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MEMORANDUM

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

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

DATE: **June 16, 2017**

SUBJECT: **Fast-Track Regulations (4774/7855)**
Peer Support Services and Family Support Partners

I have reviewed the attached fast-track regulations that will implement coverage for peer support services for eligible children and adults who have mental health disorders and/or substance use disorders. The regulations implement the directive from the 2016 *Acts of Assembly*, Chapter 780, Item 306.MMMM.1 and MMMM.3.

Based on my review, it is my view that the Director, 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.

In accordance with 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 with the initial publication of the Fast-Track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions, please feel free to call me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General/Chief

Action:
Peer Support Services and Family Support Partners
Stage: Fast-Track
6/16/17 12:18 PM [latest]

12VAC30-50-130. Skilled nursing facility services, EPSDT, 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 Service" means the same as defined in 12VAC30-130-5160.

"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.

"Caregiver," means the same as defined in 12VAC30-130-5160.

"Certified prescreener" 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.

"Direct supervisor" means the person who provides direct supervision to the Peer Recovery Specialist . The direct supervisor: 1) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS as set forth in 12VAC35-250-40, and have documented completion of the DBHDS PRS supervisor training; or 2) shall be a qualified mental health professional (QMHP) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or 3) or shall be an LMHP as defined in 12VAC35-105-20 who has documented completion of the DBHDS PRS supervisor training who is acting within their scope of practice under state law. An LMHP providing services before April 1, 2018 shall have until April 1, 2018 to complete the DBHDS PRS supervisor training.

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

"Family" or "Caregiver Legal Guardian" means the same as defined in 12VAC30-130-5160.

"Family Support Partners" means the same as defined in 12VAC30-130-5170.

"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.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person Centered" means the same as defined in 12VAC30-130-5160.

"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.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery resiliency and wellness plan" means the same as defined in 12VAC30-130-5160.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Self-Advocacy" means the same as defined in 12VAC30-130-5160.

"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.

"Strength based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

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).

(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® 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), Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), 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).

(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® 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.

f. Mental Health Family Support Partners.

(1) Mental Health Family Support Partners are Peer Recovery Support Services and are non-clinical, peer to peer activities that engage, educate, and support the caregiver and an individual s self-help efforts to improve health recovery resiliency and wellness. Mental Health Family Support Partners is a peer support service and is a strength-based, individualized, service provided to the caregiver of Medicaid-eligible individual under age 21, with a mental health disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals under 21 with complex needs who are involved with multiple systems and increase the individual's and family s confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar mental health disorder, or (ii) an adult with personal experience with a family member with a similar mental health disorder, with experience navigating behavioral health care services. The PRS shall perform the service within the scope of their knowledge, lived - experience, and education.

(2) Under the clinical oversight of the LMHP making the recommendation for Mental Health Family Support Partners the Peer Recovery Specialist in consultation with their direct supervisor shall develop a Recovery, Resiliency, and Wellness Plan based on the LMHP s recommendation for service, the individual s and the caregiver s perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the Recovery, Resiliency, and Wellness Plan shall include collaboration with the individual and the individual s caregiver. Individualized goals and strategies shall be focused on the individual s identified needs for self-advocacy and recovery. The Recovery, Resiliency, and Wellness Plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the Plan. The Recovery, Resiliency, and Wellness Plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor, the individual, and the individual s caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

(3) Documentation of required activities shall be required as set forth in 12VAC30-130-5200 (A), and (C) through (J).

(4) Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

(5) Caregivers of individuals under age 21 who qualify to receive Mental Health Family Support Partners (i) have an individual with a mental health disorder who requires recovery assistance, and (ii) meet two or more of the following:

(a) Individual and his caregiver need peer-based recovery oriented support for the maintenance of wellness and the acquisition of skills needed to support the individual;

(b) Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status;

(c) Individual and his caregiver need assistance and support to prepare the individual for a successful work/school experience;

(d) Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

(6) Individuals 18-20 years old who meet the medical necessity criteria in 12VAC30-50-226B.7 (e), who would benefit from receiving peer supports directly, and who choose to receive Mental Health Peer Support Services directly instead of through their caregiver shall be permitted to receive Mental Health Peer Support Services by an appropriate PRS.

(7) To qualify for continued Mental Health Family Support Partners, the requirements for continued services set forth in 12VAC30-130- 5180(D) shall be met.

(8) Discharge criteria from Mental Health Family Support Partners shall be the same as set forth in 12VAC30-130-5180(E).

(9) Mental Health Family Support Partners services shall be rendered on an individual basis or in a group.

(10) Prior to service initiation, a documented recommendation for Mental Health Family Support Partners services shall be made by a Licensed Mental Health Professional (LMHP) as defined in 12VAC35-105-20 who is acting within their scope of practice under state law. The recommendation shall verify that the individual meets the medical necessity criteria set forth in paragraph 4 of this section. The recommendation shall be valid for no longer than 30 calendar days.

(11) Effective July 1, 2017 a Peer Recovery Specialist "PRS" shall have the qualifications, education, and experience, and certification required by DBHDS as set forth in 12VAC35-250-10 through 12VAC35-250-50 in order to be eligible to register with the Board of Counseling at the Department of Health Professions (§ 54.1-3503) on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling at the Department of Health Professions, registration of Peer Recovery Specialists by the Board of Counseling shall be required. The PRS shall perform Mental Health Family Support Partners services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the Recovery, Resiliency, and Wellness Plan.

(12) The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

(a) Acute Care General and Emergency Department Hospital Services licensed by Virginia Department of Health.

(b) Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by Department of Behavioral Health and Developmental Services.

(c) Psychiatric Residential Treatment Facility licensed by Department of Behavioral Health and Developmental Services..

(d) Therapeutic Group Home licensed by Department of Behavioral Health and Developmental Services.

(e) Outpatient mental health clinic services licensed by Department of Behavioral Health and Developmental Services.

(f) Outpatient psychiatric services provider.

