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MEMORANDUM

TO: **BRIAN MCCORMICK**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **MARY-GRACE MENDOZA** MM
Assistant Attorney General

DATE: **December 6, 2013**

SUBJECT: **Proposed Submission - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Applied Behavior Analysis Services (12 VAC 30-50; 12 VAC 30-60; 12 VAC 30-80, 12 VAC 30-120; 12 VAC 30-130-2000 et seq.)**

This memorandum responds to your request that this Office review the proposed regulatory action titled, "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Applied Behavior Analysis Services," which establishes Medicaid coverage for applied behavior analysis services for children under the authority of the EPSDT program.

Based on my review, it is this Office's view that DMAS has the authority, subject to compliance with the provisions of Article 2 of the Administrative Process Act (APA), and has not exceeded that authority.

The change to the regulation is authorized by Va. Code §§ 32.1-324 and 32.1-325. The Medicaid authority as established by § 1902 (a) of the Social Security Act [42 U.S.C. 1396a] provides governing authority for payments for services. Section 1905 of the Social Security Act requires state Medicaid programs to provide early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals who are eligible under the plan and are younger than the age of 21, to include "Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Accordingly, it is my view that this action was properly promulgated under the standard rulemaking process as set out in Va. Code §§ 2.2-4007 through 2.2-4017.

Please call me at (804) 786-6004 if you have any questions regarding this memorandum. Thank you.

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

Proposed Text

Action: EPSDT Applied Behavior Analysis Therapy Services

Stage: Proposed 12/2/13 12:21 PM [latest]

12VAC30-50-130

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-50-130. Skilled nursing facility services, EPSDT, school health services and family planning.

A. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4. Consistent with the Omnibus Budget Reconciliation Act of 1989 § 6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act § 1905(a).

5. Community mental health services.

a. Intensive in-home services to children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his

parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks. After an initial period, prior authorization is required for Medicaid reimbursement.

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

c. Community-Based Services for Children and Adolescents under 21 (Level A).

(1) Such services shall be a combination of therapeutic services rendered in a residential setting. The residential services will provide structure for daily activities, psychoeducation, therapeutic supervision 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. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(2) In addition to the residential services, the child must receive, at least weekly, individual psychotherapy that is provided by a licensed mental health professional.

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

(4) Authorization is required for Medicaid reimbursement.

(5) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(6) Providers must be licensed by the Department of Social Services [, ~~Department of Juvenile Justice, or Department of Education~~] under the Standards for [~~Interdepartmental Regulation of~~ Interim Regulation of] Children's Residential Facilities [~~(22VAC42-10)~~ (6 VAC 35-51)] [or Department of Juvenile Justice Services under Standards for Interim Regulation of Children's Residential Facilities (35 VAC 51)] .

(7) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management.

(8) The facility/group home must coordinate services with other providers.

d. Therapeutic Behavioral Services (Level B).

(1) Such services must be therapeutic services rendered in a residential setting that provides structure for daily activities, psychoeducation, therapeutic supervision 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. DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds.

(2) Authorization is required for Medicaid reimbursement.

(3) Room and board costs are not reimbursed. Facilities that only provide independent living services are not reimbursed.

(4) Providers must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) under the Standards for Interdepartmental Regulation of Children's Residential Facilities (22VAC42-10).

(5) Psychoeducational programming must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. This service may be provided in a program setting or a community-based group home.

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

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

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

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

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

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

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

8. Applied behavior analysis services. (a) Applied behavior analysis 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 12 VAC 30-130-2000 *et seq.* Service-specific provider assessments shall be required at the onset of these services in order to receive service authorization. Individual service plans (ISP) shall be required throughout the entire duration of services. These services shall be provided in settings that

are natural or normal for a child or adolescent without a disability, such as his home, unless there is justification, which has been service authorized, in the ISP for an atypical location. Covered applied behavior analysis services shall include:

(1) Initial and periodic service-specific provider assessment by a licensed applied behavior analysis practitioner as defined in 12 VAC 30-130-2000;

(2) Development of initial and updated ISPs by a licensed applied behavior analysis practitioner as defined in 12 VAC 30-130-2000;

(3) Clinical supervision of qualified applied behavior analysis practitioners by a licensed behavioral therapy practitioner. Requirements for clinical supervision are set out in 12 VAC 30-130-2000 *et seq*;

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

(5) Training a family member in behavioral modification methods;

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

(7) Care coordination.

(b) The following shall not be covered under this service:

(1) Screening to identify physical, mental, or developmental conditions that may require evaluation or treatment. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as an applied behavior analysis service under this section.

