COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Davis Creef** DC
Assistant Attorney General
Office of the Attorney General

DATE: **February 23, 2022**

SUBJECT: **Fast-Track Regulation – Mental Health and Substance Use Case Management**

You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law. I have reviewed the attached fast-track regulations posted to the Virginia Regulatory Town Hall that would align DMAS policies regarding mental health and substance use case management with federal regulation.

Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services under Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Under Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulation serving as the Notice of Intended Regulatory Action.

If you have any questions or need additional information about these regulations, please contact me at 786-6522.

cc: Kim F. Piner, Esq.

Attachment

Proposed Text

highlight

Action: Mental Health and Substance Use Case Management
Stage: Fast-Track 1/27/22 8:48 AM [latest]

12VAC30-50-420 Case management services for seriously mentally ill adults and emotionally disturbed children

A. Target Group: The Medicaid eligible individual shall meet the DBHDS definition for "serious mental illness," or "serious emotional disturbance in children and adolescents."

1. An active client for case management shall mean 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 others including at least one face-to-face contact every 90 days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur. Authorization is required for Medicaid reimbursement.

2. There shall be no maximum service limits for case management services. ~~Case management shall not be billed for individuals who are in institutions for mental disease.~~ In accordance with 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds, in accordance with 1905(i) of the Social Security Act.

3. For individuals ages 22-64, services rendered during the same month as the admission to the IMD are reimbursable as long as the service was rendered prior to the date of the admission.

4. Case management services for individuals under age 21 and over 64 in an IMD may be billed 30 days prior to discharge as long as the case management services do not duplicate other services provided by the institution.

B. Services will be provided to the entire state.

C. Comparability of Services: Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of Services: Mental health services. Case management services assist individual children and adults, in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the individualized service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts with the individuals' significant others to promote implementation of the service plan and community adjustment;

7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of Providers:

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and individuals with serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental health case management, the provider of the services must meet certain criteria. These criteria shall be:

a. The provider must have the administrative and financial management capacity to meet state and federal requirements;

b. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

c. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services;

d. The provider must be licensed as a provider of case management services by the DBHDS; and

e. Persons providing case management services must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

(2) The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;

(3) Different types of assessments, including functional assessments, and their uses in service planning;

(4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(5) The service planning process and major components of a service plan;

(6) The use of medications in the care or treatment of the population served; and

(7) All applicable federal and state laws, state regulations, and local ordinances.

f. Persons providing case management services must have skills in:

(1) Identifying and documenting an individual's needs for resources, services, and other supports;

(2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;

(3) Identifying services and resources within the community and established service system to meet the individual's needs; and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/rehabilitative and life goals; and

(4) Coordinating the provision of services by public and private providers.

g. Persons providing case management services must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently, performing position duties under general supervision; and

(3) Engage and sustain ongoing relationships with individuals receiving services.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers.

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Case management services may not be billed concurrently with intensive community treatment services, treatment foster care case management services or intensive in-home services for children and adolescents.

12VAC30-50-430 Case management services for youth at risk of serious emotional disturbance

A. Target group: Medicaid eligible individuals who meet the DBHDS definition of youth at risk of serious emotional disturbance.

1. An active client shall mean 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 others including at least one face-to-face contact every 90-days. Billing can be submitted for an active client only for months in which direct or client-related contacts,

activity or communications occur. Authorization is required for Medicaid reimbursement.

2. There shall be no maximum service limits for case management services. Case management services must not be billed for individuals who are in institutions for mental disease or individuals of any age who are inmates of public institutions with the exceptions described in 12VAC30-50-420 A.

B. Services will be provided in the entire state.

C. Comparability of services: Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services: Mental health services. Case management services assist youth at risk of serious emotional disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan;

2. Linking the individual directly to services and supports specified in the treatment/services plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts which are nontherapy contacts with an individual's significant others to promote treatment and/or community adjustment;

7. Following up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of providers.

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers, to the community services boards only, to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act. To qualify as a provider of case management services to youth at risk of serious emotional disturbance, the provider of the services must meet the following criteria:

a. The provider must meet state and federal requirements regarding its capacity for administrative and financial management;

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

c. The provider must provide services in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services;

d. The provider must be licensed as a provider of case management services by the DBHDS; and

e. Persons providing case management services must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