(g) a Community Mental Health and Rehabilitative Services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following Community Mental Health and Rehabilitative Services as defined in 12VAC30-50-130, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30-50-430 for which the individual under 21 meets medical necessity criteria: (i) Intensive In Home; (ii) Therapeutic Day Treatment; (iii) Day Treatment/Partial Hospitalization; (iv) Crisis Intervention; (v) Crisis Stabilization; (vi) Mental Health Skill Building; or (vii) Mental Health Case Management.

(13) Only the licensed and enrolled provider as referenced in paragraph 12 of this section shall be eligible to bill and receive reimbursement from DMAS or its contractor for Mental Health Family Support Partner Services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

(14) Supervision of the PRS shall be required as set forth in 12VAC30-130-5190(E) and 12VAC30-130-5200 (G).

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

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

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

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

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 specialists, 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. 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 or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

3. Family planning services as established by § 1905(a)(4)(C) of the Social Security Act include annual family planning exams; cervical cancer screening for women; sexually transmitted infection (STI) testing; lab services for family planning and STI testing; family planning education, counseling, and preconception health; sterilization procedures; nonemergency transportation to a family planning service; and U.S. Food and Drug Administration approved prescription and over-the-counter contraceptives, subject to limits in 12VAC30-50-210.

12VAC30-50-226. Community mental health 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" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Affiliated" means any entity or property in which a provider or facility has a direct or indirect ownership interest of 5.0% or more, or any management, partnership, or control of an entity.

"Behavioral Health Service" means the same as defined in 12VAC30-130-5160.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. DMAS' designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Such authority shall include entering into or terminating contracts with providers in accordance with DMAS authority pursuant to 42 CFR Part 1002 and § 32.1-325 D and E of the Code of Virginia. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Certified prescreener" means an employee of either the local community services board/behavioral health authority or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Clinical experience" means, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health skill building, (v) crisis stabilization, or (vi) crisis intervention services, practical experience in providing direct services to individuals with diagnoses of mental illness or intellectual disability or the provision of direct geriatric services or special education services. Experience shall include supervised internships, supervised practicums, or supervised field experience. 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 established by DBHDS in the document titled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"Direct supervisor" means the person who provides direct supervision to the Peer Recovery Specialist. The direct supervisor: 1) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS as set forth in 12VAC35-250-40, and have documented completion of the DBHDS PRS supervisor training; or 2) shall be a qualified mental health professional (QMHP) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or 3) shall be an LMHP as defined in 12VAC35-105-20 who has documented completion of the DBHDS PRS supervisor training who is acting within their scope of practice under state law. An LMHP providing services before April 1, 2018 shall have until April 1, 2018 to complete the DBHDS PRS supervisor training.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

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

"Individual" means the patient, client, or recipient of services described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the service-specific provider intake. The ISP contains, but is not limited to, the individual's treatment or training needs, the individual's goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"Individualized training" means instruction and practice in functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living skills, and use of community resources; assistance with medical management; and monitoring health, nutrition, and physical condition. The training shall be rehabilitative and based on a variety of incremental (or cumulative) approaches or tools to organize and guide the individual's life planning and shall reflect what is important to the individual in addition to all other factors that affect his functioning, including effects of the disability and issues of health and safety.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"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" is 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.

"Peer recovery specialist" or "PRS" means the same as defined in 12VAC30-130-5160.

"Person Centered" means the same as defined in 12VAC30-130-5160.

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

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

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

"Qualified paraprofessional in mental health" or "QPPMH" means the same as defined in 12VAC35-105-20.

"Recovery-oriented services" means the same as defined in 12VAC30-130-5160.

"Recovery resiliency and wellness plan" means the same as defined in 12VAC30-130-5160.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Resiliency" means the same as defined in 12VAC30-130-5160.

"Review of ISP" means that the provider evaluates and updates the individual's progress toward meeting the individualized service plan objectives and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall (i) update the goals, objectives, and strategies of the ISP to reflect any change in the individual's progress and treatment needs as well as any newly identified problems; (ii) be conducted in a manner that enables the individual to participate in the process; and (iii) be documented in the individual's medical record no later than 15 calendar days from the date of the review.

"Self-Advocacy" means the same as defined in 12VAC30-130-5160.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-specific provider intake" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age.

"Strength based" means the same as defined in 12VAC30-130-5160.

"Supervision" means the same as defined in 12VAC30-130-5160.

B. Mental health services. The following services, with their definitions, shall be covered: day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health skill building. Staff travel time shall not be included in billable time for reimbursement. These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and 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. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities. All services which do not require service authorization require registration. This registration shall transmit service-specific information to DMAS or its contractor in accordance with service authorization requirements.

1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive,

comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

a. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

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

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented; or

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

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

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

2. Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

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

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

3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or

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

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

c. These services may only be rendered by an LMHP, an LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener.

4. Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial service-specific provider intake and may be reauthorized for up to an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider (LMHP), shall be defined by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. Authorization is required for Medicaid reimbursement.

a. To qualify for ICT, the individual must meet at least one of the following criteria:

(1) The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.

(2) The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

b. A written, service-specific provider intake, as defined at 12VAC30-50-130, that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services. This intake must be maintained in the individual's records.

c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in this section, within 30 days of the initiation of services.

d. The annual unit limit shall be 130 units with a unit equaling one hour.

e. These services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

5. Crisis stabilization services for nonhospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. Services may be provided for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. Only one unit of service shall be reimbursed for this intake. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. The goals of crisis stabilization programs shall be to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

b. The crisis stabilization program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

c. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of an individual who lives with family or other primary caregiver; (ii) the home of an individual who lives independently; or (iii) community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

d. This service shall not be reimbursed for (i) individuals with medical conditions that require hospital care; (ii) individuals with primary diagnosis of substance abuse; or (iii) individuals with psychiatric conditions that cannot be managed in the community (i.e., individuals who are of imminent danger to themselves or others).

e. The maximum limit on this service is 60 days annually.

f. Services must be documented through daily progress notes and a daily log of times spent in the delivery of services. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

g. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or a certified prescreener.

