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12VAC30-50-130
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 of individuals under 21 years of age, and treatment of conditions found.

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 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' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.]

a. Definitions. The following words and terms when used in [~~these regulations~~ 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, 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 [~~pre-screener~~ prescreener]" means an employee of [~~either DMAS, a BHSA, or~~] 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 [~~,~~] ~~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 (Level A), and (iv) therapeutic behavioral services (Level B),~~ 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.]

"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 [~~, for the purpose of (i) intensive in-home, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents younger than 21 (Level A), and (iv) therapeutic behavioral services (Level B), social work, psychology, sociology, counseling, special education, human child or family development, cognitive or behavioral sciences, marriage and family therapy, or art or music therapy~~ 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 [~~the same as the term defined in 12VAC35-105-20~~ 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.

"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, [~~as~~ 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 [~~assessment"~~ 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 [~~assessment~~] 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].

~~a.~~ b. Intensive in-home services [(IIH)] to children and adolescents under age 21 shall be time-limited interventions provided [~~typically but not solely in the residence~~ 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 ~~a child~~ 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 ~~child~~ individual. These services provide crisis treatment; individual and family counseling; ~~and~~ communication skills (e.g., counseling to assist the ~~child~~ individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); ~~case management activities and~~ care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. ~~After an initial period, prior authorization is required for Medicaid reimbursement.~~ 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) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for service-specific provider [~~assessments~~ intakes] and ISPs are set out in [~~12VAC30-50-130~~ this section].

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

~~b.~~ c. 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, 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 [~~psychotherapy~~ counseling].

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

(2) Service-specific provider [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for service-specific provider [~~assessments~~ intakes] and ISPs are set out in [~~12VAC30-50-130~~ this section].

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

~~c.~~ 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. ~~DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.~~ 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 ~~a licensed mental health professional~~ an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP].

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

(4) Authorization ~~is~~ 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 ~~are~~ shall not be reimbursed. ~~Facilities that only provide independent living services are not reimbursed.~~ DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) ~~Providers~~ These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or ~~Department of Education~~ Department of Behavioral Health [and] Developmental Services under the Standards for ~~Interdepartmental Regulation of~~ 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 ~~(22VAC42-10)~~ (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, [~~and~~] 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 [~~assessments~~ 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 [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for [~~assessments~~ 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.~~ e. Therapeutic behavioral 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. ~~DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.~~ 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) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

(3) Room and board costs ~~are~~ shall not be reimbursed. Facilities that only provide independent living services are not reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(4) ~~Providers~~ These residential providers must be licensed by the Department of ~~Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)~~ Behavioral Health and Developmental Services (DBHDS) under the ~~Standards~~ Regulations for ~~Interdepartmental Regulation of~~ Children's Residential Facilities ~~(22VAC42-10)~~ (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 ~~child~~ individual must receive, at least weekly, individual psychotherapy and, at least weekly, group psychotherapy that is provided as part of the program.

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

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

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

(10) The facility/group home shall coordinate necessary services with other providers. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

6. Inpatient psychiatric services shall 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:

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 [~~this chapter~~ 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.

7. 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. 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 [~~mental retardation~~ intellectual 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. 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.

12VAC30-50-226
12VAC30-50-226. Community mental health services.

A. Definitions. The following words and terms when used in [~~these regulations~~ this section] shall have the following meanings unless the context clearly indicates otherwise:

"Certified prescreener" means an employee of either the local ~~community services board~~ community services board/behavioral health authority [~~, behavioral health service administrator~~] or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Clinical experience" means [~~, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, and (vi) crisis intervention services,~~] practical experience in providing direct services on a full-time basis [(or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013)] to individuals with medically-documented diagnoses of mental illness or ~~mental retardation~~ intellectual/developmental disability or the provision of direct geriatric services or full-time [(or the equivalent part-time experience)] special education services [, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, or (vi) crisis intervention services]. Experience ~~may~~ shall include supervised internships, supervised practicums, ~~and~~ or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. This required clinical experience shall be calculated as set forth in [~~12VAC35-105-20~~ DBHDS document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013].

"Code" means the Code of Virginia.

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

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

"Human services field" means [~~for the purpose of (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, and (vi) crisis intervention services,~~ social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, behavioral sciences, marriage and family therapy, art or music therapy, and human services counseling] ~~or other degrees deemed equivalent by DMAS~~ [the same as defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013].

"Individual" means the ~~patient,~~ client~~,~~ or recipient of services ~~set out herein~~ described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated ~~statement~~ treatment plan specific to the ~~individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and estimated timetable for achieving the goals and objectives. The provider shall include the individual in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated as the needs and progress of the individual changes.~~ individual's unique treatment needs as identified in the clinical assessment. The ISP contains his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The [individual shall be included in the development of the ISP and the] ISP shall be signed by the individual. If the individual is a [~~minor~~] child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a [~~minor~~] child [or an adult who lacks legal capacity], is unable or unwilling to sign the ISP.

"Licensed [~~Mental Health Professional"~~ mental health professional"] or "LMHP" means ~~an individual licensed in Virginia as a physician, a clinical psychologist, a professional counselor, a clinical social worker, or a psychiatric clinical nurse specialist~~ [~~the same as defined in 12VAC30-105-20~~ 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].

["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" is 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.]

