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CHAPTER IV

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CHAPTEIR IV
COVERED SERVICES AND LIMITATIONS

The Virginia Medicaid Program covers a variety of psychiatric services for eligible individuals. This chapter describes these services and the requirements for the provision of them. Contents of the chapter are organized under the following main headings:

- Inpatient Psychiatric Services
- Treatment Foster Care - Case Management (TFC-CM)
- Outpatient Psychiatric Services

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

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

GENERAL INFORMATION

The Virginia Medicaid Program covers a variety of behavioral health treatment services under the Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitation and Psychiatric Services benefits for eligible members. This chapter describes these services and the requirements for the provision of psychiatric residential treatment and therapeutic group home services.

All psychiatric residential treatment facility and therapeutic group home providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the MCOs, MMPs and the BHSA and state and federal regulations.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at: https://www.magellanprovider.com/MagellanProvider.

COMMONWEALTH COORDINATED CARE PLUS (CCC Plus) PROGRAM

CCC Plus is a managed long term services and supports (LTSS) program. This mandatory Medicaid managed care program will serve individuals with disabilities and complex care needs.

Target Population –
1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible), including members enrolled in Commonwealth Coordinated Care (CCC). CCC members will transition as of January 1, 2018.

2. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver except Alzheimer's Assisted Living waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for-service.

3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program. Medallion ABD members who are not enrolled in the CCC Plus Waiver (per 2 above) will transition as of January 1, 2018.

This section relates only to individuals enrolled in CCC Plus Managed Care Program:

CCC Plus Managed Care Program enrollment status does not change the assessment and certification process for individuals seeking residential treatment services. All Independent Assessment, Certification and Coordination Teams (IACCT) teams will complete the independent certification process as described in this chapter.

Therapeutic Group Home (TGH) Services – If an individual enrolled in CCC Plus Managed Care Program is eligible for and chooses TGH services, the individual will remain enrolled in CCC Plus Managed Care Program after admission. If the individual transfers to a TGH after a PRTF stay, the CCC Plus eligible individual will be enrolled into the CCC Plus Managed Care Program.

Psychiatric Residential Treatment Facility (PRTF) Services - If the individual enrolled in CCC Plus Managed Care Program is admitted to a PRTF, they will be removed from the CCC Plus Managed Care Program effective on the day of admission to the PRTF.

MEDALLION 3.0

Medallion 3.0 is a statewide mandatory Medicaid program for Medicaid and FAMIS members. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver.

Additional information about the Medicaid MCO Medallion 3.0 program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

For MCO members, assessment and evaluation, and outpatient psychiatric therapy services (individual, family, and group) are handled through the member’s MCO. MCOs may have different service
authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member’s MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member’s MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

Certain services, however, are carved out of managed care and will continue to be obtained through fee-for-service (e.g., dental and community mental health rehabilitation services). A complete list of carved out services are located online at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc_guide_p4.pdf.

The 2011 Acts of Assembly directed Department of Medical Assistance Services (DMAS) to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization (item 297, MMMM). DMAS released a Request for Proposals (RFP) for a Behavioral Health Services Administrator (BHSA) in December 2011. The contract was awarded to Magellan Health Services in May 2013. Implementation of Magellan of Virginia (Magellan) occurred December 1, 2013.

MEDALLION 3.0

Many Medicaid eligible individuals receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the MEDALLION 3.0 Program. See Chapter 1 for more detail about this program.

For MCO members, assessment and evaluation, and outpatient psychiatric therapy services (individual, family, and group) are handled through the member’s MCO. MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member’s MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member’s MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

The following psychiatric services are carved out of the MCO Contract and are covered through fee-for-service, including for MCO members, in accordance with DMAS fee-for-service established coverage criteria and guidelines.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-124-1356 or by email to YAPrviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanhcprovider.com/MagellanProvider.

Mental Health Community Services:
  • Intensive In Home Services for Children and Adolescents Therapeutic-
Day Treatment for Children and Adolescents: Day Treatment/Partial Hospitalization
  - Psychosocial Rehabilitation/Crisis Intervention
  - Intensive Community Treatment
  - Crisis Stabilization Services
  - Mental Health Skill-building Services
  - Mental Health Case Management
  - Community Based Residential Services for Individuals under age 21 Group Home Level A
  - Therapeutic Behavioral Services Group Home Level B

Intellectual Disability Community Services:
  - Intellectual Disability Case Management Services

In addition, the following individuals will be excluded from participating in the MEDALLION MCO program if receiving mental health services as follows:
  - Individuals who are inpatient in State mental hospitals
  - Individuals who are under age 21, who are approved for DMAS Psychiatric Residential
  - Treatment Facility (PRF) (Level C) as defined in 12VAC30-130-860

Certain services, however, are carved out of managed care and will continue to be obtained through fee-for-service (e.g., dental and community mental health rehabilitation services). A complete list of carved out services are located online at:

TRANSPORTATION

Non-emergency transportation for the individual receiving services to medical appointments, including psychiatric appointments, must be authorized by and billed to the Medicaid transportation broker or the member’s assigned MCO and is not included as part of the Psychiatric service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for services under which transportation is not covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

The current transportation broker is LogistiCare and can be contacted at https://member.logisticare.com or by calling the LogistiCare reservation line at 1-866-386-8331 in order to arrange transportation services and complete forms for gas reimbursement. For more information regarding time frames for making reservations please refer to the LogistiCare website (www.logisticare.com). Individuals enrolled in an MCO must contact the individual’s MCO directly in order to arrange transportation.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-123-456 or by email to YAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

PSYCHIATRIC SERVICES MEDICAL RECORD REQUIREMENTS
The facility or agency must maintain medical records on all individuals in accordance with accepted professional standards and practice. The records must be completely and accurately documented, current-specific readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

Each psychiatric treatment session must be written at the time the service is rendered and must include the dated signature of the professional rendering the service. If a therapy session is rendered by an unlicensed therapist, and under the direct, personal supervision of a qualified, Medicaid enrolled provider, the therapy session must contain not only the dated signature of the unlicensed therapist rendering the service but also the dated signature of the qualified, Medicaid enrolled, licensed supervising provider. Each therapy session must contain the co-signature of the supervising provider on the date the service was rendered indicating that he or she has reviewed the note.

All psychiatric treatment medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider’s administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used. For additional information on physician signatures, refer to the Medicaid Physician Manual.

Acute Care Facilities

All medical record entries must also include the time of the entry, as well as the dated signature of the provider of any service or intervention. All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This includes, but is not limited to, orders, progress notes, procedure notes, patient assessments, History and Physicals (H&Ps), treatment interventions, and any other service or treatment provided.

