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I 2 VAC 30-60 - 10. Institutional care.

Institutional care will be provided by facil ities qualified to participate in Title XVIII and/or Title XIX**.**

12 YAC 30-60-20. Utilization Control: General Acute Care Hospitals (enrolled providers).

A. Prior authorization required. The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) shall not reimburse for services which are not authorized as follows:

1. DMAS shall monitor, consistent with State la w, the utilization of all inpatient hospital services. All planned inpatient hospital stays shall be preauthorized prior to admission.

2. If a Medicaid eligible individual is admitted to inpatient hospital care, on a Saturday, Sunday or holiday, or after normal working hours, it shall be the provider's responsibility to obtain the required authorization on the next work day following such admission.

3. If a provider has rendered inpatient services to an individual who lat e r is determined to be Medicaid eligible, it shall be the provider's responsibility to obtain the required authorization prior to billing the DMAS for these services.

4. Regardless of preauthorization, DMAS shall review all inpatient hospital claims for individuals over the age of 21 which suspend for exceeding the 21 day limit per admission in a 60 day period for the same or similar diagnoses prior to reimbursement for the stay until such time as DMAS implements DRG payment methodology. At such time only psychiatric inpatient hospital claims will suspend for this review.

5. DMAS shall review all claims which suspend for sterilization, hysterectomy, or abortion procedures for the presence of the required federal and state forms prior to reimbursement. If the forms are not attached to the bill and not properly completed, reimbursement for the services rendered will be denied or reduced, according to DMAS policy.

B. To determine that the DMAS enrolled hospital providers are in compliance with the regulations governing hospital utilization control found in the *Code of Federal Regulations,* 42 CFR, Chapter IV, Subpart C, §§456.50-456.145, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit. The hospital shall make all requested records available and shall provide an

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Appropriate place for the auditors to conduct such review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in 42 CFR 456.100 through 456.145.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in 42 CFR 456.105 through 456.106.

3. Verification of Utilization Management Committee meetings since the last annual audit, including dates and list of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CFR 456.145.

5. Topic of one on-going Medical Care Evaluation Studey to determine the hospital is in compliance with 42 CFR 456.145.

6. From a list of randomly selected paid claims, the hospital must provide a copy of the physician admission certification and written plan of care for each selected stay to determine the hospital's compliance with 42 CFR 456.60 and 456.80. If any o fthe required documentation does not meet the requirements found in 42 CFR 456.60 and 456.80, reimbursement may be retracted.

7. The hospital may appeal in accordance with the Code of Virginia 9-6.14:1 et seq. any adverse decisions resulting from such audits which results in retraction of payment. The appeal must be requested within 30 days of the date of the letter notifying the hospital of the retraction.

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12 VAC 30-60-21. Utilization control of non-participating out-of-state inpatient hospitals. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under any one of the following conditions. It shall be the responsibility of the hospital, when requesting prior authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain service authorization. It shall be the responsibility of the admitting physician to adhere to these restrictions. Services provided out of state for circumstances other than these specified exceptions shall not be covered. When, during post payment utilization review, inappropriate or inaccurate payments are determined to have been made for reasons other than those specified herein, DMAS shall recover the inappropriately expended funds.

A. The medical services must be needed because of a medical emergency;

B. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence.

C. The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

D. It is general practice for recipients in a particular locality to use medical resources in another state.

12 VAC 30-60-25. Freestanding psychiatric hospitals.

A. Psychiatric services in freestanding psychiatric hospitals shall only be covered for eligible persons younger than 21 years of age and older than 64 years of age.

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient free-standing psychiatric hospitals. All inpatient

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hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

C. All Medicaid services are subject to utilization review/audit. Absence of any of the required documentation may result in denial or retraction of any reimbursement. In each case for which payment for freestanding psychiatric hospital services is made under the State Plan:

1. A physician must certify at the time of admission, or at the time the hospital is notified of an individual's retroactive eligibility status, that the individual requires or required inpatient services in a freestanding psychiatric hospital consistent with 42 CFR.456.160.

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

3. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must petform a medical evaluation of the individual and appropriate professional personnel must make a psychiatric and social evaluation as cited in 42 CFR 456.170.

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include· a list of services provided under written contractual airangement with the freestanding psychiatric hospital (see Attachment 3.1 A&B, Supplement 1, Item 4b pages 6.4 and 6.5 of 45 (12 VAC 30-50-130)) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

D. If the eligible individual is 21 years of age or older, then, in order to qualify for Medicaid payment for this service, he must be at least 65 years of age.

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C. If younger than 21 years of age, it shall be documented that the individual requiring admission to a free-standing psychiatric hospital is under 21 years of age, that treatment is medically necessary and that the necessity was identified as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

1. An EPSDT physician's screening report showing the identification of the need for further psychiatric evaluation and possible treatment.

2. A diagnostic evaluation documenting a current (active) psychiatric disorder included in the DSM-III-R that supports treatment recommended. The diagnostic evaluation must be completed prior to admission.

3. For admission to free-standing psychiatric hospital for psychiatric services resulting from an EPSDT screening, a certification of the need for services as defined at 42 CFR §441.152 by an interdisciplinary team meeting the requirements of 42 CFR §441.153 or §441.156 and The Psychiatric Treatment of Minors Act (§16.1-335 et seq. *Code of Virginia).*

4. If a Medicaid eligible individual is admitted in an emergency to a freestanding psychiatric hospital on a Saturday, Sunday, holiday, or after normal working hours, it shall be the provider's responsibility obtain the required authorization on the next work day following such an admission.

5. The absence of any of the above required documentation shall result in DMAS 's denial of the requested preauthorization and coverage of subsequent hospitalization.

D. To determine that the DMAS enrolled mental hospital providers are in compliance with the· regulations governing mental hospital utilization control found in 42 CFR §456.150, an annual audit will be conducted of each enrolled hospital. This audit can be performed either on-site or as a desk audit.The hospital shall make all requested records available. and shall provide an appropriate place for the auditors to conduct such a review if done on-site. The audits shall consist of review of the following:

1. Copy of the general hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR §§456.200 through 456.245.

2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR §§
456.205 through 456.206.

