COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: EMILY MCCLELLAN
Regulatory Supervisor
Department of Medical Assistance Services

FROM: ELIZABETH M. GUGGENHEIM
Assistant Attorney General

DATE: December 10, 2019

SUBJECT: Fast Track regulations regarding CMHRS and Peers Updates

I have reviewed the attached fast track regulations, which would amend the Community Mental Health Rehabilitative Services and Peers regulations. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority.

Please be aware that this review is based solely upon whether DMAS has the legal authority to promulgate these regulations, not the appropriateness of whether they should be promulgated pursuant to the fast track process. Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either House of the General Assembly or of the Joint Commission on Administrative Rules, the Department of Medical Assistance Services 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 any additional information, please feel free to call me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General

Virginia.gov Agencies | Governor

Proposed Text

highlight

Action: CMH and Peers Updates
Stage: Fast-Track 9/9/19 2:41 PM [latest]

12VAC30-50-130. Nursing facility services, EPSDT, including school health services and family planning.

A. 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 younger than 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals younger than 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 that are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 years and older, provided for by § 1905(a) of the Social Security Act.

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

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

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

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

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

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

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

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

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

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

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

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification ~~training~~ as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

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

"EPSDT" means early and periodic screening, diagnosis, and treatment.

"Family support partners" means the same as defined in 12VAC30-130-5170.

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

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

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

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

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

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

"Peer recovery specialist" or "PRS" means the same as defined in ~~12VAC30-130-5160~~ 12VAC35-250-10.

"Peer recovery support services" means the same as defined in 12VAC35-250-10.

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

"Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who

rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

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

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

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

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

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

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

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

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

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

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

"Services provided under arrangement" means the same as defined in 12VAC30-130-850.

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

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

b. Intensive in-home services (IIH) to children and adolescents younger than 21 years of age shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All interventions and the settings of the intervention shall be defined in the Individual Service Plan.

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

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

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

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

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

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

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

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

d. Community-based services for children and adolescents younger than 21 years of age (Level A) pursuant to 42 CFR 440.031(d).

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

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

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

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

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

(6) These residential providers must be licensed by the Department of Social Services, Department of Juvenile Justice, or Department of Behavioral Health and Developmental Services under the Standards for Licensed Children's Residential Facilities (22VAC40-151), Regulation Governing Juvenile Group Homes and Halfway Houses (6VAC35-41), or Regulations for Children's Residential Facilities (12VAC35-46).

(7) Daily progress notes shall document a minimum of seven psychoeducational activities per week. Psychoeducational programming must include development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, stress management, and any care coordination activities.

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

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

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

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

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

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

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

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

(5) Daily progress notes shall document that a minimum of seven psychoeducational activities per week occurs. Psychoeducational programming must include development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

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

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

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

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

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

f. Mental health family support partners.

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

(2) Under the clinical oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S ~~making the recommendation for~~ completing the assessment recommending mental health family support partners, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the ~~LMHP's recommendation~~ assessment of the LMHP, LMHP-R, LMHP-RP, or LMHP-S for service, the individual's and the caregiver's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual and the individual's caregiver. Individualized goals

and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by (i) the LMHP, LMHP-R, LMHP-RP, or LMHP-S (ii) the PRS, (iii) the direct supervisor, (iv) the individual, and (v) the individual's caregiver within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual and the caregiver to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

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

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

(5) Caregivers of individuals younger than 21 years of age who qualify to receive mental health family support partners (i) care for an individual with a mental health disorder who requires recovery assistance and (ii) meet two or more of the following:

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

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

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

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

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

(7) To qualify for continued mental health family support partners, medical necessity criteria shall continue to be met, and progress notes shall document the status of progress relative to the goals identified in the recovery, resiliency, and wellness plan.

(8) Discharge criteria from mental health family support partners shall be the same as set forth in 12VAC30-130-5180 E.

(9) Mental health family support partners services shall be rendered on an individual basis or in a group.

