential treatment settings.

"Therapeutic group home" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents.

"Therapeutic leave" and "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 LMHP responsible for the overall supervision of the CIPOC and documented in the CIPOC that facilitate or measure treatment progress, facilitate aftercare designed to promote family/community engagement, connection and permanency, and provide for goal-directed family engagement.

~~e.~~ 2. Therapeutic ~~behavioral~~ group home services ~~(Level B)~~.

~~(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual® Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.~~

a. Therapeutic group home services for children and adolescents younger than the age of 21 years are combined treatment services. The combination of therapeutic services rendered in a residential setting provides a therapeutic structure of daily psychoeducational activities, therapeutic supervision, behavioral modification, and mental health care to ensure the attainment of therapeutic goals. The therapeutic group home shall provide therapeutic services to restore, develop, or maintain appropriate skills necessary to promote prosocial behavior and healthy living to include the development of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills. Treatment for substance use disorders shall be addressed as clinically indicated. The program shall include individualized activities provided in accordance with the IPOC and CIPOC including a minimum of one intervention per 24-hour period in addition to individual, group, and family therapies. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the individual's deviations from the service plan. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation.

b. Medical necessity criteria for admission to a therapeutic group home. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission.

(1) Admission - severity of need. The following criteria shall be met to satisfy the criteria for severity of need:

(a) The individual's behavioral health condition can only be safely and effectively treated in a 24-hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school, and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The certificate of need must demonstrate all of the following: (i) ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community

do not meet the treatment needs of the individual; (ii) proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (iii) the services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

(c) An assessment that demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool must be completed. A moderate impairment is evidenced by, but not limited to (i) frequent conflict in the family setting such as credible threats of physical harm. "Frequent" is defined as more than expected for the individual's age and developmental level; (ii) frequent inability to accept age-appropriate direction and supervision from caretakers, from family members, at school, or in the home or community; (iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions; (iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community; (v) limited ability to consider the effect of one's inappropriate conduct on others; and (vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community-based services have been given a fully adequate trial and were unsuccessful or, if not attempted, have been considered, but in either situation were determined to be to be unable to meet the individual's treatment needs and the reasons for that are discussed in the application.

(e) The individual's symptoms, or the need for treatment in a 24 hours a day, seven days a week level of care (LOC), are not primarily due to any of the following: (i) intellectual disability, developmental disability, or autistic spectrum disorder; (ii) organic mental disorders, traumatic brain injury, or other medical condition; or (iii) the individual does not require a more intensive level of care.

(f) The individual does not require primary medical or surgical treatment.

(2) Admission - intensity and quality of service. All of the following criteria shall be met to satisfy the criteria for intensity and quality of service.

(a) The therapeutic group home service has been prescribed by a psychiatrist, psychologist, or other LMHP who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual

(b) Therapeutic group home is not being used for clinically inappropriate reasons, including: (i) an alternative to incarceration, and/or preventative detention; (ii) an alternative to parents', guardian's or agency's capacity to provide a place of residence for the individual; or, (iii) a treatment intervention, when other less restrictive alternatives are available.

(c) The individual's treatment goals are included in the service specific provider intake and include behaviorally defined objectives that require, and can reasonably be achieved within, a therapeutic group home setting.

(d) The therapeutic group home is required to coordinate with the individual's community resources, including schools, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.

(e) The therapeutic group home program must incorporate nationally established, evidence-based, trauma informed services and supports that promote recovery and resiliency.

(f) Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.

(3) Continued stay criteria. The following criteria shall be met in order to satisfy the criteria for continued stay:

(a) All of the admission guidelines continue to be met and this is supported by the written clinical documentation.

(b) The individual shall meet one of the following: (i) the desired outcome or level of functioning has not been restored or improved in the timeframe outlined in the individual's CIPOC or the individual

continues to be at risk for relapse based on history or (ii) the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization.

(c) The individual shall meet one of the following: (i) the individual has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care; (ii) the individual is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care; (iii) the individual is not making progress, and the CIPOC has been modified to identify more effective interventions; or (iv) there are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

(d) There is a written, up-to-date discharge plan that (i) identifies the custodial parent or custodial caregiver at discharge; (ii) identifies the school the individual will attend at discharge; (iii) includes individualized education program (IEP) recommendations, if necessary; (iv) outlines the aftercare treatment plan (discharge to another residential LOC is not an acceptable discharge goal); and (v) lists barriers to community reintegration and progress made on resolving these barriers since last review.

(e) The active treatment plan includes structure for daily activities, psychoeducation, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. In addition to the daily therapeutic residential services, the child/adolescent must also receive psychotherapy services, care coordination, family-based discharge planning, and locality-based transition activities. Intensive family interventions, with a recommended frequency of one family therapy session per week, although twice per month is minimally acceptable. Family involvement begins immediately upon admission to therapeutic group home. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented. Under certain circumstances an alternate plan, aimed at enhancing the individual's connections with other family members and/or supportive adults may be an appropriate substitute.

(f) Less restrictive treatment options have been considered, but cannot yet meet the individual's treatment needs. There is sufficient current clinical documentation/evidence to show that therapeutic group home LOC continues to be the least restrictive level of care that can meet the individual's mental health treatment needs.

(4) Discharge criteria are as follows:

(a) Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

(b) Reimbursement shall not be made for this level of care if any of the following applies: (i) the level of functioning has improved with respect to the goals outlined in the CIPOC and the individual can reasonably be expected to maintain these gains at a lower level of treatment or (ii) the individual no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 days.

c. The following clinical interventions shall be required for each therapeutic group home resident:

(1) Preadmission service-specific provider intake shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

(2) A face-to-face behavioral health assessment shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days prior to admission and shall document a DSM-5/ICD-10 diagnosis.

(3) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 4. Recertification shall occur at least every 60 days by a LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within their scope of practice.

(4) An initial plan of care shall be completed on the day of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual and a family member or legally authorized representative. The initial plan of care shall include all of the following:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Orders for medications, psychiatric, medical, dental, and any special health care needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, social services, community integration, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care; and

(g) Plans for discharge.

(5) The CIPOC shall be completed no later than 14 calendar days after admission and shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and shall reflect the need for therapeutic group home care;

(b) Be based on input from school, home, other health care providers, the individual, and the family or legal guardian;

(c) Shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

(e) Include a comprehensive discharge plan with necessary, clinically appropriate community services to ensure continuity of care upon discharge with the child's family, school, and community.

(6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or primary caregiver. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual or a family member or legally authorized representative. The review shall include all of the following:

(a) The individual's response to the services provided;

(b) Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions; and

(c) Determinations regarding whether the services being provided continue to be required.

(7) Crisis management, clinical assessment, and individualized therapy shall be provided as indicated in the IPOC and CIPOC to address intermittent crises and challenges within the group home setting or community settings as defined in the plan of care and to avoid a higher level of care.

(8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the individual as included in the IPOC and CIPOC.

(9) Weekly individual therapy shall be provided in the therapeutic group home, or other settings as appropriate for the individual's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61.