INPATIENT PSYCHIATRIC SERVICES (ACUTE CARE HOSPITAL & RESIDENTIAL LEVEL C FREESTANDING PSYCHIATRIC HOSPITAL)

Acute Care Hospitals

Inpatient Acute Psychiatric acute inpatient services are available to individuals of all ages in psychiatric units of general acute care hospitals. For individuals 21 years of age and older, coverage is provided for days that are medically necessary and is limited to a maximum of 21 days. Within a 60 day period, this 21-day limit applies to the first eligible 21 days of hospitalization for the same diagnosis within a 60-day period. The 60-day period begins with the first approved day of a hospital admission. Only 21 total days will be covered for the same or similar diagnoses, whether incurred in one or more hospital stays or in the same or multiple hospitals, during the 60-day period. For individuals receiving treatment who are under the age of 21, inpatient psychiatric services are covered beyond the 21-day limit as long as criteria are met. Refer to the Hospital Provider Manual, Chapter IV, for specific, additional requirements for acute care facilities.
Freestanding Psychiatric Hospitals - Over Age 65Ages 22-64 Limitation Category (IMD Exclusion)

Services for individuals, ages 22 to 64, are not reimbursable by Medicaid in an Institution for Mental Diseases (IMD). “Institution for Mental Diseases” means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the individuals with intellectual disabilities is not an IMD.

Certification of Need for Care in Freestanding Psychiatric Acute Care Hospitals

A physician must certify for each individual that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a freestanding psychiatric hospital, before the Medicaid agency authorizes payment. Refer to the Hospital Provider Manual, Chapter IV, for specific, additional requirements for acute care facilities.

A physician, physician’s assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each individual that inpatient psychiatric services are needed. This recertification must be made at least every 60 days.

Medical, Psychiatric, Social Evaluations, and Admission Review - Freestanding Acute Care Psychiatric Hospitals

Prior to admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each individual’s need for care in the hospital. In addition, appropriate professional personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;
4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding psychiatric hospital or continued care in the hospital for individuals who apply for Medicaid while in the freestanding psychiatric hospital.

Plan of Care - Freestanding Acute Care Psychiatric Hospitals

Prior to admission to a freestanding psychiatric facility or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each individual. The Plan of Care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the individual;
3. Objectives;
4. Any orders for: medications, treatments, restorative and rehabilitative services,
activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;

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

6. Plans for discharge.

The attending or staff physician and other personnel involved in the individual’s care must review each Plan of Care at least every 90 days.

Freestanding (Psychiatric) Hospital and Psychiatric Residential Treatment Facility Under Age 21

Medicaid will pay for inpatient psychiatric services in a freestanding hospital and in psychiatric residential treatment facilities for individuals under age 21, whose need for services has been identified through an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening.

The criteria for Medicaid reimbursement for freestanding inpatient psychiatric services has been established based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335 et seq and §§ 37.2-809 of the Code of Virginia. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital or psychiatric residential treatment facility must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

Independent Certification of Need (CON) and Care Coordination Process Administered by Magellan

Independent Assessment, Certification and Coordination Teams (IACCT)

CMS requires, per §441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in §441.153. Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services. Effective January 1, 2017 DMAS will require that all certification teams are credentialed and contracted with Magellan in order to administer the independent certification process on behalf of DMAS. DMAS will also allow localities to enter into a partnership agreement with DMAS to administer the IACCT process in collaboration with Magellan.

The new certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

• Ensuring care coordination and higher probability for improved outcomes;
• Following strict turnaround timeframes for assessing the need for treatment and level of care requirements;
• Accessing the established Medicaid grievance process as mandated by CMS;
• Ensuring freedom of choice in service providers as mandated by CMS; and
• Implementing Medical Necessity Criteria for all members who request residential care.

All Medicaid-eligible youth must be referred to Magellan who will make referral to the IACCT team for psychiatric residential treatment facilities and therapeutic group home services. In addition, all inpatient providers and residential treatment providers must refer to Magellan to initiate the IACCT certification process to assess and certify an appropriate level of care prior to being transferred to
residential treatment or therapeutic group home care from an inpatient setting. All IACCT decisions are due within 10 business days of the referral to Magellan. A licensed mental health professional (LMHP) who is part of the IACCT will conduct a diagnostic assessment through a face-to-face meeting and the IACCT will determine the appropriate level of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

**IACCT Oversight and Support**

Magellan of Virginia, as the DMAS Behavioral Health Administrator, will provide oversight to the IACCT process and facilitate implementation of best practices.

Magellan will support the IACCT process through activities including:
- Ensure that all appropriate community services are explored in lieu of residential placement;
- Make the final medical necessity determination for residential placement;
- Handle all grievances and appeals per the established DMAS appeals process; and
- Provide freedom of choice of providers to youth and families

**Independent Team Certification**

Federal regulations (42 CFR § 441.152) require certification by an independent team (42 CFR § 441.153) that inpatient psychiatric services are needed for any individual applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility or psychiatric residential treatment facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals, including a physician. The independent team will be from the Community Services Board/Behavioral Health Authority (CSB/BHA) serving the area in which the individual resides. These certifications are not reimbursable by Medicaid. For psychiatric residential treatment for Comprehensive Services Act (CSA) children, the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5207 – 5209 of the Code of Virginia. The majority of the team (at least 3 members) and the physician must sign the Certificate of Need/DMAS 370 form (see the “Exhibits” section at the end of this chapter for a sample of this form). Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual’s situation (42 CFR §441.153). The justification for certification must be individual-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual’s needs or why community resources will not meet the individual’s current treatment needs.

A Medicaid-reimbursed admission to an acute care facility, a freestanding psychiatric facility, or a psychiatric residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for freestanding psychiatric hospital admission and for non-CSA residential
placements must be documented on the Uniform Pre-Admission Screening and Report (DBHDS 0224eMH, http://www.dbhds.virginia.gov/formsReports.asp) or similar form, which must be signed and dated by the screener and the physician (see “Exhibits” section at the end of this chapter for a sample of this form). It is not sufficient to merely check on the DBHDS 0224eMH that each of the above Certification-of-Need criteria has been met. For non-CSA residential placements, the CSB/BHA may also use the DMAS 370. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual’s needs or why community resources will not meet the individual’s current treatment needs. For emergency acute care admissions, federal regulation (42CFR 441.153) allows up to 14 days for the team responsible for the Plan of Care in the facility to certify the admission. The certification must meet the criteria listed above. The team must meet the criteria for the treatment team (42CFR 441.156) listed in this chapter under the Comprehensive Individual Plan of Care section. An emergency acute care admission is defined as a psychiatric hospitalization that is required, because the individual is a danger to himself or others or when the individual is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the individual’s psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

JACCT Process: Individuals who are admitted to Residential Treatment and apply for Medicaid coverage while in the Facility

For individuals who apply and become eligible for Medicaid while inpatient in the facility or program, the certification shall be made by the team responsible for the comprehensive individual plan of care and certification of need within 14 days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan and assessed by the children’s residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the individual is Medicaid eligible at the time of admission and is referred to the JACCT within 5 days of admission or within 5 days of being determined eligible for Medicaid.

