



# COMMONWEALTH of VIRGINIA

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## MEMORANDUM

**TO:** EMILY MCCLELLAN  
Regulatory Supervisor  
Department of Medical Assistance Services

**FROM:** JENNIFER L. GOBBLE *JLG*  
Assistant Attorney General

**DATE:** May 17, 2016

**SUBJECT:** Proposed Regulations – IMD Reimbursement Changes

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I have reviewed the attached proposed regulations that would implement reimbursement changes for professional services furnished to patients under 21 years of age in inpatient psychiatric facilities. The changes in these proposed regulations first were made by the promulgation of emergency regulations. The attached proposed regulations include a few clarifications to the language in the emergency regulations. The changes are not material and are outlined in the agency background document.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services ("DMAS"), acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act and has not exceeded that authority.

If you have any questions or need any additional information, please feel free to contact me at 786-4905.

cc: Kim F. Piner  
Senior Assistant Attorney General

## Proposed Text

### Action:

Institutions for Mental Disease Reimbursement Changes

Stage: Proposed

### **12VAC30-50-130. Skilled nursing ~~Nursing~~ facility services, EPSDT, including school health services and family planning.**

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

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

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

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

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

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

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

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

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

"Activities of daily living" means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this section. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

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

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescriber" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has

completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Clinical experience" means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual service plan" or "ISP" means the same as the term is defined in 12VAC30-50-226.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the

individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

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

"Qualified mental health professional-eligible" or "QMHP-E" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-590.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as the term is defined in 12VAC35-105-20 and consistent with the requirements of 12VAC35-105-1370.

"Service-specific provider intake" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"Services provided under arrangement" means the same as defined in 12 VAC 30-130-850.

b. Intensive in-home services (IIH) to children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual. These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response.

(1) These services shall be limited annually to 26 weeks. Service authorization shall be required for Medicaid reimbursement prior to the onset of services. Services rendered before the date of authorization shall not be reimbursed.

(2) Service authorization shall be required for services to continue beyond the initial 26 weeks.

(3) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-

specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

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

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

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

(2) Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in this section.

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

d. Community-based services for children and adolescents under 21 years of age (Level A) pursuant to 42 CFR 440.130(d).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria or an equivalent standard authorized in advance by DMAS, shall be required for this service.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

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

(4) Authorization shall be required for Medicaid reimbursement. Services that were rendered before the date of service authorization shall not be reimbursed.

(5) Room and board costs shall not be reimbursed. DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds.

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

(8) The facility/group home must coordinate services with other providers. Such care coordination shall be documented in the individual's medical record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

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

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

e. Therapeutic behavioral services (Level B) pursuant to 42 CFR 440.130(d).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision, care coordination, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness that results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the child's condition or prevent regression so that the services will no longer be needed. The application of a national standardized set of medical necessity criteria in use in the industry, such as McKesson InterQual<sup>®</sup> Criteria, or an equivalent standard authorized in advance by DMAS shall be required for this service.

(2) Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.

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

(4) These residential providers must be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46).

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

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

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

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

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

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

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2), for the

purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

a. A (i) A psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or a

(ii) 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; (iii) 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 Amount, Duration and Scope of Selected Services.

a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160, provided under the direction of a physician, pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals, and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include the following services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility: (i) arranges for and oversees the provision of all services; (ii) maintains all medical records of care furnished to the individual; and (iii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

b. Eligible services provided under arrangement with the inpatient psychiatric facility (IPF) shall vary by provider type as described in this subsection. For purposes of this section, emergency services means the same as is set out in 12VAC30-50-310 B.

(1) State freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) pharmacy services and (ii) emergency services.

(2) Private freestanding psychiatric hospitals shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

(3) Residential treatment facilities, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment; (vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

c. Inpatient psychiatric services are reimbursable only when the treatment program is fully in compliance with i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, as contained in specifically, 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

d. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

7. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia.