(10) Weekly (or more frequently if clinically indicated) group therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the IPOC or CIPOC.

(11) Family treatment shall be provided as clinically indicated, provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the IPOC or CIPOC.

(12) Family engagement activities shall be provided in addition to family therapy/counseling. Family engagement activities shall be provided at least weekly as outlined in the IPOC and CIPOC, and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the IPOC or CIPOC. For each service authorization period when family engagement is not possible, the therapeutic group home shall identify and document the specific

barriers to the individual's engagement with his family or legally authorized representatives. The therapeutic group home shall document on a weekly basis the reasons why family engagement is not occurring as required. The therapeutic group home shall document alternative family engagement strategies to be used as part of the interventions in the IPOC or CIPOC and request approval of the revised IPOC or CIPOC by DMAS or its contractor. When family engagement is not possible, the therapeutic group home shall collaborate with DMAS or its contractor on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the IPOC or CIPOC.

(13) Therapeutic passes shall be provided as clinically indicated and as paired with facility-based and community-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement activities. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating LMHP and documented in the CIPOC. Additional therapeutic leave passes shall require service authorization. Any unauthorized therapeutic leave passes shall result in retraction for those days of service.

(14) Discharge planning. Beginning at admission and continuing throughout the individual's stay at the therapeutic group home, the family or guardian, the community services board (CSB), the family assessment and planning team (FAPT) case manager, and either the managed care organization (MCO) or BHSA care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and available services in the community. Prior to discharge, the therapeutic group home shall submit an active and viable discharge plan to the BHSA for review. Once the BHSA approves the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The therapeutic group home shall request permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The therapeutic group home shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities have begun, shall establish that active transition planning has begun, shall establish that the individual has been enrolled in school, and shall provide IEP recommendations to the school if necessary. The therapeutic group home shall inform the BHSA of all scheduled appointments within 30 days of discharge and shall notify the BHSA within one business day of the individual's discharge date from the therapeutic group home.

~~(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.~~

~~(3)~~ (15) Room and board costs shall not be reimbursed. Facilities that only provide independent living services or nonclinical services that do not meet the requirements of this subsection are not ~~reimbursed~~ eligible for reimbursement. ~~DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.~~

~~(4) These residential~~ (16) Therapeutic group home services providers ~~must~~ shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

~~(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.~~

~~(6) The individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.~~

~~(7)~~ (17) Individuals shall be discharged from this service when treatment goals are met or other less intensive services may achieve stabilization.

~~(8) Service specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services.~~ (18) Services that are based upon incomplete, missing, or outdated service-specific provider intakes or ~~ISPs~~ CIPOCs shall be denied reimbursement. ~~Requirements for intakes and ISPs are set out in 12VAC30-60-61.~~

~~(9)These~~ (19) Therapeutic group home services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, a QMHP-E, or a ~~QPPMHI~~ qualified paraprofessional in mental health.

~~(10)~~ (20) The facility ~~/~~ or group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility ~~/~~ or group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, ~~and~~ what information was transmitted, and recommended next steps.

(21) Failure to perform any of the items described in this subsection shall result in a retraction of the per diem for each day of noncompliance.

~~6. Inpatient psychiatric~~ 3. Residential treatment facility services ~~shall~~ are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of an individual younger than the age of 21 years in order to prevent or minimize the need for more intensive inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for individuals younger than age 21 ~~for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:~~ these services shall (i) meet DMAS-approved psychiatric medical necessity criteria or be approved as an EPSDT service based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of his license and (ii) be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

~~a. A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or the Council on Quality and Leadership.~~

~~b. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of Part XIV (12VAC30-130-850 et seq.) of Amount, Duration and Scope of Selected Services.~~

~~c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with 42 CFR Part 441 Subpart D, as contained in 42 CFR 441.151 (a) and (b) and 441.152 through 441.156. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.~~

a. Residential treatment facility services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by:

(1) A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission; or a psychiatric facility that is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or the Council on Quality and Leadership. Providers of residential treatment facility services shall be licensed by DBHDS.

(2) Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12VAC30-50-100, 12VAC30-50-105, and 12VAC30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of 12VAC30-130 (Amount, Duration and Scope of Selected Services).

(3) Residential treatment facility services are reimbursable only when the treatment program is fully in compliance with (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 42 CFR 441.152 through 42 CFR 441.156 and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

b. Residential treatment facility services shall include assessment and re-assessment; room and board; daily supervision; combined treatment services; individual, family, and group therapy; residential care coordination; interventions; general or special education; medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing); specialty services; and discharge planning that meets the medical and clinical needs of the individual.

c. Medical necessity criteria for admission to a psychiatric residential treatment facility. The following requirements for severity of need and intensity and quality of service shall be met to satisfy the medical necessity criteria for admission:

(1) Admission - severity of need. The following criteria shall be met to satisfy the criteria for severity of need:

(a) There is clinical evidence that the patient has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either (i) there is clinical evidence that the individual would be a risk to self or others if he were not in a residential treatment program or (ii) as a result of the individual's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The individual requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to develop the adaptive and functional behavior that will allow him to live outside of a residential setting.

(e) The individual's current living environment does not provide the support and access to therapeutic services needed.

(f) The individual is medically stable and does not require the 24-hour medical or nursing monitoring or procedures provided in a hospital level of care.

(2) Admission - intensity and quality of service. The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

(b) The program provides supervision seven days per week, 24 hours per day to assist with the development of skills necessary for daily living; to assist with planning and arranging access to a range of educational, therapeutic, and aftercare services; and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes (i) at least once-a-week psychiatric reassessments; (ii) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible; (iii) psychotropic medications, when used, are to be used with specific target symptoms identified; (iv) evaluation for current medical problems; (v) evaluation for concomitant substance use issues; (vi) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his regular social environment as soon as possible, unless contraindicated. School contact should address an individualized educational plan as appropriate.

(d) A urine drug screen is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

(3) Criteria for continued stay. The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following: (i) the persistence of problems that caused the admission to a degree that continues to meet the admission

criteria (both severity of need and intensity of service needs); (ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs); (iii) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the patient can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the patient's ability to return to a less-intensive level of care.

(d) The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting the criteria in subdivision 3 c (3) (a) of this subsection, and this is documented in weekly progress notes written and signed by the provider.

(e) There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

(g) All applicable elements in admission-intensity and quality of service criteria are applied as related to assessment and treatment if clinically relevant and appropriate.

d. The following clinical activities shall be required for each residential treatment facility resident:

(1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RS, or LMHP-S within 30 days prior to admission and weekly thereafter and shall document a DSM-5/ICD-10 diagnosis.

(2) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 4. Recertification shall occur at least every 30 days by a physician acting within his scope of practice.

(3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The initial plan of care shall include:

(a) Individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

(b) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(c) A description of the functional level of the individual;

(d) Treatment objectives with short-term and long-term goals;

(e) Any orders for medications, psychiatric, medical, dental, and any special health care needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;

(f) Plans for continuing care, including review and modification to the plan of care;

(g) Plans for discharge; and

(h) Signature and date by the individual, parent, or legally authorized representative, a physician, and treatment team members.