All individuals entering psychiatric residential treatment care utilizing private medical insurance who will become eligible for enrollment in the state plan for medical assistance within 30 days following the facility admission are required to have an independent certification of need completed by the team responsible for the plan of care at the facility will provide the certificate of need using the facilities treatment team within 14 days from admission. The team providing the certificate of need must include the following professionals:

The team responsible for the plan of care shall include, as a minimum:

1. A Board-eligible or Board-certified psychiatrist; or
2. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
3. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the
Residential treatment facility or IMD shall notify Magellan of the individual's status as being under the care of the facility within five days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

IACCT Process: Inpatient Transfer to Residential Services: Referral to IACCT

1. Upon a member's admission to an inpatient facility, the facility will assess for viable discharge treatment options and develop an initial discharge plan.
2. If residential services are recommended as an option for the discharge plan, the inpatient facility will submit an online residential referral form to Magellan within one business day. Alternatively, this form can be completed telephonically with Magellan during a concurrent review.
3. When the residential referral form is received by Magellan, Magellan will contact the IACCT LMHP to begin the IACCT assessment process. The IACCT LMHP will schedule a face-to-face or telemedicine assessment (expedited, if possible), and will coordinate with the inpatient facility to gather any diagnostic and clinical assessments that were completed during the member’s inpatient treatment.
4. If the member is clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will arrange community-based services to maintain member’s stability during IACCT process.
5. If the member is not clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will continue will engage in an acute discharge planning process.

Additional information about the IACCT process is available on the Magellan of Virginia website at: Residential Service Changes.

Questions about the IACCT process may be directed by email to: RTCCChange@dmas.virginia.gov.

If an individual residing in a psychiatric residential treatment facility, requires an acute psychiatric admission, and is returning to a psychiatric residential facility, a new Certificate of Need is required. The certification may be completed by the acute facility, physician and treatment team as long as the physician meets the criteria noted in federal regulations 42 CFR 411.152-153.

A physician, or physician’s assistant or nurse practitioner acting within the scope of practice and under the supervision of a physician must recertify for each individual that inpatient psychiatric services are needed. This must be done at least every 60 days.

Initial Plan of Care

In accordance with federal requirements (42 CFR § 441.156), the team must establish a written Plan of Care at admission, which must be signed and dated by the attending or staff physician, indicating the physician has examined the individual and approved the plan. The plan must include:

- The diagnosis, symptoms, and complaints indicating the need for admission;
The within 90 days.

- A description of the functional level of the individual;
- Individual-specific treatment objectives with short- and long-term goals;
- Orders for medications, treatments, therapies, etc.;
- Plans for continuing care, including review of the Plan of Care;
- Prognosis; and
- Discharge plans.

For psychiatric residential treatment facilities, see the “Exhibit” section at the end of Chapter IV for a sample form. The sample form is not required to be used as shown, but the Initial Plan of Care must include, at a minimum, include all elements of the sample.

Any available medical, social, and psychiatric evaluations must be submitted with the Certification of Need for the freestanding inpatient psychiatric hospital. The Certification of Need must be completed and dated prior to admission and the request for authorization.

For psychiatric residential treatment admission, for CSA and non-CSA cases, a state uniform assessment instrument, the Child and Adolescent Assessment (CANS) must be completed and current within 90 days throughout the residential stay.

Development of the Comprehensive Individual Plan of Care for Psychiatric Residential Treatment

The Comprehensive Individual Plan of Care (CIPOC) is a written plan developed for each individual. The CIPOC must be completed no later than 14 days after admission for psychiatric residential treatment and must include the dated signatures of the team members specified in the federal requirements (42 CFR 441.156). The CIPOC must be completed before requesting continued stay. The Plan of Care must:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual’s situation and reflects the need for inpatient psychiatric care;
- Be developed by a team of professionals in consultation with the individual, and the individual’s parents, legal guardians, or others in whose care the individual will be released after discharge;
- State individual-specific psychiatric treatment objectives that must include measurable short- and long-term goals with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to meet the stated objectives; and
- Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in an IPF, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care – documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement.
- Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought;
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the individual’s discharge from inpatient status at the earliest possible time and ensure continuity of care with the individual’s family, school, and community upon discharge.
The CIPOC is required to include the dated signatures of the professionals designated in 42 CFR 441.156, including the physician, and will be effective at the time of the last dated signature.

See the “Exhibits” section at the end of Chapter IV for a sample form. The sample form is not required to be used as shown, but the CIPOC must, at a minimum, include all elements of the sample.

The diagnostic evaluation upon which the Plan of Care is to be developed may include medical, social, and psychological evaluations that were completed prior to the individual’s admission to the psychiatric residential treatment facility and submitted with the Certification of Need.

The medical and psychological evaluations of the need for inpatient psychiatric care must include:

- Diagnoses;
- Summary of present medical findings;
- Medical/psychiatric history;
- Mental and physical functional capacity; and
- Prognosis.

The social evaluation must include the psychosocial assessment and an evaluation of home plans and available community resources.

The provider is expected to aggressively treat individuals with a full range of therapies and educational and recreational activities. For psychiatric residential treatment, all of the services must be provided at the facility as part of the therapeutic milieu. This includes medication management, psychotherapy, and an appropriate school program. Medicaid reimbursement for inpatient psychiatric services will not be available for inpatient stays during which active treatment, according to the goals and objectives related to the individual’s diagnostic needs, is not provided, or the individual no longer requires inpatient treatment due to his or her psychiatric condition. The individual is allowed a maximum of 18 days annually of therapeutic leave while in psychiatric residential treatment. The purpose of the leave days is to facilitate discharge from psychiatric residential treatment. The therapeutic purpose, goals, and response to the leave must be documented.

It is critical that the Initial Plan of Care and the CIPOC be developed by a team of professionals in consultation with the individual and the individual’s parents, legal guardians, or others in whose care the individual will be released after discharge. In accordance with federal requirements (42 CFR § 441.156), the team must include one of the following:

- A Board-eligible or Board-certified psychiatrist; or
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases; and
- A psychologist who has a master’s degree in clinical psychology or who has been certified by the state or by the state psychological association.
The team must also include one of the following:

- A psychiatric social worker; or
- A registered nurse with specialized training, or one year’s experience, in treating individuals with mental illness; or
- An occupational therapist who is licensed, if required by the state, and who has specialized training, or one year of experience, in treating individuals with mental illness; or
- A psychologist who has a master’s degree in clinical psychology or who has been certified by the state or by the state psychological association.