~~"Qualified mental health professional" or "QMHP" means a clinician in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. If the QMHP is also one of the defined licensed mental health professionals, the QMHP may perform the services designated for the Licensed Mental Health Professionals unless it is specifically prohibited by their licenses. These QMHPs may be either a:~~

~~1. Physician who is a doctor of medicine or osteopathy and is licensed in Virginia;~~

~~2. Psychiatrist who is a doctor of medicine or osteopathy, specializing in psychiatry and is licensed in Virginia;~~

~~3. Psychologist who has a master's degree in psychology from an accredited college or university with at least one year of clinical experience;~~

~~4. Social worker who has a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education and has at least one year of clinical experience;~~

~~5. Registered nurse who is licensed as a registered nurse in the Commonwealth and has at least one year of clinical experience; or~~

~~6. Mental health worker who has at least:~~

~~a. A bachelor's degree in human services or a related field from an accredited college and who has at least one year of clinical experience;~~

~~b. Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as of January 1, 2001;~~

~~c. A bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field. The individual must also have three years clinical experience;~~

~~d. A bachelor's degree from an accredited college and certification by the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP);~~

~~e. A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field. The individual must also have three years clinical experience; or~~

~~f. Four years clinical experience.~~

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

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

["Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.]

"Qualified paraprofessional in mental health" or "QPPMH" means ~~an individual who meets at least one of the following criteria:~~ the same as defined in 12VAC35-105-20.

~~1. Registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as an Associate Psychiatric Rehabilitation Provider (APRP), as of January 1, 2001;~~

~~2. Has an associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness;~~

~~3. An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.~~

~~4. A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of clinical experience (including the 12 weeks of supervised experience).~~

~~5. College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience.~~

~~6. Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.~~

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving [~~either crisis stabilization or crisis intervention~~ services that do not require service authorization].

"Service authorization" means the [~~final determination of Medicaid reimbursement made by either DMAS or its , service authorization contractor for specified medical services for a specified individual to be rendered by a specified provider.~~ process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS

individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.]

B. Mental health services. The following services, with their definitions, shall be covered: day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health supports. Staff travel time shall not be included in billable time for reimbursement.

[1. These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services.

2. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities. All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

~~1.~~ 3.] Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

a. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that 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:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that ~~requires~~ the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented; or

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

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

e. These services may only be rendered by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, QMHP-C, [QMHP-E,] or a QPPMH.

[~~2.~~ 4.] Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

~~a.~~ (1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

~~b.~~ (2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

~~c.~~ (3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

~~d.~~ (4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

b. These services may only be rendered by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, QMHP-C, [QMHP-E,] or a QPPMH.

[~~3.~~ 5.] Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS or the BHSA [within one business day or the completion of the service-specific provider intake] to avoid duplication of services and to ensure informed care coordination. [~~This registration shall transmit to DMAS or its contractor: (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.~~]

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or

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

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

c. These services may only be rendered by an LMHP, [~~QMHP-A, or QMHP-C and an LMHP-supervisee, LMHP-resident, LMHP-RP, or~~] a certified [~~pre-screener~~ prescreener].

[~~4.~~ 6.] Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial service-specific provider [~~assessment with continuation~~ intake and may be] reauthorized for [up to] an additional 26 weeks annually based on written [~~assessment~~ intake] and certification of need by a [~~qualified~~ licensed] mental health provider [~~(QMHP)~~ (LMHP)], shall be defined [~~as~~ by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include] medical psychotherapy, psychiatric assessment, medication management, and ~~case management~~ care coordination activities offered to outpatients outside the clinic,

hospital, or office setting for individuals who are best served in the community. ~~The annual unit limit shall be 130 units with a unit equaling one hour.~~ Authorization is required for Medicaid reimbursement.

a. To qualify for ICT, the individual must meet at least one of the following criteria:

~~a.~~ (1) The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.

~~b.~~ (2) The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

~~(1) An~~ b. A written, service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services. This [~~assessment~~ intake] must be maintained in the individual's records.

~~(2) A service plan must~~ c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in [~~12VAC30-50-226~~ this section], within 30 days of the initiation of services.

d. The annual unit limit shall be 130 units with a unit equaling one hour.

e. These services may only be rendered by [~~an LMHP, QMHP-A, QMHP-C, and QPPMH~~ a team that meets the requirements of 12VAC35-105-1370].

[~~5.~~ 7.] Crisis stabilization services for nonhospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. ~~Authorization~~ Services may be authorized for up to a 15-day period per crisis episode following a ~~documented~~ face-to-face service-specific provider [~~assessment~~ intake] by [~~a~~] ~~QMHP which~~ [~~QMHP-A or QMHP-C that is reviewed and approved by~~] an LMHP [~~within 72 hours of the assessment~~, LMHP-supervisee, LMHP-resident, or LMHP-RP]. ~~The maximum limit on this service is up to eight hours (with a unit being one hour) per day up to 60 days annually.~~ Only one unit of service shall be reimbursed for this [~~assessment~~ intake]. The provision of this service to an individual shall be registered with either DMAS or the BHSA [within one calendar day of the completion of the service-specific provider intake] to avoid duplication of services and to ensure informed care coordination. [~~This registration shall transmit to DMAS or its contractor: (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. (~~See 12VAC30-50-226 B for registration requirements.]

a. The goals of crisis stabilization programs shall be to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

b. The crisis stabilization program shall provide to ~~recipients~~ individuals, as appropriate, psychiatric assessment including medication evaluation, treatment

planning, symptom and behavior management, and individual and group counseling.

c. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of ~~a recipient~~ an individual who lives with family or other primary caregiver; (ii) the home of ~~a recipient~~ an individual who lives independently; or (iii) community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

d. This service shall not be reimbursed for (i) ~~recipients~~ individuals with medical conditions that require hospital care; (ii) ~~recipients~~ individuals with primary diagnosis of substance abuse; or (iii) ~~recipients~~ individuals with psychiatric conditions that cannot be managed in the community (i.e., ~~recipients~~ individuals who are of imminent danger to themselves or others).

e. The maximum limit on this service is 60 days annually.

f. Services must be documented through daily [progress] notes and a daily log of times spent in the delivery of services. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

~~a.~~ (1) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

~~b.~~ (2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

~~c.~~ (3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or

~~d.~~ (4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

g. These services may only be rendered by an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, [~~or~~] QMHP-C [~~and~~, QMHP-E, or] a certified [~~pre-screener~~ prescreener].

[~~6.~~ 8.] Mental health support services (MHSS) shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized ~~for~~ up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider [~~assessment~~ intake], as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

a. Individuals qualifying for this service must demonstrate a clinical 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. Services are provided to individuals who without these services would be unable to remain in the community. The individual must ~~have~~ meet at least two of the following criteria on a continuing or intermittent basis:

(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization or homelessness or isolation from social supports;

(2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

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

b. The individual must demonstrate functional impairments in major life activities. This may include individuals with a dual diagnosis of either mental illness and [~~mental retardation~~ intellectual disability], or mental illness and substance abuse disorder.

c. Service-specific provider [~~assessments~~ intakes] shall be required at the onset of services and individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider [~~assessments~~ intakes] or ISPs shall be denied reimbursement. Requirements for provider-specific [~~assessments~~ intakes] and ISPs are set out in 12VAC30-50-130.

~~c.~~ d. The yearly limit for mental health support services is 372 units. One unit is [at least] one hour but less than three hours.

e. These services may only be rendered by an LMHP, [LMHP-supervisee, LMHP-resident,] QMHP-A, QMHP-C, [QMHP-E,] or QPPMH.

12VAC30-50-9999
[DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-50)

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

Length of Stay by Diagnosis and Operation, Southern Region, 1996, HCIA, Inc.

Guidelines for Perinatal Care, 4th Edition, August 1997, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists

Virginia Supplemental Drug Rebate Agreement Contract and Addenda

Office Reference Manual (Smiles for Children), prepared by DMAS' Dental Benefits Administrator, copyright 2005 (www.dmas.virginia.gov/downloads/pdfs/dental-office_reference_manual_06-09-05.pdf)

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

Virginia Medicaid Durable Medical Equipment and Supplies Provider Manual, Appendix B (rev. 1/11), Department of Medical Assistance Services

Human Services and Related Fields Approved Degrees/Experience, Department of Behavioral Health and Developmental Services (rev. 5/13)]

12VAC30-60-5
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 [~~456.1 et seq.~~ 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] 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 [~~who~~ that] either hold provisional licenses or [~~who~~] fail to enter into a Medicaid Provider Enrollment Agreement for a service prior to rendering that service.

[4. The behavioral health service authorization contractor 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.]

12VAC30-60-61
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 [~~after completion of~~ before] the [~~assessment~~ 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 [~~or~~ nor] consultant to the [~~IIH~~ 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 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.

"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 [~~is understood to mean~~ 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 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 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.

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

B. [~~These~~ 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.

~~A.~~ 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.

~~1.~~ 2. Individuals qualifying for this service ~~must~~ 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.

~~2. At~~ 3. Prior to admission, an appropriate service-specific provider [~~assessment~~ intake] ~~is made~~, as defined in 12VAC30-50-130, shall be conducted by the ~~LMHP or the QMHP and approved by the LMHP,~~ licensed mental health professional (LMHP), [~~as defined in 12VAC35-105-20,~~ LMHP-supervisee, LMHP-resident, or LMHP-RP,] documenting ~~that~~ the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the ~~client's~~ individual's residence. ~~An Individual Service Plan (ISP) must be fully completed within 30 days of initiation of services.~~ The service-specific provider [~~assessment~~ 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 [~~assessments~~ 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, [~~as defined in 12VAC35-105-20,~~ 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.

~~3.~~ 6. Services ~~must~~ shall be directed toward the treatment of the eligible ~~child~~ individual and delivered primarily in the family's residence with the ~~child~~ individual

present. ~~In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community if supported by the needs assessment and ISP.~~ [~~The assessment may be performed and~~ 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.

~~4.~~ 7. These services shall be provided when the clinical needs of the ~~child~~ individual put ~~the child~~ 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 ~~child~~ individual in the family situation, or

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

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

~~5. Services may not be billed when provided to a family while the child is not residing in the home.~~

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

~~6.~~ 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 ~~child~~ individual and responsible parent/guardian ~~must~~ shall be available and in agreement to participate in the transition.

~~7.~~ 10. At least one ~~parent~~ [~~parent/guardian~~ parent/legal guardian] or responsible adult with whom the ~~child~~ individual is living must be willing to participate in the intensive in-home services with the goal of keeping the ~~child~~ 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.]

~~8.~~ 11. The enrolled [service] provider ~~must~~ shall be licensed by the Department of ~~Mental Health, Mental Retardation and Substance Abuse Services~~ 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.