(10) Prior to service initiation, ~~a documented recommendation for mental health family support partners services shall be made~~ an assessment shall be conducted and documented by ~~a licensed mental health professional (LMHP)~~ an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is acting within his scope of practice under state law. The ~~recommendation~~ assessment shall verify that the individual meets the medical necessity criteria set forth in subdivision 5 of this subsection. The assessment shall be included as part of the recovery, resiliency, and wellness plan and medical record. ~~The recommendation shall be valid for no longer than~~

Services shall be initiated within 30 calendar days from when the assessment was complete.

(11) Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification required by DBHDS ~~in order to be eligible to register with the Virginia Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations~~ in accordance with 12VAC35-250. Peer recovery specialists shall be registered by the Board of Counseling~~, registration of peer recovery specialists by the Board of Counseling shall be required~~. The PRS shall perform mental health family support partners services under the oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S who assessed the individual and made ~~making~~ the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan.

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

(a) Acute care general and emergency department hospital services licensed by the Department of Health.

(b) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

(c) Psychiatric residential treatment facility licensed by the Department of Behavioral Health and Developmental Services.

(d) Therapeutic group home licensed by the Department of Behavioral Health and Developmental Services.

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

(f) Outpatient psychiatric services provider.

(g) A community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services as defined in this section, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30-50-430 for which the individual younger than 21 years meets medical necessity criteria (i) intensive in home; (ii) therapeutic day treatment; (iii) day treatment or partial hospitalization; (iv) crisis intervention; (v) crisis stabilization; (vi) mental health skill building; or (vii) mental health case management.

(13) Only the licensed and enrolled provider as referenced in subdivision 5 f (12) of this subsection shall be eligible to bill and receive reimbursement from DMAS or its contractor for mental health family support partner services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined not to be in compliance with DMAS requirements.

(14) Supervision of the PRS shall meet the requirements set forth in 12VAC30-50-226 B 7 l and m.

6. Inpatient psychiatric services shall be covered for individuals younger than age 21 for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2) for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by (i) a psychiatric hospital or an inpatient psychiatric program in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) a psychiatric facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities. Inpatient psychiatric hospital admissions

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

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

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

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

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

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

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

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

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

8. Addiction and recovery treatment services shall be covered under EPSDT consistent with 12VAC30-130-5000 et seq.

9. Services facilitators shall be required for all consumer-directed personal care services consistent with the requirements set out in 12VAC30-120-935.

10. Behavioral therapy services shall be covered for individuals younger than 21 years of age.

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

"Behavioral therapy" means systematic interventions provided by licensed practitioners acting within the scope of practice defined under a Virginia Department of Health Professions regulatory board and covered as remedial care under 42 CFR 440.130(d) to individuals younger than 21 years of age. Behavioral therapy includes applied behavioral analysis. Family training related to the implementation of the behavioral therapy shall be included as part of the behavioral therapy service. Behavioral therapy services shall be subject to clinical reviews and determined as medically necessary. Behavioral therapy may be provided in the individual's home and community settings as deemed by DMAS or its contractor as medically necessary treatment.

"Counseling" means a professional mental health service that can only be provided by a person holding a license issued by a health regulatory board at the Department of Health Professions, which includes conducting assessments, making diagnoses of mental disorders and conditions, establishing treatment plans, and determining treatment interventions.

"Individual" means the child or adolescent younger than 21 years of age who is receiving behavioral therapy services.

"Primary care provider" means a licensed medical practitioner who provides preventive and primary health care and is responsible for providing routine EPSDT screening and referral and coordination of other medical services needed by the individual.

b. Behavioral therapy services shall be designed to enhance communication skills and decrease maladaptive patterns of behavior, which if left untreated, could lead to more complex problems and the need for a greater or a more intensive level of care. The service goal shall be to ensure the individual's family or caregiver is trained to effectively manage the individual's behavior in the home using modification strategies. All services shall be provided in accordance with the ISP and clinical assessment summary.