C. School health services.

1. School health assistant services are repealed effective July 1, 2006.

2. School divisions may provide routine well-child screening services under the State Plan. Diagnostic and treatment services that are otherwise covered under early and periodic screening, diagnosis and treatment services, shall not be covered for school divisions. School divisions to receive reimbursement for the screenings shall be enrolled with DMAS as clinic providers.

a. Children enrolled in managed care organizations shall receive screenings from those organizations. School divisions shall not receive reimbursement for screenings from DMAS for these children.

b. School-based services are listed in a recipient's individualized education program (IEP) and covered under one or more of the service categories described in § 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate defects of physical or mental illnesses or conditions.

3. Service providers shall be licensed under the applicable state practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them shall be performed by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team.

a. Service providers shall be employed by the school division or under contract to the school division.

b. Supervision of services by providers recognized in subdivision 4 of this subsection shall occur as allowed under federal regulations and consistent with Virginia law, regulations, and DMAS provider manuals.

c. The services described in subdivision 4 of this subsection shall be delivered by school providers, but may also be available in the community from other providers.

d. Services in this subsection are subject to utilization control as provided under 42 CFR Parts 455 and 456.

e. The IEP shall determine whether or not the services described in subdivision 4 of this subsection are medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by IEP providers. The IEP providers are qualified Medicaid providers to make the medical necessity determination in accordance with their scope of practice. The services must be described as to the amount, duration and scope.

4. Covered services include:

a. Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. This coverage includes audiology services;

b. Skilled nursing services are covered under 42 CFR 440.60. These services are to be rendered in accordance to the licensing standards and criteria of the Virginia Board of Nursing. Nursing services are to be provided by licensed registered nurses or licensed practical nurses but may be delegated by licensed registered nurses in accordance with the regulations of the Virginia Board of Nursing, especially the section on delegation of nursing tasks and procedures. The licensed practical nurse is under the supervision of a registered nurse.

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.



(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with intellectual disability prior to admission to a nursing facility, or any placement issue. These services are covered in the nonschool settings also. School providers who may render these services when licensed by the state include psychiatrists, licensed clinical psychologists, school psychologists, licensed clinical social workers, professional counselors, psychiatric clinical nurse specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

e. Medical evaluation services are covered as physicians' services under 42 CFR 440.50 or as medical or other remedial care under 42 CFR 440.60. Persons performing these services shall be licensed physicians, physician assistants, or nurse practitioners. These practitioners shall identify the nature or extent of a child's medical or other health related condition.

f. Transportation is covered as allowed under 42 CFR 431.53 and described at State Plan Attachment 3.1-D (12VAC30-50-530). Transportation shall be rendered only by school division personnel or contractors. Transportation is covered for a child who requires transportation on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Transportation shall be listed in the child's IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

g. Assessments are covered as necessary to assess or reassess the need for medical services in a child's IEP and shall be performed by any of the above licensed practitioners within the scope of practice. Assessments and reassessments not tied to medical needs of the child shall not be covered.

5. DMAS will ensure through quality management review that duplication of services will be monitored. School divisions have a responsibility to ensure that if a child is receiving additional therapy outside of the school, that there will be coordination of services to avoid duplication of service.

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

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

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

**12VAC30-60-25. Utilization control: freestanding psychiatric hospitals.**

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

B. Prior authorization required. DMAS shall monitor, consistent with state law, the utilization of all inpatient freestanding psychiatric hospital services. All inpatient hospital stays shall be preauthorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

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

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

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

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

4. Before admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each recipient patient as cited in 42 CFR 441.155 and 456.180. The plan shall also include a list of services provided under written contractual arrangement with the freestanding psychiatric hospital (see 12VAC30-50-130) that will be furnished to the patient through the freestanding psychiatric hospital's referral to an employed or contracted provider, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought.

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

E. If younger than 21 years of age, it shall be documented that the individual requiring admission to a freestanding psychiatric hospital is under 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an early and periodic screening, diagnosis, and treatment (EPSDT) screening. Required patient documentation shall include, but not be limited to, the following:

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

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

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

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

G. The absence of any of the required documentation described in this subsection shall result in DMAS' denial of the requested preauthorization and coverage of subsequent hospitalization.