~~9.~~ 12. Services must only be provided by an LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or a, QMHP~~ [~~or~~] QMHP-C [~~as defined in~~, or QMHP-E.] ~~12VAC30-50-226~~ [~~12VAC35-105-20~~] Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in ~~12VAC30-50-226~~ 12VAC35-105-20.

~~10.~~ 13. The billing unit for intensive in-home service ~~is~~ 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 [~~a~~] ~~plan of care~~ [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 ~~client/family~~ 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 ~~client~~ individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans ~~must~~ shall incorporate ~~a~~ an individualized discharge plan ~~which identifies~~ 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 [~~assessment/admission~~ intake/admission] shall be documented and a new service authorization shall be required.

~~11.~~ 15. The provider ~~must~~ shall ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

~~12. Since case management services are an integral and inseparable part of this service, case management services may not be billed separately for periods of time when intensive in-home services are being provided.~~

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.]

~~13.~~ 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.

~~B.~~ 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.

~~1.~~ 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 [~~assessment~~ 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 [~~assessment~~ 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, [~~as defined in 12VAC35-105-20,~~ 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.

~~2.~~ 6. Such services ~~must~~ shall not duplicate those services provided by the school.

~~3.~~ 7. Individuals qualifying for this service ~~must~~ 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 ~~must~~ 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.

~~4.~~ 8. The enrolled provider of therapeutic day treatment for child and ~~adolescents~~ adolescent services ~~must~~ shall be licensed by ~~the Department of Mental Health, Mental Retardation and Substance Abuse Services~~ 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.

~~5.~~ 9. Services ~~must~~ shall be provided by an LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,]~~, a QMHP, or a QPPMH who is supervised by a QMHP or LMHP~~ [~~or~~] QMHP-C [~~as defined in 12VAC35-105-20,~~ or QMHP-E].

~~6.~~ 10. The minimum ~~staff-to-youth~~ staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the ~~youth~~ individual identified on the ISP.

~~7.~~ 11. The program ~~must~~ 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 ~~is~~ 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.

~~8.~~ 12. Time required for academic instruction when no treatment activity is going on ~~cannot~~ shall not be included in the billing unit.

~~9.~~ 13. Services shall be provided following a ~~diagnostic~~ service-specific provider [~~assessment~~ intake] that is ~~authorized~~ conducted by an LMHP [~~as defined in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP]. ~~Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.~~ An LMHP, [LMHP-supervisee, or LMHP-resident] shall make and document the diagnosis. The service-specific provider [~~assessment~~ intake] shall include the elements [~~specified in subsection A of this section~~ 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 [~~assessment/admission~~ intake/admission] documentation shall be prepared and a new service authorization shall be required.

~~C.~~ E. [~~Community-Based Services for Children and Adolescents~~ 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 ~~while asleep~~ between 11 p.m. and 7 a.m. The program director supervising the program/group home must be, at minimum, a ~~qualified mental health professional~~ QMHP-C [~~,~~ or QMPH-E] (as defined in 12VAC35-105-20). ~~with a bachelor's degree and have at least one year of direct work with mental health clients~~ The program director must be employed full time.

2. ~~At~~ In order for Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home must meet ~~DMAS~~ DBHDS paraprofessional staff criteria, defined in ~~12VAC30-50-226~~ 12VAC35-105-20.

3. Authorization is required for Medicaid reimbursement. ~~DMAS shall monitor the services rendered. All Community-Based Services for Children and Adolescents under 21 (Level A) must be authorized prior to reimbursement for these services. Services rendered without such authorization shall not be covered.~~ 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~~ individual service plan] (ISP) ~~(plan of care)~~, which must be fully completed within 30 days of authorization for Medicaid reimbursement.

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

6. Such service-specific provider [~~assessments~~ intakes] shall be performed by an LMHP [~~as defined in 12VAC35-105-20~~, 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.]

~~D.~~ F. Therapeutic [~~Behavioral Services for Children and Adolescents~~ behavioral services 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 ~~while asleep~~ between 11 p.m. and 7 a.m. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed 16 ~~clients~~ individuals including all sites for which the [same] clinical director is responsible. ~~The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.~~

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

~~2. At~~ 3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff ~~must~~ at the group home shall meet [~~DMAS~~ DBHDS] paraprofessional staff criteria, as defined in ~~12VAC30-50-226~~ 12VAC35-105-20. The program/group home must coordinate services with other providers.

~~3.~~ 4. All [~~Therapeutic Behavioral Services~~ therapeutic behavioral services] (Level B) ~~must~~ shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

~~4.~~ 5. Services must be provided in accordance with an ISP ~~(plan of care)~~, which ~~must~~ shall be fully completed within 30 days of authorization for Medicaid reimbursement.

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

7. Such service-specific provider [~~assessments~~ intakes] shall be performed by an LMHP [~~as defined in 12VAC35-105-20~~, an LMHP-supervisee, LMHP-resident, or LMHP-RP].

8. If an individual receiving therapeutic behavioral services for children and adolescents under 21 (Level B) is also receiving case management services, the therapeutic behavioral services provider must collaborate with the care coordinator/case manager by notifying him of the provision of Level B services and the Level B 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, shall] inform him of the individual's receipt of these Level B 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 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.]

~~E.~~ G. Utilization review. Utilization reviews for [~~Community-Based Services for Children and Adolescents~~ community-based services for children and adolescents] under 21 [years of age] (Level A) and [~~Therapeutic Behavioral Services for Children and Adolescents~~ 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 [~~violate~~ DMAS determines have violated] the DMAS marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

12VAC30-60-143
12VAC30-60-143. Mental health services utilization criteria; definitions.