6. Mental health skill-building services (MHSS) shall be defined as goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive

months as long as the individual meets the coverage criteria for this service. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. These services shall provide goal-directed training in the following areas in order to be reimbursed by Medicaid or the BHSA: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

a. Individuals qualifying for this service shall demonstrate a clinical 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. Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community.

b. Individuals ages 21 and older shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall have one of the following as a primary mental health diagnosis:

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(2) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills, such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(3) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. 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.

(4) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the service-specific provider intake date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services and shall not be required for subsequent authorizations of service. 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.

c. Individuals aged 18 to 21 years shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall not be living in a supervised setting as described in § 63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, MHSS shall only be authorized for up to six months prior to the date of transition.

(2) The individual shall have at least one of the following as a primary mental health diagnosis.

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar-I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness or serious emotional disturbance; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record; and (iv) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(3) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(4) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) temporary detention order (TDO) evaluation pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. 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.

(5) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications, within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation of medication management shall be maintained in the individual's mental health skill-building services record. For individuals not prescribed antipsychotic, mood stabilizing, or antidepressant medications, the provider shall have documentation from the medication management physician describing how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. 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.

(6) An independent clinical assessment, established in 12VAC30-130-3020, shall be completed for the individual.

d. Service-specific provider intakes shall be required at the onset of services and individual service plans (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 12VAC30-50-130.

e. The yearly limit for mental health skill-building services is 520 units. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day.

f. These services may only be rendered by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH.

g. The provider shall clearly document details of the services provided during the entire amount of time billed.

h. 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 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.

i. Limits and exclusions.

(1) Group home (Level A or B) 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.

(2) 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.

(3) Mental health skill-building services shall not be reimbursed for individuals who are also receiving services under 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.

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

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

(6) 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.

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

(8) 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).

(9) Mental health skill-building services shall not be duplicative of other services. Providers shall be required 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, QMHP-E, or QPPMH to avoid duplication of services.

(10) 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 signed and dated statements indicating that the individuals can benefit from this service.

(11) 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 shall 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 subdivision B 6 b (1) or B 6 c (2) of this section and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health skill-building services.

7. Mental Health Peer Support Services.

a. Mental Health Peer Support Services are Peer Recovery Support Services and are non-clinical, peer to peer activities that engage, educate, and support an individual s self-help efforts to improve health recovery resiliency and wellness. Mental Health Peer Support Services for Adults is a person centered, strength-based, and recovery oriented rehabilitative service for individuals 21 years or older provided by a Peer Recovery Specialist (PRS) successful in the recovery process with lived experience with a mental health disorder, who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

b. Under the clinical oversight of the LMHP making the recommendation for Mental Health Support Services, the Peer Recovery Specialist in consultation with their direct supervisor shall develop a Recovery, Resiliency, and Wellness Plan based on the LMHP s recommendation for service, the individual s perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the Recovery, Resiliency, and Wellness Plan shall include collaboration with the individual. Individualized goals and strategies shall be focused on the individual s identified needs for self-advocacy and recovery. The Recovery, Resiliency, and Wellness Plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the Plan. The Recovery, Resiliency, and Wellness plan shall be completed, signed, and dated by the LMHP, the PRS, the direct supervisor and the individual within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

c. Documentation of required activities shall be required as set forth in 12VAC30-130-5200 (A), and (C) through (J).

d. Limitations and exclusions to service delivery shall be the same as set forth in 12VAC30-130-5210.

e. Individuals 21 years or older qualifying for Mental Health Peer Support Services shall meet the following requirements:

(1) Require recovery oriented assistance and support for the acquisition of skills needed to engage in and maintain recovery; for the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and to increase responsibilities, wellness potential, and shared accountability for the individual s own recovery.

(2) Have a documented mental health disorder diagnosis.

(3) Demonstrate moderate to severe functional impairment because of the diagnosis that interferes with or limits performance in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his or her illness, living more independently).

f. To qualify for continued Mental Health Peer Support Services, the requirements for continued services set forth in 12VAC30-130-5180(D) shall be met.

g. Discharge criteria from Mental Health Peer Support Services is the same as set forth in 12VAC30-130-5180.

h. Mental Health Peer Support Services shall be rendered on an individual basis or in a group.

i. Prior to service initiation, a documented recommendation for Mental Health Peer Support Services shall be made by a Licensed Mental Health Professional (LMHP) as defined in 12VAC35-105-20 acting within the scope of practice under state law The recommendation shall verify that the individual meets the medical necessity criteria set forth in subparagraph e of this section. The recommendation shall be valid for no longer than 30 calendar days.

j. Effective July 1, 2017 a Peer Recovery Specialist "PRS" shall have the qualifications, education, experience, and certification established by DBHDS as set forth in 12VAC35-250-10 through 12VAC35-250-50 in order to be eligible to register with the Board of Counseling at the Department of Health Professions (§ 54.1-3503) on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling at the Department of Health Professions, registration of Peer Recovery Specialists by the Board of Counseling shall be required. The PRS shall perform Mental Health Peer Support Services under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the Recovery, Resiliency, and Wellness Plan. The PRS shall be employed by or have a contractual relationship with an enrolled provider licensed for one of the following:

(1) Acute Care General Hospital licensed by Virginia Department of Health.

(2) Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by the Department of Behavioral Health and Developmental Services.

(3) Outpatient mental health clinic services licensed by Department of Behavioral Health and Developmental Services.

(4) Outpatient psychiatric services provider.

(5) Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).

(6) Hospital Emergency Department Services licensed by Virginia Department of Health.

(7) Community Mental Health and Rehabilitative Services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following Community Mental Health and Rehabilitative Services defined in 12VAC30-50-226 or 12VAC30-50-420 for which the individual meets medical necessity criteria:

(a) Day Treatment/ Partial Hospitalization;

(b) Psychosocial Rehabilitation;

(c) Crisis Intervention;

(d) Intensive Community Treatment;

(e) Crisis Stabilization;

(f) Mental Health Skill Building; or

(g) Mental Health Case Management.

k. Only the licensed and enrolled provider referenced in subparagraph i of this section shall be eligible to bill Mental Health Peer Support Services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

l. Supervision of the PRS shall be required as set forth in 12VAC30-130-5190(E) and 12VAC30-130-5200(G).