For psychiatric residential treatment, the CIROC must be reviewed every 30 days, with the dated signatures of the team specified above reflecting their review.

**ACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES**

**MEDICAL NECESSITY CRITERIA**

**Definitions**

- “Acute” means within 24 hours.
- “Active Treatment” means implementation of a professionally developed and supervised individual Plan of Care.
- “Ambulatory Care” means services provided in the individual’s home community, which may include but is not limited to: outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- “On Admission” means within four hours.
- “Recent Onset” means within one week.
- “Severe Psychiatric Disorder” means clinical manifestation, symptoms, or complications which are so severe as to preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and which require 24-hour nursing/medical assessment, intervention, or monitoring.

**Medical Necessity Criteria**

- As of December 1, 2015 the eligibility criteria was changed to Medical Necessity Criteria.
- The old eligibility criteria was replaced with Magellan Medical Necessity Criteria.

Magellan defines medical necessity as: "Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are: 1. consistent with the diagnosis and treatment of a condition and the standards of good medical practice; 2. required for other than convenience; and 3. the most appropriate supply or level of service.

Magellan is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual’s biopsychosocial needs. Magellan uses the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is
individualized, active and takes into consideration the individual’s stage of readiness to change/readiness to participate in treatment.

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for an individual. While the medical necessity criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of individual situations may fall beyond their definition and scope. Thorough and careful review of each individual request for services, including consultation with supervising clinicians, will identify exceptional clinical needs to ensure that an individualized medical necessity review occurs for each individual.

All medical necessity decisions about proposed admission and/or treatment are made by the Magellan care manager after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face-to-face evaluation of the individual by a qualified clinician. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. In instances when Magellan recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan will support the individual through extra-contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment.

See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia.

Service Requirements

Intensity of Treatment Required

1. The active treatment plan must relate to the admission diagnosis and reflect:

    a. At least one of the following:

        1. Physical restraint/seclusion/isolation; or
        2. Suicidal/homicidal precautions; or
        3. Escape precautions; or
        4. Drug therapy (any route) requiring specific close medical supervision; and

    b. All of the following:

        1. A licensed professional (psychiatrist, clinical psychologist, psychiatric clinical nurse specialist, psychiatric nurse practitioner, licensed clinical social worker, marriage and family therapist, licensed professional counselor, or school psychologist) provides individual/group or family therapy on at least five out of seven days, in addition to the therapy session, at least one appropriate treatment intervention occurs on the same five out of seven days. No more than one individual therapy session per day is
billable, and there is a maximum of ten individuals per group psychotherapy session. On
days when there is no individual, group, or family therapy, there must be at least two
appropriate treatment interventions. Treatment interventions may include, but are not
limited to psychoeducational groups, socialization groups, behavioral interventions,
individual counseling, play/art/music therapy, and occupational therapy. Therapeutic
treatment interventions may be facilitated by nurses, social workers, psychologists,
mental health workers, occupational therapists, and other appropriately prepared hospital
staff; and

(4)2. The family, caretaker, or case manager is involved on an ongoing
basis with treatment planning and family members participates in family therapy at a
minimum of once per week unless documentation demonstrates, based on the treatment
plan, why it is not feasible and addresses alternative involvement in therapy; and

(4)3. Active treatment and discharge planning begin at admission.

2. Medical record documentation must include all of the following:

a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive
or negative reactions to treatment on a daily basis; and

b. Continued necessity for skilled observation, structured intervention, and support that can only
be provided at the hospital level of care; and

c. Concurrent documentation of therapeutic interventions (billable psychotherapy and non-
billable interventions that meet the weekly requirement) as provided, including individual
treatment, according to the treatment plan, specific to hours and number of days provided,
topics covered, and response to the therapy; and

d. Dated signatures of qualified providers; and

e. All medical documentation must also include the time the notations are made; and

f. If the minimum treatment outlined in C.1.b.(1) above is not provided, document why the
individual was unable to participate.

3. Therapeutic Passes:

a. One therapeutic day pass is allowed if the goals of the day pass are documented prior to the
day pass and if, on return, the effect of the day pass is documented. If the first day pass is
determined not to have reached the goals and indications exist, a second day pass may be
permitted. Day passes, which are not a part of the written plan of treatment or documented
as to expected and experienced therapeutic effect, are not permitted.

b. Overnight passes are not permitted.

4. Expected Outcome/Discharge - Continued hospital level-of-care is not appropriate and will not
be covered when a lower level of care is appropriate to meet the individual’s treatment
needs.
CRITERIA

As of June 30, 2017 Psychiatric Residential Treatment Facility services are defined in the Residential Treatment Services Manual.

Definitions:

- “Active Treatment” means implementation of a professionally developed and supervised individual Plan of Care.
- “Ambulatory Care” means services provided in the individual’s home community, which may include: outpatient therapy, crisis intervention, psychological rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- “On Admission” means within 24 hours.
- “Recent Onset” means within seven days.
- “Residential inpatient care” means a 24 hour per day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders. All services must be provided at the facility as part of the therapeutic milieu.

Medical Necessity Criteria

As of December 1, 2015 the eligibility criteria was changed to Medical Necessity Criteria. The old eligibility criteria was replaced with Magellan Medical Necessity Criteria.

Prior to admission to psychiatric residential treatment services an individual must have a valid psychiatric diagnosis and must meet specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission. The diagnosis must be current, as documented within the previous year. If a current diagnosis is not available the individual will require a mental health evaluation by either a psychiatrist or licensed clinical social worker or licensed professional counselor or a licensed psychologist prior to admission. Providers are encouraged to coordinate the evaluation through either Magellan or the individual’s Managed Care Organization to facilitate immediate access to the evaluation services and to coordinate services with the individuals established medical and psychiatric service providers.

To obtain a diagnosis through the individual’s Managed Care Organization (MCO) refer to the MCO contact information as listed in the DMAS Managed Care Member Resource Guide at:


To obtain a diagnosis for individuals enrolled as Fee for Service (FFS) contact the Magellan Call Center at:

Magellan Members
Toll-free: 1-800-424-4046
TDD: 1-800-424-4048
TTY: 711
Email: VirginiaMemberInfo@MagellanHealth.com

Magellan Providers
Toll Free: call 1 800 424 4536
Email: VAPracticesQuestions@MagellanHealth.com

Magellan defines medical necessity as: “Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are: 1. consistent with the diagnosis and treatment of a condition and the standards of good medical practice; 2. required for other than convenience; and 3. the most appropriate supply or level of service.

