COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **MEREDITH LEE**
Policy, Regulations, and Manuals Supervisor
Virginia Department of Medical Assistance Services

FROM: **MORGAN GREER**
Assistant Attorney General

DATE: **May 31, 2024**

SUBJECT: **Fast Track Regulations – Documents Incorporated by Reference: Chapter 60**

I have reviewed the attached fast-track regulations regarding the repeal of documents incorporated by reference in 12 VAC 30 – 60. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to amend the regulations and if the regulations comports with state and federal law.

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 and 325, has the authority to amend these regulations subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority. The proposed regulations are consistent with the directives in Governor Youngkin's Executive Order 19 (2022) regarding development and review of state agency regulations.

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

If you have any questions or need additional information about this action, please contact me at 804.786.6522.

cc: Kim F. Piner, Esquire

Attachment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. To determine that the DMAS enrolled mental hospital providers are in compliance with the regulations governing mental hospital utilization control found in the 42 CFR 456.150, an annual audit will be conducted of each enrolled hospital. This audit may be performed either on site or as a desk audit. The hospital shall make

all requested records available and shall provide an appropriate place for the auditors to conduct such review if done on site. The audits shall consist of review of the following:

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

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

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

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

5. Topic of one ongoing Medical Care Evaluation Study to determine the hospital is in compliance with 42 CFR 456.245.

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

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

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

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

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

4. The referral to the service provided under arrangement was not present in the patient's freestanding psychiatric hospital record;

5. The service provided under arrangement was not supported in that provider's records by a documented referral from the freestanding psychiatric hospital;

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

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

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

K. The hospitals may appeal in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) any adverse decision resulting from such audits that results in retraction of payment. The appeal must be requested pursuant to the requirements of 12VAC30-20-500 et seq.

12VAC30-60-40 Utilization control: Nursing facilities

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

B. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

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

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

E. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12VAC30-60-300 (Nursing facility criteria). In order for the additional $10 per day reimbursement to be made to the nursing facility for a recipient requiring a specialized treatment bed, the recipient must meet criteria as described in 12VAC30-60-350. Nursing facilities must obtain prior authorization for the reimbursement. DMAS shall provide the additional $10 per day reimbursement for recipients meeting criteria for no more than 246 days annually. Nursing facilities may receive the reimbursement for up to 82 days per new occurrence of a Stage IV ulcer. There must be at least 30 days between each reimbursement period. Limits are per recipient, regardless of the number of providers rendering services. Nursing facilities are not eligible to receive this reimbursement for recipients enrolled in the specialized care program.

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12VAC30-60-320 (Adult ventilation/tracheostomy specialized care criteria) or 12VAC30-60-340 (Pediatric and adolescent specialized care criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

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

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

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

H. Specialized care services.

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

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

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

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

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

d. Infection control;

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

f. Ancillary services related to a plan of care;

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

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

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

j. Nutritional elements as required;

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

l. Nonemergency transportation;

m. Discharge planning; and

n. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are under the age of 21.

12VAC30-60-50 Utilization control: Intermediate care facilities for persons with intellectual and developmental disabilities and institutions for mental disease

A. "Institution for mental disease" or "IMD" means the same as that term is defined in § 1905(i) of the Social Security Act.

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

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

D. In order for reimbursement to be made to a facility for persons with intellectual and developmental disabilities, the resident must meet criteria for placement in such facility as described in 12VAC30-60-360 and the facility must provide active treatment for intellectual or developmental disabilities.

E. In each case for which payment for nursing facility services for persons with intellectual or developmental disabilities or institution for mental disease services is made under the State Plan:

1. A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130 D 5. Recertification shall occur at least every 60 calendar days by a physician, or by a physician assistant or nurse practitioner acting within their scope of practice as defined by state law and under the supervision of a physician. The certification must be made at the time of admission or, if an individual applies for assistance while in the facility, before the Medicaid agency authorizes payment; and

2. A physician, or physician assistant or nurse practitioner acting within the scope of the practice as defined by state law and under the supervision of a physician, must recertify for each applicant at least every 60 calendar days that services are needed in a facility for persons with intellectual and developmental disabilities or an institution for mental disease.