3. Verification of Utilization Management Committee meetings, since including dates and lists of attendees to determine that the committee is meeting according to their Utilization Management meeting requirements.

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4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with the 42 CPR §§456.241 through 456.245.

5. Topic of one on-going Medical Care Evaluation Study to determine the hospital is in compliance with 42 CPR §§456.245.

6. From a list of randomly selected paid claims, the free-standing psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluation, and a written plan of care for each selected stay to determine the hospital's compliance with the *Code of Virginia* §§16.1-335 through 16.1-348 and 42 CPR §§441.152, 456.160, 456.170, and §§456.180 through 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may beretracted.

7. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:

a. The comprehensive plan of care fails to include, within three business days of the initiation of the service provided under arrangement, all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;

b. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;

c. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;

d. The referral to the service provided under written contractual arrangement was not present in the patient's freestanding psychiatric hospital record or the record of the provider of services under arrangement;

e. The medical records from the provider of services under arrangement (i.e., any admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings) were not present in the patient's freestanding psychiatric hospital record, or had not been requested in writing by the freestanding psychiatric hospital within seven business days of completion of the service or services provided under arrangement; or

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f. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services provider prior to submission of the emergency services provider's claim for payment.

8. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.

9. The hospital may appeal in accordance with the Code of Virginia § 2.2-4000 et seq. any adverse decisions resulting from such audits which results in retraction of payment. The appeal must be requested pursuant to the requirements of 12 VAC 30- 20-500 et seq.

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C. Utilization control: Nursing facilities. 12 VAC 30-60-40.

1. Long-term care of residents in nursing facilities will be provided in accordance with Federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

2. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than fourteen days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

3. The Department of Medical Assistance Services shall periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

4. Nursing faciltieis must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

5. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12 VAC 30-60-300 (Nursing Facililty Criteria). In order for the additional $10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as described in 12 VAC 30-60-350. Nursing facilities must obtain prior authorization for reimbursement. DMAS shall provide the additional $10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.

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In order for the additional $10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as descrived in 12 VAC 30-60-350. Nursing facilities must obtain prior authorization for the reimbursement. DMAS shall provide the additional $10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12 VAC 30-60-320 (Adult Ventilation/Tracheostomy Specialized Care Criteria) or 12 VAC 30-60-340 (Pediatric/Adolescent Specialized Care Criteria). In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care servies requirements are set forth below.

In each case for which payment for nursing facility or specialized care services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once ecvery 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with DMAS to provide nursing facility care. Providdders must agree to provide care to at least four residnets who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

    a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

    b. Skilled nursing services by a registered nurse available 24 hours a day;

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c. Coordinated multidisciplinary team approach to mee the needs of the resident;

d. Infection control

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week.

f. Ancillary services related to a plan of care;

g. Respiratory therapy services by a board-certified therapist (for ventilator pateitns, these services must be available 24 hours per day);

h. Psychology services by a licensed clinical psychologist, a licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist-psychiatric related to a plan of care;

i. Necessary durable medical equipment and supplies as required by the plan of care;

j. Nutritional elements as required by the plan of care;

k. A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activieis as other residents;

l. Nonemergency transportation;

m. Discharge planning; and

n. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medcaid specialized care recipients who are under the age of 31.

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2. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are eligible for such services.

I. Contract Termination. The specialized care provider contract shall be terminated upon the demonstration of one or more of the following conditions:

1. The provider is no longer certified to participate in the Medicare or Medicaid programs.

2. The provider violates provisions of the written contract for specialized care.

3. The provider gives written notice to DMAS at least 30 days in advance that it wishes to terminate the contract.

D. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutions for Mental Disease (IMD)

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

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

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3. In order for reimbursement to be made to a facility for the mentally retarded, the resident must meet criteria for placement in such facility as described in Supplement 1, Part 4, to Attachment 3.1-C and the facility must provide active treatment for mental retardation.

4. In each case for which payment for nursing facility services for the mentally retarded or institution for mental disease services is made under the State Plan:

   a. a physician must certify for each applicant or recipient that inpatient care is needed in a facility for the mentally retarded or an institution for mental disease. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

   b. a physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by State law and under the supervision of a physician, must recertify for each applicant at least every 365 days that services are needed in a facility for the mentally retarded or institution for mental disease.

5. When a resident no longer meets criteria for facilities for the mentally retarded or an institution for mental disease or no longer requires active treatment in a facility for the mentally retarded, then the resident must be discharged.

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

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E. Psychiatric Services resulting from an EPSDT screening. Repealed. (12 VAC 30-60-60)

E. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). (12 VAC 30-60-61).

1. Community mental health services for children.

a. Intensive in-home services for children and adolescents:

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

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

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

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

(2) At admission, an appropriate assessment is made by the Licensed Mental Health Professional (LMHP) or an individual who is an LMHP-eligible, as that term is defined in Supplement 1 of Attach 3.1-A&B, pp 6a and 30-31.4, or an individual who is LMHP-eligible documenting that service needs can best be met through intervention provided typically but not solely in the client's residence. A LMHP-eligible individual is someone who is actively working toward licensure and is complyng with requirements of the relevant professional board in Virginia. A LMHP or a LMHP-eligible individual must make and document the diagnosis. The assessment shall include, but is not limited to: medical, psychiatric, educational, and social history, and recent behavioral history. The assessment shall be utilized to develop the Individual Service Plan (ISP), which must be fully completed within 30 days of initiation of services.

(3) Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present. The assessment referenced in paragraph (2) above must be done face-to-face in the residence. In some circumstances, such as a lack of privacy or unsafe conditions, the assessment and provision of services may be provided in the community if the rationale is supported in the clinical record.