Magellan is committed to the philosophy of providing treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meet the individual’s biopsychosocial needs. Magellan uses the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less intensive settings or levels of care as their changing clinical needs dictate. At any level of care, each treatment is individualized, active and takes into consideration the individual’s stage of readiness to change/readiness to participate in treatment.

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for an individual. While the medical necessity criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of individual situations may fall beyond their definition and scope. Thorough and careful review of each individual request for services, including consultation with supervising clinicians, will identify exceptional clinical needs to ensure that an individualized medical necessity review occurs for each individual.

All medical necessity decisions about proposed admission and/or treatment are made by the Magellan care manager after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face-to-face evaluation of the individual by a qualified clinician. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. In instances when Magellan recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan will support the individual through extra-contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment.

See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800 424 4536 or by email to VAPracticesQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Service Requirements

Intensity of Treatment Required - To meet criteria for admission, the intensity of treatment must relate to the severity of illness with the goal of improving the individual’s condition so services will no longer be needed, or preventing progression to an acute stage.

1. The active treatment plan must relate to the admission diagnosis and reflect all of the...
Chapter Subject: Covered Services and Limitations

Covered Services and Limitations

Page Revision Date: 4/2/2017

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Covered Services and Limitations

**Covered Services and Limitations**

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<tr>
<td>A. Individual therapy (including family therapy) is provided by a qualified professional (e.g., psychologist, social worker, nurse practitioner, or marriage and family therapist with education and experience with children and adolescents) to address the individual's needs and is billable. (See the “Exhibit” section at the end of this chapter for examples of therapy documentation); and</td>
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<td>B. A minimum of 21 distinct sessions (excluding individual therapy, school attendance, and family therapy) of appropriate treatment interventions are provided each week (i.e., group, psychosocial, educational activities, with specific topics focused on individual needs, insight oriented and/ or behavior modifying). (Group psychotherapy coverage is limited to one per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as separately billable group psychotherapy sessions. There is a maximum of ten individuals per group psychotherapy session). Play/Therapy, occupational therapy, and physical therapy may be included, however, these modalities of treatment must not be the major treatment modality; and</td>
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<td>C. The family, guardian, caretaker, or case manager is involved on an ongoing basis with treatment planning. The family, guardian, or caretaker participates in family therapy at a minimum of twice monthly except when the family dysfunction is a reason for admission, then family therapy should be at least once per week. At least one of these family therapy sessions must be face-to-face each month. Family therapy is limited to one unit per day, regardless of the number of participants or family members in the session. If the family, guardian, or caretaker is not involved as required, documentation must demonstrate why it is not feasible or not in the best interest of the child for the family to participate. Alternatives for treatment due to lack of family involvement should be addressed (telephone therapy is a non-reimbursable service) and the discharge plan revised to address the lack of family involvement; and</td>
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<tr>
<td>D. Active treatment and comprehensive discharge planning for inpatient placement and treatment must begin at admission. A lack of family or guardian involvement in discharge planning does not mean that discharge planning is not conducted. Discharge planning, at a minimum, should be an on-going discussion with the individual about managing symptoms, accessing and using resources, etc., upon discharge.</td>
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3. Medical record documentation must include **all of the following:**

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<th>Medical record documentation must include all of the following:</th>
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<td>A. Stabilization or improvement of presenting psychiatric symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and</td>
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| B. Concurrent documentation of therapeutic interventions (billable psychotherapy and non-billable interventions that meet the 21 intervention per week requirement) as provided. Progress notes for each session must describe how the activities of the session relate to the individual specific goals, the frequency and duration of the session, the level of participation in treatment, the type of session (e.g., group, individual), and the plan for the next session. Notes must contain the dated signatures of the qualified providers. The non-billable sessions that count towards the required...
21 interventions each week must be therapeutic in nature and relate to individual-specific mental health needs, and the documentation of the session must clearly reflect this. Sessions that relate to normal activities of daily living that require normal adult supervision, and are not related to the individual’s mental health needs, do not meet the 21 intervention-per-week requirement (for example, educational, socialization, recreational, current events, nursing, and grooming) that do not have a mental health focus (such as watching the news on television, a group that discusses dating, a nursing group that discusses foot care, a book group, a group on general hygiene, or a basketball game), would not count towards the requirement, and:

d. For CSA cases, a current CANS. (The CANS must be submitted in order to obtain an initial service authorization (12VAC30-130-870) and for continued stay. The CANS must be more than 90 days prior to submission. (Note an individual may have multiple continued stay reviews, and an updated CANS is required for each review.)) and:

e. If the minimum treatment outlined in B.1 above is not provided, document why the individual was unable to participate. A note documenting the individual’s refusal to attend a session does not count as a provided intervention.

* Providers must clearly document timely, consistent and diligent efforts of requesting the updated CANS from the local CSA entities.

**Therapeutic Passes:**

1. Therapeutic passes are permitted if the goals of the pass are part of the CIPOC. The goals of a particular visit must be documented prior to granting the pass and, on return, its effects must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to a day pass. The function of the pass is to assess the individual’s ability to function outside the structured environment and to function appropriately within the family and community.

2. Days away from the facility may occur only after the completion and documentation of successful day passes and are a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 18 days of therapeutic leave annually are billable. Days of leave are counted from the date of admission to Medicaid-covered services.

3. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent psychiatric residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent psychiatric residential treatment would also be considered a new admission.

4. None of the days away from the psychiatric residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS residential authorization.

**Locality Responsibility**
At the time of placement, the locality is responsible for ensuring that the correct responsible city or county name or code number is submitted to the provider for CSA cases. The locality code will be transmitted to the service authorization file in the MMIS and will be credited in the monthly CSA report provided to the Office of Comprehensive Services for any Medicaid-paid claims for psychiatric residential treatment placements. The locality should be the fiscally responsible locality and be the same as the one noted on the CSA Reimbursement Rate Certification form (see the “Exhibits” section at the end of this chapter for a sample of this form).

Restraint and Seclusion

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

Providers must submit to the BHSA a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities. Detailed information regarding this requirement can be found in Chapter II of this manual.