F. When a resident no longer meets criteria for facilities for persons with intellectual and developmental disabilities or for an institution for mental disease, or no longer requires active treatment in a facility for persons with intellectual and developmental disabilities then the resident shall be discharged.

G. ~~All services provided in an ICF/ID shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.~~ (Reserved.)

H. All services provided in an IMD shall be provided with the applicable provider agreement and all documents referenced therein.

I. Psychiatric services in IMDs shall only be covered for eligible individuals younger than 21 years of age.

J. IMD services provided without service authorization from DMAS or its contractor shall not be covered.

K. Absence of any of the required IMD documentation shall result in denial or retraction of reimbursement.

L. In each case for which payment for IMD services is made under the State Plan:

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

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

3. Before admission to an IMD or before authorization for payment, the attending physician or staff physician shall perform a medical evaluation of the individual, and appropriate personnel shall complete a psychiatric and social evaluation as described in 42 CFR 456.170.

4. Before admission to an IMD or before authorization for payment, the attending physician or staff physician shall establish a written plan of care for each individual as described in 42 CFR 441.155 and 42 CFR 456.180.

M. It shall be documented that the individual requiring admission to an IMD who is younger than 21 years of age, that treatment is medically necessary, and that the necessity was identified as a result of an independent certification of need team review. Required documentation shall include the following:

1. Diagnosis~~, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition 2013, American Psychiatric Association,~~ based on nationally recognized criteria, and based on an evaluation by a psychiatrist completed within 30 calendar days of admission or if the diagnosis is confirmed, in writing, by a previous evaluation completed within one year within admission.

2. A certification of the need for services as defined in 42 CFR 441.152 by an interdisciplinary team meeting the requirements of 42 CFR 441.153 or 42 CFR 441.156 and the Psychiatric Treatment of Minors Act (§ 16.1-335 et seq. of the Code of Virginia).

N. The use of seclusion and restraint in an IMD shall be in accordance with 42 CFR 483.350 through 42 CFR 483.376. Each use of a seclusion or restraint, as defined in 42 CFR 483.350 through 42 CFR 483.376, shall be reported by the service provider to DMAS or its contractor within one calendar day of the incident.

12VAC30-60-120 <u>Quality management: Intensive physical rehabilitative services and CORF services</u>
A. Within 24 hours of an individual's admission for either intensive inpatient rehabilitation or CORF services, a physician shall be required to complete and sign and date the admission certification statement, as defined in 12VAC30-50-225 and 42 CFR 456.60, of the need for intensive rehabilitation or CORF services and the initial plan of care or orders.

1. Excluding CORF services, all other plans of care for inpatient rehabilitation services, including 60-day recertifications and the 60-day plan of care renewal orders shall be ordered by either a physician or a licensed practitioner of the healing arts including, but not limited to, nurse practitioners or physician assistants, within the scope of their licenses under state law.

2. If therapy services are recertified by a practitioner of the healing arts other than a physician, supervision shall be performed by a physician as required by §§ 54.1-2952 and 54.1-2957.01 of the Code of Virginia and 42 CFR 456.60.

3. For CORF providers, federal requirements do not permit nurse practitioners or physician assistants to order CORF intensive rehabilitation services. A physician shall be responsible for all documentation requirements including, but not limited to, admission certifications, recertifications, plans of care, progress notes, discharge orders, and any other required documentation (42 CFR 485.58(a)(i)).

4. Admission certification requirements shall apply to all individuals who are currently Medicaid eligible and to those individuals for whom a retroactive Medicaid eligibility determination is anticipated for coverage of an inpatient rehabilitative stay or for CORF services.

B. Within 72 hours of an individual's admission to an intensive rehabilitation or CORF program or upon notification to the provider of the individual's Medicaid eligibility or that his Medicare benefits are exhausted, the provider shall notify DMAS or its contractor in writing, or as required, of the individual's admission and the medical need for service authorization.