A. This section sets out the utilization criteria and standards relative to the community mental health services set out in 12VAC30-50-226. [~~This section also contains definitions for the~~ The] following words and terms [~~which~~ when used in this section] shall have the following meanings unless the context indicates otherwise:

"Licensed mental health professional" or "LMHP" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130.

"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.

"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as defined in 12VAC30-50-130.]

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130].

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130].

["Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in [~~12VAC35-105-20~~ 12VAC30-50-130.]

~~A.~~ B. Utilization reviews shall include determinations that providers meet the following requirements:

1. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to the delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service that the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.

2. The provider shall document and maintain individual case records in accordance with state and federal requirements.

3. The provider shall ensure eligible ~~recipients~~ individuals have free choice of providers of mental health services and other medical care under the Individual Service Plan.

4. 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. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

5. If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. [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 this documentation into the electronic health record.]

6. The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

7. The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's

condition requires assistance for participation, assistance shall be provided. The ISP shall be updated annually or as the needs and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on the needs and progress of the individual [~~changes~~ change] shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete. All ISPs shall be completed, signed, and contemporaneously dated by the [LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A [~~or,~~] QMHP-C, [~~as defined in 12VAC35-105-20~~ or QMHP-E] preparing the ISP within a maximum of 30 days of the date of the completed [~~assessment~~ intake] unless otherwise specified. The [child's or adolescent's] ISP shall also be signed by the parent/legal guardian and [the adult] individual [shall sign his own]. [~~Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP.~~ If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual unable to sign the ISP.]

[~~C. Direct clinical services provided on a part-time basis will be reviewed by DMAS or its contractor based on the number of hours provided and counted based upon how many full-time (40 hours) weeks of service were provided.~~]

~~B.~~ [~~D.~~ C.] Day treatment/partial hospitalization services shall be provided following a ~~diagnostic~~ service-specific provider [~~assessment~~ intake] and be authorized by the ~~physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or licensed clinical nurse specialist-psychiatric~~ LMHP [~~as defined in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP]. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP [~~or~~, LMHP-supervisee, LMHP-resident, LMHP-RP,] the ~~QMHP~~ QMHP-A, [~~as defined~~ QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~at 12VAC30-50-226~~ [~~in 12VAC35-105-20,~~] within 30 days of service initiation.

1. The enrolled provider of day treatment/partial hospitalization shall be licensed by ~~DMHMRSAS~~ DBHDS as providers of day treatment services.

2. Services shall only be provided by an LMHP, [LMHP-supervisee, LMHP-resident, or LMHP-RP,] ~~a QMHP~~ QMHP-A, QMHP-C, [QMHP-E,] or a qualified paraprofessional under the supervision of a ~~QMHP~~ QMHP-A, QMHP-C, [QMHP-E,] or an LMHP [~~as defined at 12VAC30-50-226 in 12VAC35-105-20~~, LMHP-supervisee, LMHP-resident, or LMHP-RP].

3. The program shall operate a minimum of two continuous hours in a 24-hour period.

4. Individuals shall be discharged from this service when other less intensive services may achieve or maintain psychiatric stabilization.

~~C.~~ [~~E.~~ D.] Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

1. Psychosocial rehabilitation services shall be provided following ~~an~~ a service-specific provider [~~assessment which~~ intake that] clearly documents the need for

services. ~~The~~ This [~~assessment~~ intake that] shall be completed by either an LMHP~~, or a QMHP, and~~ [~~QMHP-A, or QMHP-C. If the service-specific provider assessment is done by a QMHP-A or a QMHP-C, it shall be approved by a an LMHP within 30~~ calendar days of admission to services LMHP-supervisee, LMHP-resident, or LMHP-RP]. An ISP shall be completed by either the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP,] or the ~~QMHP~~ QMHP-A, [QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP] within 30 calendar days of service initiation. ~~Every~~ At least every three months, the LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or~~ the ~~QMHP~~ QMHP-A, [~~or the~~] QMHP-C, [or QMHP-E] must review, modify as appropriate, and update the ISP.

2. Psychosocial rehabilitation services of any individual that continue more than six months ~~must~~ shall be reviewed by an LMHP, [LMHP-supervisee, LMHP-resident, or LMHP-RP] who ~~must~~ shall document the continued need for the service. The ISP shall be rewritten at least annually.

3. The enrolled provider of psychosocial rehabilitation services shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of psychosocial rehabilitation or clubhouse services.

4. Psychosocial rehabilitation services may be provided by [~~either~~] an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~a QMHP~~ QMHP-A, [~~or~~] QMHP-C, [QMHP-E,] or a qualified paraprofessional under the supervision of [~~either~~] a ~~QMHP~~ QMHP-A, a QMHP-C, [a QMHP-E,] or an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP].

5. The program shall operate a minimum of two continuous hours in a 24-hour period.

6. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the ~~client's~~ individual's understanding or ability to access community resources.

~~D. Admission to crisis~~ [~~F.~~ E.] Crisis intervention services ~~is~~ shall be indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.

1. The crisis intervention services provider shall be licensed as a provider of [~~outpatient services~~ emergency services] by ~~DMHMRSAS~~ DBHDS [pursuant to 12VAC35-105-30].