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

1. Copy of the mental hospital's Utilization Management Plan to determine compliance with the regulations found in the 42 CFR 456.200 through 456.245.
2. List of current Utilization Management Committee members and physician advisors to determine that the committee's composition is as prescribed in the 42 CFR 456.205 and 456.206.
3. Verification of Utilization Management Committee meetings, including dates and list of attendees to determine that the committee is meeting according to their utilization management meeting requirements.
4. One completed Medical Care Evaluation Study to include objectives of the study, analysis of the results, and actions taken, or recommendations made to determine compliance with 42 CFR 456.241 through 456.245.
5. Topic of one ongoing Medical Care Evaluation Study to determine the hospital is in compliance with 42 CFR 456.245.
6. From a list of randomly selected paid claims, the freestanding psychiatric hospital must provide a copy of the certification for services, a copy of the physician admission certification, a copy of the required medical, psychiatric, and social evaluations, and the written plan of care for each selected stay to determine the hospital's compliance with §§ 16.1-335 through 16.1-348 of the Code of Virginia and 42 CFR 441.152, 456.160, 456.170, 456.180 and 456.181. If any of the required documentation does not support the admission and continued stay, reimbursement may be retracted.
7. The freestanding psychiatric hospital shall not receive a per diem reimbursement for any day that:
  - a. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement all services that the individual needs while at the freestanding psychiatric hospital and that will be furnished to the individual through the freestanding psychiatric hospital's referral to an employed or contracted provider of services under arrangement;
  - b. The comprehensive plan of care fails to include within three business days of the initiation of the service the prescribed frequency of such service or includes a frequency that was exceeded;
  - c. The comprehensive plan of care fails to list the circumstances under which the service provided under arrangement shall be sought;
  - d. The referral to the service provided under arrangement was not present in the patient's free standing psychiatric hospital record;
  - e. The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;
  - f. The medical records from the provider of services under arrangement (i.e., any admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings) were not present in the patient's freestanding psychiatric hospital record, or had not been requested in writing by the freestanding psychiatric hospital within seven days of completion of the service or services provided under arrangement; or had been requested in writing within seven days of completion of the service or services, but had not been received within 30 days of the request, and had not been re-requested;
  - g. The freestanding psychiatric hospital did not have a fully executed contract or an employee relationship with the provider of services under arrangement in advance of the provision of such services. For emergency services, the freestanding psychiatric hospital shall have a fully executed contract with the emergency services hospital provider prior to submission of the ancillary provider's claim for payment.
8. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service billed prior to receiving a referral from the freestanding psychiatric hospital or in excess of the amounts in the referral.
9. The hospitals may appeal in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) any adverse decision resulting from such audits which results in retraction of payment.

The appeal must be requested within ~~30 days of the date of the letter notifying the hospital of the retraction~~ pursuant to the requirements of 12VAC30-20-500 et seq.

Part V  
Inpatient Hospital Payment System  
Article 1  
Application of Payment Methodologies

**12VAC30-70-201. Application of payment methodologies.**

A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12VAC30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.

B. Article 3 (12VAC30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals shall be subject to the provisions of Supplement 3 (12VAC30-70-10 through 12VAC30-70-130).

C. Inpatient hospital facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) shall be reimbursed costs except for inpatient psychiatric services furnished under early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals younger than age 21. These inpatient services shall be reimbursed according to 12VAC30-70-415 and shall be provided according to the requirements set forth in 12VAC30-50-130 and 12VAC30-60-25 H. Facilities may also receive disproportionate share hospital (DSH) payments. The criteria for DSH eligibility and the payment amount shall be based on subsection F of 12VAC30-70-50. If the DSH limit is exceeded by any facility, the excess DSH payments shall be distributed to all other qualifying DBHDS facilities in proportion to the amount of DSH they otherwise receive.

D. Transplant services shall not be subject to the provisions of this part. Reimbursement for covered liver, heart, and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre-hospitalization and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse the actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.