1. This notification shall include a description of the admitting diagnosis, plan of care, and expected progress and a physician's written admission certification statement that the individual meets the rehabilitation admission criteria. DMAS or its contractor shall review such requests for service authorization and make a determination based on medical necessity criteria (see 12VAC30-50-225) as designated by DMAS, and notify the provider of its decision. If services are approved, DMAS or its contractor shall establish and notify the provider of an approved length of stay. Additional lengths of stay shall be requested by the provider prior to the end date of the initial service authorization and must be approved by DMAS or its contractor for reimbursement. Admissions or lengths of stay not authorized by DMAS or its contractor shall not be approved for reimbursement.

2. For continued intensive rehabilitation or CORF services, the individual must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team.

C. Documentation of rehabilitation services required by DMAS for reimbursement for all disciplines of intensive rehabilitation or CORF services shall include all of the following:

1. A written physician admission certification statement.

2. A 60-day written recertification statement if a continued stay is determined to be medically necessary by the physician or other licensed practitioner of the healing arts within the scope of his license. Admission certification or recertification statements for CORF services shall be signed and dated only by licensed physicians.

3. A physician's written initial plan of care shall include orders for medications, the frequency and duration of services, required rehabilitation therapies, diet, medically necessary treatments, and other required services such as psychology, social work, and therapeutic recreation services.

a. Except for CORF services, the plan of care may be written by either a physician or by a licensed practitioner of the healing arts within the scope of his license.

b. For CORF services, the plan of care shall be written, signed, and dated only by a licensed physician.

4. An initial evaluation that describes the individual's clinical signs and symptoms necessitating admission to the rehabilitation program.

5. A description of any prior treatment and attempts to rehabilitate the individual.

6. An accurate and complete chronological description of the individual's clinical course and progress in treatment.

7. Documentation, by each participating therapy discipline, of a comprehensive plan of care developed by the licensed therapist.

8. Documentation that an interdisciplinary coordinated team plan of care specifically designed for the individual has been developed within seven days of admission.

9. Detailed documentation of all treatment rendered to the individual in accordance with each discipline's plan of care with specific attention to frequency, duration, modality, the individual's response to treatment, and the identification of the licensed therapist or therapy assistant and dated signature of who provided such treatment.

10. Documentation of all changes in the individual's condition or conditions.

11. Documentation describing a discharge plan that includes the anticipated improvements in functional levels, the timeframes necessary to meet the individual's goals, and the individual's discharge destination.

12. Discharge summary shall be completed by each licensed discipline offering services to include goal outcomes. The provider may complete the discharge summary before the individual's discharge or up to 30 days after the date of the individual's discharge.

D. Services not specifically documented in the individual's medical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided.

E. Intentional altering of medical record documentation shall be prohibited. If corrections in medical records are ~~indicated, then they shall be made consistent with the procedures in~~ required, the agency's provider-specific rehabilitation guidance documents ~~(see https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual).~~ provide information on the procedures to be used.

F. The interdisciplinary rehabilitative team shall meet and prepare written documentation of the interdisciplinary team plan of care within seven days of admission. Interdisciplinary rehabilitative team conferences shall be held as needed but at least every two weeks to assess and document the individual's progress or problems impeding progress. The interdisciplinary rehabilitative team shall assess the validity of the rehabilitation goals established at the time of the initial evaluation, determine if rehabilitation criteria continue to be met, and revise the individual's goals as needed. A simple reading review by the various interdisciplinary rehabilitative team members of each other's notes shall not constitute an interdisciplinary rehabilitative team conference. Where practical, the individual or family or both shall participate in the interdisciplinary rehabilitative team conferences. A dated summary of the conferences, documenting the names and professional titles of the interdisciplinary rehabilitative team members present, shall be recorded in the clinical record and shall reflect the reassessments of the various interdisciplinary rehabilitative team members.

G. DMAS or its contractor shall perform quality management reviews to determine if services were appropriately provided as verified in the medical record documentation and to ensure that the services provided to Medicaid individuals were medically necessary and appropriate and that the individual continued to meet intensive rehabilitation criteria throughout the entire admission in the rehabilitation program.