Service Limitations

- Psychiatric residential treatment services may not be billed concurrently with any Community Mental Health Rehabilitation Services, with one exception: Intensive In-Home Services for Children and Adolescents (ID021). This service may be billed for up to seven days, immediately upon admission to a psychiatric residential treatment facility or immediately prior to discharge from a psychiatric residential treatment facility, to transition the individual from home to the psychiatric residential treatment facility or from the psychiatric residential treatment facility to home, as applicable.
- Providers may not bill another payer source for any supervisory services; daily supervision, including one on one, is included in the Medicaid per diem reimbursement.
- Psychiatric residential treatment services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic educational needs of the individual.
- FAMIS Fee for Service does not cover psychiatric residential treatment services.
- Some examples of non-reimbursable services include:
  1. Remedial education (tutoring, mentoring)
  2. Evaluation for educational placement or long-term placement
  3. Day care
  4. Psychological testing for educational diagnosis, school, or institutional admission and/or placement
TREATMENT FOSTER CARE - CASE MANAGEMENT (TFC-CM)

Treatment Foster Care - Case Management (TFC-CM) means an activity that assists Medicaid eligible individuals in gaining and coordinating access to necessary care and services appropriate to their needs.

TFC-CM is directed toward children or youth with a behavioral disorder or emotional disturbance referred to Treatment Foster Care by the Family Assessment and Planning Team of the Comprehensive Services Act (CSA) for Youth and Families or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5208 of the Code of Virginia. “Child” or “youth” means any Medicaid-eligible child under age 21 years of age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPTs) are multidisciplinary teams of professionals established by each locality in accordance with § 2.2-5207 of the Code of Virginia to assess the needs of individuals (children and youth) referred to the team. The FAPT shall develop individual service plans for individuals and families reviewed by the team. The FAPT shall refer the individuals needing TFC-CM to a qualified participating treatment foster care case manager.

TFC-CM is a component of treatment foster care through which a treatment foster care case manager provides treatment planning, monitors the care plan, and links the individual to other community resources as necessary to address the special identified needs of the individual. Services to the individuals shall be delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board. The following activities are considered covered services related to TFC-CM services:

1. Care planning, monitoring of the plan of care, and discharge planning;
2. Case management; and
3. Evaluation of the effectiveness of the individual’s plan of care.

Duties of a TFC Case Manager are to:

- Perform a periodic assessment to determine the individual’s needs for psychosocial, nutritional, medical, and educational services;
- Develop individualized treatment and service plans to describe the services and resources needed to meet the needs of the individual and to help access those services and resources;
- Coordinate services and service planning with other agencies and providers involved with the
individual including the FAPT;

- Refer the individual to services and support specified in the individualized treatment and service plans;
- Directly assist the child to locate or obtain needed services and resources; and
- Follow up and monitor ongoing progress in each case to ensure services are delivered by continually evaluating and reviewing each individual’s Plan of Care;

If an individual is temporarily out of the home, documentation of active treatment foster care case management services is required to bill for the time the individual is out of the home in the following situations:

1. Placement for inpatient services, in cooperation with the facility, to assist in discharge planning for transition back to the home;
2. Runaway – if the treatment foster care case manager is actively involved in finding the individual to be returned to the home; and
3. Detention – refer to the Chapter III discussion on “inmate” and verify Medicaid eligibility.
4. No other type of case management may be billed concurrently with treatment foster care case management.

**Caseload Size:** The TFC Case Manager shall have a maximum of 12 individuals in his/her caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

1. The TFC-Case Manager’s job responsibilities exceed those listed in the agency’s job description for a caseworker, as determined by the supervisor.
2. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents.
3. Exception: A TFC-Case Manager may have a maximum caseload of 15 individuals as long as no more than 10 of the individuals are in TFC and the above criteria for adjusting the caseload downward do not apply.
4. There shall be a maximum of six individuals in the caseload for a beginning trainee that may be increased to nine by the end of the first year and to 12 by the end of the second year.
5. There shall be a maximum of three individuals in a caseload for a student intern, if any work in the agency.

**Treatment Teams in TFC-CM**

The TFC-CM provider shall assure that a professional staff person provides leadership to the treatment team, which includes managing team decision-making regarding the care and treatment of the individual and services to the individuals treatment foster care family. The provider must provide information and training to the treatment team members as necessary. The provider must involve the
The individual and the individual’s treatment foster care family in treatment team meetings, plans, and decisions and keep them informed of the individual’s progress whenever possible. Treatment team members shall consult as often as necessary, but no less than quarterly.

Initial Plan of Care

The initial plan of care delineates the services that are to be provided to the individual at admission. This document must be completed within 14 calendar days of the placement or be subject to retraction until completed.

Treatment and Service Plans in TFC-CM

The TFC-CM provider shall prepare and implement an individualized comprehensive plan for each individual in its care. When available, the birth parents shall be consulted unless parental rights have been terminated. If birth parents cannot be consulted, the agency shall document the reason in the individual’s record.

Comprehensive Treatment and Service Plan in TFC-CM

The treatment foster care (TFC) case manager and other designated child-placing agency staff shall develop and implement for each individual in care an individualized comprehensive treatment plan within the first 45 calendar days of placement that shall include:

1. A comprehensive assessment of the individual’s emotional, behavioral, educational, and medical needs;
2. The treatment goals and objectives, including the individual’s specific problems, behaviors, and skills to be addressed, the criteria for achievement, and target dates for each goal and objective;
3. The TFC-CM provider’s program of therapies, activities, and services, including the specific methods of program of therapies, activities, and services, the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources to ensure a continuity of care with the individual’s family, school and community;
4. The discharge plan and the target date for discharge from the program;
5. For individuals age 16 and over, a description of the programs and services that will help the individual transition from foster care to independent living; and
6. The plan shall be signed and dated by the treatment foster care case manager. It shall indicate all members of the treatment team who participated in its development.

The TFC case manager shall include and work with the individual, the custodial agency, the treatment foster care parents, and the birth parents, where appropriate, in the development of the treatment plan, and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the individual’s birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the
development of the treatment and service plan, the TFC case manager shall document the reasons in the individual’s record.

The TFC case manager shall provide supervision, training, support, and guidance to foster families in implementing the treatment plan for the individual.

Progress Reports and Ongoing Services Plans in TFC-CM

The TFC case manager shall complete written progress reports beginning 90 calendar days after the date of the individual’s placement and every 90 calendar days thereafter. The progress report shall specify the time period covered and include:

1. Progress on the individual’s specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented, including:

   a. A description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each goal and objective;

   b. A description of the therapies, activities, and services provided during the previous 90 calendar days toward the treatment goals and objectives; and

   c. Any changes needed for the next 90 calendar days.

2. Services provided during the last 90 calendar days toward the discharge goals, including plans for reunification of the individual and birth family or placement with relatives, any changes in these goals, and services to be provided during the next 90 calendar days, including:

   a. The individual’s assessment of his or her progress and his or her description of services needed, where appropriate;

   b. Contacts between the individual and the individual’s birth family, where appropriate;

   c. Medical needs, specifying medical treatment provided and still needed and medications provided;

   d. An update to the discharge plans including the projected discharge date; and

   e. A description of the programs and services provided to individuals 16 and older to help the individual transition from foster care to independent living, where appropriate.

Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year. The case manager shall date and sign each progress report. The dated signature indicates the effective date of the report.

The case manager shall include each child who has the ability to understand in the preparation of the child’s treatment and service plans and progress reports or document the reasons this was not possible. The child’s comments shall be recorded in the report. The case manager shall include and work with the child, the treatment foster parents, the custodial agency, and the birth parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.
Contacts with the Child in TFC-CM

1. There shall be face-to-face contact between the TFC case manager and the individual, based upon the individual’s treatment and service plan and as often as necessary, to ensure that the individual is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be with the individual in the treatment foster care home. One of the contacts shall include the individual and at least one treatment foster parent and shall assess the relationship between the individual and the treatment foster parents. The two required face-to-face contacts cannot occur on the same day.

3. The contacts shall assess the individual’s progress and provide guidance to the treatment foster parents, monitor service delivery, and allow the individual to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Individuals who are able to communicate shall be interviewed privately at least once a month.

6. The TFC case manager shall record all medications prescribed for each individual and all reported side effects or adverse reactions.

Unless specifically prohibited by a court or the custodial agency, foster children shall have access to regular contact with their birth families as described in the treatment and service plan. The TFC case manager shall work actively to support and enhance the family relationships and work directly with the individual’s birth family toward reunification as specified in the treatment and service plan.

Professional Clinical or Consultative Services in TFC-CM

In consultation with the custodial agency, the TFC case manager shall provide or arrange for an individual to receive psychiatric, psychological, and other clinical services as recommended or identified in the treatment service plan.

Case management (CM) services by any source other than the TFC agency is considered a duplication of services. Medicaid reimbursed targeted case management, including Mental Health CM, Intellectual Disability CM, and other services that have CM as an intrinsic part of the service such as Intensive In-Home Services cannot be billed when the child is receiving TFC-CM. Duplication of services is subject to retraction.

Record Documentation in TFC-CM

Entries in Case Records: All entries shall include the dated signature of the staff person who performed the service. If a TFC-CM provider has offices in more than one location, the record shall identify the office that provided the service. Each individual’s record shall contain documentation that verifies the services rendered for billing.

Narratives in the Individual’s Record: Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in these regulations and shall cover: treatment and
services provided; all contacts related to the individual; visitation between the individual and the individual’s birth family; and other significant events. Each contact with the individual, his or her birth family, treatment foster care family, or other individuals in the course of providing case management services must be documented in the individual’s record. Narratives must include the dated signature of the TFC case manager.

**Plans of Care:** Copies of all assessments and Plans of Care must be filed in the individual’s case record.

**Timeliness:** The dated signature of the service provider on required documentation indicates the completion date of the document.

**Assessment**

Each individual must be assessed by a Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5209 of the Code of Virginia. The team must assess the individual’s immediate and long-range therapeutic needs, developmental priorities, personal strengths and liabilities, the potential for reunification with the individual’s family, set treatment objectives, and prescribe therapeutic modalities to achieve the plan’s objectives. The assessment must include the dated signatures of a majority (at least three) of the FAPT members.

**TFC Medical Necessity Criteria**

The individual must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on the CANS. The individual’s condition must meet one of the three levels described below:

a. **Level I:** Moderate impairment with one or more of the following moderate risk factors as documented on the CANS.
   (1) Needs intensive supervision to prevent harmful consequences;
   (2) Moderate/frequent disruptive or non-compliant behaviors in home setting that increase the risk to self or others; or
   (3) Needs assistance of trained professionals as caregivers.

b. **Level II:** The individual must display a significant impairment with problems with authority, impulsivity, and caregiver issues as documented on the CANS. For example, the individual must:
   (1) Be unable to handle the emotional demands of family living;
   (2) Need 24-hour immediate response to crisis behaviors; or
   (3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

c. **Level III:** The individual must display a significant impairment with severe risk factors as documented on the CANS. The individual must demonstrate risk behaviors that create significant risk of harm to self or others.

**OUTPATIENT PSYCHIATRIC SERVICES**
Outpatient psychiatric services are provided in a practitioner’s office, mental health clinic, individual’s home, or nursing facility. If services are provided in a setting other than the office or a clinic, this must be documented. Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by the professionally licensed, Medicaid enrolled qualified provider. Psychiatric services require a plan of care.

**Beginning on July 26, 2017** Outpatient psychiatric services **do not** require service authorization after 26 units in the first year of treatment. During the first year of treatment, there may be an additional 26 units when authorized. The initial 26 units may be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 units in subsequent years, but these units require a service authorization. The 26-unit restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one psychiatric diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria. If the service limit is met, for individuals under the age of 21, additional sessions may be available when medically necessary, through the EPSDT program and require service authorization. See Appendix C in this manual for instructions on service authorizations. Medication management does not require service authorization and is not subject to the unit limit.

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Individuals who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus providers who are trained and practicing within the scope of their practice, in working with individuals with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained in treatment of both substance use and mental health disorders, they should refer the member to an appropriate service provider. Both providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment.

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

**Effective April 1, 2017, DMAS will implement Addiction and Recovery Treatment Services (ARTS) program for all members.** For more information on the services, criteria, and staffing requirements, refer to the ARTS Provider Manual.


A crosswalk of the 2013 CPT code changes is included in the above referenced Medicaid Memo. DMAS uses the AMA’s CPT-Current Procedural Terminology-Professional Edition for reporting services and procedures, audits, and claims processing. The US Department of Health and Human Services designated the CPT code set as the national coding standard for health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA). This means for all financial and administrative health care transactions sent electronically, the CPT code
set is to be used.

**Medical Necessity Criteria**

- As of December 1, 2015 the eligibility criteria was changed to Medical Necessity Criteria. The old eligibility criteria was replaced with Magellan Medical Necessity Criteria.

Magellan defines medical necessity as: "Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are: 1. consistent with the diagnosis and treatment of a condition and the standards of good medical practice; 2. required for other than convenience; and 3. the most appropriate supply or level of service.

Magellan is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual’s biopsychosocial needs. Magellan uses the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the individual’s stage of readiness to change/readiness to participate in treatment.

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for an individual. While the medical necessity criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of individual situations may fall beyond their definition and scope. Thorough and careful review of each individual request for services, including consultation with supervising clinicians, will identify exceptional clinical needs to ensure that an individualized medical necessity review occurs for each individual.

All medical necessity decisions about proposed admission and/or treatment are made by the Magellan care manager after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face-to-face evaluation of the individual by a qualified clinician. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. In instances when Magellan recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan will support the individual through extra contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment.