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services. Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public). The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1 shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury that has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services rendered in emergency departments that DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician that may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD diagnosis codes and necessary supporting documentation. As used here, the term "ICD" is defined in 12VAC30-95-5.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD code designations, and the impact on recipients and providers. As used here, the term "ICD" is defined in 12VAC30-95-5.

2. Dentists' services.

3. Mental health services including: (i) community mental health services, (ii) services of a licensed clinical psychologist, ~~or~~ (iii) mental health services provided by a physician, or (iv) peer support services.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME) and supplies.

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

"DMERC" means the Durable Medical Equipment Regional Carrier rate as published by the Centers for Medicare and Medicaid Services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

"HCPCS" means the Healthcare Common Procedure Coding System, Medicare's National Level II Codes, HCPCS 2006 (Eighteenth edition), as published by Ingenix, as may be periodically updated.

a. Obtaining prior authorization shall not guarantee Medicaid reimbursement for DME.

b. The following shall be the reimbursement method used for DME services:

(1) If the DME item has a DMERC rate, the reimbursement rate shall be the DMERC rate minus 10%. For dates of service on or after July 1, 2014, DME items subject to the Medicare competitive bidding program shall be reimbursed the lower of:

(a) The current DMERC rate minus 10% or

(b) The average of the Medicare competitive bid rates in Virginia markets.

(2) For DME items with no DMERC rate, the agency shall use the agency fee schedule amount. The reimbursement rates for DME and supplies shall be listed in the DMAS Medicaid Durable Medical Equipment (DME) and Supplies Listing and updated periodically. The agency fee schedule shall be available on the agency website at www.dmas.virginia.gov.

(3) If a DME item has no DMERC rate or agency fee schedule rate, the reimbursement rate shall be the manufacturer's net charge to the provider, less shipping and handling, plus 30%. The manufacturer's net charge to the provider shall be the cost to the provider minus all available discounts to the provider. Additional information specific to how DME providers, including manufacturers who are enrolled as providers, establish and document their cost or costs for DME codes that do not have established rates can be found in the relevant agency guidance document.

c. DMAS shall have the authority to amend the agency fee schedule as it deems appropriate and with notice to providers. DMAS shall have the authority to determine alternate pricing, based on agency research, for any code that does not have a rate.

d. The reimbursement for incontinence supplies shall be by selective contract. Pursuant to § 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the Commonwealth assures that adequate services/devices shall be available under such arrangements.

e. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical

equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12VAC30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment that is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services.

8. Laboratory services (other than inpatient hospital). The agency's rates for clinical laboratory services were set as of July 1, 2014, and are effective for services on or after that date.

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. Supplemental payments for services provided by Type I physicians.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Type I physicians for furnished services provided on or after July 2, 2002. A Type I physician is a member of a practice group organized by or under the control of a state academic health system or an academic health system that operates under a state authority and includes a hospital, who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 2, 2002, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for Type I physician services and Medicare rates. Effective August 13, 2002, the supplemental payment amount for Type I physician services shall be the

difference between the Medicaid payments otherwise made for physician services and 143% of Medicare rates. Effective January 3, 2012, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 181% of Medicare rates. Effective January 1, 2013, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 197% of Medicare rates. Effective April 8, 2014, the supplemental payment amount for Type I physician services shall be the difference between the Medicaid payments otherwise made for physician services and 201% of Medicare rates.

c. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

d. Supplemental payments shall be made quarterly no later than 90 days after the end of the quarter.

e. Payment will not be made to the extent that the payment would duplicate payments based on physician costs covered by the supplemental payments.

17. Supplemental payments for services provided by physicians at Virginia freestanding children's hospitals.

a. In addition to payments for physician services specified elsewhere in this State Plan, DMAS provides supplemental payments to Virginia freestanding children's hospital physicians providing services at freestanding children's hospitals with greater than 50% Medicaid inpatient utilization in state fiscal year 2009 for furnished services provided on or after July 1, 2011. A freestanding children's hospital physician is a member of a practice group (i) organized by or under control of a qualifying Virginia freestanding children's hospital, or (ii) who has entered into contractual agreements for provision of physician services at the qualifying Virginia freestanding children's hospital and that is designated in writing by the Virginia freestanding children's hospital as a practice plan for the quarter for which the supplemental payment is made subject to DMAS approval. The freestanding children's hospital physicians also must have entered into contractual agreements with the practice plan for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective July 1, 2011, the supplemental payment amount for freestanding children's hospital physician services shall be the difference between the Medicaid payments otherwise made for freestanding children's hospital physician services and 143% of Medicare rates subject to the following reduction. Final payments shall be reduced on a prorated basis so that total payments for freestanding children's hospital physician services are $400,000 less annually than would be calculated based on the formula in the previous sentence. Payments shall be made quarterly no later than 90 days after the end of the quarter. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

18. Supplemental payments for services provided by physicians affiliated with publicly funded medical schools in Tidewater.

a. In addition to payments for physician services specified elsewhere in the State Plan, the Department of Medical Assistance Services provides supplemental payments to physicians affiliated with publicly funded medical schools in Tidewater for furnished services provided on or after October 1, 2012. A physician affiliated with a publicly funded medical school is a physician who is employed by a publicly funded medical school that is a political subdivision of the Commonwealth of Virginia, who provides clinical services through the faculty practice plan affiliated with the publicly funded medical school, and who has entered into contractual agreements for the assignment of payments in accordance with 42 CFR 447.10.

b. Effective October 1, 2012, the supplemental payment amount for services furnished by physicians affiliated with publicly funded medical schools in Tidewater shall be the difference between the Medicaid payments otherwise made for physician services and 135% of Medicare rates. The methodology for determining the Medicare equivalent of the average commercial rate is described in 12VAC30-80-300.

19. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in the regulations, DMAS provides supplemental payments to qualifying nonstate government-owned or government-operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. Effective July 1, 2005, a qualifying clinic is a clinic operated by a

community services board. The state share for supplemental clinic payments will be funded by general fund appropriations.

b. The amount of the supplemental payment made to each qualifying nonstate government-owned or government-operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the upper payment limit attributed to each clinic according to subdivision 19 d of this subsection and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in subdivision 19 b (1) of this subsection for each qualifying clinic by the aggregate difference for all such qualifying clinics; and

(3) Multiplying the proportion determined in subdivision 19 b (2) of this subsection by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments for furnished services made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

d. To determine the aggregate upper payment limit referred to in subdivision 19 b (3) of this subsection, Medicaid payments to nonstate government-owned or government-operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12VAC30-80-190 B 2) in regard to the state agency fee schedule for Resource Based Relative Value Scale. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.

20. Personal assistance services (PAS) for individuals enrolled in the Medicaid Buy-In program described in 12VAC30-60-200. These services are reimbursed in accordance with the state agency fee schedule described in 12VAC30-80-190. The state agency fee schedule is published on the DMAS website at http://www.dmas.virginia.gov.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-80-32. Reimbursement for substance use disorder services.

A. Physician services described in 12VAC30-50-140, other licensed practitioner services described in 12VAC30-50-150, and clinic services described in 12VAC30-50-180 for assessment and evaluation or treatment of substance use disorders shall be reimbursed using the methodology in 12VAC30-80-30 and 12VAC30-80-190 subject to the following reductions for psychotherapy services for other licensed practitioners.

1. Psychotherapy services of licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

2. Psychotherapy services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioners, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

3. The same rates shall be paid to governmental and private providers. These services are reimbursed based on the Common Procedural Terminology codes and Healthcare Common Procedure Coding System codes. The agency's rates were set as of July 1, 2007, and are updated as described in 12VAC30-80-190. All rates are published on the Department of Medical Assistance Services (DMAS) website at www.dmas.virginia.gov.

B. Rates for the following addiction and recovery treatment services (ARTS) physician and clinic services shall be based on the agency fee schedule: medication assisted treatment induction with a visit unit of service; individual and group opioid treatment service with a 15-minute unit of service; and substance use care coordination with a monthly unit of service. The agency's rates shall be set as of April 1, 2017. The Medicaid

and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to public and private providers. All rates are published on the DMAS website at www.dmas.virginia.gov.

C. Community ARTS rehabilitation services. Per diem rates for clinically managed low intensity residential services (ASAM Level 3.1), partial hospitalization (ASAM Level 2.5), and intensive outpatient (ASAM Level 2.1) for ARTS shall be based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payments shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov.

D. ARTS federally qualified health center or rural health clinic services (ASAM Level 1.0) for assessment and evaluation or treatment of substance use disorder, as described in 12VAC30-130-5000 et seq., shall be reimbursed using the methodology described in 12VAC30-80-25.

E. Substance use case management services. Substance use case management services, as described in 12VAC30-50-491, shall be reimbursed a monthly rate based on the agency fee schedule. The Medicaid and commercial rates for similar services as well as the cost for providing services shall be considered when establishing the fee schedules so that payment shall be consistent with economy, efficiency, and quality of care. The same rates shall be paid to governmental and private providers. The agency's rates shall be set as of April 1, 2017, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov.

F. Peer support services. Peer support services as described in 12VAC30-130-5160 through 12VAC30-130-5210 furnished by enrolled providers or provider agencies as described in 12VAC30-130-5190 shall be reimbursed based on the agency fee schedule for 15 minute units of service. The agency s rates set as of July 1, 2017 are effective for services on or after that date. All rates are published on the DMAS website at: www.dmas.virginia.gov.

12VAC30-130-5160. Addiction Recovery Treatment Services (ARTS) Peer Support Services and Family Support Partners: Definitions.

The following words and terms when used in this part shall have the following meanings:

"Behavioral Health Service" means treatments and services for mental and/or substance use disorders.

"Caregiver" means the family members, friends, or neighbors who provide unpaid assistance to a Medicaid member with a mental health or substance use disorder or co-occurring mental health and substance use disorder. "Caregiver" does not include individuals who are employed to care for the member.

"Direct supervisor" means the person who provides direct supervision to the Peer Recovery Specialist. The direct supervisor: 1) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by DBHDS as set forth in 12VAC35-250-40, and have documented completion of the DBHDS PRS supervisor training; or 2) shall be a practitioner who has documented completion of the DBHDS PRS supervisor training and who meets (i)-(xii) in the definition of "Credentialed Addiction Treatment Professional" found in 12VAC30-130-5020, and who is acting within their scope of practice under state law; or 3) shall be a Certified substance abuse counselor (CSAC) as defined in Virginia Code §54.1-3507.1 who has documented completion of the DBHDS PRS supervisor training if they are acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. If a practitioner referenced in item 2 of this paragraph or a CSAC referenced in item 3 of this paragraph provides services before April 1, 2018, they shall have until April 1, 2018 to complete the DBHDS PRS supervisor training.

"Peer Recovery Specialist" or "PRS" means a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services (DBHDS) as set forth in 12VAC35-250-10 through 12VAC35-250-50 and who has received certification in good standing by a certifying body recognized by DBHDS as set forth in 12VAC35-250-40. A PRS is professionally qualified and trained (i)

to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental health disorders, substance use disorders, or both ii) to provide peer support as a self-identified individual successful in the recovery process with lived experience with mental health disorders or substance use disorders, or co-occurring mental health and substance use disorders, and (iii) to offer support and assistance in helping others in the recovery and community-integration process. A PRS may be a parent of a minor or adult child with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services.

"Person Centered" means a collaborative process where the individual participate in the development of their treatment goals and make decisions on the services provided.

"Recovery-oriented services" means providing support and assistance to an individual with mental health or substance use disorders or both so that the individual (i) improves their health, recovery, resiliency and wellness; (ii) lives a self-directed life; and (iii) strives to reach their full potential.