(2) Services other than the initial service-specific provider assessment that are provided but are not based upon the individual's ISP or linked to a service in the ISP. Time not actively involved in providing services directed by the ISP shall not be reimbursed.

(3) Services that are based upon an incomplete, missing, or outdated service-specific provider assessment or ISP.

(4) Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.

(5) Services that are provided by a service provider but are rendered primarily by a relative or guardian who is legally responsible for the individual's care.

(6) Services that are provided in a clinic or provider's office without documented justification for the location.

(7) Services that are provided in the absence of the individual and a parent or other authorized caregiver identified in the ISP with the exception of care coordination and clinical supervision.

(8) Provider travel time.

C. School health services.

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

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

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

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

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

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

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

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

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

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

4. Covered services include:

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

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

(1) The coverage of skilled nursing services shall be of a level of complexity and sophistication (based on assessment, planning, implementation and evaluation) that is consistent with skilled nursing services when performed by a licensed registered nurse or a licensed practical nurse. These skilled nursing services shall include, but not necessarily be limited to dressing changes, maintaining patent airways, medication administration/monitoring and urinary catheterizations.

(2) Skilled nursing services shall be directly and specifically related to an active, written plan of care developed by a registered nurse that is based on a written

order from a physician, physician assistant or nurse practitioner for skilled nursing services. This order shall be recertified on an annual basis.

c. Psychiatric and psychological services performed by licensed practitioners within the scope of practice are defined under state law or regulations and covered as physicians' services under 42 CFR 440.50 or medical or other remedial care under 42 CFR 440.60. These outpatient services include individual medical psychotherapy, group medical psychotherapy coverage, and family medical psychotherapy. Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation 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 specialist, marriage and family therapists, and school social workers.

d. Personal care services are covered under 42 CFR 440.167 and performed by persons qualified under this subsection. The personal care assistant is supervised by a DMAS recognized school-based health professional who is acting within the scope of licensure. This practitioner develops a written plan for meeting the needs of the child, which is implemented by the assistant. The assistant must have qualifications comparable to those for other personal care aides recognized by the Virginia Department of Medical Assistance Services. The assistant performs services such as assisting with toileting, ambulation, and eating. The assistant may serve as an aide on a specially adapted school vehicle that enables transportation to or from the school or school contracted provider on days when the student is receiving a Medicaid-covered service under the IEP. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

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

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

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

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

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

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

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

12VAC30-50-150
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-50-150. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometrists' services. Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services are not provided.

D. Other practitioners' services; psychological services, psychotherapy. Limits and requirements for covered services are found under Outpatient Psychiatric Services (see 12VAC30-50-140 D).

1. These limitations apply to psychotherapy sessions provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric/licensed marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist. Psychiatric services are limited to an initial availability of 26 sessions without prior authorization. An additional extension of up to 26 sessions during the first treatment year must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding treatment year when prior authorized by DMAS or its designee. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

2. Psychological testing is covered when provided, within the scope of their licenses, by licensed clinical psychologists or licensed clinical social workers/licensed professional counselors/licensed clinical nurse specialists-psychiatric, marriage and family therapists who are either independently enrolled or under the direct supervision of a licensed clinical psychologist.

E. Outpatient substance abuse services are limited to an initial availability of 26 sessions without prior authorization during the first treatment year. An additional extension of up to 26 sessions is available during the first treatment year and must be prior authorized by DMAS or its designee. The availability is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of

the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening and the above limits have been exceeded.

1. Outpatient substance abuse services shall be provided by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner, or an individual who holds a bachelor's degree and certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed in this section, or an individual who holds a bachelor's degree and is a certified addictions counselor (CAC) who is under the direct supervision of one of the licensed practitioners listed in this section. The provider must also be qualified in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities. Outpatient substance abuse treatment services are further defined in 12VAC30-50-228.

2. Psychological and psychiatric substance abuse services shall be prescribed treatment that is directly and specifically related to an active written plan designed and signature-dated by one of the professionals listed in subdivision 1 of this subsection.

3. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria as prescribed in Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R), Second Edition.

4. Psychological or psychiatric substance abuse services may be provided in an office or a clinic.

F. Behavior analyst and assistant behavior analyst services shall be covered when provided by an agency licensed by the Department of Behavioral Health and Developmental Services to provide Outpatient Services with Applied Behavior Analysis Track as set out in 12 VAC 30-50-130 (B) and 12 VAC 30-60-61.

Statutory Authority

12VAC30-60-61
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-61. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); community mental health services for children; applied behavior analysis services for children.