(4) The CIPOC shall be completed no later than 14 calendar days after admission by the treatment team. The residential treatment facility shall request authorizations from families to release confidential information to collect information from medical and behavioral health treatment providers, schools, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for residential treatment facility care;

(b) Be developed by an interdisciplinary team of physicians and other personnel specified in this subdivision 3 d of this subsection who are employed by or provide services to the individual in the facility in consultation with the individual, family member, or legally authorized representative, or appropriate others into whose care the individual will be released after discharge;

(c) Shall state treatment objectives that shall include measurable, evidence-based, short-term and long-term goals and objectives; family engagement activities; and the design of community-based aftercare with target dates for achievement;

(d) Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the individual and family treatment needs; and

(e) 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.

(5) The CIPOC shall be reviewed every 30 calendar days by the team specified in this subdivision 3 d of this subsection to determine that services being provided are or were required from a residential treatment facility and to recommend changes in the plan as indicated by the individual's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the individual, parent, or legally authorized representative, a physician, and treatment team members.

(6) Individual therapy shall be provided three times per week (or more frequently based upon the individual's needs) provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the IPOC, CIPOC, and progress notes in accordance with the requirements in this subsection.

(7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the IPOC, CIPOC, and progress notes in accordance with the requirements in this subsection.

(8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in the IPOC, CIPOC, and progress notes in accordance with the individual and family or legally authorized representative's goals and the requirements in this subsection.

(9) Family engagement shall be provided in addition to family therapy/counseling. Family engagement shall be provided at least weekly as outlined in the IPOC and CIPOC, and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the IPOC and CIPOC. For each service authorization period when family engagement is not possible, the psychiatric residential treatment facility shall identify and document the specific barriers to the individual's engagement with his family or legally authorized representatives. The psychiatric residential treatment facility shall document on a weekly basis, the reasons that family engagement is not occurring as required. The psychiatric residential treatment facility shall document alternate family engagement strategies to be used as part of the interventions in the IPOC or CIPOC and request approval of the revised IPOC or CIPOC by DMAS or its contractor. When family engagement is not possible, the psychiatric residential treatment facility shall collaborate with DMAS or its contractor on a weekly basis to develop individualized family engagement strategies and document the revised strategies in the IPOC or CIPOC.

(10) Three interventions shall be provided per 24-hour period including nights and weekends. 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 IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation based on the needs of the individual.

(11) Therapeutic passes shall be provided as clinically indicated and as paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating physician and documented

in the CIPOC. Additional therapeutic leave passes shall require service authorization. Any unauthorized therapeutic leave passes shall result in retraction for those days of service.

(12) Discharge planning. Beginning at admission and continuing throughout the individual's placement at the residential treatment facility, the parent or legally authorized representative, the community services board (CSB), the family assessment planning team (FAPT) case manager, if appropriate, and either the managed care organization (MCO) or BHSA care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and identify the available services in the community. Prior to discharge, the residential treatment facility shall submit an active discharge plan to the BHSA for review. Once the BHSA approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The residential treatment facility shall request written permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The residential treatment facility shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the individual has been enrolled in school, and shall provide individualized education program (IEP) recommendations to the school if necessary. The residential treatment facility shall inform the BHSA of all scheduled appointments within 30 calendar days of discharge and shall notify the BHSA within one business day of the individual's discharge date from the residential treatment facility.

(13) Failure to perform any of the items as described in subdivisions 3 d (1) through 3 d (12) of this subsection up until the discharge of the individual shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of noncompliance.

e. The team developing the CIPOC shall meet the following requirements:

(1) At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child/adolescent psychiatry, the team must be capable of all of the following: assessing the individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the individual's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include either:

(a) A board-eligible or board-certified psychiatrist;

(b) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

(c) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed clinical psychologist.

(3) The team shall also include one of the following: an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

4. Requirements applicable to both therapeutic group homes and residential treatment facilities: independent certification teams.

a. The independent certification team shall certify the need for residential treatment or therapeutic group home services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with the BHSA.

b. The independent certification team shall be approved by DMAS through a memorandum of understanding with a locality or be approved under contractual agreement with the BHSA. The team shall initiate and coordinate referral to the family assessment and planning team (FAPT) as defined in §§ 2.2-5207 and 2.2-5208 of the Code of Virginia to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

d. The LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, as part of the independent certification team, shall meet with an individual and his parent or legally authorized representative within two business days from a request to assess the individual's needs and begin the process to certify the need for an out-of-home placement.

e. The independent certification team shall meet with an individual and his parent or legally authorized representative within 10 business days from a request to certify the need for an out-of-home placement.

f. The independent certification team shall assess the treatment needs of the individual to issue a certificate of need (CON) for the most appropriate medically-necessary services. The certification shall include the dated signature and credentials for each of the team members who rendered the certification. Referring or treatment providers shall not actively participate during the certification process but may provide supporting clinical documentation to the certification team.

g. The CON shall be effective for 30 calendar days prior to admission.

h. The independent certification team shall provide the completed CON to the facility within one calendar day of completing the CON.

i. The individual and his parent or legally authorized representative shall have the right to freedom of choice of service providers.

j. If the individual or his parent or legally authorized representative disagrees with the independent certification team's recommendation, the parent or legally authorized representative may appeal the recommendation in accordance with 12VAC30-110-10.

k. If the LMHP, as part of the independent certification team, determines that the individual is in immediate need of treatment, the LMHP shall refer the individual to an appropriate Medicaid-enrolled emergency services provider in accordance with 12VAC30-50-226 or shall refer the individual for emergency admission to a residential treatment facility or therapeutic group home under subdivision 4 m of this subsection, and shall also alert the individual's managed care organization.

l. For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP, including LMHP-S, LMHP-R, and LMHP-RP. An individual's parent or legally authorized representative shall be included in the certification process.

m. For emergency admissions, an assessment must be made by the team responsible for the comprehensive individual plan of care (CIPOC). Reimbursement shall only occur when a certificate of need is issued by the team responsible for the comprehensive individual plan of care within 14 days after admission. The certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid. After processing an emergency admission the residential treatment facility or institution for mental diseases (IMD) shall notify the BHSA of the individual's status as being under the care of the facility within five days.

n. For all individuals who apply and become eligible for Medicaid while an inpatient in a facility or program, the certification team shall refer the case to the DMAS-contracted BHSA for referral to the local FAPT to facilitate care coordination and consideration of educational coverage and other supports not covered by DMAS.

o. For individuals who apply and become eligible for Medicaid while an inpatient in the facility or program, the certification shall be made by the team responsible for the comprehensive individual plan of care and shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify the BHSA of the individual's status as being under the care of the facility within five days of the individual becoming eligible for Medicaid benefits.