(2) The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues;

(3) Different types of assessments, including functional assessments, and their uses in service planning;

(4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(5) The service planning process and major components of a service plan;

(6) The use of medications in the care or treatment of the population served; and

(7) All applicable federal and state laws, state regulations, and local ordinances.

f. Persons providing case management services must have skills in:

(1) Identifying and documenting an individual's need for resources, services, and other supports;

(2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;

(3) Identifying services and resources within the community and established service system to meet the individual's needs; and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/ rehabilitative and life goals; and

(4) Coordinating the provision of services by diverse public and private providers.

g. Persons providing case management services must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently performing position duties under general supervision; and

(3) Engage and sustain ongoing relationships with individuals receiving services.

F. Providers may bill Medicaid for mental health case management to youth at risk of serious emotional disturbance only when the services are provided by qualified mental health case managers.

G. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

H. Payment for case management services under the plan must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case management may not be billed concurrently with intensive community treatment services, treatment foster care case management services, or intensive in-home services for children and adolescents.

12VAC30-50-491 Substance use case management services for individuals who have a primary diagnosis of substance use disorder

A. Target group:

1. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for a substance use disorder. Tobacco-related disorders or caffeine-related disorders and nonsubstance-related disorders shall not be covered. Substance use case management shall include an active individual service plan (ISP) that requires a minimum of two substance use case management service activities each month and at least one face-to-face contact with the individual at least every 90 calendar days.

2. There shall be no maximum service limits for case management services.

3. In accordance with 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

4. For individuals ages 22-64, services rendered during the same month as the admission to the IMD are reimbursable as long as the service was rendered prior to the date of the admission.

5. Case management services for individuals under age 21 and over age 64 in an IMD may be billed 30 days prior to discharge as long as the case management services do not duplicate other services provided by the institution.

B. Services will be provided to the entire state.

C. Comparability of services: Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

D. Definition of services: Substance use case management services assist individuals and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the individual's basic needs. Substance use case management is reimbursable on a monthly basis only when the minimum substance use case management service activities are met. ~~Substance use case management services are not reimbursable for individuals while they are residing in institutions, including institutions for mental disease, except that substance use case management may be reimbursed during the month prior to discharge to allow~~

~~for discharge planning. This is limited to two one-month periods during a 12-month period.~~ Tobacco-related disorders or caffeine-related disorders and nonsubstance-related disorders shall not be covered. Substance use case management does not include maintaining service waiting lists or periodically contacting or tracking individuals to determine potential service needs. Substance use case management services are to be person centered, individualized, and culturally and linguistically appropriate to meet the individual's and family member's needs.

Substance use case management service activities to be provided shall include:

1. Assessing needs and planning services to include developing a substance use case management individual service plan (ISP). The ISP shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service;

2. Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;

3. Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's ISP and his community adjustment;

4. Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the individual as developed in the ISP;

5. Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;

6. Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments;

7. Monitoring service delivery through contacts with individuals receiving services and service providers and site and home visits to assess the quality of care and satisfaction of the individual;

8. Providing follow-up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;

9. Advocating for individuals in response to their changing needs, based on changes in the ISP;

10. Planning for transitions in the individual's life;

11. Knowing and monitoring the individual's health status, any medical condition, and medications and potential side effects and assisting the individual in accessing primary care and other medical services, as needed; and

12. Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other participants, or staff at risk of serious harm.

E. Qualifications of providers:

1. The provider of substance use case management services must meet the following criteria:

a. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements;

b. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements; and

c. The enrolled provider must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of substance abuse case management services.

2. Providers may bill Medicaid for substance use case management only when the services are provided by a professional or professionals who meet at least one of the following criteria:

a. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least either (i) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness;

b. Licensure by the Commonwealth as a registered nurse with (i) at least one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or

c. Certification as a Board of Counseling Certified Substance Abuse Counselor (CSAC), CSAC Supervisee or CSAC-Assistant under clinical supervision as defined in 18VAC115-30-10 et seq.

F. The state assures that the provision of substance use case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible individuals shall have free choice of the providers of substance use case management services.

2. Eligible individuals shall have free choice of the providers of other services under the plan.

G. Payment for substance use case management or substance use care coordination services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other Title XIX program authorities for this same purpose.