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(4) These services shall be provided when the clinical needs of the child put the child at risk for out-of-home placement and:

(a) When services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or

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

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

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

(7) At least one parent or responsible adult with whom the child is living must be willing to participate in the intensive in-home services, with the goal of keeping the child with the family.

(8) The enrolled provider must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as a provider of intensive in-home services.

(9) Services must be provided by a LMHP or a QMHP as defined in Supp. 1 of Attach 3.1 A&B, pp 6a and 30-31.4. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in Supp. 1 of Attach 3.1 A&B, pp 30-31.4.

(10) The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in-home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter of weeks of service. Intensive in-home services below the five hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or non-home based services. If there is a lapse in service for more than two weeks, the reason for the lapse and the rationale for the continued need for the service must be documented.

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The ISP must be reviewed, updated to determineif there are changes, and signed by the client or family or both.

(11) The provider must ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual. For full time staff, the staff to client ratio shall not exceed five cases per staff. The ratio for half-time staff to clients is 1 to 3. Staff that work less than half-time must be cleardd with the licensing specialist for mor than one case. A case load may be 1:6 staff to client ratio if the staff is transitioning one of the clients off of the case laod for up to 30 days.

(12) A full-time clinical supervisor may not have more than ten QMHPs to supervise. A half-time clinical supervisor may not have more than five QMHPs to supervise.

(13) Emergency assistance shall be available 24 hours per day, seven days a week.

(14) Providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements shall be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider's participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in provider appropriate agency guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.

(15) If an individual receiving intensive in-home services is also receiving targeted case management services, the provider must collaborate with the targeted case manager and provide notification of the provision of services. The provider must also inform the primary care provider of the child's receipt of community mental health rehabilitative services. In addition, the provider must send monthly updates to the targeted case manager on the individual's progress. A discharge summary must be sent to the targeted case manager within 30 days of the service discontinuation date.

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b. Therapeutic day treatment for children and adolescents.

(1) Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

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

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

(i) this programming during the school day; or

(ii) this programming to supplement the school day or school year.

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

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

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

(2) Such services must not duplicate those services provided by the school.

(3) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

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

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

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

(4) The enrolled provider of therapeutic day treatment for child and adolescents services must be licensed by the DBHDS to provide day support services.

(5) Services must be provided by a LMNP or QMHP.

(6) The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP. The staff-to-youth ratio shall not exceed one clinical staff to six clients.

(7) The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day.

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Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

(8) Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

(9) Services shall be provided following a diagnostic assessment that is authorized by a LMHP or individual who is LMHP-eligible. A LMHP or LMHP-eligible individual must make the diagnosis. Services must be provided in accordance with an ISP based upon the diagnostic assessment and which must be fully completed within 30 days of initiation of the service. The diagnostic assessment must include the elements specified by DMAS in the Community Mental Health Rehabiltiation manual. The assessment shall incude, but is not limited to: medical, psychiatric, educationa, and social history, and recent behavioral history.

(10) If an individual receiving therapeutic day treatment is receiving targeted case management services, the provider must collaborate with the targeted case manager and provide notification of the provision of services. The provider must also inform the primary care provider of the child's receipt of community mental health rehabilitative services. In addition, the provider must send monthly updates to the targeted case manager on the individual's progress. A discharge summary must be sent to the targeted case manager on the individual's progresss. A discharge summary must be sent to the targeted case manager within 30 daysof the service discontinuation date.

(11) Providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements shall be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider's participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in the provider-appropriate agency guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.

(12) If there is a lapse in service for more than two weeks, the reason fo rth elapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed, updated to determine if there are changes, and signed by the client, when appropriate and family.

Additional information regarding Therapeutic Day Treatment, including types of providers and qualifications, may be found at Supplement 1, Attachment 3.1-A&B, pp. 3.15 through 31.10 of 79.

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2. Community Based Services for Children and Adolescents under 21 (Level A).

   a. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while asleep. The program director supervising the program/group home must be, at minimum, a qualified mental health professional (as defined in Supp 1 of Attach 3.1 A&B, pp 6a and 30-31.4) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.

   b. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, defined in Supp 1 of Attach 3.1 A&B, pp 6a and 31.5.

   c. Authorization is required for Medicaid reimbursement. DMAS shall monitor the services rendered. All Community Based Services for Children and Adolescents under 21 (Level A) must be authorized by DMAS prior to reimbursement for these services. Services rendered without such authorization shall not be covered. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.

   Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

   d. Services must be provided in accordance with an Individual Service Plan (ISP) (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.

   e. Prior to admission, a disgnostic assessment is done according to DMAs specifications described in the Community Mental Health Rehabilitation manual; this assessment shall be used to develop the ISP. The assessment shall include, but is not limited to: medical, psychiatric, educational, and social history and recent behavioral history.

   f. If an individual receiving Community-Based Services for Children and Adolescents under 21 (Level A) is also receiving care coordination services the provider must collaborate with the care manager by notifying the care manager of the provision of Level A services and send monthly updates on the individual's progress. The provider msut alos inform the primary care provider of the child's receipt of community mental health rehabilitative services. A discharge dummary msut be sent when the service is discontinued.

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3. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B).

   a. The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 while asleep. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed sixteen clients including all sites for which the clinical director is responsible. The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.

   b. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4. The program/group home must coordinate services with other providers.

   c. All Therapeutic Behavioral Services (Level B) must be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

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

   e. Prior to admission, a diagnostic assessment is done according to DMAS specififcatrions described int eh Community Menatl Health Rehabiltiation amanual; this assessment shall be used to develop the ISP. The assessment shall incude, but is not limited to, medical, psychiatric, educational, and social history, and recent behavioral history.

   f. If an individual receiving Day Therapeutic Behavioral services for Children and Adolescents under 21 (Level B) is also receiving care coordination services, the provider msut collaborate with the care manager by notifying the care manager of the provision of Level B services and send monthly updates on the individual's progress. A discharge summary must be sent when the service is discontinued. The provider must also inform the primary care provider of the child's receipt community mental health rehabilitation services. A discharge summary must be sent when the services are discontinued.