c. Behavioral therapy services shall be covered when recommended by the individual's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS or its contractor to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities. Criteria for medical necessity are set out in 12VAC30-60-61 H. Service-specific provider intakes shall be required at the onset of these services in order to receive authorization for reimbursement. Individual service plans (ISPs) shall be required throughout the entire duration of services. The services shall be

provided in accordance with the individual service plan and clinical assessment summary. These services shall be provided in settings that are natural or normal for a child or adolescent without a disability, such as the individual's home, unless there is justification in the ISP, which has been authorized for reimbursement, to include service settings that promote a generalization of behaviors across different settings to maintain the targeted functioning outside of the treatment setting in the individual's home and the larger community within which the individual resides. Covered behavioral therapy services shall include:

(1) Initial and periodic service-specific provider intake as defined in 12VAC30-60-61 H;

(2) Development of initial and updated ISPs as established in 12VAC30-60-61 H;

(3) Clinical supervision activities. Requirements for clinical supervision are set out in 12VAC30-60-61 H;

(4) Behavioral training to increase the individual's adaptive functioning and communication skills;

(5) Training a family member in behavioral modification methods as established in 12VAC30-60-61 H;

(6) Documentation and analysis of quantifiable behavioral data related to the treatment objectives; and

(7) Care coordination.

C. School health services.

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

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

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

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

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

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

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

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

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

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

4. Covered services include:

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

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

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

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

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

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the

Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

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

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

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

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

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

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

2. Family planning services shall be defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

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

12VAC30-50-226. Community mental health services.

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

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

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

"Behavioral health service" means the same as defined in 12VAC30-130-5160.

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

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

"Clinical experience" means, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health skill building, (v) crisis stabilization, or (vi) crisis intervention services, practical experience in providing direct services to individuals with diagnoses of mental illness or intellectual disability or the provision of direct geriatric services or special education services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be established by DBHDS in the document titled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

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

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification ~~training~~ as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a qualified mental health professional (QMHP-A, QMHP-C, or QMHP-E) as defined in 12VAC35-105-20 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or (iii) shall be an LMHP, LMHP-R, LMHP-RP, or LMHP-S who has documented completion of the DBHDS PRS supervisor training who is acting within his scope of practice under state law. An LMHP, LMHP-R, LMHP-RP, or LMHP-S providing services before April 1, 2018, shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

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

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

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

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

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

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

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

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

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific

site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

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

"Peer recovery specialist" or "PRS" means the same as defined in ~~12VAC30-130-5160~~ 12VAC35-250-10.

"Peer recovery support services" means the same as defined in 12VAC35-250-10.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, ~~limited annually to 780 units,~~ include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing

access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS~~, DMAS contractors, or the BHSA~~ or its contactor within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Mental health skill-building services (MHSS) shall be defined as goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. These services shall provide goal-directed training in the following areas in order to be reimbursed by Medicaid or the BHSA: (i) functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

a. Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community.

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

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

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

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

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

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

(3) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

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

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

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

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

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

(b) Major depressive disorder;

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

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

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

(4) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) temporary detention order (TDO) evaluation pursuant to § 37.2-809 B of the Code of Virginia. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

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

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

d. Service-specific provider intakes shall be required at the onset of services and individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in 12VAC30-50-130.

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

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

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

h. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The

provider shall coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

i. Limits and exclusions.

(1) Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's respective facility. Individuals residing in facilities may, however, receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

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

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

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

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

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

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

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

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

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

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

7. Mental health peer support services.

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

b. Under the clinical oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S assessing the individual and making the recommendation for mental health support services, the peer recovery specialist in consultation with his direct supervisor shall develop a recovery, resiliency, and wellness plan based on the ~~LMHP's~~ recommendation of the LMHP, LMHP-R, LMHP-RP, or LMHP-S for service, the individual's perceived recovery needs, and any clinical assessments or service specific provider intakes as defined in this section within 30 calendar days of the initiation of service. Development of the recovery, resiliency, and wellness plan shall include collaboration with the individual. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery. The recovery, resiliency, and wellness plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the plan. The recovery, resiliency, and wellness plan shall be completed, signed, and dated by (i) the LMHP, LMHP-R, LMHP-RP, or LMHP-S, (ii) the PRS, (iii) the direct supervisor, and (iv) the individual within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the individual, encouraging the individual to take a proactive role in developing and updating goals and objectives in the individualized recovery planning.