H. The state assures that the individual will not be compelled to receive substance use case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

I. The state assures that providers of substance use case management service do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

J. The state assures that substance use case management is only provided by and reimbursed to community case management providers.

K. The state assures that substance use case management does not include the following:

1. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

2. Activities for which an individual may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c)of the Social Security Act.

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

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

"Child or adolescent" means the same as "adolescent or child" defined in 12VAC30-50-130.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC30-50-130.

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

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

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

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC30-50-130.

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

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

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

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

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

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

the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

5. If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

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

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

(a) Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review the ISP, modify the ISP as appropriate, and update the ISP, and all of these activities shall occur with the individual in a manner in which the individual may participate in the process. The ISP shall be rewritten at least annually.

(b) The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly-identified problems.

(c) Documentation of ISP review shall be added to the individual's medical record no later than 15 days from the calendar date of the review as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E, and the individual.

C. Day treatment/partial hospitalization services shall be provided following a service-specific provider intake and be authorized by the LMHP, LMHP-R, LMHP-RP, or LMHP-S. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, the QMHP-

A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days of service initiation.

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

2. Services shall only be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-C, QMHP-E, or an LMHP, LMHP-R, LMHP-RP, or LMHP-S as defined at 12VAC35-105-20, except for LMHP-R, LMHP-RP, and LMHP-S, which are defined in 12VAC30-50-226.

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

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

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

1. Psychosocial rehabilitation services shall be provided following a service-specific provider intake that clearly documents the need for services. This intake shall be completed by either an LMHP, LMHP-R, LMHP-RP, or LMHP-S. An ISP shall be completed by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, or the QMHP-A, QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days of service initiation. At least every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-C, or QMHP-E must review, modify as appropriate, and update the ISP.

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

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

4. Psychosocial rehabilitation services may be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

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

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

E. Initiation of crisis intervention services shall be indicated following a service-specific provider intake that documents a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. In order to receive reimbursement, providers shall register this service

with DMAS or its contractor within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

1. The crisis intervention services provider shall be licensed as a provider of emergency services by DBHDS.

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

3. 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.

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

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. There are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

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

7. An LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener shall conduct a face-to-face service-specific provider intake. The intake shall document the need for and the anticipated duration of the crisis service.

8. Crisis intervention shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener.

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

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

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

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is an ISP in effect that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, and others including a minimum of one face-to-face individual contact

within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

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

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

4. Reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions pursuant to 12VAC30-50-420 and 12VAC30-50-430.

~~4.~~ 5. The ISP shall document the need for case management and be fully completed within 30 calendar days of initiation of the service. The case manager shall review the ISP at least every ~~three months~~ 90 calendar days. ~~The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review~~. Such reviews shall be documented in the individual's medical record.

6. Reviews will be due by the end of the month following the 90th calendar day from when the last review was completed. If needed, a grace period will be granted up to the last day of the next month. When the review was completed in a grace period, the next subsequent review shall be required within 90 calendar days from when the review was due and not the date of the actual review.

~~5.~~ 7. The ISP shall also be updated at least annually.

~~6.~~ 8. The provider of case management services shall be licensed by DBHDS as a provider of case management services.

G. Intensive community treatment (ICT).

1. A service-specific provider intake that documents eligibility and the need for this service shall be completed by either the LMHP, LMHP-R, LMHP-RP, or LMHP-S prior to the initiation of services. This intake documentation shall be maintained in the individual's records.

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

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

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

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There

must also be at least a weekly note documenting panrogress or lack of progress toward goals and objectives as outlined on the ISP.

H. Crisis stabilization services.

1. This service shall be initiated following a face-to-face service-specific provider intake by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener, as defined in 12VAC30-50-226.

2. In order to receive reimbursement, providers shall register this service with DMAS or its contractor within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

3. The service-specific provider intake must document the need for crisis stabilization services.

4. The Individual Service Plan (ISP) must be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-R, LMHP-RP, LMHP-S, certified prescreener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.

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

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

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

8. Providers of residential crisis stabilization shall be licensed by DBHDS as providers of residential or nonresidential crisis stabilization services. Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health nonresidential crisis stabilization.