"Recovery, Resiliency, and Wellness Plan" means a written set of goals, strategies, and actions to guide the individual and the healthcare team to move the individual toward the maximum achievable independence and autonomy in the community.. The comprehensive documented wellness plan shall be developed by the individual, or caregiver as applicable, the PRS, and the direct supervisor within 30 days of the initiation of services and shall describe how the plan for peer support services and activities will meet the individual s needs. This document shall be updated as the needs and progress of the individual changes and shall document the individual s or caregiver s, as applicable, request for any changes in peer support services. The Recovery, Resiliency and Wellness Plan is a component of the individual's overall plan of care and shall be maintained by the enrolled provider in the individual s medical record.

"Resiliency" means the ability to respond to stress, anxiety, trauma, crisis, or disaster.

"Self-Advocacy" means an empowerment skill that allows the individual to effectively communicate preferences and choice.

"Strength-based" means to emphasize individual strengths, assets and resiliencies.

"Supervision" means the ongoing process performed by a direct supervisor who monitors the performance of the PRS and provides regular documented consultation and instruction with respect to the skills and competencies of the PRS.

12VAC30-130-5170. Addiction Recovery and Treatment Services (ARTS) Peer Support Services and Family Support Partners: Service Definitions.

A. ARTS Peer Support Services and ARTS Family Support Partners are Peer Recovery Support Services and are non-clinical, peer to peer activities that engage, educate, and support an individual s, and as applicable, the caregiver's self-help efforts to improve health recovery resiliency and wellness. These services shall be available to either:

1. Individuals 21 years or older with mental health or substance use disorders or co-occurring mental health and substance use disorders which is the focus of the support; or

2. The caregiver of individuals under 21 years old who have a mental health or substance use disorder or co-occurring mental health and substance use disorder which is the focus of the support.

3. Individuals 18-20 years old who meet the medical necessity criteria set forth in 12VAC30-130-5180(A) who would benefit from receiving peer supports directly, and who choose to receive ARTS Peer Support Services directly instead of through their family shall be permitted to receive Peer Support Services by an appropriate PRS.

B. ARTS Peer Support Services for Adults is a person centered, strength-based, and recovery oriented rehabilitative service for individuals 21 years or older provided by a Peer Recovery Specialist (PRS) successful in the recovery process with lived experience with substance use disorders or co-occurring mental health and

substance use disorders who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

C. ARTS Family Support Partners is a peer support service and is a strength-based, individualized, service provided to the caregiver of Medicaid-eligible individual under age 21, with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals under age 21 with complex needs who are involved with multiple systems and increase the individual's and family s confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar substance use disorder or co-occurring mental health and substance use disorder, or (ii) an adult with personal experience with a family member with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of their knowledge, lived - experience, and education.

D. ARTS Peer Support Services shall be rendered on an individual basis or in a group.

12VAC30-130-5180. Addiction Recovery and Treatment Services (ARTS) Peer Support Services and Family Support Partners: Medical Necessity Criteria.

A. In order to receive ARTS Peer Support Services, individuals 21 years or older shall meet the following requirements:

1. The individual shall have a substance use disorder or co-occurring mental health and substance use and disorder diagnosis.

2. The individual shall require recovery oriented assistance and support for:

a. the acquisition of skills needed to engage in and maintain recovery;

b. the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and

c. increasing responsibilities, wellness potential, and shared accountability for the individual s own recovery.

3. The individual shall demonstrate moderate to severe functional impairment as a result of the diagnosis, and the functional impairment shall be of a degree that it interferes with or limits performance in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his or her illness, living more independently).

B. Caregivers of individuals under age 21 who qualify for ARTS Family Support Partners (i) have an individual with a substance use disorder or co-occurring mental health and substance use disorder who requires recovery assistance, and (ii) meets two or more of the following:

1. Individual and his caregiver need peer-based recovery oriented services for the maintenance of wellness and acquisition of skills needed to support the individual;

2. Individual and his caregiver need assistance to develop self-advocacy skills to assist the individual in achieving self-management of the individual's health status;

3. Individual and his caregiver need assistance and support to prepare the individual for a successful work/school experience; or

4. Individual and his caregiver need assistance to help the individual and caregiver assume responsibility for recovery.

5. Individuals 18-20 years old who meet the medical necessity criteria in paragraph A who would benefit from receiving peer supports directly, and who choose to receive Peer Support Services directly instead of through their family shall be permitted receive Peer Support Services by an appropriate PRS.

D. To qualify for continued ARTS Peer Support Services and ARTS Family Support Partners, medical necessity criteria shall continue to be met and progress notes shall document the status of progress relative to the goals identified in the Recovery Resiliency and Wellness Plan.

E. Discharge shall occur when one or more of the following is met:

1. Goals of the Recovery Resiliency and Wellness Plan have been met; or

2. The Individual, or as applicable for individuals under 21, the caregiver, requests discharge; or

3. The individual, or as applicable for individuals under 21, the caregiver, fail to make minimum contact requirements set forth in 12VAC30-130-5210 (L) and (M) or the individual or caregiver, as applicable, discontinues participation in services.

12VAC30-130-5190. Addiction Recovery and Treatment Services (ARTS) Peer Support Services and Family Support Partners: Provider and Setting Requirements .

A. Effective July 1, 2017 a Peer Recovery Specialist "PRS" shall have the qualifications, education, and experience established by DBHDS as set forth in 12VAC35-250-10 through 12VAC35-250-50 and show certification in good standing by U.S. Department of Veteran s Affairs, NAADAC, a member board of the International Certification, and Reciprocity Consortium (IC&RC), or any other certifying body or state certification with standards comparable to or higher than those specified by the DBHDS in order to be eligible to register with the Board of Counseling at the Department of Health Professions (Virginia Code § 54.1-3503) on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling at the Department of Health Professions, registration of Peer Recovery Specialists by the Board of Counseling shall be required.

