12VAC30-10-150. Amount, duration, and scope of services: Medically needy.

This State plan covers the medically needy. The services described below and in 12VAC30-50-40 et seq. are provided. Services for medically needy include:

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in §1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in §1902(a)(1) through (20). The services are provided as defined in 42 CFR 440, Subpart A and in §1902, 1905, and 1915 of the Act.

The above-stated is applicable with respect to nurse-midwife services under §1902(a)(17).

(ii) Prenatal care and delivery services for pregnant women.

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in 12VAC30-50-40 for recipients under age 18 and recipients entitled to institutional services.

(vi) Home health services to recipients entitled to nursing facility services as indicated in 12VAC30-10-220 of this plan.

(vii) Services for the medically needy do not include services in an institution for mental diseases for individuals over age 65.

(viii) Services for the medically needy do not include services in an intermediate care facility for the mentally retarded.

(ix) Services for the medically needy do not include inpatient psychiatric services for individuals under age 21, other than those covered under Early and Periodic Screening, Diagnosis and Treatment (at 12 VAC 30-50-130).

(x) Services for the medically needy do not include respiratory care services provided to ventilator dependent individuals. See 12VAC30-10-300 of this plan.

(xi) Home and community care for functionally disabled elderly individuals is not covered.

12VAC30-50-40 et seq. identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the

ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

12VAC30-50-30. Services not provided to the categorically needy.

The following services and devices are not provided to the categorically needy:

1. Chiropractors' services.

2. Private duty nursing services.

3. Dentures.

4. Other diagnostic and preventive services other than those provided elsewhere in this plan: diagnostic services (see 12VAC30-50-95 et seq.).

5. Inpatient psychiatric facility services for individuals under 22 years of age, other than those covered under Early and Periodic Screening, Diagnosis, and Treatment (at 12 VAC 30-50-130).

6. Special tuberculosis (TB) related services under §1902(z)(2)(F) of the Act.

7. Respiratory care services (in accordance with §1920(e)(9)(A) through (C) of the Act).

8. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with §1920 of the Act).

9. Any other medical care and any type of remedial care recognized under state law specified by the Secretary: services of Christian Science Nurses; personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

12VAC30-50-70. Services or devices not provided to the medically needy.

1. Chiropractors' services.

2. Private duty nursing services.

3. Dentures.

4. Diagnostic or preventive services other than those provided elsewhere in the State Plan.

5. Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for mental disease(s).

6. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with §1905(a)(4)(A) of the Act, to be in need of such care in a public institution, or a distinct part thereof, for the mentally retarded or persons with related conditions.

7. Inpatient psychiatric facility services for individuals under 22 years of age (other than those covered under Early and Periodic Screening, Diagnosis, and Treatment (12 VAC 30-50-130).

8. Special tuberculosis (TB) services under §1902(z)(2)(F) of the Act.

9. Respiratory care services (in accordance with §1920(e)(9)(A) through (C) of the Act).

10. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with §1920 of the Act).

11. Services of Christian Science nurses.

12. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

13. Home and community care for functionally disabled elderly individuals, as defined, described and limited in 12VAC30-50-410 through 12VAC30-50-470.

14. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (i) authorized for the individual by a physician in accordance with a plan of treatment, (ii) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (iii) furnished in a home.

12VAC30-50-130. Skilled nursing facility services, EPSDT, ~~community mental 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).

~~C.~~ 5. Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

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

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

b. A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

c. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12 VAC 30-50-100 and 12 VAC 30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of 12 VAC 30-130-850 et seq.

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

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

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

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

12VAC30-50-250. Inpatient psychiatric facility services for individuals under 22 years of age.

Inpatient psychiatric facility services for individuals under 22 years of age are not provided, other than those provided under Early and Periodic Screening, Diagnosis, and Treatment (12 VAC 30-50-130).

12 VAC 30-80-21. Inpatient psychiatric services in residential treatment facilities (under EPSDT). Effective January 1, 2000, the state agency shall pay for inpatient psychiatric services in residential treatment facilities provided by participating providers, under the terms and payment methodology described below.

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

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

PART XIV.

Residential Psychiatric Treatment for Children and Adolescents

12 VAC 30-130-850. Definitions.

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

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

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

"Comprehensive individual plan of care" or "CIPOC" means a written plan developed for each recipient in accordance with 12 VAC 30-130-890 to improve his condition to the extent that inpatient care is no longer necessary.

"Initial plan of care" means a plan of care established at admission, signed by the attending physician or staff physician which meets the requirements in 12 VAC 30-130-890.

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

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

12 VAC 30-130-860. Service coverage; eligible individuals; service certification.

A. Residential treatment programs shall be 24-hour supervised medically necessary out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include but shall not be limited to

assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child;

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

C. Active treatment shall be required. Residential treatment services shall be designed to serve the mental health needs of children. In order to be reimbursed by Medicaid for residential treatment, the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. The service definitions do not include interventions and activities designed only to meet the supportive non-

mental health special needs, including, but not limited to personal care, habilitation or academic educational needs of the recipients.

D. Eligible individual. A recipient under the age of 21 years whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of his psychiatric condition requires services on an inpatient basis under the direction of a physician; and the services can reasonably be expected to improve his condition or prevent further regression so that the services will no longer be needed.

E. Certification of the need for services; independent certifying team. In order for Medicaid to reimburse for residential treatment to be provided to a recipient, the need for the service must be certified according to the standards and requirements set forth in 42 CFR 441.153 and set out below. At least one member of the independent certifying team must have pediatric mental health expertise.

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

a. That includes a licensed physician;

b. That has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; AND

c. That has knowledge of the recipient's mental health history and current situation.

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

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

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

c. Be signed by a physician member of the team.

12 VAC 30-130-870. Preauthorization.

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

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

C. Information which is required in order to obtain admission preauthorization for Medicaid payment shall include:

1. A completed state designated uniform assessment instrument as specified in a guidance document.

2. A certification of the need for this service by the team described in 12 VAC 30-130-860 that:

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

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

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

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

   a. Diagnosis, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), including Axis I (Clinical Disorders), Axis II (Personality Disorders/Mental Retardation, Axis III (General Medical Conditions), Axis IV

(Psychosocial and Environmental Problems), and Axis V (Global Assessment of Functioning);

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

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

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

e. The level of family support available; AND

f. The initial plan of care as defined and specified at 12 VAC 30-130-890.

D. Denial of authorization shall be subject to the reconsideration process. Denial of service may be appealed by the recipient consistent with 12 VAC 30-110-10 et seq.; denial of reimbursement may be appealed by the provider consistent with the Administrative Process Act § 9-6.14:4.1 et seq.

12 VAC 30-130-880. Provider qualifications.

A. All providers must provide all residential treatment services as defined within these regulations and set forth in 42 CFR Part 441 Subpart D.

B. Providers must be either:

1. A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations and licensed by DMHMRSAS as a residential treatment program; OR

2. A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and licensed by DMHMRSAS as a residential treatment program.

12 VAC 30-130-890. Plans of care; review of plans of care.

A. An initial plan of care must be completed at admission and a Comprehensive Individual Plan of Care must be completed no later than 14 days after admission.

B. Initial plan of care must include:

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

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

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

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

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

6. Plans for discharge.

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

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

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

3. State treatment objectives which must include measurable short and long term goals;

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

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

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

1. Determine that services being provided are or were required on an inpatient basis, AND

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

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

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

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

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

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

   c. Setting treatment objectives; AND

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

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

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

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

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

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

a. A psychiatric social worker;

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

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

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

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

12 VAC 30-130-891 through 12 VAC 30-130-899. Reserved.