I. Mental health skill-building services as defined in 12VAC30-50-226 B 6.

1. At admission, an appropriate face-to-face service-specific provider intake must be conducted, documented, signed, and dated by the LMHP, LMHP-R, or LMHP-RP. Providers shall be reimbursed one unit for each intake utilizing the appropriate billing code. Service-specific provider intakes shall be repeated upon any lapse in services of more than 30 calendar days. Services of any individual that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service in the individual's medical record.

2. The primary psychiatric diagnosis shall be documented as part of the intake. The LMHP, LMHP-R, LMHP-RP, or LMHP-S performing the intake shall document the primary mental health diagnosis on the intake form.

3. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall complete, sign, and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP. The total

time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall indicate the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished, and criteria for discharge as part of a discharge plan that includes the projected length of service. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.

4. Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in a manner in which he may participate with the process, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

a. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem.

b. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to either DMAS or the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows or has reason to know of the individual's nonadherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any nonadherence to the prescribed medication regimen. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any concerns about medication nonadherence (provided that the individual has consented to such sharing of information). The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the prescribing professional works for;

d. Date and time of call;

e. Reason for the care coordination call;

f. Description of medication regimen issue or issues to be discussed; and

g. Whether or not there was a resolution of medication regimen issue or issues.

8. Discharge summaries shall be prepared by providers for all of the individuals in their care. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record.

9. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record. The provider shall document evidence of the individual's prior psychiatric services history, as required by 12VAC30-50-226 B 6 b (3) and 12VAC30-50-226 B 6 c (4), by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Documentation of telephone contacts with the prior provider shall include the following minimum elements:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the professional works for;

d. Date and time of call;

e. Specific placement provided;

f. Type of treatment previously provided;

g. Name of treatment provider; and

h. Dates of previous treatment.

Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

10. The provider shall document evidence of the psychiatric medication history, as required by 12VAC30-50-226 B 6 b (4) and 12VAC30-50-226 B 6 c (5), by maintaining a photocopy of prescription information from a prescription bottle or by contacting the current or previous prescribing provider of health care services or pharmacy after obtaining written consent from the individual. Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain (i) the name of the prescribing physician, (ii) the name of the medication with dosage and frequency, and (iii) the date of the prescription shall be sufficient to meet these criteria. Family member statements shall not suffice to meet this requirement.

11. In the absence of such documentation, the current provider shall document all contacts (i.e., telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements: (i) name and title of caller, (ii) name and title of prior professional who was called, (iii) name of organization that the professional works for, (iv) date and time of call, (v) specific prescription confirmed, (vi) name of prescribing physician, (vii) name of medication, and (viii) date of prescription.

12. Only direct face-to-face contacts and services to an individual shall be reimbursable.

13. Any services provided to the individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction or tutoring in reading, science, mathematics, or GED.

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

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

16. Provider qualifications. The enrolled provider of mental health skill-building services must be licensed by DBHDS as a provider of mental health community support (defined in 12VAC35-105-20). Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. Mental health skill-building services shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the mental health skill-building services record.

17. Mental health skill-building services shall be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

18. If mental health skill-building services are provided in a therapeutic group home or assisted living facility, effective July 1, 2014, there shall be a yearly limit of up to 416 units per fiscal year and a weekly limit of up to 8 units per week, with at least half of each week's services provided outside of the group home or assisted living facility. There shall be a daily limit of a maximum of 2 units. Prior to July 1, 2014, the previous limits shall apply. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

19. Limits and exclusions.

a. Therapeutic group home and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's respective facility. Individuals residing in facilities may, however, receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

b. Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

c. Mental health skill-building services shall not be reimbursed for individuals who are also receiving independent living skills services, the Department of Social Services independent living program (22VAC40-151), independent living services (22VAC40-131 and 22VAC40-151), or independent living arrangement (22VAC40-131) or any Comprehensive Services Act-funded independent living skills programs.

d. Mental health skill-building services shall not be available to individuals who are receiving treatment foster care (12VAC30-130-900 et seq.).

e. Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.

f. Mental health skill-building services shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of mental health skill-building services.

g. Mental health skill-building services shall not be available for residents of psychiatric residential treatment centers except for the intake code H0032 (modifier U8) in the seven days immediately prior to discharge.

h. Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver (12VAC30-120-1000 et seq.), Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.), and EPSDT services (12VAC30-50-130).

i. Mental health skill-building services shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E to avoid duplication of services.

j. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill-building services unless their physicians issue a signed and dated statement indicating that the individuals can benefit from this service.

k. Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 B 6 b (1) or 12VAC30-50-226 B 6 c (2) and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services.

