COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **USHA KODURU**
Assistant Attorney General

DATE: **March 2, 2017**

SUBJECT: **12 VAC 30-50-130 Proposed Regulations for Behavioral Analysis Services**

I have reviewed the attached proposed regulations establishing Medicaid coverage for behavior therapy services for children under the Early and Periodic Screening, Diagnosis, and Treatment program. Based on that review, it is my view that the Director, acting on behalf of the Board pursuant to Virginia Code § 32.1-325, 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.

Virginia Code § 32.1-325 grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance, and §§ 32.1-324 and 325 grant the authority to the Director to administer the Plan according to the Board's requirements. Additionally, Section 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] (the *Act)* provides governing authority for payment for Medicaid services. Section 1905 of the *Act* requires states to provide certain medically necessary services whether or not covered under the State plan to individuals under the age of 21. These regulations will amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services also will be required.

If you have any additional questions, please contact me at 786-4074.

cc: Kim F. Piner, Esquire

Attachment

Proposed Text

Action:
EPSDT Behavioral Therapy Services
Stage: Proposed
11/21/16 2:52 PM [latest]

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. 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 12-20 years of age; a child means an individual from birth up to 12 years of age.

"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.

"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.

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

"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 a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"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.

"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.

"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 or members, 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.

b. Intensive in-home services (IIH) to children and adolescents under age 21 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) These services shall be limited annually to 26 weeks. 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 authorization shall be required for services to continue beyond the initial 26 weeks.

(3) 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.

(4) 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, 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 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 under 21 years of age (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, 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), Standards for Interim Regulation of Children's Residential Facilities (6VAC35-51), 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, but is not limited to, 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).

(1) Such services must be therapeutic services rendered in a residential setting that provides 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, 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 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.

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.) of Amount, Duration and Scope of Selected Services.

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. Behavioral therapy services shall be covered for individuals under the age of 21.

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

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using the principles and methods of behavior analysis to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Behavioral therapy" means systematic interventions provided by licensed practitioners acting within the scope of practice defined under a Virginia Health Professions Regulatory Board and covered as remedial care under 42 CFR § 440.130(d) within the home to individuals under 21 years of age. Behavioral therapy includes, but is not limited to, applied behavioral analysis and is primarily provided in the family home. Family counseling and 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 intermittently provided in community settings when approved settings are deemed by DMAS or its contractor as medically necessary treatment.

"Family home" means the family residence and includes a child living with natural or adoptive parents, relatives, or a guardian, or the family residence of the child's permanent or temporary foster care or pre-adoption placement.

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

"Licensed assistant behavior analyst" means a person who has met the licensing requirements of 18VAC85-150-10 et seq. and holds a valid license issued by the Department of Health Professions.

"Licensed behavior analyst" means a person who has met the licensing requirements of 18VAC85-150-10 et seq. and holds a valid license issued by the Department of Health Professions.

"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. The services shall be provided in accordance with the individual service plan 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 (ISP) 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 their 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 patient's residence 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;

(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. ~~Service providers~~ 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~~ 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 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 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.

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

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

"At risk" means one or more of the following: (i) within the two weeks before the intake, the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of residential treatment facility Level C services, (b) transitioning out of a group home Level A or B services, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

"Individual" means the Medicaid-eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age or adolescents ages 12 through 20 years.

"New service" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.

"Out-of-home placement" means placement in one or more of the following: (i) either a Level A or Level B group home; (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) Level C residential facility; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"Service-specific provider intake" means the evaluation that is conducted according to the Department of Medical Assistance Services (DMAS) intake definition set out in 12VAC30-50-130.

B. Utilization review requirements for all services in this section.

1. The services described in this section shall be rendered consistent with the definitions, service limits, and requirements described in this section and in 12VAC30-50-130.

2. Providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

3. ISPs shall meet all of the requirements set forth in 12VAC30-60-143(B)(7).

C. ~~Intensive~~ Utilization review of intensive in-home (IIH) services for children and adolescents.

1. The service definition for intensive in-home (IIH) services is contained in 12VAC30-50-130.

2. Individuals qualifying for this service shall 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 to be authorized for these services:

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 documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

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

3. Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis 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 intake shall describe how the individual's clinical needs put the individual at risk of out-of-home placement and shall be conducted face-to-face in the individual's residence. Claims for services that are based upon service-specific provider intakes that are incomplete, outdated (more than 12 months old), or missing shall not be reimbursed.

4. An individual service plan (ISP) shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.

5. DMAS shall not reimburse for dates of services in which the progress notes are not individualized and child-specific. Duplicated progress notes shall not constitute the required child-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

6. Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family's residence with the individual present. As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP. For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

7. These services shall be provided when the clinical needs of the individual put him at risk for out-of-home placement, as these terms are defined in this section:

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

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

The service-specific provider intake shall describe how the individual meets either subdivision a or b of this subdivision.

8. Services shall not be provided if the individual is no longer a resident of the home.

9. 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 individual and responsible parent/guardian shall be available and in agreement to participate in the transition.

10. At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

11. The enrolled ~~service~~ provider shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of intensive in-home services. The provider shall also have a provider enrollment agreement with DMAS or its contractor in effect prior to the delivery of this service that indicates that the provider will offer intensive in-home services.

12. Services must only be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C, or QMHP-E. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12VAC35-105-20.

13. The billing unit for intensive in-home service shall be 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 an ISP 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 individual/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 individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive or nonhome based services.

14. The ISP, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and 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. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the ~~service~~ provider, the provider shall discharge the individual. If the individual continues to need services, then a new intake/admission shall be documented and a new service authorization shall be required.

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

16. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the ~~service~~ provider shall contact the case manager and provide notification of the provision of services. 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. ~~Service providers~~ 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 the information in the electronic health records.

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

18. Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000(E).

19. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or guardian, shall inform him of the individual's receipt of IIH services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

D. ~~Therapeutic~~ Utilization review of therapeutic day treatment for children and adolescents.

1. The service definition for therapeutic day treatment (TDT) for children and adolescents is contained in 12VAC30-50-130.

2. 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.

3. The service-specific provider intake shall document the individual's behavior and describe how the individual meets these specific service criteria in subdivision 2 of this subsection.

4. Prior to admission to this service, a service-specific provider intake shall be conducted by the LMHP as defined in 12VAC35-105-20.

5. An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the parent/guardian within 30 days of initiation of services and shall meet all requirements of an ISP as defined in 12VAC30-50-226. Individual progress notes shall be required for each contact with the individual and shall meet all of the requirements as defined in 12VAC30-50-130.

6. Such services shall not duplicate those services provided by the school.

7. Individuals qualifying for this service shall 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 shall 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 documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary.

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

8. The enrolled provider of therapeutic day treatment for child and adolescent services shall be licensed by DBHDS to provide day support services. The provider shall also have a provider enrollment agreement in effect with DMAS prior to the delivery of this service that indicates that the provider offers therapeutic day treatment services for children and adolescents.

9. Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C or QMHP-E.

10. The minimum staff-to-individual ratio as defined by DBHDS licensing requirements shall ensure that adequate staff is available to meet the needs of the individual identified on the ISP.

11. The program shall 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 shall be 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.

12. Time required for academic instruction when no treatment activity is going on shall not be included in the billing unit.

13. Services shall be provided following a service-specific provider intake that is conducted by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. An LMHP, LMHP-supervisee, or LMHP-resident shall make and document the diagnosis. The service-specific provider intake shall include the elements as defined in 12VAC30-50-130.

14. If an individual receiving services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager and provide notification of the provision of services. 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. ~~Service providers~~ Providers and case managers 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.

15. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or parent/legal guardian, shall inform him of the child's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. The parent/legal guardian shall be required to give written consent that this provider has permission to inform the primary care provider of the child's or adolescent's receipt of community mental health rehabilitative services.

16. 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).