5. Requirements applicable to both therapeutic group homes and residential treatment facilities - service authorization.

a. Authorization shall be required and shall be conducted by DMAS, its behavioral health services administrator, or its utilization management contractor using medical necessity criteria specified in this subsection.

b. An individual shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this subsection to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the individual will require a mental health evaluation by an LMHP employed or contracted with the independent certification team to establish a diagnosis, and recommend and coordinate referral to the available treatment options.

c. At authorization, an initial length of stay shall be agreed upon by the individual and parent or legally authorized representative with the treating provider, and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement, and obtaining authorization for continued stay.

d. Information that is required to obtain authorization for these services shall include:

(1) A completed state-designated uniform assessment instrument approved by DMAS;

(2) A certificate of need completed by an independent certification team specifying all of the following:

(a) The ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the individual;

(b) Alternative community-based care was not successful;

(c) Proper treatment of the individual's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

(d) The services can reasonably be expected to improve the individual's condition or prevent further regression so that a more intensive level of care will not be needed;

(3) Diagnosis as defined in the DSM-5 and based on (i) an evaluation by a psychiatrist or LMHP that has been completed within 30 days of admission or (ii) a diagnosis confirmed in writing by an LMHP after review of a previous evaluation completed within one year of admission;

(4) A description of the individual's behavior during the seven days immediately prior to admission;

(5) A description of alternate placements and community mental health and rehabilitation services and traditional behavioral health services pursued and attempted and the outcomes of each service.

(6) The individual's level of functioning and clinical stability.

(7) The level of family involvement and supports available.

(8) The initial plan of care (IPOC).

6. Requirements applicable to both therapeutic group homes and residential treatment facilities - continued stay criteria. For a continued stay authorization or a reauthorization to occur, the individual shall meet the medical necessity criteria as defined in this subsection to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS, the behavioral health services administrator, or the utilization management contractor. A current CIPOC and a current (within 30 days) summary of progress related to the goals and objectives of the CIPOC shall be submitted to DMAS, the behavioral health services administrator, or the utilization management contractor for continuation of the service. The service provider shall also submit:

a. A state uniform assessment instrument, completed no more than 30 business days prior to the date of submission;

b. Documentation that the required services have been provided as defined in the CIPOC;

c. Current (within the last 14 days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the individual's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

7. Requirements applicable to therapeutic group homes and residential treatment facilities - EPSDT services. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by DMAS, a DMAS contractor, or the BHSA. In unique EPSDT cases, DMAS, the DMAS contractor, or the BHSA may authorize specialized services beyond the standard therapeutic group home or residential treatment medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in inpatient settings, therapeutic group homes, and residential treatment facilities on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS, the DMAS contractor, or the BHSA. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT inpatient, residential treatment, or therapeutic group home service.

~~7.~~ 8. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

~~C.~~ E. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services.

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual or developmental disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D. Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

~~D.~~ F. Family planning services and supplies for individuals of child-bearing age.

1. Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility nor services to promote fertility.

12VAC30-60-5. Applicability of utilization review requirements.

A. These utilization requirements shall apply to all Medicaid covered services unless otherwise specified.

B. Some Medicaid covered services require an approved service authorization prior to service delivery in order for reimbursement to occur.

1. To obtain service authorization, all providers' information supplied to the Department of Medical Assistance Services (DMAS), service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records.

2. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered ~~unless specified otherwise~~.

C. DMAS, or its designee, shall perform reviews of the utilization of all Medicaid covered services pursuant to 42 CFR 440.260 and 42 CFR Part 456.

D. DMAS shall recover expenditures made for covered services when providers' documentation does not comport with standards specified in all applicable regulations.

E. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

F. Utilization review requirements specific to community mental health services, as set out in 12VAC30-50-130 and 12VAC30-50-226, shall be as follows:

1. To apply to be reimbursed as a Medicaid provider, the required Department of Behavioral Health and Developmental Services (DBHDS) license shall be either a full, annual, triennial, or conditional license. Providers must be enrolled with DMAS or the ~~BHSA~~ behavioral health services administrator (BHSA) to be reimbursed. Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

2. Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of community mental health services.

3. Payments shall not be permitted to health care entities that either hold provisional licenses or fail to enter into a Medicaid Provider Enrollment Agreement including a BHSA contract for a service prior to rendering that service.

4. The DMAS-contracted behavioral health ~~service authorization contractor~~ services administrator shall apply a national standardized set of medical necessity criteria in use in the industry~~, such as McKesson InterQual Criteria,~~ or an equivalent standard authorized in advance by DMAS. Services that fail to meet medical necessity criteria shall be denied service authorization.

5. For purposes of Medicaid reimbursement for services provided by staff in residency, the following terms shall be used after their signatures to indicate such status:

a. LMHP-Rs shall use the term "Resident" after their signatures.

b. LMHP-RPs shall use the term "Resident in Psychology" after their signatures.

c. LMHP-Ss shall use the term "Supervisee in Social Work" after their signatures.

12VAC30-60-50. Utilization control: Intermediate ~~Care Facilities~~ care facilities for ~~the Mentally Retarded (ICF/MR)~~ persons with intellectual and developmental disabilities and ~~Institutions~~ institutions for ~~Mental Disease~~ mental disease (IMD).

A. "Institution for mental disease" or "IMD" means the same as that term is defined in the Social Security Act, § 1905(i).

~~A.~~ B. With respect to each Medicaid-eligible resident in an ~~ICF/MR~~ intermediate care facility for persons with intellectual and developmental disabilities (ICF/ID) or IMD in Virginia, a written plan of care must be developed prior to admission to or authorization of benefits in such facility, and a regular program of independent professional review (including a medical evaluation) shall be completed periodically for such services. The purpose of the review is to determine: the adequacy of the services available to meet his current health needs and promote his maximum physical well being; the necessity and desirability of his continued placement in the facility; and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Long-term care of residents in such facilities will be provided in accordance with federal law that is based on the resident's medical and social needs and requirements.

~~B.~~ C. With respect to each ~~ICF/MR~~ ICF/ID or IMD, periodic ~~on-site~~ onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), shall be conducted. The review shall include, with respect to each recipient, a determination of the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, the necessity and desirability of continued placement in the facility, and the feasibility of meeting his health care needs through alternative institutional or noninstitutional services. Full reports shall be made to the state agency by the review team of the findings of each inspection, together with any recommendations.

~~C.~~ D. In order for reimbursement to be made to a facility for ~~the mentally retarded~~ persons with intellectual and developmental disabilities, the resident must meet criteria for placement in such facility as described in 12VAC30-60-360 and the facility must provide active treatment for ~~mental retardation~~ intellectual or developmental disabilities.

~~D.~~ E. In each case for which payment for nursing facility services for ~~the mentally retarded~~ persons with intellectual or developmental disabilities or institution for mental disease services is made under the State Plan:

1. ~~A physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease.~~ A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 5. Recertification shall occur at least every 60 days by a physician, or by a physician assistant or nurse practitioner acting within their scope of practice as defined by state law and under the supervision of a physician. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

2. A physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by state law and under the supervision of a physician, must recertify for each applicant at least every ~~365~~ 60 days that services are needed in a facility for ~~the mentally retarded~~ persons with intellectual disability or institution for mental disease.