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An [~~Individual Service Plan~~ individual service plan] (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP ~~must~~ shall be developed or revised by the fourth face-to-face contact to reflect the short-term counseling goals ~~by the fourth face-to-face contact~~.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding

number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Travel by staff to provide out-of-clinic services ~~is~~ shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

7. An LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~a QMHP~~ [~~QMHP-A, QMHP-C,~~] or a certified prescreener [, as defined in 12VAC30-50-226,] ~~must~~ shall conduct a face-to-face service-specific provider [~~assessment~~ intake]. [~~If the QMHP QMHP-A or QMHP-C performs the service-specific provider assessment, it must be reviewed and approved by an LMHP or a certified prescreener within 72 hours of the face-to-face service-specific provider assessment. The service-specific provider assessment shall document the need for and the anticipated duration of the crisis service.~~] ~~Crisis intervention will be provided by an LMHP, a certified prescreener, or a QMHP.~~

8. Crisis intervention shall be provided by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP, or] a certified prescreener [~~, a QMHP-A, or a QMHP-C~~].

~~8.~~ [~~9. Crisis intervention shall not require an ISP.~~]

[9. ~~10.~~] For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. ~~Preadmission~~ These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met.

[10. ~~11.~~] Services ~~must~~ shall be documented through daily notes and a daily log of time spent in the delivery of services.

~~E.~~ [~~G.~~ F.] Case management services ~~(pursuant to 12VAC30-50-226)~~ pursuant to 12VAC30-50-420 (seriously mentally ill adults and emotionally disturbed children) or 12VAC30-50-430 (youth at risk of serious emotional disturbance).

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is ~~a plan of care~~ an ISP in effect ~~which~~ that requires regular direct or client-related contacts or activity or communication with the ~~client~~ individuals or families, significant others, service providers, and others including a minimum of one face-to-face ~~client~~ individual contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity, or communications occur.

2. The Medicaid eligible individual shall meet the ~~DMHMRSAS~~ DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.

4. The ISP ~~must~~ shall document the need for case management and be fully completed within 30 calendar days of initiation of the service~~, and the~~. The case

manager shall review the ISP at least every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall also be updated at least annually.

6. The provider of case management services shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of case management services.

~~F.~~ [~~H.~~ G.] Intensive community treatment (ICT) [~~for adults~~].

1. ~~An~~ A service-specific provider [~~assessment which~~ intake that] documents eligibility and the need for this service shall be completed by either the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~or the QMHP~~ [~~, QMHP-A, or the QMHP-C~~] prior to the initiation of services. This [~~assessment~~ intake] ~~must~~ shall be maintained in the individual's records. Proper completion of the service-specific provider [~~assessment~~ intake] shall comport with the requirements of 12VAC30-50-130.

2. An individual service plan, based on the needs as determined by the service-specific provider [~~assessment~~ intake], must be initiated at the time of admission and must be fully developed by either the LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP] ~~or the QMHP~~, QMHP-A, [~~or~~] QMHP-C, [or QMHP-E] and approved by the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] within 30 days of the initiation of services.

3. ICT may be billed if the ~~client~~ individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

4. The enrolled ICT provider shall be licensed by the ~~DMHMRSAS~~ DBHDS as a provider of intensive community services or as a program of assertive community treatment, and must provide and make available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on call.

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

~~G.~~ [~~I.~~ H.] Crisis stabilization services.

1. This service ~~must~~ shall be authorized following a face-to-face service-specific provider [~~assessment~~ intake] by either an LMHP, [LMHP-supervisee, LMHP-resident, LMHP-RP, or] a certified prescreener, [as defined in 12VAC30-50-226.] ~~or~~ [~~a~~] ~~QMHP~~ [~~QMHP-A, or QMHP-C This assessment must be reviewed and approved by a licensed mental health professional within 72 hours of the assessment.~~]

2. The service-specific provider [~~assessment~~ intake] must document the need for crisis stabilization services. [~~and anticipated duration of need~~]

3. The Individual Service Plan (ISP) must be developed or revised within ~~10 business days of the approved assessment or reassessment~~ [~~24 hours~~ three calendar days] of admission to this service. The LMHP, [LMHP-supervisee,

LMHP-resident, LMHP-RP,] certified prescreener, QMHP-A, [~~or~~] ~~QMHP~~ QMHP-C [, or QMHP-E] shall develop the ISP.

4. Room and board, custodial care, and general supervision are not components of this service.

5. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

6. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

7. Providers of [residential] crisis stabilization shall be licensed by ~~DMHMRSAS~~ DBHDS as providers of [~~outpatient services~~ mental health residential crisis stabilization]. [Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health nonresidential crisis stabilization.]

~~H.~~ [~~J.~~ I.] Mental health support services. Refer to 12VAC30-50-226 for criteria, service authorization requirements, and service-specific provider [~~assessments~~ intakes] that shall apply for individuals in order to qualify for this service.

1. ~~At~~ Prior to admission, an appropriate face-to-face service-specific provider [~~assessment~~ intake] must be ~~made~~ completed, signed, and dated, and documented by the LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] ~~or the QMHP~~ indicating that service needs can best be met through mental health support services. ~~The assessment must be performed by the LMHP or the QMHP and approved by the LMHP within 30 days of the date of admission. The LMHP or the QMHP will complete the ISP within 30 days of the admission to this service.~~

2. The ISP, ~~must~~ as defined in 12VAC30-50-226, shall be completed, signed, and dated by [either] a [LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP,] QMHP-A, [~~or~~] QMHP-C [, or QMHP-E] within 30 calendar days of service initiation, and shall indicate the specific supports and services to be provided and the goals and objectives to be accomplished. The LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] or ~~QMHP will~~ QMHP-A [, QMHP-C, or QMHP-E] shall supervise the care if delivered by the qualified paraprofessional. [If the care is supervised by the QMHP-A, QMHP-E, or QMHP-C, then the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP shall review and approve the supervision of the care delivered by the qualified paraprofessional.]