17. If there is a lapse in services greater than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, a new intake/admission documentation shall be prepared and a new service authorization shall be required.

E. ~~Community-based~~ Utilization review of community-based services for children and adolescents under 21 years of age (Level A).

1. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 between 11 p.m. and 7 a.m. The program director supervising the program/group home must be, at minimum, a QMHP-C or QMHP-E (as defined in 12VAC35-105-20). The program director must be employed full time.

2. In order for Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home must meet DBHDS paraprofessional staff criteria, defined in 12VAC35-105-20.

3. Authorization is required for Medicaid reimbursement. All community-based services for children and adolescents under 21 (Level A) require authorization prior to reimbursement for these services. 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), which must be fully completed within 30 days of authorization for Medicaid reimbursement.

5. Prior to admission, a service-specific provider intake shall be conducted according to DMAS specifications described in 12VAC30-50-130.

6. Such service-specific provider intakes shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.

7. If an individual receiving community-based services for children and adolescents under 21 (Level A) is also receiving case management services, the provider shall collaborate with the case manager by notifying the case manager of the provision of Level A services and shall send monthly updates on the individual's progress. When the individual is discharged from Level A services, a discharge summary shall be sent to the case manager within 30 days of the service discontinuation date. ~~Service providers~~ Providers and case managers who are using the same electronic health record for the individual shall meet requirements for the delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

F. ~~Therapeutic~~ Utilization review of therapeutic behavioral services for children and adolescents under 21 years of age (Level B).

1. The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 between 11 p.m. and 7 a.m. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed 16 individuals including all sites for which the same clinical director is responsible.

2. The program director must be full time and be a QMHP-C or QMHP-E with a bachelor's degree and at least one year's clinical experience.

3. For Medicaid reimbursement to be approved, at least 50% of the provider's direct care staff at the group home shall meet DBHDS paraprofessional staff criteria, as defined in 12VAC35-105-20. The program/group home must coordinate services with other providers.

4. All therapeutic behavioral services (Level B) shall be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.

5. Services must be provided in accordance with an ISP, which shall be fully completed within 30 days of authorization for Medicaid reimbursement.

6. Prior to admission, a service-specific provider intake shall be performed using all elements specified by DMAS in 12VAC30-50-130.

7. Such service-specific provider intakes shall be performed by an LMHP, an LMHP-supervisee, LMHP-resident, or LMHP-RP.

8. If an individual receiving therapeutic behavioral services for children and adolescents under 21 (Level B) is also receiving case management services, the therapeutic behavioral services provider must collaborate with the care coordinator/case manager by notifying him of the provision of Level B services and the Level B services provider shall send monthly updates on the individual's treatment status. When the individual is discharged from Level B services, a discharge summary shall be sent to the care coordinator/case manager within 30 days of the discontinuation date.

9. The provider shall determine who the primary care provider is and, upon receiving written consent from the individual or parent/legal guardian, shall inform him of the individual's receipt of these Level B services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted. If these individuals are children or adolescents, then the parent/legal guardian shall be required to give written consent that this provider has permission to inform the primary care provider of the individual's receipt of community mental health rehabilitative services.

G. Utilization review. Utilization reviews for community-based services for children and adolescents under 21 years of age (Level A) and therapeutic behavioral services for children and adolescents under 21 years of age (Level B) shall include determinations whether providers meet all DMAS requirements, including compliance with DMAS marketing requirements. Providers that DMAS determines have violated the DMAS marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000(E).

H. Utilization review of behavioral therapy services for children.

1. In order for Medicaid to cover behavioral therapy services, the provider shall be enrolled with DMAS or its contractor as a Medicaid provider. The provider enrollment agreement shall be in effect prior to the delivery of services for Medicaid reimbursement.

2. Behavioral therapy services shall be covered for individuals younger than 21 years of age when recommended by the individual's primary care provider, 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.

3. Behavioral therapy services require service authorization. Services shall be authorized only when eligibility and medical necessity criteria are met.