~~E.~~ F. When a resident no longer meets criteria for facilities for ~~the mentally retarded~~ persons with intellectual or developmental disabilities, or an institution for mental disease or no longer requires active treatment in a facility for ~~the mentally retarded~~ persons with intellectual or developmental disabilities, then the resident ~~must~~ shall be discharged.

~~F.~~ G. All services provided in an ~~IMD and in an ICF/MR~~ ICF/ID shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

H. All services provided in an IMD shall be provided with the applicable provider agreement and all documents referenced therein.

I. Psychiatric services in IMDs shall only be covered for eligible individuals younger than 21 years of age.

J. IMD services provided without service authorization shall not be covered.

K. Absence of any of the required IMD documentation shall result in denial or retraction of reimbursement.

L. In each case for which payment for IMD services is made under the State Plan:

1. A physician shall certify at the time of admission, or at the time the IMD is notified of an individuals' retroactive eligibility status, that the individual requires or required inpatient services in an IMD consistent with 42 CFR 456.160.

2. The physician or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, shall recertify at least every 60 days that the individual continues to require inpatient services in an IMD.

3. Before admission to an IMD or before authorization for payment, the attending physician or staff physician shall perform a medical evaluation of the individual, and appropriate personnel shall complete a psychiatric and social evaluation as described in 42 CFR 456.170.

4. Before admission to a residential treatment facility or before authorization for payment, the attending physician or staff physician shall establish a written plan of care for each individual as described in 42 CFR 441.155 and 42 CFR 456.180.

M. It shall be documented that the individual requiring admission to an IMD is younger than 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an independent certification of need team review. Required documentation shall include the following:

1. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition 2013, American Psychiatric Association, and based on an evaluation by a psychiatrist completed within 30 days of admission or if the diagnosis is confirmed, in writing, by a previous evaluation completed within one year within admission.

2. A certification of the need for services as defined in 42 CFR 441.152 by an interdisciplinary team meeting the requirements of 42 CFR 441.153 or 42 CFR 441.156 and the Psychiatric Treatment of Minors Act (§ 16.1-335 et seq. of the Code of Virginia).

N. The use of seclusion and restraint in an IMD shall be in accordance with 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 DMAS or the BHSA within one calendar day of the incident.

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context indicates otherwise:

"At risk" means one or more of the following: (i) within the two weeks before the intake, the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of residential treatment facility ~~Level C~~ services, (b) transitioning out of a therapeutic group home ~~Level A or B services~~, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) therapeutic day treatment for children and adolescents, and (iii) therapeutic group homes. Experience shall not include unsupervised internships, unsupervised practicums, or unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled "Human Services and Related Fields Approved Degrees/Experience" issued March 12, 2013, revised May 3, 2013.

"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

"Individual" means the Medicaid-eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age or adolescents ages 12 through 20 years.

"New service" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.

"Out-of-home placement" means placement in one or more of the following: (i) ~~either a Level A or Level B~~ therapeutic group home; (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) ~~Level C~~ residential treatment facility; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"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 contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and individual-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress or lack of progress toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Service-specific provider intake" means the evaluation that is conducted according to the Department of Medical Assistance Services (DMAS) intake definition set out in 12VAC30-50-130.

B. The services described in this section shall be rendered consistent with the definitions, service limits, and requirements described in this section and in 12VAC30-50-130.

C. Intensive in-home (IIH) services for children and adolescents.

1. The service definition for intensive in-home (IIH) services is contained in 12VAC30-50-130.

2. Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis to be authorized for these services:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

3. Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the individual's residence. The service-specific provider intake shall describe how the individual's clinical needs put the individual at risk of out-of-home placement and shall be conducted face-to-face in the individual's residence. Claims for services that are based upon service-specific provider intakes that are incomplete, outdated (more than 12 months old), or missing shall not be reimbursed.

4. An individual service plan (ISP) shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and

individual's parent/guardian within 30 days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.

5. DMAS shall not reimburse for dates of services in which the progress notes are not individualized and child-specific. Duplicated progress notes shall not constitute the required child-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

6. Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family's residence with the individual present. As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP. For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

7. These services shall be provided when the clinical needs of the individual put him at risk for out-of-home placement, as these terms are defined in this section:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the individual in the family situation, or

b. When the individual's residence as the setting for services is more likely to be successful than a clinic.

The service-specific provider intake shall describe how the individual meets either subdivision a or b of this subdivision.

8. Services shall not be provided if the individual is no longer a resident of the home.

9. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The individual and responsible parent/guardian shall be available and in agreement to participate in the transition.

10. At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

11. The enrolled service provider shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of intensive in-home services. The provider shall also have a provider enrollment agreement with DMAS or its contractor in effect prior to the delivery of this service that indicates that the provider will offer intensive in-home services.

12. Services must only be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12VAC35-105-20.

13. The billing unit for intensive in-home service shall be one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per individual/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive or nonhome based services.

14. The ISP, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual. Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP. If there is a lapse

in 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. If the individual continues to need services, then a new intake/admission shall be documented and a new service authorization shall be required.

15. The provider shall ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

16. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the service provider shall contact the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the individual's status. A discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of the information in the electronic health records.

17. Emergency assistance shall be available 24 hours per day, seven days a week.

18. Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

19. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or guardian, shall inform him of the individual's receipt of IIH services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

D. Therapeutic day treatment for children and adolescents.

1. The service definition for therapeutic day treatment (TDT) for children and adolescents is contained in 12VAC30-50-130.

2. Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

a. Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.

b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

3. The service-specific provider intake shall document the individual's behavior and describe how the individual meets these specific service criteria in subdivision 2 of this subsection.

4. Prior to admission to this service, a service-specific provider intake shall be conducted by the LMHP as defined in 12VAC35-105-20.

5. An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the parent/guardian within 30 days of initiation of services and shall meet all requirements of an ISP as defined in 12VAC30-50-226. Individual progress notes shall be required for each contact with the individual and shall meet all of the requirements as defined in ~~12VAC30-50-130~~ 12VAC30-60-61.

6. Such services shall not duplicate those services provided by the school.

7. Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional

impairments in major life activities. Individuals shall meet at least two of the following criteria on a continuing or intermittent basis:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary.

c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

8. The enrolled provider of therapeutic day treatment for child and adolescent services shall be licensed by DBHDS to provide day support services. The provider shall also have a provider enrollment agreement in effect with DMAS prior to the delivery of this service that indicates that the provider offers therapeutic day treatment services for children and adolescents.

9. Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C or QMHP-E.

10. The minimum staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the individual identified on the ISP.

11. The program shall operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service shall be defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

12. Time required for academic instruction when no treatment activity is going on shall not be included in the billing unit.

13. Services shall be provided following a service-specific provider intake that is conducted by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. An LMHP, LMHP-supervisee, or LMHP-resident shall make and document the diagnosis. The service-specific provider intake shall include the elements as defined in 12VAC30-50-130.

14. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager and provide notification of the provision of services. In addition, the provider shall send monthly updates to the case manager on the individual's status. A discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. Service providers and case managers using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

15. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or parent/legal guardian, shall inform him of the child's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. The parent/legal guardian shall be required to give written consent that this provider has permission to inform the primary care provider of the child's or adolescent's receipt of community mental health rehabilitative services.

16. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

17. If there is a lapse in services greater than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, a new intake/admission documentation shall be prepared and a new service authorization shall be required.

~~E. Community-based services for children and adolescents under 21 years of age (Level A).~~

~~1. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 between 11 p.m. and 7 a.m. The program director supervising the program/group home must be, at minimum, a QMHP-C or QMHP-E (as defined in 12VAC35-105-20). The program director must be employed full time.~~

~~2. In order for Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home must meet DBHDS paraprofessional staff criteria, defined in 12VAC35-105-20.~~

~~3. Authorization is required for Medicaid reimbursement. All community-based services for children and adolescents under 21 (Level A) require authorization prior to reimbursement for these services. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.~~

~~4. Services must be provided in accordance with an individual service plan (ISP), which must be fully completed within 30 days of authorization for Medicaid reimbursement.~~

~~5. Prior to admission, a service specific provider intake shall be conducted according to DMAS specifications described in 12VAC30-50-130.~~

~~6. Such service specific provider intakes shall be performed by an LMHP, an LMHP supervisee, LMHP resident, or LMHP-RP.~~

~~7. If an individual receiving community based services for children and adolescents under 21 (Level A) is also receiving case management services, the provider shall collaborate with the case manager by notifying the case manager of the provision of Level A services and shall send monthly updates on the individual's progress. When the individual is discharged from Level A services, a discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for the delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.~~

~~F.~~ E. Therapeutic ~~behavioral services~~ group home for children and adolescents under 21 years of age ~~(Level B)~~.

1. The staff ratio must be ~~at least 1 to 4 during the day and at least 1 to 8 between 11 p.m. and 7 a.m.~~ approved by the Office of Licensure at the Department of Behavioral Health and Developmental Services. The clinical director ~~must~~ shall be a licensed mental health professional. The caseload of the clinical director must not exceed 16 individuals including all sites for which the same clinical director is responsible.

2. The program director ~~must~~ shall be full time and be a QMHP-C or QMHP-E with a bachelor's degree and at least one year's clinical experience.

3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the therapeutic group home shall meet DBHDS ~~paraprofessional staff~~ qualified paraprofessional in mental health (QPPMH) criteria, as defined in 12VAC35-105-20. The ~~program/group~~ therapeutic group home ~~must~~ shall coordinate services with other providers.

4. All therapeutic ~~behavioral~~ group home services ~~(Level B)~~ shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

5. Services must be provided in accordance with ~~an ISP~~ a CIPOC, as defined in 12VAC30-50-130, which shall be fully completed within 30 days of authorization for Medicaid reimbursement.

6. Prior to admission, a service-specific provider intake shall be performed using all elements specified by DMAS in 12VAC30-50-130.

7. Such service-specific provider intakes shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.

8. If an individual receiving therapeutic ~~behavioral~~ group home services for children and adolescents under 21 ~~(Level B)~~ is also receiving case management services, the therapeutic ~~behavioral~~ group home services provider must collaborate with the care coordinator/case manager by notifying him of the provision of ~~Level B~~ therapeutic group home services and the ~~Level B~~ therapeutic group home services provider shall send monthly updates on the individual's treatment status. ~~When the individual is discharged from Level B services, a discharge summary shall be sent to the care coordinator/case manager within 30 days of the discontinuation date.~~

9. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or ~~parent/legal guardian~~ parent or legally authorized representative, shall inform him of the individual's receipt of ~~these Level B~~ therapeutic group home services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. If these

individuals are children or adolescents, then the ~~parent/legal guardian~~ parent or legally authorized representative shall be required to give written consent that this provider has permission to inform the primary care provider of the individual's receipt of community mental health rehabilitative services.

~~G. Utilization review. Utilization reviews for community based therapeutic group home services for children and adolescents under 21 years of age (Level A) and therapeutic behavioral services for children and adolescents under 21 years of age (Level B) shall include determinations whether providers meet all DMAS requirements, including compliance with DMAS marketing requirements. Providers that DMAS determines have violated the DMAS marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.~~

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-60)

Department of Medical Assistance Services Provider Manuals (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals):

Virginia Medicaid Nursing Home Manual

Virginia Medicaid Rehabilitation Manual

Virginia Medicaid Hospice Manual

Virginia Medicaid School Division Manual

Development of Special Criteria for the Purposes of Pre-Admission Screening, Medicaid Memo, October 3, 2012, Department of Medical Assistance Services

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), copyright 2000, American Psychiatric Association

Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition, copyright 2001, American Society on Addiction Medicine, Inc.

Medicaid Special Memo, Subject: New Service Authorization Requirement for an Independent Clinical Assessment for Medicaid and FAMIS Children's Community Mental Health Rehabilitative Services, dated June 16, 2011, Department of Medical Assistance Services

Medicaid Special Memo, Subject: Changes to Children Community Mental Health Rehabilitative Services - Children's Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services

Medicaid Special Memo, Subject: Changes to Community Mental Health Rehabilitative Services - Adult-Oriented Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services

Human Services and Related Fields Approved Degrees/Experience, updated May 3, 2013, Department of Behavioral Health and Human Services

Part XIV
Residential Psychiatric Treatment for Children and Adolescents (Repealed)

12VAC30-130-850. ~~Definitions.~~ (Repealed.)

~~The following words and terms when used in this part shall have the following meanings, unless the context clearly indicates otherwise:~~

~~"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.~~

~~"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.~~

~~"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12VAC30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.~~

~~"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12VAC30-130-890.~~

~~"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.~~

~~"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.~~

12VAC30-130-860. Service coverage; eligible individuals; service certification. (Repealed.)

~~A. Residential treatment programs (Level C) shall be 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include, but shall not be limited to, assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child.~~

~~B. Residential treatment programs (Level C) shall provide a total, 24 hours per day, specialized form of highly organized, intensive and planned therapeutic interventions that shall be utilized to treat some of the most severe mental, emotional, and behavioral disorders. Residential treatment is a definitive therapeutic modality designed to deliver specified results for a defined group of problems for children or adolescents for whom outpatient day treatment or other less intrusive levels of care are not appropriate, and for whom a protected, structured milieu is medically necessary for an extended period of time.~~

~~C. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) and Community-Based Services for Children and Adolescents under 21 (Level A) must be therapeutic services rendered in a residential type setting such as a group home or program that provides structure for daily activities, psychoeducation, therapeutic supervision and mental health care to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child or adolescent must have a medical need for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities.~~

~~D. Active treatment shall be required. Residential Treatment, Therapeutic Behavioral and Community-Based Services for Children and Adolescents under age 21 shall be designed to serve the mental health needs of children. In order to be reimbursed for Residential Treatment (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community Based Services for Children and Adolescents under 21 (Level A), the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. These services do not include interventions and activities designed only to meet the supportive nonmental health special needs, including but not limited to personal care, habilitation or academic educational needs of the recipients.~~