~~2.~~ 3. Every three months, the LMHP [, LMHP-supervisee, LMHP-resident, LMHP-RP,] ~~or the QMHP must~~ QMHP-A, [~~or~~] QMHP-C [, or QMHP-E] shall review, modify as appropriate, and update the ISP showing a new signature and date of each revision. [If the ISP review is conducted by the QMHP-A, QMHP-C, or QMHP-E, then it shall be reviewed/approved/signed/dated by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.] The ISP ~~must~~ shall be rewritten, signed, and dated by either a QMHP-A, QMHP-C, [~~or~~ QMHP-E,] an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] at least annually.

~~3.~~ 4. Only direct face-to-face contacts and services to individuals shall be reimbursable.

~~4.~~ 5. Any services provided to the ~~client~~ individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic

educational programs as instruction in reading, science, mathematics, or the individual's work towards obtaining a GED.

~~5.~~ 6. Any services provided to ~~clients~~ individuals that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting ~~a client~~ an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

~~6.~~ 7. Room and board, custodial care, and general supervision are not components of this service.

~~7.~~ 8. This service is not billable for individuals who reside in facilities where staff are expected to provide such services under facility licensure requirements.

~~8.~~ 9. Provider qualifications. The enrolled provider of mental health support services ~~must~~ shall be licensed by ~~DMHMRSAS~~ DBHDS as a provider of supportive in-home services, intensive community treatment, or as a program of assertive community treatment. Individuals employed or contracted by the provider to provide mental health support services ~~must~~ shall have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.

~~9.~~ 10. Mental health support services, which continue for six consecutive months, ~~must~~ shall be reviewed and renewed at the end of the six-month period of authorization by an LMHP [, LMHP-supervisee, LMHP-resident, or LMHP-RP] who ~~must~~ shall document the continued need for the services.

~~10.~~ 11. Mental health support services ~~must~~ shall be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.

12VAC30-60-9999
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

12VAC30-130-2000
Part XVII
Marketing of Provider Services

12VAC30-130-2000. Marketing requirements and restrictions.

A. Purpose. The purpose of these rules shall be to define how providers shall be permitted to market their services to potential Medicaid or FAMIS beneficiaries and individuals who may or may not be currently enrolled with the particular provider. This shall apply to providers of community mental health services (12VAC30-50-226) and Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) community mental health services (12VAC30-50-130) with the exception of Part C services.

B. Definitions.

"Beneficiaries" means individuals of any age and their families who are using or who may use community mental health rehabilitative services.

"DMAS" means the Department of Medical Assistance Services.

"FAMIS" means Family Access to Medical Insurance Security.

["Marketing materials" means any material created to promote services through any media including, but not limited to, written materials, television, radio, websites, and social media.]

"Provider" means an individual or organizational entity that is appropriately licensed as required and enrolled as a DMAS provider of community mental health and substance abuse services.

C. Requirements.

1. Marketing and promotional activities (including provider promotional activities) shall comply with all [~~relevant~~ applicable] federal and state laws.

2. Providers shall provide clearly written materials that completely and accurately describe the Medicaid or FAMIS behavioral health service or services offered, the beneficiary eligibility requirements to receive the service or services, applicable fees and other charges, and all other information required for beneficiaries and their families to make fully informed decisions about enrollment into the service or services offered by the provider that is marketing its services.

3. Providers shall distribute their marketing materials only in the service locations approved within the license issued by the Licensing Division of the Department of Behavioral Health and Developmental Services.

4. Providers shall receive DMAS approval of all marketing materials and all changes to prior-approved marketing materials prior to their use or dissemination. Providers shall receive the DMAS marketing plan approval before engaging in any marketing activity.

a. Within 30 calendar days of receipt of providers' submissions, DMAS shall review submitted individual marketing materials and services and either approve them or deny their use or direct that specified modifications be made.

b. Providers failing to implement DMAS' required changes, or those which use [unapproved or] disapproved materials, shall be subject to termination of the provider agreement pursuant to 12VAC30-130-2000 E.

D. Limits and prohibitions.

1. Providers shall not offer cash or [~~other~~] noncash incentives to their enrolled or prospective members for the purposes of marketing, retaining beneficiaries within the providers' services, or rewarding behavior changes in compliance with goals and objectives stated in beneficiaries' individual service plans.

2. While engaging in marketing activities, providers shall not:

a. Engage in any marketing activities that could misrepresent the service or DMAS;

b. Assert or state that the beneficiary must enroll with the provider in order to prevent the loss of Medicaid or FAMIS benefits;

c. Conduct door-to-door, telephone, unsolicited school presentations, or other cold call marketing directed at potential or current beneficiaries;

d. Conduct any marketing activities or use marketing materials that are not specifically approved by DMAS;

e. Make home visits for direct or indirect marketing or enrollment activities except when specifically requested by the beneficiary or family;

f. Collect or use Medicaid or FAMIS confidential information or Medicaid or FAMIS protected health information (PHI), as that term is defined in Health Insurance Portability and Accountability Act of 1996 (HIPAA), that may be either provided by another entity or obtained by marketing provider, to identify and market services to prospective beneficiaries;

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about beneficiaries for any purposes other than the performance of the provider's obligations relative to its DMAS provider agreement;

h. Contact, after the effective date of disenrollment, beneficiaries who choose to disenroll from the provider except as may be specifically required by DMAS;

i. Conduct service assessment or enrollment activities at any marketing or community event; or

j. Assert or state (either orally or in writing) that the provider is endorsed either by the Centers for Medicare and Medicaid Services, DMAS, or any other federal or state governmental entities.