4. Prior to treatment, an appropriate service-specific provider intake shall be conducted, documented, signed and dated by a licensed behavior analyst (LBA), licensed assistant behavior analyst (LABA), or LMHP, LMHP-R, LMHP-RP, or LMHP-S, acting within the scope of their practice, 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 behavior therapy. The service-specific provider intake shall be conducted face-to-face in the individual's residence with the individual and parent or guardian. A new service-specific provider intake 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.

5. The ISP shall be developed upon admission to the service and reviewed within 30 days of admission to the service to ensure that all treatment goals are reflective of the individual's clinical needs, and shall describe each treatment goal, targeted behavior, 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, care coordination, 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 LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S and the individual and individual's parent/guardian. The ISP shall be reviewed every three months (at the same time the service specific provider intake is conducted and documented) and 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.

6. Reimbursement for the initial service-specific provider intake and the initial ISP shall be limited to five hours without service authorization. If additional time is needed to complete these documents, service authorization shall be required.

7. Clinical supervision shall be required for Medicaid reimbursement of behavioral therapy services that are rendered by an LABA, LMHP-R, LMHP-RP, or LMHP-S or unlicensed staff consistent with the scope of practice as described by the applicable Virginia Health Professions Regulatory Board. 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 supervised staff about the individual s progress and the effectiveness of the ISP.

8. The following shall not be covered under this service:

(a) 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 a behavioral therapy service under this section.

(b) Services other than the initial service-specific provider intake 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.

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

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

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

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

(g) 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 treatment review processes described in 12VAC30-60-61(H)(11)(e), care coordination and clinical supervision.

(h) Services provided by a Local Education Agency.

(i) Provider travel time.

9. Behavioral therapy services shall not be reimbursed concurrently with community mental health services described in 12VAC30-50-130(B)(5) or 12VAC30-50-226, or behavioral, psychological, or psychiatric therapeutic consultation described in 12VAC30-120-1000, 12VAC30-120-756, or 12VAC30-135-320.

10. If the individual is receiving targeted case management services under the Medicaid state plan (defined in 12VAC30-50-410 through 12VAC30-50-499, the provider shall notify the case manager of the provision of behavioral 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 pursuant to a valid release of information. 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.

11. Other standards to ensure quality of services:

(a) Services shall be delivered only by a LBA, LABA, LMHP, LMHP-R, LMHP-RP, LMHP-S, or clinically supervised unlicensed staff consistent with the scope of practice as described by the applicable Virginia Health Professions regulatory board.

(b) 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 and documented in the ISP.

(c) Individual-specific progress notes shall be created contemporaneously with the service activities, and shall document the name and Medicaid number of each individual; the provider's name, signature, 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. Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress and generalization for the child and family members toward the therapy goals as defined in the service plan.

(d) 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.

(e) Billable time is permitted for the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S to better define behaviors and develop documentation strategies to measure treatment performance and the efficacy of the ISP objectives, provided that these activities are documented in a progress note as described above.

12. Failure to comply with any of the requirements in 12VAC30-50-130 or in this section shall result in retraction.

12VAC30-80-97. Fee-for-service: Behavioral therapy services (under EPSDT).

A. Payment for behavioral therapy 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 agency s 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 agency s website at www.dmas.virginia.gov

B. Providers shall be required to refund payments made by Medicaid if they fail to maintain adequate documentation to support billed activities.

12VAC30-120-380. Medallion ~~II~~ 3.0 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, but shall not be limited to, (i) dental and orthodontic services for children up to age 21; (ii) for all others, dental services (as described in 12VAC30-50-190), (iii) school health services (as defined in 12VAC30-120-360), (iv) 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, (v) 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 12VAC30-50-415), and~~; (vi) long-term care services provided under the § 1915(c) home-based and community-based waivers including related transportation to such authorized waiver services; and (vii) behavioral therapy services (as defined in 12VAC30-50-130).

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. 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.

3. Providers shall be required to refund payments if they fail to maintain adequate documentation to support billed activities.

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.