~~E. An individual eligible for Residential Treatment Services (Level C) is a recipient under the age of 21 years whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of his psychiatric condition requires services on an inpatient basis under the direction of a physician.~~

~~An individual eligible for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a Licensed Mental Health Professional.~~

~~An individual eligible for Community Based Services for Children and Adolescents under 21 (Level A) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a qualified mental health professional. The services for all three levels can reasonably be expected to improve the child's or adolescent's condition or prevent regression so that the services will no longer be needed.~~

~~F. In order for Medicaid to reimburse for Residential Treatment (Level C), Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community Based Services for Children and Adolescents under 21 (Level A), the need for the service must be certified according to the standards and requirements set forth in subdivisions 1 and 2 of this subsection. At least one member of the independent certifying team must have pediatric mental health expertise.~~

1. For an individual who is already a Medicaid recipient when he is admitted to a facility or program, certification must:

a. Be made by an independent certifying team that includes a licensed physician who:

(1) Has competence in diagnosis and treatment of pediatric mental illness; and

(2) Has knowledge of the recipient's mental health history and current situation.

b. Be signed and dated by a physician and the team.

2. For a recipient who applies for Medicaid while an inpatient in the facility or program, the certification must:

a. Be made by the team responsible for the plan of care;

b. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

c. Be signed and dated by a physician and the team.

12VAC30-130-870. Preauthorization. (Repealed.)

A. Authorization for Residential Treatment (Level C) shall be required within 24 hours of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At preauthorization, an initial length of stay shall be assigned and the residential treatment provider shall be responsible for obtaining authorization for continued stay.

B. DMAS will not pay for admission to or continued stay in residential facilities (Level C) that were not authorized by DMAS.

C. Information that is required in order to obtain admission preauthorization for Medicaid payment shall include:

1. A completed state-designated uniform assessment instrument approved by the department.

2. A certification of the need for this service by the team described in 12VAC30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the recipient;

b. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will not be needed.

3. Additional required written documentation shall include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation, Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the seven days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12VAC30-130-890.

D. Continued stay criteria for Residential Treatment (Level C): information for continued stay authorization (Level C) for Medicaid payment must include:

1. A state uniform assessment instrument, completed no more than 90 days prior to the date of submission;

2. Documentation that the required services are provided as indicated;

3. Current (within the last 30 days) information on progress related to the achievement of treatment goals. The treatment goals must address the reasons for admission, including a description of any new symptoms amenable to treatment;

4. Description of continued impairment, problem behaviors, and need for Residential Treatment level of care.

E. Denial of service may be appealed by the recipient consistent with 12VAC30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

F. DMAS will not pay for services for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), and Community Based Services for Children and Adolescents under 21 (Level A) that are not prior authorized by DMAS.

G. Authorization for Level A and Level B residential treatment shall be required within three business days of admission. Authorization for services shall be based upon the medical necessity criteria described in 12VAC30-50-130. The authorized length of stay must not exceed six months and may be reauthorized. The provider shall be responsible for documenting the need for a continued stay and providing supporting documentation.

H. Information that is required in order to obtain admission authorization for Medicaid payment must include:

1. A current completed state-designated uniform assessment instrument approved by the department. The state-designated uniform assessment instrument must indicate at least two areas of moderate impairment for Level B and two areas of moderate impairment for Level A. A moderate impairment is evidenced by, but not limited to:

a. Frequent conflict in the family setting, for example, credible threats of physical harm.

b. Frequent inability to accept age appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

c. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

d. Impaired ability to form a trusting relationship with at least one caretaker in the home, school or community.

e. Limited ability to consider the effect of one's inappropriate conduct on others, interactions consistently involving conflict, which may include impulsive or abusive behaviors.

2. A certification of the need for the service by the team described in 12VAC30-130-860 that:

a. The ambulatory care resources available in the community do not meet the specific treatment needs of the child;

b. Proper treatment of the child's psychiatric condition requires services in a community based residential program; and

c. The services can reasonably be expected to improve the child's condition or prevent regression so that the services will not be needed.

3. Additional required written documentation must include all of the following:

a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, effective October 1, 1996), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation), Axis III (General Medical Conditions), Axis IV (Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

b. A description of the child's behavior during the 30 days immediately prior to admission;

c. A description of alternative placements tried or explored and the outcomes of each placement;

d. The child's functional level and clinical stability;

e. The level of family support available; and

f. The initial plan of care as defined and specified at 12VAC30-130-890.

I. Denial of service may be appealed by the child consistent with 12VAC30-110; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

J. Continued stay criteria for Levels A and B:

1. The length of the authorized stay shall be determined by DMAS or its contractor.

2. A current Individual Service Plan (ISP) (plan of care) and a current (within 30 days) summary of progress related to the goals and objectives on the ISP (plan of care) must be submitted for continuation of the service.

3. For reauthorization to occur, the desired outcome or level of functioning has not been restored or improved, over the time frame outlined in the child's ISP (plan of care) or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. Any one of the following must apply:

a. The child has achieved initial service plan (plan of care) goals but additional goals are indicated that cannot be met at a lower level of care.

b. The child is making satisfactory progress toward meeting goals but has not attained ISP goals, and the goals cannot be addressed at a lower level of care.

c. The child is not making progress, and the service plan (plan of care) has been modified to identify more effective interventions.

d. There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.

K. Discharge criteria for Levels A and B.

1. Reimbursement shall not be made for this level of care if either of the following applies:

a. The level of functioning has improved with respect to the goals outlined in the service plan (plan of care) and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

12VAC30-130-880. ~~Provider qualifications.~~ (Repealed.)

A. Providers must provide all Residential Treatment Services (Level C) as defined within this part and set forth in 42 CFR Part 441 Subpart D.

B. Providers of Residential Treatment Services (Level C) must be:

1. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

2. A residential treatment program for children and adolescents licensed by DMHMRSAS that is located in a psychiatric unit of an acute general hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. A psychiatric facility that is (i) accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Quality and Leadership in Supports for People with Disabilities, or the Council on Accreditation of Services for Families and Children and (ii) licensed by DMHMRSAS as a residential treatment program for children and adolescents.

C. Providers of Community Based Services for Children and Adolescents under 21 (Level A) must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

D. Providers of Therapeutic Behavioral Services (Level B) must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

12VAC30-130-890. ~~Plans of care; review of plans of care.~~ (Repealed.)

A. For Residential Treatment Services (Level C), an initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care (CIPOC) must be completed no later than 14 days after admission.

B. Initial plan of care (Level C) must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the recipient;

3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care;

6. Plans for discharge; and

7. Signature and date by the physician.

C. The CIPOC for Level C must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and must reflect the need for inpatient psychiatric care;

2. Be developed by an interdisciplinary team of physicians and other personnel specified under subsection F of this section, who are employed by, or provide services to, patients in the facility in consultation with the recipient and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;

3. State treatment objectives that must include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

5. Describe comprehensive discharge plans and coordination of inpatient services and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

D. Review of the CIPOC for Level C. The CIPOC must be reviewed every 30 days by the team specified in subsection F of this section to:

1. Determine that services being provided are or were required on an inpatient basis; and

2. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

E. The development and review of the plan of care for Level C as specified in this section satisfies the facility's utilization control requirements for recertification and establishment and periodic review of the plan of care, as required in 42 CFR 456.160 and 456.180.

