12 VAC30-50-130. Skilled Nursing Facility Services, EPSDT, and Family Planning.

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

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

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

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

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

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

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

5. Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These

services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

b. Therapeutic day treatment shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; medication; education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.

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

(i) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(ii) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a licensed mental health professional.

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

(iv) Authorization is required for Medicaid reimbursement.

(v) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(vi) Providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Education under the Standards for Interdepartmental Regulation of Children's Residential Facilities.

(vii) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management.

(viii) The facility/group home must coordinate services with other providers.

d. Therapeutic Behavioral Services (Level B).

(i) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a

condition due to mental, behavioral or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(ii) Authorization is required for Medicaid reimbursement.

(iii) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(iv) Providers must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities.

(v) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community based group home.

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

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

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

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

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

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

C. Family planning services and supplies for individuals of child-bearing age.

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

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

C. Family planning services and supplies for individuals of child-bearing age.

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

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

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); 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 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 LMHP or the QMHP and approved by the LMHP, documenting that service needs can best be met through intervention provided typically but not solely in the client's residence. An Individual Service Plan (ISP) 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. In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community if supported by the needs assessment and ISP.

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 12 VAC 30-50-226. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12 VAC 30-50-226.

10. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per client/family 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 weeks of service. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

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

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

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

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:

(1) This programming during the school day; or

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

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

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

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

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 Department of Mental Health, Mental Retardation and Substance Abuse Services to provide day support services.

5. Services must be provided by a LMHP, a QMHP or a QPPMH who is supervised by a QMHP or LMHP.

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.

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. 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. Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

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

1. The staff ratio must be at least 1 to 6 during the day and at least 1 to10 while asleep. The program director supervising the program/group home must be, at minimum, a qualified mental health professional (as defined in 12VAC35-105-20) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.

2. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, defined in 12VAC30-50-226.

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

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

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

1. 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.

2. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, as defined at 12VAC30-50-226. The program/group home must coordinate services with other providers.

3. 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.

4. 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. Utilization Review

1. 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.

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

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

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

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

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

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

An individual eligible for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is a child, under the age of 21 years, for whom proper treatment of his

psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a Licensed Mental Health Professional.

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

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

1. For an individual who is already a Medicaid recipient when he is admitted to a facility or program, certification must be made by an independent certifying team that:

a. Includes a licensed physician who~~;~~ :

~~b.~~ (i) Has competence in diagnosis and treatment of pediatric mental illness; and

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

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

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

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

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

c. Be signed and dated by a physician ~~member~~ and ~~of~~ the team.

12VAC30-130-870. Preauthorization.

A. Authorization for ~~residential treatment~~ Residential Treatment (Level C) shall be required within one business day of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At preauthorization, an initial length of stay shall be assigned and the residential treatment provider shall be responsible for obtaining authorization for continued stay. ~~Reimbursement for residential treatment will be implemented on January 1, 2000. For cases already in care, DMAS will reimburse beginning January 1, 2000, or from the date when the required documentation is received and approved if the provider has a valid Medicaid provider agreement in effect on that date.~~

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

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

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

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

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

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

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

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

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

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

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

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

e. The level of family support available; and

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

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

1. A State Uniform Assessment Instrument, completed no more than 90 days prior to the date of submission;
2. Documentation that the required services are provided as indicated;
3. Current (within the last 30 days) information on progress related to the achievement of treatment goals. The treatment goals must address the reasons for admission, including a description of any new symptoms amenable to treatment;
4. Description of continued impairment, problem behaviors, and need for Residential Treatment level of care.

~~D.~~ E. Denial of service may be appealed by the recipient consistent with 12VAC30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act (§9-6.14:4.1 et seq. of the Code of Virginia).

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

G. Authorization for Level A and Level B residential treatment shall be required within three (3) business days of admission and shall be conducted by DMAS or its utilization management contractor using medical necessity criteria specified by DMAS. At the time of such preauthorization, an initial length of stay must be assigned and the provider shall be responsible for obtaining authorization for continued stay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. The level of family support available; and

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

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

J. Continued Stay Criteria for Levels A and B:

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

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

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

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

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

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

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

K. Discharge Criteria for Levels A and B.

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

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

or

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

12VAC30-130-880. Provider qualifications.

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

B. Providers of residential treatment services (Level C) must be:

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

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

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

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

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

12VAC30-130-890. Plans of care; review of plans of care.

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

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

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

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

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

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

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

6. Plans for discharge~~.~~, and

7. The initial plan of care must be signed and dated by the physician.

C. The Comprehensive Individual Plan of Care (CIPOC) for Level C must meet all of the following criteria:

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

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

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

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

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

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

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

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

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

F. Team developing the Comprehensive Individual Plan of Care for Level C. The following requirements must be met:

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

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

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

c. Setting treatment objectives; and

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

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

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

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

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

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

a. A psychiatric social worker;

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

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

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

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

H. For Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B), the initial plan of care must be completed at admission by the Licensed Mental Health Professional (LMHP) and a Comprehensive Individual Plan of Care must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

I. For Community Based Services for Children and Adolescents under 21 (Level A), the initial plan of care must be completed at admission by the QMHP and a Comprehensive

Individual Plan of Care must be completed by the QMHP no later than 30 days after admission. The individualized plan of care must be signed and dated by the Program director.

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

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

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

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

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

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

6. Plans for discharge

K. The Comprehensive Individual Plan of Care (CIPOC) for Levels A and B must meet all of the following criteria:

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

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

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

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

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

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

1. The response to services provided; and

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

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

4. Updates must be signed and dated by the service provider.

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