4. Utilization Review: Utilization reviews for Community Based Services for Children and Adolescents under 21 (Level A) and Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) shall include determinations whether providers meet all DMAS requirements, including compliance with DMAS marketing requirements. Providers that violate the DMAS marketing requirements will be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time will result in the termination of the provider's participation agreement for this service.

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Durable Medical Equipment (DME) and Supplies. (12 VAC 30-60-75)

A. No provider shall have a claim of ownership on DME covered by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity (CMN), when there is an error in the ordering physician's CMN, or when the equipment was rented. DMAS shall not cover the DME and supply provider for services that are provided either: (i) prior to the date prescribed by the physician; (ii) prior to the date of the delivery; or (iii) when services are not provided in accordance with DMAS' published regulations and guidance doucments. In instances when the DME or supply is shipped directly to the Medicaid individual, the DME provider shall confirm that the DME or supplies have been received by the individual before submittig the claim for payment to DMAS.

B. DME providers, as defined in Attachment 3.1A&B, supplement 1, page 13 (12 VAC 30-50-165), shall retain copies on file of the fully completed CMN and all applicable supporting documentation for post payment audit reviews. Coverage that has been made by Medicaid shall be retracted if the DME and supplies have not been ordered on the CMN. Additional supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation shall not replace the requirement for a properly completed CMN. The dates of the supporting documentation shall coincide with the dates of service on the CMN. DME providers shall not create or revise CMNs or supporting documentation for durable medical equipment and supplies that have been provided once the post payment audit review has been initiated.

C. Individuals requiring only DME or supplies may obtain such services directly from the DME provider without having to consult or obtain services from a home health service or home health provider. Supplies used for treatment during a home health visit shall be included in the visit rate of the home health provider. Treatment supplies left in the home to maintain treatment after the visits shall be charged separately.

D. CMN requirements. The CMN shall have two required components: (i) the physician's order and (ii) the clinical diagnosis. Failure to have a complete CMN may result in nonpayment of services rendered or retraction of payments made subsequent to post payment audits.

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1. Physician's order.

   a. The physician's compelte order shall appear on theface of the CMN. A compelte order on the CMN shall consist of the item's complete description, the quantity ordered, the frequency of use, and the physician's signature and compelt date of signing as defined in Attachment 3.1 A&B, Supplement 1, page 13 (12 VAC 30-50-165). If the DME provider determines that the prescribing physician's signature and compete date of signing are missing, he shall consider the CMNto be invalid and he shall requiest a new CMN.

   b. The following CMN fileds (as indicated by an asterisk on the CMN) shall be required for coverage:

   (1) The ordered item's description. If the item is an E1399 (miscellaneous), the description of the item shall not be "miscellaneous DME", but the provider shall specify the DME item or supply.

   (2) The quantity ordered as found in the physician's order. For expendable supplies the provider shall designate supplies needed for one month. If an item is not needed every month, the provider may designate an alternate time frame.

   (3) The frequency of use of the DME item or supply.

   (4) The physician's signature and full date. If either the signature or full date, or both, are missing, then the entire CMN shall be deemed to be invalid and a new CMN shall be obtained. The physician's signature certifies that the ordered DME and supplies are a part of the treatment plan and are medically necessary for the Medicaid individual.

   c. The begin service date on the CMN is optional.

   (1) If the provider enters a begin service date, the CMN must be signed and dated by the physician within 60 days of the begin service date in order fo rth eCMN to srart from the begin date.

   (2) If no begin service date is documented on the CMN, the date of the physician's signature shall be the start date of the CMN.

2. The clinical diagnosis.

   a. The narrative description of the clinical diagnosis shall be recorded on the face of the CMN.

   b. The recording on the face of the CMN of the relevant ICD-9 diagnosis code shall be optional.

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3. Supporting documentation.

   a. Supporting documetnation may be included in the additional informaton attached to the CMN.

   b. The attachment of supporting documentation shall not replace the requirement for a properly completed CMN.

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K. Optometrists services are limit to examinations (refractions) after preauthorization by the State Agency except for eyeglasses as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

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K. Utilization control. Special Services. Repealed.

L. Standards in other specialized high quality programs such as the program of Crippled Children's Services will be incorporated as appropriate.

M. Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

N. Intensive Physical Rehabilitative Services.

1.1 A patient qualifies for intensive inpatient or outpatient physical rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to improve his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

1.2 In addition to the disability requirement, participates must meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing

1. Occupational Therapy
2. Physical Therapy
3. Cognitive Rehabilitation
4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

2.1 Within 72 hours of a patient's admission to an intensive rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be requested in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

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3.1 Documentation of rehabilitation services must, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;
B. Describe any prior treatment and attempts to rehabilitate the patient;
C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;
D. Document that a multi-disciplinary co-ordinated treatment plan specifically designated for the patient has been developed:
E. Document in detail of all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;
F. Document each change in each of the patient's conditions;
G. Describe responses to and the outcome of treatment; and
H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

3.2 Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided. All intensive rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual.

4.1 For a patient with potential for physical rehabilitation for which an outpatient assessment cannot be adequately performed, an intensive evaluation of no more than seven (7) calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

4.2 If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is not being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

4.3 Admissions for evaluation and/or training for solely vocational or education purposes or for developmental or behavioral assessments are not covered services.

5.1 Team conferences shall be held as often as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

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5.2 Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal in unlikely or further rehabilitation can be achieved in less intensive setting.

5.3 Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

6.1 Properly documented medical reasons for furlough may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

7.1 Discharge planning must be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

8.1 Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative Nursing

Rehabilitative Nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability. Rehabilitative Nursing are those services furnished a patient which meet all of the following conditions:

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1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation.