F. Team developing the CIPOC for Level C. The following requirements must be met:

1. At least one member of the team must have expertise in pediatric mental health. Based on education and experience, preferably including competence in child psychiatry, the team must be capable of all of the following:

a. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

b. Assessing the potential resources of the recipient's family;

c. Setting treatment objectives; and

d. Prescribing therapeutic modalities to achieve the plan's objectives.

2. The team must include, at a minimum, either:

a. A board-eligible or board-certified psychiatrist;

b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

3. The team must also include one of the following:

a. A psychiatric social worker;

b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals;

c. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or

d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

G. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.

H. For Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), the initial plan of care must be completed at admission by the licensed mental health professional (LMHP) and a CIPOC must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

I. For Community Based Services for Children and Adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a CIPOC must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the program director.

J. Initial plan of care for Levels A and B must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the child;

3. Treatment objectives with short-term and long-term goals;

4. Any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and

6. Plans for discharge.

K. The CIPOC for Levels A and B must meet all of the following criteria:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;

2. The CIPOC for both levels must be based on input from school, home, other healthcare providers, the child and family (or legal guardian);

3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and

5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child's family, school, and community.

L. Review of the CIPOC for Levels A and B. The CIPOC must be reviewed, signed, and dated every 30 days by the QMHP for Level A and by the LMHP for Level B. The review must include:

1. The response to services provided;

2. Recommended changes in the plan as indicated by the child's overall response to the plan of care interventions; and

3. Determinations regarding whether the services being provided continue to be required.

Updates must be signed and dated by the service provider.

M. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement.

Part XVIII
Behavioral Health Services

12VAC30-130-3000. Behavioral health services.

A. Behavioral health services that shall be covered only for individuals from birth through 21 years of age are set out in 12VAC30-50-130 ~~B 5~~ and include~~:~~ (i) intensive in-home services (IIH), (ii) therapeutic day

treatment (TDT), (iii) ~~community-based services for children and adolescents (Level A)~~ therapeutic group homes, and (iv) ~~therapeutic behavioral services (Level B)~~ psychiatric residential treatment facilities.

B. Behavioral health services that shall be covered for individuals regardless of age are set out in 12VAC30-50-226 and include: (i) day treatment/partial hospitalization, (ii) psychosocial rehabilitation, (iii) crisis intervention, (iv) case management as set out in 12VAC30-50-420 and 12VAC30-50-430, (v) intensive community treatment (ICT), (vi) crisis stabilization services, and (vii) mental health support services (MHSS).

12VAC30-130-3020. Independent clinical assessment requirements; behavioral health level of care determinations and service eligibility. (Repealed.)

~~A. The independent clinical assessment (ICA), as set forth in the Virginia Independent Assessment Program (VICAP-001) form, shall contain the Medicaid individual-specific elements of information and data that shall be required for an individual younger than the age of 21 to be approved for intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) or any combination thereof. Eligibility requirements for IIH are in 12VAC30-50-130 B 5 b. Eligibility requirements for TDT are in 12VAC30-50-130 B 5 c. Eligibility requirements for MHSS are in 12VAC30-50-226 B 8.~~

~~1. The required elements in the ICA shall be specified in the VICAP form with either the BHSA or CSBs/BHAs and DMAS.~~

~~2. Service recommendations set out in the ICA shall not be subject to appeal.~~

~~B. Independent clinical assessment requirements.~~

~~1. Effective July 18, 2011, an ICA shall be required as a part of the service authorization process for Medicaid and Family Access to Medical Insurance Security (FAMIS) intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) for individuals up to the age of 21. This ICA shall be performed prior to the request for service authorization and initiation of treatment for individuals who are not currently receiving or authorized for services. The ICA shall be completed prior to the service provider conducting an intake or providing treatment.~~

~~a. Each individual shall have at least one ICA prior to the initiation of either IIH or TDT, or MHSS for individuals up to the age of 21.~~

~~b. For individuals who are already receiving IIH services or TDT, or MHSS, as of July 18, 2011, the requirement for a completed ICA shall be effective for service reauthorizations for dates of services on and after September 1, 2011.~~

~~c. Individuals who are being discharged from residential treatment (DMAS service Levels A, B, or C) or inpatient psychiatric hospitalization do not need an ICA prior to receiving community IIH services or TDT, or MHSS. They shall be required, however, to have an ICA as part of the first subsequent service reauthorization for IIH services, TDT, MHSS, or any combination thereof.~~

~~2. The ICA shall be completed and submitted to DMAS or its service authorization contractor by the independent assessor prior to the service provider submitting the service authorization or reauthorization request to the DMAS service authorization contractor. Failure to meet these requirements shall result in the provider's service authorization or reauthorization request being returned to the provider.~~

~~3. A copy of the ICA shall be retained in the service provider's individual's file.~~

~~4. If a service provider receives a request from parents or legal guardians to provide IIH services, TDT, or MHSS for individuals who are younger than 21 years of age, the service provider shall refer the parent or legal guardian to the BHSA or the local CSB/BHA to obtain the ICA prior to providing services.~~

~~a. In order to provide services, the service provider shall be required to conduct a service-specific provider intake as defined in 12VAC30-50-130.~~

~~b. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider shall submit a service authorization request to DMAS service authorization contractor. The service-specific provider's intake for IIH services, TDT, or MHSS shall not occur prior to the completion of the ICA by the BHSA or CSB/BHA, or its subcontractor.~~

c. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual's life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian.

d. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age.

e. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation in accordance with Part I (12VAC30-110-10 et seq.) In the alternative, the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically indicated, the service provider may submit the supplemental information with a service authorization request to the DMAS service authorization contractor. The DMAS service authorization contractor will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

5. If the individual is in immediate need of treatment, the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with 12VAC30-50-226 and shall also alert the individual's managed care organization.

C. Requirements for behavioral health services administrator and community services boards/behavioral health authorities.

1. When the BHSA, CSB, or BHA has been contacted by the parent or legal guardian, the ICA appointment shall be offered within five business days of a request for IIH services and within 10 business days for a request for TDT or MHSS, or both. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian.

2. The independent assessor shall conduct the ICA with the individual and the parent or legal guardian using the VICAP-001 form and make a recommendation for the most appropriate medically necessary services, if indicated. Referring or treating providers shall not be present during the assessment but may submit supporting clinical documentation to the assessor.

3. The ICA shall be effective for a 30-day period.

4. The independent assessor shall enter the findings of the ICA into the DMAS service authorization contractor's web portal within one business day of conducting the assessment. The independent clinical assessment form (VICAP-001) shall be completed by the independent assessor within three business days of completing the ICA.

D. The individual or his parent or legal guardian shall have the right to freedom of choice of service providers.

VA.R. Doc. No. R17-4495; Filed January 31, 2017, 4:07 p.m.