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

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

e. Individuals 21 years or older qualifying for mental health peer support services shall meet the following requirements:

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

(2) Have a documented mental health disorder diagnosis.

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

f. To qualify for continued mental health peer support services, medical necessity criteria shall continue to be met, and progress notes shall document the status of progress relative to the goals identified in the recovery, resiliency, and wellness plan.

g. Discharge criteria from mental health peer support services is the same as set forth in 12VAC30-130-5180 E.

h. Mental health peer support services shall be rendered on an individual basis or in a group.

i. Prior to service initiation, ~~a documented recommendation for mental health peer support services shall be made~~ an assessment shall be conducted and documented by ~~a licensed mental health professional acting~~ an LMHP, LMHP-R, LMHP-RP, or LMHP-S within the scope of practice under state law. The ~~recommendation~~ assessment shall verify that the individual meets the medical necessity criteria set forth in subdivision 7 e of this subsection. The assessment shall be included as part of the recovery, resiliency, and wellness plan and medical record. ~~The recommendation shall be valid for no longer than~~ Services shall be initiated within 30 calendar days from when the assessment was complete.

j. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, experience, and certification established by DBHDS ~~in order to be eligible to register with the Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by~~ in accordance with 12VAC35-250. Effective December 18, 2017, Peer Recovery Specialists shall also be registered with the Board of Counseling, ~~registration of peer recovery specialists by the Board of Counseling shall be required~~. The PRS shall perform mental health peer support services under the oversight of the LMHP who assessed the individual and made ~~making~~ the recommendation for services and providing the clinical oversight of the recovery, resiliency, and wellness plan. The PRS shall be employed by or have a contractual relationship with an enrolled provider licensed for one of the following:

(1) Acute care general hospital licensed by the Department of Health.

(2) Freestanding psychiatric hospital and inpatient psychiatric unit licensed by the Department of Behavioral Health and Developmental Services.

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

(4) Outpatient psychiatric services provider.

(5) Rural health clinics and federally qualified health centers.

(6) Hospital emergency department services licensed by the Department of Health.

(7) Community mental health and rehabilitative services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following community mental health and rehabilitative services defined in this section or 12VAC30-50-420 for which the individual meets medical necessity criteria:

(a) Day treatment or partial hospitalization;

(b) Psychosocial rehabilitation;

(c) Crisis intervention;

(d) Intensive community treatment;

(e) Crisis stabilization;

(f) Mental health skill building; or

(g) Mental health case management.

k. Only the licensed and enrolled provider referenced in subdivision 7 j of this subsection shall be eligible to bill mental health peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

l. Supervision of the PRS shall be required as set forth in the definition of "supervision" in 12VAC30-130-5160. Supervision of the PRS shall also meet the following requirements: the direct supervisor shall perform direct supervision of the PRS as needed based on the level of urgency and intensity of service being provided. The direct supervisor shall have an employment or contract relationship with the same provider entity that employs or contracts with the PRS. Direct supervisors shall maintain documentation of all supervisory sessions. In no instance shall supervisory sessions be performed less than as provided below:

(1) If the PRS has less than 12 months experience delivering peer support services or family support partners, he shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of a 30-minute session, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty.

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

m. ~~the~~ The supervisor shall be under the clinical oversight of the LMHP, LMHP-R, LMHP-RP, or LMHP-S who assessed the individual and made ~~making~~ the recommendation for services, and the peer recovery specialist in consultation with his direct supervisor shall conduct and document a review of the recovery, resiliency, and wellness plan every 90 calendar days with the individual and the caregiver, as applicable. The review shall be signed by the PRS and the individual and, as applicable, the identified family member or caregiver. Review of the recovery, resiliency, and wellness plan means the PRS evaluates and updates the individual's progress every 90 calendar days toward meeting the plan's goals and documents the outcome of this review in the individual's medical record. For DMAS to determine that these reviews are complete, the reviews shall (i) update the goals and objectives as needed to reflect any change in the individual's recovery as well as any newly identified needs, (ii) be conducted in a manner that enables the individual to actively participate in the process, and (iii) be

documented by the PRS in the individual's medical record no later than 15 calendar days from the date of the review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

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

requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

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

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

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

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

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

C. Day treatment/partial hospitalization services shall be provided following a service-specific provider intake and be authorized by the LMHP, LMHP-R, LMHP-RP, or LMHP-S. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days of service initiation.