B. Prior to service initiation, a documented recommendation for service by a practitioner who meets (i)-(xii) in the definition of "Credentialed Addiction Treatment Professional" found in 12VAC30-130-5020, and who is acting within their scope of practice under state law shall be required. A CSAC, as defined in Virginia Code §54.1-3507.1, may also provide a documented recommendation for service if they are acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. The PRS shall perform ARTS Peer Services under the oversight of the practitioner described in this paragraph making the recommendation for services and providing the clinical oversight of the Recovery, Resiliency, and Wellness Plan. The recommendation shall verify that the individual meets the medical necessity criteria set forth in 12VAC30-130-5180A or B, as applicable.

C. The PRS shall be employed by or have a contractual relationship with the enrolled provider licensed for one of the following:

1. Acute Care General Hospital ASAM 4.0 licensed by Virginia Department of Health as defined in 12VAC30-130-5150.

2. Freestanding Psychiatric Hospital or Inpatient Psychiatric Unit ASAM Levels 3.7 and 3.5 licensed by Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5130 through 5140.

3. Residential Placements ASAM Levels 3.7, 3.5, 3.3, and 3.1 licensed by Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5110 through 12VAC30-130-5140.

4. ASAM Levels 2.5, 2.1, and licensed by Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5090 and 12VAC30-130-5100.

5. ASAM Level 1 as defined in 12VAC30-30-5080.

6. Opioid Treatment Program (OTP) as defined in 12VAC30-130-5050.

7. Office Based Opioid Treatment (OBOT) as defined in 12VAC30-130-5060.

8. Hospital Emergency Department Services licensed by Virginia Department of Health.

9. Pharmacy Services licensed by Virginia Department of Health.

D. Only the licensed and enrolled provider referenced in paragraph C above shall be eligible to bill and receive reimbursement from DMAS or its contractor for ARTS Peer Support Services. Payments shall not be permitted to providers that fail to enter into a enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

E. The Direct Supervisor, as defined in 12VAC30-130-5160, shall perform direct supervision of the PRS as needed based on the level of urgency and intensity of service being provided. The Direct Supervisor shall have an employment (or contract) relationship with the same provider entity that employs/contracts with the PRS. (Direct supervisors shall maintain documentation of all supervisory sessions. In no instance shall supervisory sessions be performed less than as outlined below:

1. If the PRS has less than 12 months experience delivering ARTS Peer Support Services or ARTS Family Support Partners, they shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty.

2. If the PRS has been delivering ARTS peer recovery services over 12 months and fewer than 24 months they must receive monthly face-to-face, one-to-one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. The direct supervisor must be available by phone for consult within 24 hours of service delivery if needed for challenging situations.

F. The caseload assignment of a full time PRS shall not exceed 12 to 15 individuals at any one time and 30 to 40 individuals annually allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-time PRS shall not exceed six to nine individuals at any one time and 15 annually.

12VAC30-130-5200. Peer Support Services and Family Support Partners: Documentation of Required Activities.

A. The recommendation for services shall include the dated signature and credentials of the practitioner described in 12VAC30-130-5190(B) who made the recommendation. The recommendation shall be included as part of the Recovery, Resiliency, and Wellness Plan and medical record. The recommendation shall verify that the individual meets the medical necessity criteria. The recommendation shall be valid for no longer than 30 calendar days.

B. Under the clinical oversight of the practitioner making the recommendation described in 12VAC50-130-5190(B) for ARTS Peer Support Services or ARTS Family Support Partners, the Peer Recovery Specialist in consultation with their direct supervisor shall develop a Recovery, Resiliency, and Wellness Plan based on the recommendation for service, the individual s, and as applicable, the caregiver s, perceived recovery needs and multidisciplinary assessment as defined in 12VAC30-130-5020 within 30 calendar days of the initiation of service. Development of the Recovery, Resiliency, and Wellness Plan shall include collaboration with the individual and, as applicable, the identified family member or caregiver involved in the individual s recovery. Individualized goals and strategies shall be focused on the individual s identified needs for self-advocacy and recovery. The Recovery, Resiliency, and Wellness Plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the Plan. The Recovery, Resiliency, and Wellness plan shall be completed, signed, and dated by the practitioner making the recommendation, the PRS, the direct supervisor, the individual, and as applicable the identified family member or caregiver involved in the individual s recovery within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and as

applicable the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

C. Services shall be delivered in accordance with the individual s goals and objectives as identified in the Recovery, Resiliency, and Wellness Plan and consistent with the recommendation of the referring practitioner who recommended services. As determined by the goal(s) identified in the Recovery, Resiliency, and Wellness Plan, services may be rendered in the provider s office or in the community, or both. The level of services provided and total time billed by the enrolled provider for the week shall not exceed the frequency established in the Recovery, Resiliency, and Wellness Plan.

D. Under the clinical oversight of the practitioner described in 12VAC30-130-5190(B) making the recommendation, the Peer Recovery Specialist in consultation with their direct supervisor shall conduct and document a Review of the Recovery, Resiliency, and Wellness Plan every 90 calendar days with the individual and caregiver as applicable. The review shall be signed by the PRS and the individual and as applicable the identified family member or caregiver. Review of the Recovery Resiliency and Wellness Plan means the PRS evaluates and updates the individual's progress every 90 days toward meeting the Plan s goals and documents the outcome of this review in the individual s medical record. For DMAS to determine that these reviews are complete, the reviews shall (i) update the goals and objectives as needed to reflect any change in the individual's recovery as well as any newly identified needs; (ii) be conducted in a manner that enables the individual to actively participate in the process; and (iii) be documented by the PRS in the individual's medical record no later than 15 calendar days from the date of the review.

E. Progress notes as defined in 12VAC30-50-130 shall be required and shall record the date, time, place of service, participants, face to face or telephone contact and circumstance of contact, regardless of whether or not a billable service was provided, and shall summarize the purpose and content of the session along with the specific strategies and activities utilized as related to the goals in the Recovery Resiliency and Wellness Plan. Documentation of specific strategies and activities shall fully disclose the details of services rendered and align with the Recovery, Resiliency, and Wellness Plan. Strategies and activities shall include at a minimum: 1) person centered, strength based planning to promote the development of self-advocacy skills; 2) empowering the individual to take a proactive role in the development and updating of their Recovery, Resiliency, and Wellness Plan; 3) crisis support; and 4) assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the Recovery Resiliency and Wellness Plan so that the individual: i) remains in the least restrictive setting; ii) achieves their goals and objectives identified in the Recovery Resiliency and Wellness Plan; iii) self-advocates for quality physical and behavioral health services; and iv) has access to strength-based behavioral health services, social services, educational services and other supports and resources.