H. When a provider has been determined during a quality management review as not complying with DMAS regulations, DMAS or its contractor may request corrective action plans from the provider. The corrective action plan shall address how the provider will become compliant with DMAS regulations and requirements in the areas for which the provider has been cited for noncompliance.

I. Properly documented medical reasons for furlough visits away from the inpatient rehabilitation provider may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough shall not be reimbursed by DMAS.

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

K. Each of the following intensive rehabilitation professionals have specific licensure and documentation requirements based on their disciplines that shall be adhered to. This subsection outlines these requirements for physician, nursing, physical therapy, occupational therapy, speech-language pathology, cognitive rehabilitation therapy, psychology, social work, therapeutic recreation, and prosthetic/orthotic services as follows:

1. Physician services are those services furnished to an individual that meet all of the following conditions:

a. The individual shall be under the care of a physician who is legally authorized to practice and is acting within the scope of his license, or a licensed practitioner of the healing arts as defined in 12VAC30-50-225. The physician shall be licensed by the Virginia Board of Medicine and have specialized training or experience in the field of physical medicine and rehabilitation;

b. Within 24 hours of an individual's admission, the physician shall provide a written initial admission certification consistent with 42 CFR 456.60. The physician shall provide a 60-day written recertification statement of the continued need for intensive physical rehabilitation services. DMAS shall not provide reimbursement for services that are not supported by physician written admission certifications and 60-day recertifications;

c. The physician plan of care shall be written to include orders for medications, rehabilitation therapies, treatments, diet, and other required services pursuant to 42 CFR 456.80. Failure to obtain the physician written renewal of the plan of care every 60 days shall result in nonpayment for services rendered; and

d. The service shall be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice.

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

a. The services shall be directly and specifically related to a written plan of care developed by a registered nurse licensed by the Virginia Board of Nursing who is experienced in physical rehabilitation;

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

c. The services shall be provided with the expectation, based on the physician's assessment of the individual's rehabilitation potential, that the individual's condition will improve significantly, as determined by the physician and the interdisciplinary rehabilitative team, in a reasonable and generally predictable period of time as determined by the nurse or therapist, or these services shall be necessary to the establishment of a safe and effective maintenance therapy program required in connection with a specific diagnosis; and

d. The service shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the service shall comport with accepted standards of medical practice.

3. Physical therapy services are those services furnished to an individual that meet all of the following conditions:

a. The services shall be directly and specifically related to a written plan of care developed by a physical therapist licensed by the Virginia Board of Physical Therapy;

b. The services shall be of a level of complexity and sophistication or the individual's condition shall be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapy assistant who is licensed by the Virginia Board of Physical Therapy and under the direct supervision of a qualified licensed physical therapist;

c. The services shall be provided with the expectation, based on the physician's assessment of the individual's rehabilitation potential, that the individual's condition will improve significantly, as determined by the physician and the interdisciplinary rehabilitative team, in a reasonable and generally predictable period of time, or these services shall be necessary to the establishment of a safe and effective maintenance therapy program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of medical practice.

4. Occupational therapy services are those services furnished to an individual that meet all of the following conditions:

a. The services shall be directly and specifically related to a written plan of care developed by an occupational therapist certified by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine;

b. The services shall be of a level of complexity and sophistication or the individual's condition shall be of a nature that the services can only be performed by an occupational therapist registered and certified by the National Board for Certification in Occupational Therapy or an occupational therapy assistant certified by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine under the direct supervision of a qualified occupational therapist as defined in subdivision 4 a of this subsection;

c. The services shall be provided with the expectation, based on the physician's assessment of the individual's rehabilitation potential, that the individual's condition will improve significantly, as determined by the physician and the interdisciplinary rehabilitative team, in a reasonable and generally predictable period of time, or these services shall be necessary to the establishment of a safe and effective maintenance therapy program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of medical practice.