12VAC30-60-185 Utilization review of substance use case management

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

"Face-to-face" means the same as that term is defined in 12VAC30-130-5020.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-130-5020.

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

"Register" or "registration" means notifying the Department of Medical Assistance Services or its contractor that an individual will be receiving services that do not require service authorization, such as outpatient services for substance use disorders or substance use case management.

B. Utilization review: substance use case management services.

1. The Medicaid enrolled individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a substance use disorder. Tobacco-related disorders or caffeine-related disorders and non-substance-related disorders shall not be covered.

2. Reimbursement shall be provided only for "active" case management. An active client for substance use case management shall mean an individual for whom there is a current substance use individual service plan (ISP) in effect that requires a minimum of two distinct substance use case management activities being performed each calendar month and at a minimum one face-to-face client contact at least every 90-calendar-day period.

3. Billing can be submitted for an active recipient only for months in which a minimum of two distinct substance use case management activities are performed.

4. An ISP shall be completed within 30 calendar days of initiation of this service with the individual in a person-centered manner and shall document the need for active substance use case management before such case management services can be billed. The ISP shall require a minimum of two distinct substance use case management activities being performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days. The substance use case manager shall review the ISP with the individual at least every 90 calendar days for the purpose of evaluating and updating the individual's progress toward meeting the individualized service plan objectives. Such reviews shall be documented in the individual's medical record.

5. Reviews will be due by the end of month following the 90th calendar day from when the last review was completed. If needed, a grace period will be granted up to the last day of the next month. When the review was completed in a grace period, the next subsequent review shall be required within 90 calendar days from when the review was due and not the date of the actual review.

~~5.~~ 6. The ISP shall be reviewed with the individual present~~, and the outcome of the review shall be documented in the individual's medical record~~.

~~C. Utilization review: substance use case management services.~~

~~1. Utilization review general requirements. Utilization reviews shall be conducted by DMAS or its designated contractor. Reimbursement shall be provided only when there is an active ISP, a minimum of two distinct substance use case management activities are performed each calendar month, and there is a minimum of one face-to-face client contact at least every 90-calendar-day period. Billing can be submitted only for months in which a minimum of two distinct substance use case management activities are performed within the calendar month.~~

~~2.~~ 7. In order to receive reimbursement, providers shall register this service with the managed care organization or the DMAS contractor, as required, within one business day of service initiation to avoid duplication of services and to ensure informed and seamless care coordination between substance use treatment and substance use case management providers.

~~3. The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a substance use disorder with the exception of tobacco-related disorders or caffeine-related disorders and non-substance-related disorders.~~

~~4.~~ 8. ~~Substance use case management shall not be billed for individuals in institutions for mental disease, except during the month prior to discharge to allow for discharge planning, limited to two months within a 12-month period.~~ Substance use case management shall not be billed concurrently with any other type of Medicaid reimbursed case management and care coordination.

~~5. The ISP, as defined in 12VAC30-130-5020, shall document the need for substance use case management and be fully completed within 30 calendar days of initiation of the service, and the substance use case manager shall review the ISP at least every 90 calendar days. Such reviews shall be documented in the individual's medical record. If needed, a grace period will be granted following the date of the last review. When the review is completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the date the review was initially due and not the date of actual review.~~

~~6.~~ 9. The ISP shall be updated and documented in the individual's medical record at least annually and as an individual's needs change.

~~7.~~ 10. The provider of substance use case management services shall be licensed by the Department of Behavioral Health and Developmental Services as a provider of substance use case management and credentialed by the DMAS contractor or the managed care organization as a provider of substance use case management services.

~~8.~~ 11. Progress notes, as defined in subsection A of this section, shall be required to disclose the extent of services provided and corroborate the units billed.

12. Reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions pursuant to 12VAC30-50-491.

13. Utilization reviews shall be conducted by DMAS or its designated contractor.