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MEMORANDUM

TO: **SYREETA B. STEWART**
Regulations and Guidance Documents Supervisor
Virginia Department of Medical Assistance Services

FROM: **MORGAN GREER**
Senior Assistant Attorney General

DATE: **June 12, 2026**

SUBJECT: **Fast Track Regulations – Brain Injury Services Case Management**

I have reviewed the attached fast-track regulations regarding amendments to the Virginia Administrative Code to reflect the requirements contained in 2022 Special Session I, House Bill 680 that amended §32.1-325(A) of the Code of Virginia and directed the Board of Medical Assistance Services to include in the state plan a provision for the payment of medical assistance for targeted case management services for individuals with severe traumatic brain injury. The proposed regulations appear to be consistent with state plan amendments 23-0008, 24-0010, and VA-24-0012, which were approved by Centers for Medicare and Medicaid Services.

Based on my review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority. The proposed regulations appear to be consistent with the provisions of 2022 Special Session I, House Bill 680.

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

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

cc: Kim F. Piner, Esquire

Attachment

12VAC30-50-492 Brain Injury Services Case Management

A. Target group: Medicaid eligible individuals age 18 and older who have a physician or primary care physician documented diagnosis of a severe traumatic brain injury (TBI). Individuals under the age of 21 may receive case management services through other state plan options, including developmental disability case management (12VAC30-50-490), mental health and addictions treatment case management (12VAC30-50-430 and 12VAC30-50-491), treatment foster care case management (12VAC30-50-480) or early intervention case management for those aged below three years (12VAC30-50-415) who meet the criteria to receive case management services. Medicaid eligible individuals who qualify for other state plan targeted case management options may only receive one targeted case management service at a time. The individual will need to choose the targeted case management service option which meets their individualized service and support needs. Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, brain tumor, Alzheimer's disease, and similar neuro- degenerative diseases) shall not be covered. The TBI shall be severe as indicated by a T-score of 50 or above on the Mayo-Portland Adaptability Inventory (MPAI-4).

B. Case management services will be made available for up to 180 days consecutive days of a covered stay in a medical institution. This does not apply to individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

C. Services will be provided to the entire state.

D. Comparability of services: Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B) of the Act.

E. Definition of services: Brain injury services case management services are services furnished to assist individuals eligible under the State Plan in gaining access to needed medical, social, educational and other services. An individual receiving brain injury services case management services shall have an individual service plan that requires a minimum of one brain injury services case management service activity each month and at least one face-to-face contact with the individual at least every 90 calendar days.

Brain injury case management service activities to be provided shall include:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services, including services provided as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service if applicable. These assessment activities include:

a. Taking client history;

b. Identifying the individual's needs and completing related documentation;

c. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual; and

d. Periodic reassessments include evaluating and updating the individual's progress toward meeting the individual service plan objectives and shall occur as needed and at a minimum every 90 calendar days during a review of the individual service plan with the individual.

2. Development (and periodic revision) of a specific individual service plan that is based on the information collected through the assessment that:

a. Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

b. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

c. Identifies a course of action to respond to the assessed needs of the eligible individual.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social,

educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the individual service plan;

a. Enhancing and linking to community integration through increased opportunities for community access and involvement, such as opportunities to learn living skills to promote community adjustment to the maximum extent possible, vocational, civic, recreational services, and the use of other local community resources available to the general public;

(1) Making collateral contacts for the direct benefit of the individual with the individual's significant others (legally responsible individuals, legal guardians, service providers, anyone with a role in the individual's recovery) with properly authorized releases to promote implementation of the individual's individual service plan and community adjustment;

(2) Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits to promote implementation of the individual's individual service plan and community adjustment; and

(3) Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

4. Monitoring and follow-up activities:

a. Activities and contacts that are necessary to ensure the individual service plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

(1) Services are being furnished in accordance with the individual's individual service plan;

(2) Services in the individual service plan are adequate; and

(3) Changes in the needs or status of the individual are reflected in the individual service plan. Monitoring and follow-up activities include making necessary adjustments in the individual service plan and service arrangements with providers.

b. On an annual basis, the person-centered individual service plan is conducted to review current status and changes from previous years. It also includes a review of provider plans. As needed outside the annual review, the case manager may convene a meeting to re-evaluate the appropriateness of the plan if the individual's needs have changed. Case Managers conduct reviews every 90 calendar days of their services plans and effectiveness of that plan to determine if it remains appropriate and if modifications are needed.