See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia.

**Documentation Required**

*(What must be in the medical record)*

- History, to include:
  - The onset of the diagnosis and functional limitations;
  - Family dynamics; ability.desire of the family/caretakers to participate and follow through
with treatment;
- Reasons that may require consideration (foster care, dysfunctional family);
- Previous treatment and outcomes;
- Medications, current and history of;
- Medical history if relative to current treatment;
- Treatment——— received —through —other —programs —(Department —of Aging and
Rehabilitative Services, day treatment, Special Education, Community Services
Board/Behavioral Health Authority, or the Department of Behavioral Health and
Developmental Services clinics.
- Functional limitations; if any
- Plan(s) of Care (POC), and review of the plan of care signed and dated by the qualified
provider. An initial plan of care is required to be completed at the time of a prior
authorization request.
- Services shall be medically prescribed treatment that is directly and specifically related to
an active written plan designed and signature-dated by the qualified provider.
- The initial plan of care must be completed prior to the start of services.
- The POC may be incorporated in the Psychiatric Diagnostic Interview.
- The POC must be completed at the time of a service authorization request.
- The POC should be amended as needed throughout the time of treatment.
- Medical Evaluation (evidence of coordination with the primary care physician (PCP), if
applicable, or documentation that it is not applicable). The purpose of the evaluation is to
rule out any underlying medical condition as causing the symptoms, and to ensure that any
underlying medical conditions are being treated.
- Results of a Diagnostic Evaluation done within the past year.
- The chief complaint should relate to the psychiatric diagnosis that is current, within
the past year.
  - See the Exhibits section of this chapter for a list of recommended screening tools.
- Progress Notes for each unit (must be individual-specific, must describe how the
activities of the session relate to the individual-specific goals, describe the therapeutic
intervention, the length of the session, the level of participation in treatment, the
modalities of treatment, the type of session [group, individual, medication management], the progress
or lack thereof toward the goals, and the plan for the next treatment and must contain the
dated signatures of the providers).
- Evidence of Discharge Planning

Plan of Care (elements of the initial and ongoing plan of care)
Required for all psychiatric services, including medication management
- Focus of the Plan must be related to the diagnosis. Must have a current DSM-psychiatric
diagnosis including current mental status documented in the medical progress notes.
• Must indicate individual-specific goals related to symptoms and behaviors.
• Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation).
• Must indicate estimated length that treatment will be needed.
• Must indicate frequency of the treatments/duration of the treatment.
• Must indicate documentation of the family/caregiver participation.
• Qualified provider must sign and date the plan of care.

The Plan of Care (POC) must be reviewed by the qualified provider every 90 calendar days or every sixth session, whichever time frame is shorter, from the date of the provider’s signature. The review may be incorporated into the progress notes, but must be identifiable as a review of the POC.

• Has there been a relapse?
• Has there been a significant change in the environment?
• Is the individual at risk for moving to a higher level of care?
• Positive/negative changes relative to the symptoms.

- Documented review of the plan of care by the qualified provider.

## Covered Services and Limitations

- **Specific Service Limits**

- The individual, family, and group psychotherapy are limited to no more than three visits in a seven-day period when performed as an outpatient service.

- Individual therapy coverage is limited to once per day.

- A psychiatric diagnostic interview examination, 90791 or 90792, includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory, or other medical diagnostic studies. Review of records or reports are included in the interview examination. The psychiatric diagnostic interview, 90791 or 90792, is limited to once per year per provider per individual and does not require a service authorization.

- Group therapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy. There is a maximum of ten individuals per group session. Groups are expected to be held for a minimum of 30 minutes.

- Family therapy is limited to once per day and is expected to be held for a minimum of 30 minutes.
Multiple-family group therapy is a non-covered service.

Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with an intellectual disability prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests. DMAS allows one per six-month period and up to seven units. Should the testing exceed the limits of frequency or units, the provider must provide the documentation with the claim as to the medical necessity for the testing and a list of the specific tests conducted. Testing does not require service authorization.

Separate payment will be allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

Non-Covered Psychiatric Services

The following services are non-covered services:

- Broken appointments;
- Remedial education (tutoring, mentoring);
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Occupational therapy;
- Teaching “grooming” skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;
- Telephone consultations;
- Mail order prescriptions;
- Psycho-education for the purpose of educating the individual’s guardian about the diagnosis and any related symptoms/treatment;
- Teaching parenting skills;
- Case management as part of outpatient therapy services;
- Treatment team meetings;
- Interpretation of examinations, procedures and data, and the preparation of reports are non-
covered services. This includes CPT code 90885 (psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes).

- Medical hypnotherapy and environmental intervention remain non-covered services.

**Telemedicine Services**

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated September 30, 2009 — Expanded DMAS Telemedicine Coverage - Effective November 1, 2009.

The telemedicine equipment and transmission speed must be technically sufficient to support the service billed to DMAS. Staff involved in the telemedicine encounter need to be trained in the use of the telemedicine equipment and competent in the operation of it. Individual medical records at the hub, main site, and spoke sites are to document the telemedicine encounter consistent with the service documentation described in Chapter II of the DMAS provider manuals. The documentation is to specifically reference telemedicine as the means for conducting the medical service. Other coverage described in this provider manual is applicable including the information on claims processing.

Some medical professional associations have protocols for conducting telemedicine. Practitioners billing DMAS for telemedicine are encouraged to follow those protocols so long as they are consistent with DMAS coverage. All telemedicine activities are to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended and all other applicable state and federal laws and regulations.

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services. Telemedicine services do not include telephone conversations or Internet e-mail communications between providers or providers and recipients. Providers must be physically present in Virginia during the telemedicine encounter, until further notice from DMAS. Telemedicine encounters must be conducted in a confidential manner and any information sharing consistent with applicable federal and state laws and regulations and DMAS policy. (Skype does not meet this requirement.) Health Information Portability and Accountability Act of 1996 (HIPPA) confidentiality requirements are applicable to telemedicine encounters.

For telemedicine billing codes, refer to Chapter V of the Physician Manual. Questions may be emailed to DMAS at: Vatelmed@dmas.state.va.us.

**Care Coordination**

DMAS and the BHSA agree that care coordination has two (2) main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Examples when the BHSA may provide care coordination to assist
individuals and families include:

- Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management.

- An MCO liaison at the BHSA will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care.

- Care coordination with Primary Care Physicians (PCPs).

All provider forms can be found in Provider Forms Search under the Provider Services section of the MMIS Portal at: [https://www.virginia Medicaid.dmas.virginia.gov/](https://www.virginia Medicaid.dmas.virginia.gov/).
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