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis, and

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical Therapy: Physicial therapy services are those furnished a patient which meet all of the following conditions:

l. The service shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physicial therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physicial therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physicial therapist licensed by the Board of Medicine;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

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C. Occupational Therapy: Occupational therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a occupational therapist registered and certified by the American Occupational Therapy Certification Board;

2. The services shall by of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-Language Therapy: Speech-Language Therapy services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology, or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

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4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive Rehabilitation: Cognitive Rehabilitation services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

3. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

4. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are consequence of and related to a neurologic event;

5. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

6. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology: Psychology services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

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b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law, a licensed clinical social worker, a licensed professional counselor, or a licensed clinical nurse specialist-psychiatric;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

7. Social work services are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

8. Recreational therapy are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

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b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

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3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

I. Prosthetic/Orthotic Services

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial Prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

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12VAC 30-60-130. Hospice services.

A Admission criteria

1. Service election. To be eligible for hospice coverage under Medicare or Medicaid, the recipient shall be "terminally ill", defined as having a life expectancy of six months or less, and, and except for individuals under 21 years of age, elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director, or the attending physician and the physician member of the interdisciplinary team, must initially certify the life expectancy. The election statement shall include (i) identification of the hospice that will provide care to the individual; (ii) the individual's or representative's acknowledgement that he has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal illness; (iii) with the exception of children, defined as persons younger than 21 years of age, acknowledgement that certain Medicaid services are waived by the election; (iv) the effective date of the election; and (v) the signature of the individual or representative.

2. Service revocation. The recipient shall have the right to revoke his election of hospice services at any time during the covered hospice periods. DMAS shall be contacted if the recipient revokes his hospices services. If the recipient reelects the hospice services, the hospice periods will begin as an initial time frame. Therefore, the above certification and time requirements will apply. The recipient cannot retroactively receive hospice benefits from previously unused hospice period. The recipient's written revocation statement shall be maintained in the recipient's medical record.

B. General conditions. The general conditions provided in this subsection apply to nursing care, medical social services, physician services, counseling services, short-term inpatient care, durable medical equipment and supplies, drugs and biologicals, home health aide and homemaker services, and rehabilitation services.

The recipient shall be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy. Hospice services may be provided in the recipient's home or in a freestanding hospice, hospital or nursing facility.

The hospice shall obtain the written certification that an individual is terminally ill in accordance with the following procedures:

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1. For the initial 90-day benefit period of hospice coverage, a Medicaid written certification (DMAS 420) shall be signed and dated by the medical director of the hospice and the attending physician, or the physician member of the hospice interdisciplinary team and the attending physician, at the beginning of the certification period. This initial certification shall be submitted for preauthorization within 14 days from the physician's signature date. This certification shall be maintained in the recipient's medical record.

2. For the subsequent 90-day hospice period, a Medicaid written certification (DMAS 420) shall be signed and dated before or on the begin date of the 90-day hospice period by the medical director of the hospice or the physician member of the hospice's interdisciplinary team. The certification shall include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification of continued need for hospice services shall be maintained in the recipient's medical record.

3. After the second 90-day hospice period and until the recipient is no longer in the Medicaid hospice program, a Medicaid written certification shall be signed and dated every 60 days on or before the begin date of the 60-day period. This certification statement shall be signed and dated by the medical director of the hospice or the physician member of the hospice's interdisciplinary team. The certification shall include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification shall be maintained in the recipient's medical record.

C. Utilization review. Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the recipients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided. All hospice services shall be provided in accordance with guidelines established in the Virginia Medicaid Hospice Manual.

D. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

1. Interdisciplinary team. An interdisciplinary team shall include at least the following individuals: a physician (either a hospice employee or a contract physician), a registered nurse, a social worker, and a pastoral or other counselor. Other professionals may also be members of the interdisciplinary team depending on the terminally ill recipient's medical needs.

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2. Nursing care. Nursing care shall be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

3. Medical social services. Medical social services shall be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Physician services. Physician services shall be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy.

5. Counseling services. Counseling services shall be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

6. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

7. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

8. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

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9. Home health aide and homemaker services. Home health aides providing services to hospice recipients shall meet the qualifications specified for home health aides by 42 CFR 484.80. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services shall be provided under the general supervision of a registered nurse.

10. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

a. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

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b. Physical therapy services shall be those furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

c. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

(1) The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology;

(2) The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology; and

(3) The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice, including the requirement that the amount, frequency, and duration of the services shall be reasonable.

11. Documentation of hospice services shall be maintained in the recipient's medical record. Coordination of patient care between all health care professionals should be maintained in the recipient's medical record.

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§10.0 Community mental health services. (12 VAC 30-60-140)

A. Utilization review general requirements.

1. Utilization reviews shall be conducted, at a minimum annually at each enrolled provider, by the state Department of Medical Assistance Services (DMAS) or its contractors. During each review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.

B. The DMAS or its contractor review shall include the following items:

1. medical or clinical necessity of the delivered service;

2. the admission to service and level of care was appropriate;

3. the services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in Attachment 3.1 A and B, Supplement 1 §13d Rehabilitative services;

4. delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

C. Mental health services utilization criteria. (12 VAC 30-60-143) Utilization reviews shall include determinations that providers meet the following requirements.

a. The provider shall meet the federal and state requirements for administrative and financial management capacity.

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

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

d. The providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements will be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider’s participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in the provider appropriate guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.

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e. If an individual receiving services is also receiving targeted case management services, the provider must collaborate with the targeted case manager by notifying the case manager of the provisions of Community Mental Health Rehabilitative services and send monthly updates on the individual's progress. The provider must inform the primary care provider of the child's receipt of community mental health rehabilitative services. A discharge summary must be sent when the services are discontinued.