A. Intensive in-home services for children and adolescents.

1. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which 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:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

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

2. At admission, an appropriate assessment is made by the LMHP or the QMHP and approved by the LMHP, documenting that service needs can best be met through intervention provided typically but not solely in the client's residence. An Individual Service Plan (ISP) must be fully completed within 30 days of initiation of services.

3. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present. In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community if supported by the needs assessment and ISP.

4. These services shall be provided when the clinical needs of the child put the child at risk for out-of-home placement:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation, or

b. When the child's residence as the setting for services is more likely to be successful than a clinic.

5. Services may not be billed when provided to a family while the child is not residing in the home.

6. Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The child and responsible parent/guardian must be available and in agreement to participate in the transition.

7. At least one parent or responsible adult with whom the child is living must be willing to participate in the intensive in-home services with the goal of keeping the child with the family.

8. The enrolled provider must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services as a provider of intensive in-home services.

9. Services must be provided by an LMHP or a QMHP as defined in 12VAC30-50-226. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12VAC30-50-226.

10. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

11. The provider must ensure that the maximum staff-to-caseload ratio fully meets the needs of the individual.

12. Since case management services are an integral and inseparable part of this service, case management services may not be billed separately for periods of time when intensive in-home services are being provided.

13. Emergency assistance shall be available 24 hours per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

1. Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

a. Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.

b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:

(1) This programming during the school day; or

(2) This programming to supplement the school day or school year.

c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.

d. Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.

e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

2. Such services must not duplicate those services provided by the school.

3. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which 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:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.

b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.

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

4. The enrolled provider of therapeutic day treatment for child and adolescents services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide day support services.

5. Services must be provided by an LMHP, a QMHP or a QPPMH who is supervised by a QMHP or LMHP.

6. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

7. The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

8. Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

9. Services shall be provided following a diagnostic assessment that is authorized by an LMHP. Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

C. Community-Based Services for Children and Adolescents under 21 (Level A).

1. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while asleep. The program director supervising the program/group home must be, at minimum, a qualified mental health professional (as defined in 12VAC35-105-20) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.

2. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, defined in 12VAC30-50-226.

3. Authorization is required for Medicaid reimbursement. DMAS shall monitor the services rendered. All Community-Based Services for Children and Adolescents under 21 (Level A) must be authorized prior to reimbursement for these services. Services rendered without such authorization shall not be covered. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.

4. Services must be provided in accordance with an Individual Service Plan (ISP) (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.

D. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B).

1. The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 while asleep. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed 16 clients including all sites for which the clinical director is responsible. The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.

2. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, as defined in 12VAC30-50-226. The program/group home must coordinate services with other providers.

3. All Therapeutic Behavioral Services (Level B) must be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

4. Services must be provided in accordance with an ISP (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.

E. Utilization review. Utilization reviews for Community-Based Services for Children and Adolescents under 21 (Level A) and Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) shall include determinations whether providers meet all DMAS requirements.

F. Utilization review of applied behavior analysis services.

1. For DMAS or its contractor to authorize payments for this service, the individual shall meet the criteria established in 12 VAC 30-130-2000(D).

2. Prior to treatment, an appropriate service-specific provider assessment shall be conducted, documented, signed and dated by a licensed applied behavior analysis therapy practitioner, documenting the individual's diagnosis (including a description of the behavior or behaviors targeted for treatment with their frequency, duration, and intensity) and describing how service needs can best be met through intervention provided typically but not solely in the individual's residence. The service-specific provider assessment shall be conducted face-to-face in the individual's residence with the individual and an adult family member. A new service-specific provider assessment shall be conducted and documented every three months, or more often if needed, to observe the individual and family interaction, review clinical data, and revise the ISP as needed.

3. The ISP shall meet the requirements described in 12 VAC 30-130-2000 *et seq.* The ISP shall describe each targeted behavior, the goal and one or more measurable objectives for each targeted behavior, the behavioral modification strategy to be used to manage each targeted behavior, the plan for parent or caregiver training, and the measurement and data collection methods to be used for each targeted behavior in the ISP. The ISP shall be fully completed, signed and dated by a licensed applied behavior analysis therapy practitioner and the individual and individual's parent/guardian. The ISP shall be updated as the individual progresses and his needs change, but at least annually, and shall be signed by either the parent or legal guardian and the individual. Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP.

4. Clinical supervision shall be required for Medicaid reimbursement of applied behavior analysis services that are rendered by a qualified applied behavior analysis practitioner who does not meet the definition of a licensed applied behavior analysis practitioner. Clinical supervision shall occur at least weekly and, as documented in the individual's medical record, shall include a review of progress notes and data and dialogue with the qualified applied behavior analysis therapy practitioner about the individuals progress and the effectiveness of the ISP.