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

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

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

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

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

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

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

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

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

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

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

E. Initiation of crisis intervention services shall be indicated following a service-specific provider intake that documents a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. In order to receive reimbursement, providers shall register this service with DMAS~~, DMAS contractors, or the BHSA~~ or its contractor within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

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

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

3. An individual service plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

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

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

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

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

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

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

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

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

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is an ISP in effect that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, and others including a minimum of one face-to-face individual contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

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

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

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

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

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

G. Intensive community treatment (ICT).

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

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

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

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

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

H. Crisis stabilization services.

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

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

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

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

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

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

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

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

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

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

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

3. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall complete, sign, and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall indicate the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished, and criteria for discharge as part of a discharge plan that includes the projected length of service. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.

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

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

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

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

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

7. If the provider knows or has reason to know of the individual's nonadherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any nonadherence to the prescribed medication regimen. The LMHP,

LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any concerns about medication nonadherence (provided that the individual has consented to such sharing of information). The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:

a. Name and title of caller;

b. Name and title of professional who was called;

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

d. Date and time of call;

e. Reason for the care coordination call;

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

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

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

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

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the professional works for;

d. Date and time of call;

e. Specific placement provided;

f. Type of treatment previously provided;

g. Name of treatment provider; and

h. Dates of previous treatment.

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

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

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

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

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

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

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

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

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

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

19. Limits and exclusions.

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

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

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

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

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

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

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

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

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

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

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

B 6 c (2) and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services.

~~J. Except as noted in subdivision I 18 of this section and in 12VAC30-50-226 B 6 e, the limits described in this regulation and all others identified in 12VAC30-50-226 shall apply to all service authorization requests submitted to either DMAS or the BHSA as of July 27, 2016. As of July 27, 2016, all annual limits, weekly limits, daily limits, and reimbursement for services shall apply to all services described in 12VAC30-50-226 regardless of the date upon which service authorization was obtained.~~

12VAC30-130-5160. Peer support services and family support partners: definitions.

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

"Behavioral health service" means treatments and services for mental or substance use disorders.

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

"Direct supervisor" means the person who provides direct supervision to the peer recovery specialist. The direct supervisor (i) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification ~~training~~ as a PRS under a certifying body approved by DBHDS, and have documented completion of the DBHDS PRS supervisor training; (ii) shall be a practitioner who has documented completion of the DBHDS PRS supervisor training, meets ~~clauses (i) through (xii) of~~ the definition of "credentialed addiction treatment professional" found in 12VAC30-130-5020, and is acting within his scope of practice under state law; or (iii) shall be a certified substance abuse counselor (CSAC) as defined in § 54.1-3507.1 of the Code of Virginia who has documented completion of the DBHDS PRS supervisor training if he is acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional. If a practitioner referenced in clause (ii) of this definition or a CSAC referenced in clause (iii) of this definition provides services before April 1, 2018, he shall have until April 1, 2018, to complete the DBHDS PRS supervisor training.

"Peer recovery specialist" or "PRS" means a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services ~~and who has received certification in good standing by a certifying body recognized by DBHDS. A PRS is professionally qualified and trained (i) to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental health disorders, substance use disorders, or both; (ii) to provide peer support as a self-identified individual successful in the recovery process with lived experience with mental health disorders or substance use disorders, or co-occurring mental health and substance use disorders; and (iii) to offer support and assistance in helping others in the recovery and community integration process. A PRS may be a parent of a minor or adult child with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services.~~ in 12VAC35-250-10.

"Peer recovery support services" means the same as defined in 12VAC35-250-10.

"Person centered" means a collaborative process where the individual participates in the development of his treatment goals and makes decisions about the services provided.