F. Brain injury services case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

G. Qualifications of providers:

1. The provider of brain injury case management services must meet the following criteria:

a. The enrolled provider must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of case management services;

b. The enrolled provider shall guarantee that individuals have access to emergency services on a 24-hour basis;

c. The enrolled provider shall demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

d. The enrolled provider must have the administrative and financial management capacity to meet state and federal requirements; and

e. The enrolled provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

2. Providers may bill Medicaid for brain injury case management only when the services are provided by a professional or professionals who meet the following criteria:

a. At least a bachelor's degree from an accredited college or university and a Qualified Brain Injury Support Provider (QBISP) or Certified Brain Injury Specialist (CBIS) or

b. Licensure by the Commonwealth as a registered nurse and a QBISP or CBIS.

H. The state assures that the provision of brain injury case management services will not restrict an individual's free choice of providers in violation of § 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of brain injury services case management services.

2. Eligible recipients will have free choice of the providers of other services under the plan.

I. Access to services. The Commonwealth assures the following:

1. Case management services will not be used to restrict an individual's access to other Medicaid services.

2. Individuals will not be compelled to receive case management services, condition receipt of case management services on receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services, and the receipt of case management services shall not be a condition for receipt of other Medicaid services.

3. Providers of case management services do not exercise DMAS authority to authorize or deny the provision of other Medicaid services.

J. Payment for brain injury case management services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other program authorities for this same purpose.

K. Brain injury case management shall not include the following:

1. Activities not consistent with the definition of case management services in 42 CFR 440.169.

2. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

3. Activities integral to the administration of foster care programs.

4. Activities for which third parties are liable to pay, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c) of the Social Security Act.

12VAC30-80-110 Fee-for-service: case management

A. Targeted case management for early intervention (Part C) children.

1. Targeted case management for children from birth to three years of age who have developmental delay and who are in need of early intervention is reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates are effective for services on or after October 11, 2011. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management defined for another target group shall not be billed concurrently with this case management service except for case management services for high risk infants provided under 12VAC30-50-410. Providers of early intervention case management shall coordinate services with providers of case management services for high risk infants, pursuant to 12VAC30-50-410, to ensure that services are not duplicated.

3. Each entity receiving payment for services as defined in 12VAC30-50-415 shall be required to furnish the following to DMAS, upon request:

- a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate; and
- b. Cost information used by practitioner.

4. Future rate updates will be based on information obtained from the providers. DMAS monitors the provision of targeted case management through post-payment review (PPR). PPRs ensure that paid services were rendered appropriately, in accordance with state and federal policies and program requirements, provided in a timely manner, and paid correctly.

B. Reimbursement for targeted case management for high risk pregnant women and infants and children.

1. Targeted case management for high risk pregnant women and infants up to two years of age defined in 12VAC30-50-410 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one day. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection except for case management for early intervention provided under 12VAC30-50-415. Providers of case management for high risk pregnant women and infants and children shall coordinate services with providers of early intervention case management to ensure that services are not duplicated.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:

- a. Data on the hourly utilization of this service furnished to Medicaid members; and
- b. Cost information used by practitioners furnishing this service.

5. Rate updates will be based on utilization and cost information obtained from the providers.

C. Reimbursement for targeted case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance.

1. Targeted case management services for seriously mentally ill adults and emotionally disturbed children defined in 12VAC30-50-420 or for youth at risk of serious emotional disturbance defined in 12VAC30-50-430 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for seriously mentally ill adults and emotionally disturbed children and for youth at risk of serious emotional disturbance may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management services under this subsection.

4. Each provider receiving payment for the services under this subsection will be required to furnish the following to the Medicaid agency, upon request:

- a. Data on the hourly utilization of these services furnished to Medicaid members; and
- b. Cost information used by the practitioner furnishing these services.

5. Rate updates will be based on utilization and cost information obtained from the providers.

D. Reimbursement for targeted case management for individuals with intellectual disability or developmental disability.

1. Targeted case management for individuals with intellectual disability defined in 12VAC30-50-440 and individuals with developmental disabilities defined in 12VAC30-50-450 shall be reimbursed at the lower of the state agency fee schedule or the actual charge (the charge to the general public). The unit of service is one month. All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of September 10, 2013, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

2. Case management for individuals with intellectual disability or developmental disability may not be billed when it is an integral part of another Medicaid service.

3. Case management defined for another target group shall not be billed concurrently with the case management service under this subsection.

4. Each provider receiving payment for the service under this subsection will be required to furnish the following to the Medicaid agency, upon request:

a. Data on the hourly utilization of this service furnished to Medicaid members; and

b. Cost information by practitioners furnishing this service.

5. Rate updates will be based on utilization and cost information obtained from the providers.

E. Targeted case management for individuals with traumatic brain injuries defined in 12VAC30-50-492 shall be reimbursed through a state-developed fee schedule rate. The same rates shall be paid to governmental and private providers. The agency's rates were set as of July 1, 2023, and are effective for services on or after that date. All rates are published on the DMAS website at www.dmas.virginia.gov.