5. In order for Medicaid to cover applied behavior analysis services, the provider shall (i) be licensed by DBHDS to provide Outpatient Services with Applied Behavior Analysis Track and (ii) be enrolled with DMAS as a Medicaid Applied Behavior Analysis provider. The provider enrollment agreement shall be in effect prior to the delivery of services for Medicaid reimbursement.

6. Claims for services that have been based upon service-specific provider assessments that are incomplete, outdated (more than three months old), or missing altogether shall not be reimbursed.

Statutory Authority

12VAC30-80-97
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-80-97. Fee-for-service: Applied behavior analysis services (under EPSDT).

A. Payment for applied behavior analysis services for individuals younger than 21 years of age shall be the lower of the state agency fee schedule or actual charge (charge to the general public). All private and governmental fee-for-service providers shall be reimbursed according to the same methodology. The agencys rates were set as of October 1, 2011, and are effective for services on or after that

date until rates are revised. Rates are published on the agencys website at **www.dmas.virginia.gov**

B. Provider travel time shall not be included in billable time for reimbursement.

C. Local Education Agency providers shall not be reimbursed for applied behavior analysis services.

D. Reimbursement for the initial service-specific provider assessment and the initial preparation of the ISP shall be limited to five hours without service authorization. Reimbursement of a service-specific provider assessment requiring more than five hours shall require service authorization. Authorization shall be required for reimbursement of all other applied behavior analysis services that are reimbursed by Medicaid.

12VAC30-120-380
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

1. Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

2. Services that shall be provided outside the MCO network shall include, but are not limited to, those services identified and defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include dental and orthodontic services for children up to age 21; for all others, dental services (as described in 12VAC30-50-190), school health services (as defined in 12VAC30-120-360), community mental health services (rehabilitative, targeted case management and the following substance abuse treatment services; emergency services (crisis); intensive outpatient services; day treatment services; substance abuse case management services; and opioid treatment services), as defined in 12VAC30-50-228 and 12VAC30-50-491, EPSDT Early Intervention services provided pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004 (as defined in 12VAC30-50-131)~~,and~~ ; long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services; and applied behavior analysis services (as defined in 12 VAC 30-130-2000 *et seq.*), including services provided by licensed behavior analysts and licensed assistant behavior analysts.

3. The MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

B. Except for those services specifically carved out in subsection A of this section, EPSDT services shall be covered by the MCO and defined by the contract between DMAS and the MCO. The MCO shall have the authority to determine the provider of service for EPSDT screenings.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain records as required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

I. In accordance with 42 CFR 447.50 through 42 CFR 447.60, MCOs shall not impose any cost sharing obligations on enrollees except as set forth in 12VAC30-20-150 and 12VAC30-20-160.

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to reimburse for or provide coverage of a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.

12VAC30-130-2000
THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-130-2000. EPSDT Applied Behavior Analysis Services.

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

"Applied behavior analysis" means a behavior modification strategy for individuals younger than 21 years of age that employs systematic interventions typically provided in the individuals home.

"Accredited college or university" means a school that is listed as accredited on the U.S. Department of Education College Accreditation database found on the U.S. Department of Education website. Schools that are not listed on the database do not meet the standard as accredited. Degrees that have been obtained from schools outside the United States will be reviewed individually by the Department of Behavioral Health and Developmental Services.

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

"Clinical experience" means (for the purpose of Medicaid reimbursement of applied behavior analysis) providing direct psychiatric or mental health services to children and adolescents or providing direct rehabilitative services to children and adolescents who have an intellectual or other developmental disability. Supervised internships, supervised practicums, and supervised field experiences obtained as a part of an accredited college degree program shall count towards the clinical experience requirement. The clinical experience requirement is based on full time experience (40 hours a week). Partial credit towards the clinical experience requirement can be counted on a prorated basis (i.e. 20 hours equals half time). Clinical experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience.

"Clinical supervision" means oversight to ensure the efficacy of therapy programming and that other services for the individual are being coordinated in accordance with the individual's assessed clinical needs.

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

"DMAS" means the Department of Medical Assistance Services.

"EPSDT" means early and periodic screening, diagnostic, and treatment services as defined in § 1905(r) of the *Social Security Act*, 42 U.S.C. § 1396d.

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

"Individual service plan" or "ISP" means the same as the term is defined in 12 VAC 30-50-226.

"Licensed applied behavior analysis practitioner" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, registered psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, licensed behavior analyst, or licensed assistant behavior analyst who is practicing within the scope of his training, experience, and license.

"Outpatient service" means the same as the term is defined in 12 VAC 35-105-20.

"Primary care provider" means a 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.