2. Therapeutic day treatment/partial hospitalization services shall be provided following an initial diagnostic assessment completed and authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or licensed clinical nurse specialist-psychiatric. The assessment shall be utilized to develop the Individual Service Plan (ISP). The ISP shall be fully completed by either the LMHP or the QMHP as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4 within 30 days of service initiation.

a. The enrolled provider of therapeutic day treatment/partial hospitalization shall be licensed by DBHDS as providers of therapeutic day treatment services.

b. ervices shall be provided by an LMHP, a QMHP, or a qualified paraprofessional under the supervision of a QMHP or an LMHP as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4.

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

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

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

a. Psychosocial rehabilitation services shall be provided following an assessment which clearly documents the need for services. The assessment shall be completed by an LMHP, or a QMHP, and approved by an LMHP within 30 days of admission to services. the assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history. An ISP shall be completed by the LMHP or the QMHP within 30 days of service initiation. Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP.

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b. Psychosocial rehabilitation services of any individual that continues more than six months must be reviewed by an LMHP who must document the continued need for the service. The ISP shall be rewritten at least annually.

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

d. Psychosocial rehabilitation services may be provided by an LMHP, a QMHP, or a qualified paraprofessional under the supervision of a QMHP or an LMHP.

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

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

4. Admisison to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.

a. The crisis intervention services provider shal be licensed as aprovider of outpatient services by DBHDS.

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

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

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

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

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

g. An LMHP, a QMHP, or certified prescreener must conduct a face-to-face assessment. If the QMHP performs the assessment, it must be reviewed and approved by a LMHP or certified prescreener within 72 hours of the face-to-face assessment. The assessment shall document the need for and the anticipated duration of the crisis service. Crisis intervention will be provided by an LMHP, certified prescreener, or QMHP.

h. Crisis intervention shall not require an ISP.

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

j. Services must be documented through daily notes and a daily log of time spent in the delivery of services.

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10. Services must be documented through daily notes and a daily log of time spent in the delivery of services.

E. Case management services. (pursuant to Supp 1 of Attachment 3.1 A&B, pp 30-31.4)

NOTE: Subsection E (Case Management Services) has been moved to Supplement 2 of Attachment 3.1, page 3.1-A, page 6.1 of 25, Subsection I.

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F. Intensive community treatment (ICT) for adults.

a. An assessment which documents eligibility and need for this service shall be completed by the LMHP or the QMHP prior to the initiation of services. This assessment must be maintained in the indivdaul's records. This assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history.
b. An Individual Service Plan, based on the needs as determined by the assessment, must be initiated at the time of admission and must be fully developed by the LMHP or QMHP and approved by the LMHP within 30 days of the initiation of services.
c. ICT may be billed if the client is brought by ICT staff to see the psychiatrist. Documentation must be present to support this intervention. DMAS does not include time and transportation services in ICT reimbursement.
d. The enrolled ICT provider shall be licensed by the DBHDS as a provider of intensive community sevices or as a program of assertive commuinuity treatment, andmust provide andmake available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on call.
e. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

G. Crisis stabilization services.

a. This service must be authorized following a face-to-face assessment by an LMHP, a certified pre-screener, or a QMHP. If the assessment is provided by a certified pre-screener or QMHP, this assessment must be reviewd and approved by a LMHP within 72 hours of the assessment. The signoff by the LMHP constitutes authorization for the service.

b. The assessment must document the need for crisis stabilization services and antifipate dduatrion fo need. The assessment shall incude, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history.

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c. The Individual Service Plan (ISP) must be developed or revised within 10 business days of the approved assessment or reassessment. The LMHP, certified pre-screener, or QMHP shall develop the ISP.
d. Room and board, custodial care, and general sukpervision are not components of this service.
e. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization servives are provided but docuemtnaiton must clearly support the separation of the services with distinct treatment goals.
f. Individuals qualifying for this ervice must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which uts the individual at risk of psychiatric hospitalization.
g. Provides of crisis stabilization shall be licensed by DBHDS as providers of outpatient services.

H. Mental health support services.

1. At admission, an appropriate face-to-face assessment must be made and documented by the LMHP or a LMHP-eligible, indicating that service needs can best be met through mental health support services. This admission assessment must be completed by the LMHP, or the LMHP-eligible, within 30 days of the date of admission. This admission assessment shal be utilized to develop the Individual Service Plan (ISP). The assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history. The LMHP or the QMHP will compelte the ISP within 30 days of the admission to this service. The ISP must indicate the specific supports and services to be provided and the goals and objectives to be accomplished. The LMHP or the QmHP will supervise the care if delivered by the qualified paraprofessional.

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b. Every three months, the LMHP or the LMHP-eligible, or the QMHP must review, modify as appropriate, and update the ISP. If the QMHP reviews the ISP, it must be rviewed face to face with the LMHP or the LMHP-eligible, and must be documented in the client's record. The ISP must be rewritten at least annually.
c. Only direct face-to-face contacts and services to individuals shall be reimbursable.
d. Any services provided to the client that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.
e. Any services provided to clients that are strictly vocational in nature shall not be billable. However, support activities and activities directly relate dot assisting a client to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.
f. Room and board, custodial care, and general supervision are not components of this service.
g. This sevice is not billable for individuals who reside in facilities where staff are expected to provide such services under facility licensure requirements.
h. Provider qualifications. The enrolled provider of mental health support services must be licensed by DBHDS as a provider of supportive in-home services, intensive community treatment, or as a program of assertive community treatment. Individuals employed or contracted by the provider to provide mental health support services must have training in the charactieristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.

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i. Mental health support services, which continue for six consecutive months, must be reviewed and renewed at the end of the six-month period of authorization by an LMHP or LMHP-eligible who must document the continued need for the services. The LMHP or LMHP-eligible must see the client face-to-face to conduct the six-month review.
j. Mental health support services must be docuemtned through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.

D. Mental retardation utilization criteria. Repealed.

B. Substance abuse treatment services utilization review criteria (12 VAC 30-60-147)

1. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The services referenced below msut be rendered to program participants and docuemtned in their case file in order for this residential service to be reimbursed by Medicaid. The residential facilities in which these services are provided shall have 16 beds or less. Covered services are found at Supp 3 to Attach 3.1 A&B, pp 2 through 4 of 8.

a. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in Supp. 3 to Attach 3.1 A&B, pp 6 through 8 of 8. The assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history.