5. Speech-language pathology therapy services are those services furnished to an individual that meet all of the following conditions:

a. The services shall be directly and specifically related to a written plan of care developed by a speech-language pathologist licensed by the Virginia Board of Audiology and Speech-Language Pathology or, if exempted from licensure by statute, meeting the requirements in 42 CFR 440.110(c);

b. The services shall be of a level of complexity and sophistication or the individual's condition shall be of a nature that the services can only be performed by either a speech-language pathologist licensed by the Virginia Board of Audiology and Speech-Language Pathology or by a speech-language assistant who has been certified by the board and who is under the direct supervision of the speech-language pathologist;

c. The services shall be provided with the expectation, based on the physician's assessment of the individual's rehabilitation potential, that the individual's condition will improve significantly, as determined by the physician and the interdisciplinary rehabilitative team, in a reasonable and generally predictable period of time, or these services shall be necessary to the establishment of a safe and effective maintenance therapy program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of medical practice.

6. Cognitive rehabilitation therapy services are those services furnished to an individual that meet all of the following conditions:

a. The services shall be directly and specifically related to a written plan of care developed by a clinical psychologist experienced in working with the neurologically impaired and licensed by the Virginia Board of Psychology;

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

c. Cognitive rehabilitation therapy services shall be provided by occupational therapists, speech-language pathologists, or psychologists, or all of these, who have experience in working with neurologically impaired individuals when such services have been ordered by a physician or other licensed practitioner;

d. The cognitive rehabilitation services shall be an integrated part of the individual's interdisciplinary plan of care and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

e. The services include therapeutic activities to improve a variety of cognitive functions, for example orientation, attention/concentration, reasoning, memory, recall, discrimination, and behavior; and

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

7. Psychological services are those services furnished to an individual that meet all of the following conditions:

a. Services shall be ordered by a physician or other licensed practitioner;

b. The services shall be of a level of complexity and sophistication or the individual's condition shall be of a nature that the services as set out in the written plan of care can only be developed and performed by a qualified, licensed psychologist as required by the Virginia Board of Psychology or a licensed clinical social worker, a licensed professional counselor, or a licensed clinical nurse specialist-psychiatric;

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

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of medical practice.

8. Social work services are those services furnished to an individual that meet all of the following conditions:

a. Services shall be ordered by a physician or other licensed practitioner;

b. The services shall be of a level of complexity and sophistication or the individual's condition shall be of a nature that the services as set out in the written plan of care can only be performed by a qualified social worker licensed by the Virginia Board of Social Work;

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

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of practice.

9. Therapeutic recreation services are those services furnished to an individual that meet all of the following conditions:

a. Services shall be ordered by a physician or other licensed practitioner;

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

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

d. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of practice.

10. Prosthetic/orthotic services.

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

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

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

d. The services shall be directly and specifically related to a written plan of care approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist who shall be certified in maxillofacial prosthetics.

e. The services shall be provided with the expectation, based on the physician's or other licensed practitioner's assessment of the individual's rehabilitation potential, that the individual's condition will improve significantly in a reasonable and predictable period of time, or these services shall be necessary to the establishment of a safe and effective maintenance therapy program.

f. The services shall be specific and provide effective treatment for the individual's condition. The amount, frequency, and duration of the services shall comport with accepted standards of medical and dental practice.

12VAC30-60-130 Hospice services
A. Admission criteria.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12VAC30-60-150 Quality management review of outpatient rehabilitation therapy services
A. The following general conditions shall apply to reimbursable outpatient rehabilitation therapy services:

1. The covered services and medical necessity criteria as set out in 12VAC30-50-200 shall apply to these outpatient rehabilitation therapy services.

2. Outpatient rehabilitative therapy services, as defined in 42 CFR 440.130, shall be prescribed by a licensed physician or a licensed practitioner of the healing arts, specifically either a nurse practitioner or physician assistant, and be part of a written plan of care.

3. Quality management reviews shall be performed by DMAS or its contractor to ensure that all rehabilitative services provided to Medicaid individuals are medically necessary and appropriate. Services not specifically documented in the individual's medical record as having been rendered shall be deemed not to have been rendered and no reimbursement shall be provided.

B. Covered outpatient rehabilitative therapy services. Rehabilitation services shall be initiated by a physician or licensed practitioner for the evaluation and plan of care. Both require a physician or licensed practitioner signature, title, and full date.