"Qualified applied behavior analysis practitioner" means (i) a registered nurse with at least one year of clinical experience; or (ii) an individual with at least one year of clinical experience and a bachelor's or higher degree in psychology, sociology,

social work, special education, rehabilitation counseling, child development, or other cognitive or behavioral sciences from an accredited college or university.

"Service-specific provider assessment" means the face-to-face interaction in which the licensed applied behavior analysis practitioner obtains information from the individual, and parent or other family member or members, as appropriate, about health status. It includes the documented history of the severity, intensity, and duration of health care problems and issues and contains 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 (physical, sexual, or drug), 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 assessment summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the licensed behavioral therapy practitioner.

B. Applied behavior analysis services shall be covered pursuant to all of the requirements contained in 12 VAC 30-50-130 B, 12 VAC 30-50-150, 12 VAC 30-60-61, 12 VAC 30-80-97, 12 VAC 30-120-380, and 12 VAC 30-130-2000 *et seq.* 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 restrictive level of care. The service goal shall be to ensure the individual's family or caregiver is trained to effectively manage the individuals behavior in the home using behavioral modification strategies.

C. Except for the initial service-specific provider assessment, applied behavior analysis therapy services shall be described in an ISP developed and signed and dated on the date of service by a licensed applied behavior analysis therapy practitioner.

D. Applied behavioral analysis services shall be service authorized only when all of the following are present:

1. The individual's residence is more likely to be a successful setting for services to stabilize the individual in the family situation than a clinic setting.

2. Less intensive treatment modalities have been seriously considered or have not been successful in effectively modifying the targeted behavior.

3. The individual is not eligible to receive community mental health services described in 12 VAC 30-50-130(B) or 12 VAC 30-50-226 or is diagnosed with a condition that can be appropriately managed with another covered service.

4. The individual has a current psychiatric diagnosis that is relevant to the need for applied behavior analysis and the individual is clinically stable to benefit from treatment at this level of care.

5. The individual meets at least two of the following criteria on a continuing or intermittent basis:

a. Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalia speech, or impairment in receptive or expressive language.

b. Severe impairment in social interaction, social reasoning, social reciprocity, and interpersonal relatedness.

c. Frequent, intense behavioral outbursts that are self injurious or aggressive towards others.

d. Disruptive obsessive, repetitive, or ritualized behaviors.

e. Difficulty with sensory integration.

6. At least one parent/guardian or responsible adult with whom the individual is living actively participates in the applied behavior analysis services. For continued service authorization, the parent/guardian or responsible adult implements behavioral strategies that help the individual to effectively manage maladaptive behaviors, in the home and community settings, beyond the treatment session.

7. The individual actively participates in the treatment and, for continue service authorization, makes measurable, documented progress in improving the behaviors targeted in the ISP. The individual demonstrates the ability to make long term gains by decreasing maladaptive behaviors and increasing adaptive behaviors, such as the ability to manage maladaptive behaviors beyond the treatment sessions in the home and community settings.

E. Applied behavior analysis services shall not be reimbursed concurrently with community mental health services described in 12 VAC 30-50-130(B)(5) or 12 VAC 30-50-226, or behavioral, psychological, or psychiatric therapeutic consultation described in 12 VAC 30-120-249, 12 VAC 30-120-756, or 12 VAC 30-135-320.

F. Care coordination. If the individual is receiving targeted case management services under the Medicaid state plan (defined in 12 VAC 30-50-410 through 12 VAC 30-50-499), the provider shall notify the case manager of the provision of applied behavior analysis therapy services unless the parent or guardian requests that the information not be released. In addition, the provider shall send monthly updates to the case manager on the individual's status. A discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. A refusal of the parent or guardian to release information shall be documented in the medical record for the date the request was discussed.

G. Other standards to ensure quality of services.

1. Services shall be delivered only by a licensed applied behavior analysis practitioner or a qualified applied behavior analysis therapy practitioner as defined in 12 VAC 30-130-2000 *et seq.*

2. Individual-specific services shall be directed toward the treatment of the eligible individual and delivered in the family's residence unless an alternative location is justified in the ISP.

3. Individual-specific progress notes shall document the name and Medicaid number of each individual, the service provider's name and date and time of service. Documentation shall include activities provided, length of services provided, the individual's reaction to that day's activity, and documentation of the

individual's and the parent or caregiver's progress toward achieving each behavioral objective through analysis and reporting of quantifiable behavioral data.

4. Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service.

5. Billable time is allowed for the applied behavior analysis practitioner to better define behaviors and develop documentation strategies to measure treatment performance and the efficacy of the ISP objectives.

Statutory Authority