F. Progress notes shall reflect collaboration between the PRS and the individual in the development of the progress note. If contact with the individual cannot be made, the service is not billable. However, the progress note shall reflect attempts to contact the individual. Progress notes shall contain the dated signature of the PRS who provided the service .

G. The enrolled provider shall ensure that documentation of all supervision sessions is maintained in a supervisor's log or the PRS's personnel file.

H. The enrolled provider shall have oversight of the individual s record and maintain individual records in accordance with state and federal requirements. The enrolled provider shall ensure documentation of all activities shall ensure documentation of all relevant information about the Medicaid individuals receiving services. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. This documentation shall be written, signed, and dated at the time the services are rendered.

I. The enrolled provider may integrate an individual s peer support record with the individual s other records maintained within same provider agency or facility, provided all peer support documentation is clearly identified. Logs and progress notes documenting the provision of services shall corroborate billed services.

J. Collaboration shall be required with behavioral health service providers and shall include the PRS, the individual, or caregiver as applicable and shall involve discussion regarding initiation of services and updates on the individual s status and changes in the individual s progress. Documentation of all collaboration shall be maintained in the individual s record.

12VAC30-130-5210. Peer Support Services and Family Support Partners: Limitations and Exclusions to Service Delivery.

A. An approved service authorization submitted by the enrolled provider shall be required prior to service delivery in order for reimbursement to occur. To obtain service authorization, all providers information supplied to the Department of Medical Assistance Services or its contractor shall be fully substantiated throughout the individual s record.

B. Service shall be initiated within 30 calendar days of the documented recommendation. The recommendation shall be valid for no longer than 30 calendar days.

C. Services rendered in a group setting shall have a ratio of no more than 10 individuals to one PRS and progress notes shall be included in each individual s record.

D. General support groups which are made available to the public to promote education and global advocacy do not qualify as Peer Support Services or Family Support Partners.

E. Non Covered activities include transportation, record keeping or documentation activities (including but not limited to progress notes, tracking hours and billing, and other administrative paperwork), services performed by volunteers, household tasks, chores, grocery shopping, on the job training, case management, outreach to potential clients, and room and board.

F. A unit of service shall be defined as 15 minutes. Peer Support Services and Family Support Partners shall be limited to four hours per day (up to 16 units per calendar day) and nine hundred (900) hours per calendar year. Service delivery limits may be exceeded based upon documented medical necessity and service authorization approval.

G. If a service recommendation for Mental Health Peer Support Services or Mental Health Family Support Partners as set forth in 12VAC 30-50-226 or 12VAC30-50-130 is made in addition to a service recommendation for ARTS Peer Support Services or ARTS Family Support Partners as set forth in 12VAC 30-130-5160 through12VAC30-130-5210, the enrolled provider shall coordinate services to ensure the 4 hour daily service limit is not exceeded. No more than a total of four hours of one type of service, or a total of four hours of a combination of service types, up to 16 units of total service, shall be provided per calendar day. The enrolled provider cannot bill DMAS separately for: i) MH peer services (Mental Health Peer Support Services or Mental Health Family Support Partners) and ii) ARTS peer services (Peer Support Services or ARTS Family Support Partners) rendered on the same calendar day unless the MH peer services and ARTS peer services are rendered at different times. A separate annual service limit of up to 900 hour shall apply to Mental Health Peer Support Services or Mental Health Family Support Partners Service and ARTS Peer Support Services or ARTS Family Support Partners.

H. The PRS shall document each 15-minute unit in which the individual was actively engaged in Peer Support Services or Family Support Partners. Meals and breaks and other non-covered services listed in this section shall not be included in the reporting of units of service delivered. Should an individual receive other services during the range of documented time in/time out for Peer Support hours, the absence of or interrupted services must be documented.

I. Service delivery shall be based on the individual's identified needs, established medical necessity criteria, and goals identified in the individual Recovery Resiliency and Wellness Plan.

J. Billing shall occur only for services provided with the individual present. Telephone time is supplemental rather than replacement of face to face contact and is limited to 25% or less of total time per recipient per calendar year. Justification for services rendered with the individual via telephone shall be documented. Any telephone time rendered over the 25% limit will be subject to retraction.

K. Peer Support Services or Family Support Partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space. Peer Support Services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting.

L. Contact shall be made with the individual receiving Peer Support Services or Family Support Partners a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be

either face-to-face or telephone contact depending on the individual s support needs and documented preferences.

M. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed 2 units. After two consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur.

N. Family Support Partners is not billable for siblings of the targeted individual for whom a need is specified unless there is applicability to the targeted individual/family. The applicability to the targeted individual must be documented.

O. Family Support Partners services shall not be billed for an individual who resides in a congregate setting in which the caregivers are paid (such as child caring institutions, or any other living environment that is not comprised of more permanent caregivers). An exception would be for an individual actively preparing for transition back to a single-family unit, the caregiver is present during the intervention, and the service is directed to supporting the unification/reunification of the individual and his/her caregiver and takes place in that home and community. The circumstances surrounding the exception shall be documented.

P. Individuals with the following conditions are excluded from Family Support Partners unless there is clearly documented evidence and diagnosis of a substance use disorder or mental health disorder overlaying the diagnosis: developmental disability including intellectual disabilities, organic mental disorder including dementia or Alzheimer s, or traumatic brain injury. There must be documented evidence that the individual is able to participate in the service and benefit from Family Support Partners.

Q. Claims that are not adequately supported by appropriate up to date documentation may be subject to recovery of expenditures. Progress notes, as defined in 12VAC30-50-130, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes shall be subject to recovery of expenditures.

R. The enrolled provider shall be subject to utilization reviews conducted by DMAS or its designated contractor.