E. Reduction of payments methodology.

1. For state fiscal years 2003 and 2004, the Department of Medical Assistance Services (DMAS) shall reduce payments to hospitals participating in the Virginia Medicaid Program by \$8,935,825 total funds, and \$9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the total reduction amount shall be determined as provided in this subsection.

2. Determine base for revenue forecast.

a. DMAS shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and outpatient reimbursed cost, as recorded by DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated statewide HMO average percentage of Medicaid

business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.

b. For freestanding psychiatric hospitals, DMAS shall use estimated Medicaid revenues for the six-month period (January 1, 2001, through June 30, 2001), times two, and adjusted for inflation by 4.3% for state fiscal year 2002, 3.1% for state fiscal year 2003, and 3.7% for state fiscal year 2004, as reported by DRI-WEFA, Inc.'s, hospital input price level percentage moving average.

3. Determine forecast revenue.

a. Each Type I hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 a of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type I hospitals.

b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal year 2003 and 2004 forecast reimbursement is based on the proportion of non-HMO business (see subdivision 2 of this subsection) with respect to the DMAS forecast of SFY 2003 and 2004 inpatient and outpatient operating revenue for Type II hospitals.

4. Each hospital's total yearly reduction amount is equal to their respective state fiscal year 2003 and 2004 forecast reimbursement as described in subdivision 3 of this subsection, times 3.235857% for state fiscal year 2003, and 3.235857%, for the first two quarters of state fiscal year 2004 and 2.88572% for the last two quarters of state fiscal year 2004, not to be reduced by more than \$500,000 per year.

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in subdivision 4 of this subsection. Payment reduction offsets not covered by claims remittance by May 15, 2003, and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30, 2003, or 2004, as applicable.

F. Consistent with 42 CFR 447.26 and effective July 1, 2012, the Commonwealth shall not reimburse inpatient hospitals for provider-preventable conditions (PPCs), which include:

1. Health care-acquired conditions (HCACs). HCACs are conditions occurring in any hospital setting, identified as a hospital-acquired condition (HAC) by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

2. Other provider preventable conditions (OPPCs) as follows: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; or (iii) surgical or other invasive procedure performed on the wrong patient.

#### **12VAC30-70-321. Hospital specific operating rate per day.**

A. The hospital specific operating rate per day shall be equal to the labor portion of the statewide operating rate per day, as determined in subsection A of 12VAC30-70-341, times the hospital's Medicare wage index plus the nonlabor portion of the statewide operating rate per day.

B. For rural hospitals, the hospital's Medicare wage index used in this section shall be the Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher.

C. Effective July 1, 2008, and ending after June 30, 2010, the hospital specific operating rate per day shall be reduced by 2.683%.

~~D. The hospital specific rate per day for freestanding psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of this section plus the hospital specific capital rate per day for freestanding psychiatric cases.~~

~~E. The hospital specific capital rate per day for freestanding psychiatric cases shall be equal to the Medicare geographic adjustment factor for the hospital's geographic area, times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.~~

~~F. The statewide capital rate per day for freestanding psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of freestanding psychiatric facilities licensed as hospitals.~~

~~G. The capital cost per day of freestanding psychiatric facilities licensed as hospitals shall be the average charges per day of psychiatric cases times the ratio total capital cost to total charges of the hospital, using data available from Medicare cost report.~~

**12VAC30-70-415. Reimbursement for freestanding psychiatric hospital services under EPSDT.**

A. The freestanding psychiatric hospital specific rate per day for psychiatric cases shall be equal to the hospital specific operating rate per day, as determined in subsection A of 12VAC30-70-321 plus the hospital specific capital rate per day for freestanding psychiatric cases.

B. The freestanding psychiatric hospital specific capital rate per day for psychiatric cases shall be equal to the Medicare geographic adjustment factor (GAF) for the hospital's geographic area times the statewide capital rate per day for freestanding psychiatric cases times the percentage of allowable cost specified in 12VAC30-70-271.