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

"Recovery, resiliency, and wellness plan" means a written set of goals, strategies, and actions to guide the individual and the health care team to move the individual toward the maximum achievable independence and autonomy in the community. The documented comprehensive wellness plan shall be developed ~~by~~ with the LMHP, LMHP-R, LMHP-RP, or LMHP-S who conducted the assessment and made the recommendation, along with the individual or caregiver, as applicable, the PRS, and the direct supervisor within 30 days of the initiation of services and shall describe how the plan for peer support services and activities will meet the individual's needs. This document shall be updated as the needs and progress of the individual change and shall document the individual's or caregiver's, as applicable, request for any changes in peer support services. The recovery, resiliency, and wellness plan is a component of the individual's overall plan of care and shall be maintained by the enrolled provider in the individual's medical record.

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

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

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

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

12VAC30-130-5170. Peer support services and family support partners: service definitions.

A. ARTS peer support services and ARTS family support partners are peer recovery support services and are nonclinical, peer-to-peer activities that engage, educate, and support an individual's, and as applicable the caregiver's, self-help efforts to improve health recovery, resiliency, and wellness. These services shall be available to either:

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

2. The caregiver of individuals younger than 21 years of age with mental health or substance use disorders or co-occurring mental health and substance use disorders that are the focus of the support.

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

B. ARTS peer support services for adults is a person centered, strength-based, and recovery-oriented rehabilitative service for individuals 21 years of age or older provided by a peer recovery specialist successful in the recovery process with lived experience with substance use disorders or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

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

D. ARTS peer recovery support services shall be rendered on an individual basis or in a group.

12VAC30-130-5190. Peer support services and family support partners: provider and setting requirements.

A. Effective July 1, 2017, a peer recovery specialist shall have the qualifications, education, ~~and~~ experience, and certification ~~established~~ required by DBHDS in accordance with 12VAC35-250. ~~and show certification in good standing by the U.S. Department of Veterans Affairs, NAADAC - the Association of Addiction Professionals, a member board of the International Certification and Reciprocity Consortium, or any other certifying body or state certification with standards comparable to or higher than those specified by DBHDS to be eligible to register with the Board of Counseling on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling, registration of peer recovery specialists by the Board of Counseling shall be required.~~ Effective December 18, 2017, peer recovery specialists shall also be registered with the Board of Counseling.

B. Prior to service initiation, a documented ~~recommendation for service~~ assessment by a practitioner who meets ~~clauses (i) through (xii) of~~ the definition of "credentialed addiction treatment professional" found in 12VAC30-130-5020 and who is acting within his scope of practice under state law shall be required. A certified substance abuse counselor, as defined in § 54.1-3507.1 of the Code of Virginia, may also provide a documented ~~recommendation for service~~ assessment if he is acting under the supervision or direction of a licensed substance use

treatment practitioner or licensed mental health professional. The PRS shall perform ARTS peer services under the oversight of the practitioner described in this subsection ~~making the recommendation for services~~ conducting the assessment and providing the clinical oversight of the recovery, resiliency, and wellness plan. The ~~recommendation~~ assessment shall verify that the individual meets the medical necessity criteria set forth in 12VAC30-130-5180 A or B, as applicable.

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

1. Acute care general hospital (ASAM Level 4.0) licensed by the Department of Health as defined in 12VAC30-130-5150.

2. Freestanding psychiatric hospital or inpatient psychiatric unit (ASAM Levels 3.5 and 3.7) licensed by the Department of Behavioral Health and Developmental Services as defined in 12VAC30-130-5130 and 12VAC30-130-5140.

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

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

5. ASAM Level 1.0 as defined in 12VAC30-30-5080.

6. Opioid treatment services as defined in 12VAC30-130-5050.

7. Office-based opioid treatment as defined in 12VAC30-130-5060.

8. Hospital emergency department services licensed by the Department of Health.

9. Pharmacy services licensed by the Department of Health.

D. Only a licensed and enrolled provider referenced in subsection C of this section shall be eligible to bill and receive reimbursement from DMAS or its contractor for ARTS peer support services. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not to be in compliance with DMAS requirements.

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

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

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

F. The caseload assignment of a full-time PRS shall not exceed 15 individuals at any one time allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-time PRS shall not exceed nine individuals at any one time. There are no minimum limits for full-time or part-time PRS caseloads.