A plan of care for therapy services shall (i) include the specific procedures and modalities to be used, (ii) identify the specific discipline to carry out the plan of care, and (iii) indicate the frequency and duration of services.

C. All practitioners and providers of therapy services shall be required to meet state and federal licensing or certification requirements, or both as may be applicable.

D. Documentation of physical therapy, occupational therapy, and speech-language pathology services provided in outpatient settings of acute and rehabilitation hospitals, nursing facilities, home health agencies, and rehabilitation agencies shall at a minimum include:

1. An initial evaluation that describes the clinical signs and symptoms of the individual's condition, including an accurate and complete chronological picture of the individual's clinical course and treatments. The initial evaluation or the reevaluation shall be signed, titled, and dated by the licensed therapist (i) when an individual is initially admitted to a service, (ii) when there is a significant change in the individual's condition, or (iii) when an individual is readmitted to a service.

2. A written plan of care specifically developed for the individual shall be signed, titled, and fully dated by a licensed therapist. Within 21 days of the plan of care start date, the physician or a licensed practitioner shall sign, title, and fully date the plan of care and it shall:

a. Describe specifically the anticipated goal-related improvements in functional level, frequency and duration of the ordered therapy or therapies, and the anticipated timeframes necessary to meet these long-term and short-term individual goals, including participation by the appropriate rehabilitation therapist or therapists, the individual, and the family or caregiver, as may be appropriate; and

b. Include a discharge plan that contains the anticipated improvements in functional levels and the anticipated timeframes necessary to meet the individual goals:

(1) For outpatient rehabilitative services for acute conditions, as defined in 12VAC30-50-200, the plan of care must be reviewed, updated, and signed and dated at least every 60 days by the licensed therapist and the physician or other licensed practitioner;

(2) For outpatient services for long-term, nonacute conditions, as defined in 12VAC30-50-200, the plan of care must be reviewed, updated, and signed and dated at least every 12 months by the licensed therapist and the physician or other licensed practitioner.

3. The documentation of all treatment rendered to the individual in the progress notes, in accordance with the written plan of care with specific attention to frequency, duration, modality, and the individual's response to treatment. The licensed therapist must sign, title, and fully date all progress notes in the medical record. If therapy assistants provide the treatment under the supervision of a licensed therapist, the assistant shall also sign, title, and fully date the progress notes in the medical record.

4. A description of all changes in the individual's condition, response to the rehabilitative written plan of care, and appropriate revisions to the written plan of care.

5. A discharge summary to be completed by the licensed therapist who is providing the service at the time that the service is terminated, including a description of the individual's response to services, level of independence in carrying out learned skills and abilities, assistive technology necessary to carry out and maintain activities and skills, and recommendations for continued services (i.e., referrals to alternate providers, home maintenance programs, training to individuals or caregivers, etc.).

6. The therapist's signature, title, and full date (month/day/year) shall appear on all documentation; if therapy assistants provide the treatment, under the supervision of a licensed therapist, the supervising licensed therapist must document the findings of the supervisory onsite visit every 30 days.

E. Restrictions.

1. The intentional altering of medical record documentation shall be prohibited and is fraudulent. If corrections are ~~indicated, then they shall be made in medical records consistent with the procedures in~~ <u>required,</u> the agency's provider-specific guidance documents ~~(see https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual).~~ <u>provide information on the procedures to be used.</u>

2. DMAS shall not reimburse for evaluations provided prior to the date of the physician's or other licensed practitioner's signature. DMAS shall not reimburse for provider-initiated additional reevaluations that are not specific to DMAS requirements and that are in excess of DMAS' requirements.

12VAC30-60-170 <u>Utilization review of treatment foster care (TFC) case management services</u>

A. Service description and provider qualifications. TFC case management is a community-based program where treatment services are designed to address the special needs of children. TFC case management focuses on a continuity of services, is goal directed and results oriented. Services shall not include room and board. Child-placing agencies licensed or certified by the Virginia Department of Social Services and that meet the provider qualifications for treatment foster care set forth in Part XV (12VAC30-130-900 et seq.) of this chapter shall provide these services.