(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of

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the appropriately authorized professionals , based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior toadmission.

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(c) Services for the individual must be preauthorized annually by DMHMRSAS.

(d) Each individual must have a written plan of care developed by the provider which must be fully complete within 30 days of initiation of the service, with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.

(e) The provider must update the plan of care at least annually.

(f) The individual's record must contain adequate documentation concemmg progress or lack thereof in meeting plan of care goals.

(g) The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be at least four but less .than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of e reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

(h) The provider must be licensed by DMHMRSAS.

2. Appropriate use of case management services for persons with mental retardation requires the following conditions to be met:

a. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services must be obtained from DMHMRSAS Care Coordination Unit annually.

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b. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of on face-to-face contact within a 90-day period.

c. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

(1) The plan of care shall be reviewed by the case manager every three months to erisure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a gr;tce period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.

(2) The need for case management services shall be assessed and justified through the development of an annual consumer service plan.

d. The individual's record must contain adequate documentation concernmg progress or lack thereof in meeting the consumer service plan goals.

E. Substance abuse treatment services utilization review criteria. (12 VAC 30-60-147)

1. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid. \

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a. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC 30-50-510.

(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment *o(* Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

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(4) The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

(5) The ISP shall be reviewed and updated every two weeks.

(6) Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

(7) Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

(8) While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently r dered toher.

(9) Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

b. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

(1) The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.

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2. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24- hour access to services for the woman and ongoing training and consultation to the staff of the program.

3. In addition, the provider must proviµe access to the following services either through staff at the residential program or through contract:

(a) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(b) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(c) Medication management as needed or at least quarterly for women in the program, which mi.ist be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(d) Psychological treatment, as appropriate, for women present in the program, with clinical superv1srnn provided by a clinical psychologist licensed to practice by the Board of Psychology.

(e) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

2. Program and staff qualifications. In order to be eligible for Medicaid reim bursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide residential substance abuse services.

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b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abus<;: counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; ervice coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

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C. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC 30-50-510.

b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II. I (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II. I (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

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e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face-to-face therapeutic contact with the woman which is directly related to her ISP shall be documented at least once per week.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-fr e environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, mental retardation or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.

b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.

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c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Prof ssions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine m consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement , the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

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(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Licensed Professional Counselors , Marriage and Family Therapists and Substance Abuse Treatment Professionals or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibiilties; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

B. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

1. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC 30-50-510.

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a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level ill.3 (Clinically-Managed Medium-futensity Residential Treatment) or Level ill.5 (Clinically-Managed Medium/High futensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level ID.3 (Clinically- Managed Medium-futensity Residential Treatment) or Level ill.5 (Clinically-Managed Medium-High futensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance- Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

b. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

d. The fudividual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

e. The ISP shall be reviewed and updated every two weeks.

f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

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g. Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently rendered to her.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

2. Linkages to other services. Access to the following services shall be provided and documented ih either the woman's n;cord or the program documentation:

a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.

b. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.

c. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(1) Psychiatric assessments as needed , which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professio ns.

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(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

3. Program and staff qualifications . In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide residential substance abuse services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

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(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

C. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in 12VAC 30-50-510.

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b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.I (Intensive Outpatient Treatment) or Level II.5 (Partial Hospjtalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II. I (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face-to-face therapeutic contact with the woman which is directly related to her ISP shall be documented at least once per week.

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i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority seryices of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, mental retardation or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.

b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.

c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

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(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine m consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

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(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordtnation; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

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Q. General Outpatient Physical Rehabilitation Services

1. Scope

A. Medicaid covers general outpatient physical rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals and by rehabilitation agencies which have a provider agreement with the Department of Medical Assistance Services (DMAS).

B. Outpatient rehabilitative services shall be prescribed by a physician and be part of a written plan of care.

C. Outpatient rehabilitative services shall be provided in accordance with guidelines found in the Virginia Medicaid Rehabilitation Manual, with the exception of such services provided in school divisions which shall be provided in accordance with guidelines found in the Virginia Medicaid School Division Manual. Utilization review shall include determinations that providers meet all the requirements of Virginia state regualtions found at VR 460-04-3.1300. Utilization review shall be performed to ensure that services are appropriately provided and that services provided to Medicaid recipients are medically necessary and appropriate.

2. Covered Outpatient Rehabilitative Services.

A. Covered outpatient rehabilitative services shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of hospitals, rehabilitation agencies, and home health agencies.

D. Covered outpatient rehabilitative services for long-term, chronic conditions shall include physical therapy, occupational therapy, and speech-language pathology services. Any one of these services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Such services may be provided by outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, and school divisions.

3. Eligibility Criteria for Outpatient Rehabilitative Services. To be eligible for general outpatient rehabilitative services, the patient must require at least one of the following services: physical therapy, occupational therapy, and speech-language pathology services. All rehabilitative services must be prescribed by a physician.

3. Criteria for the Provision of Outpatient Rehabilitative Services. All practitioners and providers of services shall be required to meet State and Federal licensing and/or certification requirements. Services not specifically documented in patient's medical record as having been rendered shall be deemed not to have been rendered, and no coverage shall be provided.

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A. Physical therapy services meeting all of the following conditions shall be furnished to patients:

1. Physical therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and is under the direct supervision of a physical therapist licensed by the Board of Medicine. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

B. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

1. Occupational therapy services shall be directly and specifically related to an active written care plan designed by a physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board, a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association when under the supervision of an occupational therapist as defined above, or an occupational therapy assistant who is certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined above. When occupational therapy services are provided by a qualified occupational therapy assistant or a graduate engaged in supplemental clinical experience required before registration, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

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3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that amount, frequency, and duration of the services shall be reasonable.