C. The statewide capital rate per day for psychiatric cases shall be equal to the weighted average of the GAF-standardized capital cost per day of facilities licensed as freestanding psychiatric hospitals.

D. The capital cost per day of facilities licensed as freestanding psychiatric hospitals shall be the average charges per day of psychiatric cases times the ratio total of capital cost to total charges of the hospital, using data available from Medicare cost report.

E. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS, according to the reimbursement methodology prescribed for each provider in 12VAC30-80 or elsewhere in the State Plan, to a provider of services under arrangement if all of the following are met:

1. The services are included in the active treatment plan of care developed and signed as described in section 12VAC30-60-25 C 4 and

2. The services are arranged and overseen by the freestanding psychiatric hospital treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the freestanding psychiatric hospital or under contract for services provided under arrangement.

**12VAC30-70-417. Reimbursement for inpatient psychiatric services in residential treatment facilities (Level C) under EPSDT.**

A. Effective January 1, 2000, DMAS shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers under the terms and payment methodology described in this section.

B. Effective January 1, 2000, payment shall be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by DMAS based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute direct payment for all residential psychiatric treatment facility services, excluding all services provided under arrangement that are reimbursed in the manner described in subsection D of this section.

C. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by DMAS at such time as required by DMAS. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, DMAS shall take action in accordance with its policies to assure that an overpayment is not being made.

D. Effective July 1, 2014, services provided under arrangement, as defined in subdivisions B 6 a and B 6 b of 12VAC30-50-130, shall be reimbursed directly by DMAS to a provider of services provided under arrangement according to the reimbursement methodology prescribed for that provider type elsewhere in the State Plan if all of the following are met:

1. The services provided under arrangement are included in the active written treatment plan of care developed and signed as described in section 12VAC30-130-890 and

2. The services provided under arrangement are arranged and overseen by the residential treatment facility treatment team through a written referral to a Medicaid enrolled provider that is either an employee of the residential treatment facility or under contract for services provided under arrangement.

**12VAC30-80-21. Inpatient psychiatric services in residential treatment facilities (under EPSDT). Reimbursement for services furnished individuals residing in a freestanding psychiatric hospital or residential treatment center (Level C).**

~~A. Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described in this section.~~

~~B. Methodology. Effective January 1, 2000, payment will be made for inpatient psychiatric services in residential treatment facilities using a per diem payment rate as determined by the state agency based on information submitted by enrolled residential psychiatric treatment facilities. This rate shall constitute payment for all residential psychiatric treatment facility services, excluding all professional services.~~

~~C. Data collection. Enrolled residential treatment facilities shall submit cost reports on uniform reporting forms provided by the state agency at such time as required by the agency. Such cost reports shall cover a 12-month period. If a complete cost report is not submitted by a provider, the Program shall take action in accordance with its policies to assure that an overpayment is not being made.~~

Reimbursement for all services furnished to individuals younger than 21 years of age who are residing in a freestanding psychiatric hospital or residential treatment center (Level C) shall be based on the freestanding psychiatric hospital reimbursement described in 12VAC30-70-415 and the residential treatment center (Level C) reimbursement described in 12VAC30-70-417 and reimbursement of services provided under arrangement described in 12VAC30-80.

Part XIV

Residential Psychiatric Treatment for Children and Adolescents

**12VAC30-130-850. Definitions.**

The following words and terms when used in this part shall have the following meanings, unless the context clearly indicates otherwise:

"Active treatment" means implementation of a professionally developed and supervised individual plan of care that must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

"Certification" means a statement signed by a physician that inpatient services in a residential treatment facility are or were needed. The certification must be made at the time of admission, or, if an individual applies for assistance while in a mental hospital or residential treatment facility, before the Medicaid agency authorizes payment.

"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12VAC30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.

"Emergency services" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Individual" or "individuals" means the child or adolescent younger than 21 years of age who is receiving this covered service.

"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician, that meets the requirements in 12VAC30-130-890.