B. Utilization control.

1. Assessment. Each child referred for TFC case management must be assessed by a Family Assessment and Planning Team (FAPT) under the Comprehensive Services Act or by an interdisciplinary team approved by the State Executive Council. For purposes of high quality case management services, the team must (i) assess the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and

liabilities; (ii) assess the potential for reunification of the child's family; (iii) set treatment objectives; and (iv) prescribe therapeutic modalities to achieve the plan's objectives.

2. Qualified assessors. A qualified assessor is a Family Assessment and Planning Team as authorized under §§ 2.2-5207, 2.2-5208, and 2.2-5209 of the Code of Virginia.

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

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

a. Level I: Moderate impairment with one or more of the following moderate risk factors as documented on the state-designated uniform assessment instrument:

(1) Needs intensive supervision to prevent harmful consequences;

(2) Moderate/frequent disruptive or noncompliant behaviors in home setting that increase the risk to self or others;

(3) Needs assistance of trained professionals as caregivers.

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

(1) Be unable to handle the emotional demands of family living;

(2) Need 24-hour immediate response to crisis behaviors; or

(3) Have severe disruptive peer and authority interactions that increase risk and impede growth.

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

5. TFC case management admission documentation required. Before Medicaid preauthorization will be granted, the referring entity must submit the following documentation. The documentation will be evaluated by DMAS or its designee to determine whether the child's condition meets the department's medical necessity criteria.

a. A completed state-designated uniform assessment instrument;

b. Diagnosis ~~(Diagnostic Statistical Manual, Fourth Revision (DSM IV),~~ based on nationally recognized criteria~~, including Axis I (Clinical Disorders); Axis II (Personality Disorders/Mental Retardation); Axis III (General Medical Conditions); Axis IV (Psychosocial and Environmental Problems); and Axis V (Global Assessment of Functioning)~~;

c. A description of the child's immediate behavior prior to admission;

d. A description of alternative placements tried or explored;

e. The child's functional level;

f. Clinical stability;

g. The level of family support available;

h. Initial plan of care; and

i. One of the following:

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

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

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

C. Noncovered services. Permanency planning and other activities performed by foster care workers shall not be considered covered services and shall not be reimbursed.

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

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

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

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

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

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

B. Utilization review: substance use case management services.

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

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

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

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

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

C. Utilization review: substance use case management services.

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

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

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

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

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

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

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

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

12VAC30-60-9999 ~~DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-60).~~ (Repealed.)
~~Department of Medical Assistance Services Provider Manuals (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManuals):~~

~~Virginia Medicaid Nursing Home Manual~~

~~Virginia Medicaid Rehabilitation Manual~~

~~Virginia Medicaid Hospice Manual~~

~~Virginia Medicaid School Division Manual~~

~~Development of Special Criteria for the Purposes of Pre-Admission Screening, Medicaid Memo, October 3, 2012, Department of Medical Assistance Services~~

~~Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), copyright 2000, American Psychiatric Association~~

~~Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition, copyright 2001, American Society on Addiction Medicine, Inc.~~

~~Medicaid Memo, Reissuance of the Pre-Admission Screening (PAS) Provider Manual, Chapter IV, November 22, 2016, Department of Medical Assistance Services~~

~~Medicaid Special Memo, Subject: New Service Authorization Requirement for an Independent Clinical Assessment for Medicaid and FAMIS Children's Community Mental Health Rehabilitative Services, dated June 16, 2011, Department of Medical Assistance Services~~

~~Medicaid Special Memo, Subject: Changes to Children Community Mental Health Rehabilitative Services - Children's Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services~~

~~Medicaid Special Memo, Subject: Changes to Community Mental Health Rehabilitative Services - Adult-Oriented Services, July 1, 2010 & September 1, 2010, dated July 23, 2010, Department of Medical Assistance Services~~

~~Approved Degrees in Human Services and Related Fields for QMHP Registration, adopted November 3, 2017, revised February 9, 2018~~