C. Speech-language therapy services shall be those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology; and

3. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

5. Authorization for Services

A. Physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, rehabilitation agencies, home health agencies, or school divisions shall include authorization for up to twenty-four (24) visits (without authorization) by each ordered rehabilitative service annually. The provider shall maintain documentation to justify the need for services. A visit shall be defined as the duration of time that a rehabilitative therapist is with a client to provide services prescribed by the physician. Visits shall not be defined in measurements or increments of time.

B. The provider shall request from DMAS authorization for treatments deemed necessary by a physician beyond the number authorized. Documentation for medical justification must include physician orders or a plan of care signed by the physician. Authorization for extended services shall be based on individual need. Payment shall not be made for additional service unless the extended provision of services has been authorized by DMAS. Periods of care beyond those allowed which have not been authorized by DMAS shall not be approved for payment.

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6. Documentation Requirements.

   A. Documentation of general outpatient rehabilitative services provided by a hospital-based outpatient setting, home health agency, school division, or a rehabilitation agency shall, at a minimum:

      1. describe the clinical signs and symptoms of the patient's condition;

      2. include an accurate and complete chronological picture of the patient's clinical course and treatments;

      3. document that a plan of care specifically designed for the patient has been developed based upon a comprehensive assessment of the patient's needs;

      4. include a copy of the physician's orders and plan of care;

      5. include all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response, and identify who provided care (include full name and title);

      6. describe changes in each patient's condition and response to the rehabilitative treatment plan; and

      7. describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

   B. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

7. Service Limitations. The following general conditions shall apply to reimbursable physical rehabilitative services:

   A. Patient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his license.

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B. Services shall be furnished under a written plan of treatment and must be established and periodically reviewed by a physician. The requested services or items must be necessary to carry out the plan of treatment and must be related to the patient's condition.

C. A physician recertification shall be required periodically, must be signed and dated by the physician who reviews the plan of treatment, and may be obtained when the plan of treatment is reviewed. The physician recertification statement must indicate the continuing need for services and should estimate how long rehabilitative services will be needed.

D. The physician orders for therapy services shall include the specific procedures and modalities to be used, identify the specific discipline to carry out the plan of care, and include the frequency and duration for services.

E. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

F. Rehabilitation care is to be terminated regardless of the approved length of stay when further progress toward the established rehabilitation goal is unlikely or when the services can be provided by someone other than the skilled rehabilitation professional.

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12 VAC 30-60-170.
Utilization review of treatment foster care case management services (TFC). Service description and provider Qualifications. TFC case management is a community based program where treamtne sercies are designed to address the special needs of children. TFC case management focuses on a continuity of services, is goal directed and results oriented. Services shall not include room and board. Child placing agencies licensed or certified by the Virginia Department of Social Services and which meet the provider qualifications for treatment foster care set forth in these regulations shall provide these services.

A. Utilization Control.

1. Assessment. Each child referred for TFC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act or by an interdisciplinary team approved by the State Executive Council. For purposes of high quality case management services, the team must: (i) Assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (ii) Assess the potential for reunification of the recipient's family; (iii) Set treatment objectives; and (iv) Prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified assessors. A Family Assessment and Planning Team (FAPT) as authorized by the *Code of Virginia* § § 2.1-753, 754 and 755.

3. Preauthorization. Preauthorization shall be required for Medicaid payment of TFC case management services for each admission and will be conducted by DMAS or its utilization management contractor. When service is authorized, an initial length of stay will be assigned. The provider must request authorization for continued stay. Failure to obtain authorization of Medicaid reimbursement for this service within 10 days of admission will result in denial of payments or recovery of expenditures.

4. Medical Necessity Criteria. Children whose conditions meet this medical necessity criteria will be eligible for Medicaid payment for TFC case management. TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs, would be at risk for placement into a more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs, or group homes. The child must have documented moderate to severe impairment and moderate to severe risk factors as recorded on a state designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. Level I. The child must display moderate impairment with one or more of the following moderate risk factors, as documented on the state designated uniform assessment instrument:

(1) Needs instensive supervision to prevent harmful consequences;
(2) Moderate/frequent disruptive or noncompliant behaviors in home setting which increase the risk to self or others;
(3) Needs assistance of trained professionals as caregivers.

b. Level II. The child must display a significant impairment or problems with authority, impulsivity, and caregiver issues, as documented on the state designated uniform assessment instrument. For example, the child must:

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(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 child must display a significant impairment with severe risk factors as documented on the state designated uniform assessment instrument. Child must demonstrate risk behaviors that create significant risk of harm to self or others.

1. FC Case Management Admission Documentation Required. Before Medicaid preauthorization will be granted, the referring entity must submit to DMAS the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the Department's medical necessity criteria.

a. A completed state designated uniform assessment instrument together; AND

b. All of the following docuementation:

(1) Diagnosis, (Diagnostic Statistical Manual, Fourth Revision (DSM IV), including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Pshychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning;

(2) Description of the child's immediate behavior prior to admission;

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d. Description of alternatives tried or explored;

e. The child's functional level;

f. Clinical stability;

g. The level of family support available;

h. Initial plan of care, AND

i. One of the following:

(i) Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care; or

(ii) Certification by the FAPT that TFC case management is medically necessary.

1. Penalty for failure to obtain preauthorization or to prepare and maintain the previously described documentation. The failure to obtain authorization for this service within 10 days of admission or to develop and maintain the documenteation enumerated above will result in denial of payments or recovery expenditures.

B. Non-covered services. Permanency planning and other activities performed by foster care workers shall not be considered covered services and shall not be reimbursed.

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ALTERNATIVE BENEFITS
REPEALED IN SPA TN 14-10, EFFECTIVE 1/1/2014
ALTERNATIVE BENEFITS

DISEASE MANAGEMENT—REPEALED

This page replaces pages 57 through 64 of 64 of Attachment 3.1-C.

Next page is Supplement 1 to Attachment 3.1-C Nursing Facility Criteria