"Inpatient psychiatric facility" or "IPF" means a private or state-run freestanding psychiatric hospital or psychiatric residential treatment center.

"Recertification" means a certification for each applicant or recipient that inpatient services in a residential treatment facility are needed. Recertification must be made at least every 60 days by a physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician.

"Recipient" or "recipients" means the child or adolescent younger than 21 years of age receiving this covered service.

"Services provided under arrangement" means services including but not limited to physician and other health care services that are furnished to children while they are in an IPF which are billed by the arranged practitioners separately from the IPF per diem.

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

A. All Medicaid services are subject to unitization review/audit. The absence of any of the required documentation may result in denial or retraction of any reimbursement.

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

B.C. 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 individual;
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 individual and a list of services provided under arrangement (see 12VAC30-50-130 for eligible services provided under arrangement) that will be furnished to the individual through the RTC-Level C's referral to an employed or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought;
5. Plans for continuing care, including review and modification to the plan of care;
6. Plans for discharge; and
7. Signature and date by the physician.

C.D. The 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 individual'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 individual and his parents, legal guardians, or appropriate others in whose care he will be released after discharge;
3. 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. Include a list of services provided under arrangement (described in 12VAC30-50-130) that will be furnished to the individual through referral to an employee or a contracted provider of services under arrangement, including the prescribed frequency of treatment and the circumstances under which such treatment shall be sought; and

5. 6. 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 individual's family, school, and community.

D-E. Review of the CIPOC 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 individual's overall adjustment as an inpatient.

E-F. 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-G. Team developing the CIPOC 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 individual's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- b. Assessing the potential resources of the recipient's individual'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.H. All Medicaid services are subject to utilization review. Absence of any of the required documentation may result in denial or retraction of any reimbursement. The RTC Level C shall not receive a per diem reimbursement for any day that:

1. The initial or comprehensive written plan of care fails to include within three business days of the initiation of the service provided under arrangement;

(a) The prescribed frequency of treatment of such service, or includes a frequency that was exceeded;

(b) All services that the individual needs while residing at the RTC and that will be furnished to the individual through the RTC Level C referral to an employed or contracted provider of services under arrangement.

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

3. The referral to the service provided under arrangement was not present in the individual's RTC-Level C record;

4. The service provided under arrangement was not supported in that provider's records by a documented referral from the RTC-Level C;

5. The medical records from the provider of services under arrangement (i.e., any admission and discharge documents, treatment plans, progress notes, treatment summaries, and documentation of medical results and findings) were not present in the individual's RTC-Level C record, or had not been requested in writing by the RTC-Level C within seven days of discharge from or completion of the service or services provided under arrangement, or had been requested in writing within seven days of discharge from or completion of the service or services provided under arrangement, but not received within 30 days of the request, and not re-requested; or

6. The RTC-Level C did not have a fully executed contract or employee relationship with an independent provider of services under arrangement in advance of the provision of such services. For emergency services, the RTC-Level C shall have a fully executed contract with the emergency services provider prior to submission of the emergency service provider's claim for payment.

7. A physician's order for the service under arrangement is not present in the record.

8. The service under arrangement is not included in the individual's CIPOC within 30 calendar days of the physician's order.

I. The provider of services under arrangement shall be required to reimburse DMAS for the cost of any such service provided under arrangement that was (i) furnished prior to receiving a referral or (ii) in excess of the amounts in the referral. Providers of services under arrangement shall be required to reimburse DMAS for the cost of any such services provided under arrangement that were rendered in the absence of an employment or contractual relationship.

H.J. 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 CIPOC must be completed by the LMHP no later than 30 days after admission. The assessment must be signed and dated by the LMHP.

I.K. 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 CIPOC 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.L. 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.M. The 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~~ individual'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~~ health care providers, the ~~child~~ individual 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~~ individual's family, school, and community.

L.N. Review of the CIPOC 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;
2. Recommended changes in the plan as indicated by the child's overall response to the plan of care interventions; and
3. Determinations regarding whether the services being provided continue to be required.

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.~~