E. Termination. Providers [~~who~~ that (i)] conduct any marketing activity that is not specifically approved by DMAS [~~or who~~, (ii)] violate any of the [~~above~~] prohibitions [in this section,] or [(iii) fail to meet] requirements shall be subject to termination of their provider agreements for the services affected by the marketing plan/activity. [Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).]

12VAC30-130-3000

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), and (iv) therapeutic behavioral services (Level B).

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).

12VAC30-130-3010
12VAC30-130-3010. Definitions.

The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

"Behavioral health authority" or "BHA" means the local agency that administers services set out in § 37.2-601 of the Code of Virginia.

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

"Community services board" or "CSB" means the local agency that administers services set out in § 37.2-500 of the Code of Virginia.

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

"DMAS" means the Department of Medical Assistance Services.

"Independent assessor" means a professional who performs the independent clinical assessment who may be employed by either the behavioral health services administrator, community services boards/behavioral health authorities (CSBs/BHAs) or their subcontractors.

"Independent clinical assessment" or "ICA" means the assessment that is performed under contract with DMAS either by the behavioral health services administrator or the CSB/BHA, or its subcontractor, prior to the initiation of (i) intensive in-home (IIH) services or therapeutic day treatment (TDT) as set out in 12VAC30-50-130 and (ii) mental health support services (MHSS) for children and adolescents (MHSS) as set out in 12VAC30-50-226.

"VICAP" means the form entitled Virginia Independent Clinical Assessment Program that is required to record an individual's independent clinical assessment information.

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

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 [~~assessment~~ 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 [~~assessment~~ 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 [~~assessment~~ 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 [~~assessment~~ 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 [~~the appeals process~~ 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.

12VAC30-130-3030
12VAC30-130-3030. Application to services.

A. Intensive in-home (IIH) services.

1. Prior to the provision of IIH services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is either employed by or contracted with a behavioral health services administrator (BHSA), community services board (CSB), behavioral health authority (BHA), or a subcontractor to the BHSA, CSB, or BHA in accordance with DMAS approval.

2. IIH services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.

B. Therapeutic day treatment (TDT) [services].

1. Prior to the provision of TDT services, an independent clinical assessment shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB, BHA, or the subcontractor of the BHSA, CSB, or BHA in accordance with DMAS approval.

2. TDT services that are rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.

C. Mental health support services (MHSS).

1. Prior to the provision of MHSS, an independent clinical assessment, as defined in 12VAC30-130-3010, shall be conducted by a person who meets the licensed mental health professional definition found at 12VAC35-105-20 and who is employed by or contracted with a BHSA, CSB or BHA, or a subcontractor of a BHSA, CSB, or BHA in accordance with DMAS approval.

2. MHSS rendered in the absence of the required prior independent clinical assessment shall not be reimbursed.

[D. Other Medicaid-covered community mental health services. DMAS may apply the independent clinical assessment requirement to any of the other Medicaid-covered community mental health services set out in 12VAC30-50-130 and 12VAC30-50-226 with appropriate and timely notice to providers. In such situations, DMAS shall not deny coverage to providers' claims for these affected services absent at least a 30-day notice of this change.]

12VAC30-130-9998
FORMS (12VAC30-130)

Forms accompanying Part II of this chapter:

Virginia Uniform Assessment Instrument

Forms accompanying Part III of this chapter:

MI/MR Supplement Level I (form and instructions)

MI/MR Supplement Level II.

Forms accompanying Part VII of this chapter:

Request for Hospice Benefits DMAS-420, Revised 5/91

Forms accompanying Part VIII of this chapter:

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986

Forms accompanying Part IX of this chapter:

Patient Information form

Instructions for Completion DMAS-122 form

Forms accompanying Part XII of this chapter:

Health Insurance Premium Payment (HIPP) Program Insurance Information Request Form

Health Insurance Premium Payment (HIPP) Program Medical History Form (HIPP Form-7, Rev. 11/92).

Health Insurance Premium Payment (HIPP) Program Employers Insurance Verification Form (HIPP Form-2, Rev. 11/92)

Health Insurance Premium Payment (HIPP) Program Employer Agreement (HIPP Form-3, Rev. 11/92)

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Determination (HIPP Form-4, Rev. 11/92)

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Approval

Health Insurance Premium Payment (HIPP) Program Notice of HIPP Status (HIPP Form-6, Rev. 11/92)

Inventory for Client and Agency Planning (ICAP) Response Booklet, D9200/D9210, 1986

Forms accompanying Part XIV of this chapter:

Residential Psychiatric Treatment for Children and Adolescents, FH/REV (eff. 10/99)

Forms accompanying Part XV of this chapter:

Treatment Foster Care Case Management Agreement, TFC CM Provider Agreement DMAS-345, FH/REV (eff. 10/99)

Forms accompanying Part XVIII of this chapter:

Virginia Independent Clinical Assessment Program (VICAP) (eff. 6/11)