CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV

GENERAL INFORMATION

The Virginia Medicaid Program covers a variety of behavioral health treatment services under the Addiction and Recovery Treatment Services (ARTS), Mental Health Services and Psychiatric Services benefits for eligible youth. This chapter describes the requirements for the provision of youth mental health residential treatment services which include psychiatric residential treatment facility (PRTF) and therapeutic group home (TGH) services.

All PRTF and TGH providers of youth mental health residential treatment services are responsible for adhering to this manual, all DMAS policies and state and federal regulations.

For more information on ARTS services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

FEE FOR SERVICE (FFS) SERVICE AUTHORIZATION CONTRACTOR

Acentra serves as the current FFS service authorization contractor for medical and behavioral health services provided under Medicaid FFS. Acentra performs the following FFS behavioral health related functions: service registration and authorization of behavioral health services; maintains a behavioral health crisis hotline; provides training to providers and stakeholders; conducts member outreach and education; and, performs utilization management for members in FFS.

Providers may contact Acentra directly by phone at 1-888-827-2884 or via email at VAproviderissues@kepro.com. More information is located at: https://vamedicaid.dmas.virginia.gov/sa

MEDICAID MANAGED CARE ORGANIZATIONS (MCOs)

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid MCOs. MCOs must adhere to all DMAS requirements, service authorization criteria and reimbursement rates, and MCO benefit service limits may not be less than FFS benefit limits. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Certain services, including Residential Treatment Services, are carved out of the Medicaid MCO contracts and continue to be covered through FFS.

RESIDENTIAL TREATMENT SERVICES COVERAGE FOR YOUTH ENROLLED IN MANAGED CARE

The following Residential Treatment Services are carved-out of the Cardinal Care Managed Care contracts and are covered for Medicaid enrollees through FFS, in accordance with DMAS FFS established coverage criteria and guidelines.

Please note that FAMIS and FAMIS MOMS enrollees covered by Cardinal Care Managed Care are not eligible for Residential Treatment Services including TGHs and PRTFs.

Managed Care Coverage and Eligibility: TGH and EPSDT TGH Admissions

If a Medicaid enrollee in a MCO is eligible for and chooses TGH or EPSDT TGH services, the youth will remain enrolled in their MCO after admission. If a youth eligible for Medicaid transfers to a TGH after a PRTF stay, the youth will be enrolled into a MCO. The TGH per diem is service authorized by the FFS service authorization contractor. Services allowed to be billed outside of the TGH per diem, including all professional services are covered by the MCOs. See Chapter 5 for additional information on services that can be billed outside of the TGH per diem.

Managed Care Coverage and Eligibility: PRTF and EPSDT PRTF Admissions

Medicaid members who are placed in a PRTF or EPSDT PRTF setting are not eligible to participate in the Medicaid MCO programs. If the Medicaid enrollee is admitted to a PRTF, they will be removed from the MCO effective on the day of admission to the PRTF. The PRTF per diem and behavioral health professional services are covered by the FFS service authorization contractor. See Chapter 5 for additional information on services that can be billed outside of the PRTF per diem.

Co-Occurring Disorders

A co-occurring disorder is the presence of substance use and mental health disorders occurring simultaneously without implication as to the causal effect of one over the other, nor which disorder is primary versus secondary. Youth who are experiencing a co-occurring substance use and mental health disorder may experience greater impairments in functioning. Thus, providers who are trained and practicing within the scope of their practice, in working with youth with both substance use and mental health disorders should ensure both conditions are addressed in treatment. If a provider is not trained or licensed by DBHDS in the treatment of both substance use and mental health disorders, they should refer the youth to an appropriate service provider.

For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance abuse services if medical necessity criteria are met

for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented.

Addiction and Recovery Treatment Services (ARTS) Residential Treatment Services

ARTS residential services for youth include: American Society of Addiction Medicine (ASAM) Levels of Care. The ASAM levels of residential services vary in intensity from low, medium, to high. If the youth's primary diagnosis is a substance use disorder, please submit an ARTS residential service request to the Managed Care Organization (MCO) for managed care enrolled members or the FFS service authorization contractor for fee-for-service (FFS) enrolled members. For assistance or a list of ARTS residential providers, contact the youth's MCO or the FFS service authorization contractor. Providers can also be contacted directly for services.

For more information on ARTS services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) is transportation of a Medicaid member to a non-emergency Medicaid-covered service. NEMT is not transportation where emergency services are required. Members should dial 9-1-1 if immediate response is needed for emergencies or worsening conditions that threaten life or limb.

To arrange NEMT for FFS or MCO enrolled members please contact the contracted transportation broker to arrange for transportation. A transportation contacts list for both FFS and MCOs is available on the DMAS website at https://www.dmas.virginia.gov/for-providers/transportation/non-emergency-transport/.

Medicaid covers non-emergency Medicaid transportation to residential treatment covered services and interventions including the provision of family engagement activities.

Non-emergency transportation to and from Medicaid-covered services, including psychiatric appointments, must be preauthorized by and billed to the Medicaid transportation broker for FFS members or the member's assigned MCO or MCO transportation contractor and is not included as part of the Residential Treatment Service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for transportation to and from Medicaid-covered services. Additional information is available on the DMAS website at https://www.dmas.virginia.gov/for-providers/transportation/non-emergency-transport/ and http://transportation.dmas.virginia.gov/.

To make transportation reservations or request mileage reimbursement preauthorization for the FFS NEMT program please call 1-866-386-8331 Reservations for transportation must be made five days in advance unless the trip is urgent in nature.

TELEMEDICINE SERVICES

DMAS reimburses for telemedicine services under limited circumstances. Refer to the Telehealth Services Supplement for additional information.

DEFINITIONS

Refer to Appendix A for definitions of terms used in this Chapter.

RESIDENTIAL TREATMENT SERVICES

Residential Treatment Services as defined by this program manual consist of two levels of care: PRTF services and TGH services. Each level of care is defined as a distinct program with all applicable program rules grouped according to the level of care.

Residential Treatment Services include benefits available to youth who meet the service specific medical necessity criteria based on diagnoses made by LMHPs, LMHP-Rs, LMHP-RPs and LMHP-Ss acting within their scope of practice.

All services must be described with sufficient detail in an IPOC or CIPOC based on assessed needs of the youth defined in the assessment, the plan of care, most recent treatment team review and clinical review of the youth's treatment needs and are subject to approval for Medicaid reimbursement. These services are person-centered with emphasis on the delivery of youth guided and family driven principles. The youth who are receiving these services shall be included in all service planning activities.

Family Finding Coordination with LDSS

For all youth placed in foster care, LDSS staff will initiate and administer a Relative Search/Parent Locator service to identify family and other connections that may be viable for youth upon admission to a TGH or PRTF. LDSS workers are responsible to assume the lead role in family finding activities including finding alternate family members to participate in family engagement. The facility's collaboration with the LDSS will serve to promote the location of additional family members by the LDSS in order to facilitate family finding and family engagement.

The facility will coordinate efforts with the FFS service authorization contractor and the youth's MCO as applicable to achieve effective family engagement strategies. The FFS service authorization contractor's care managers will coordinate strategies and care management at least every 30 calendar days.

Residential Treatment Services Per Diem

Please refer to Chapter 5 for information on services included in the PRTF and TGH per diem and those services that can be reimbursed in addition to the per diem.

Services Provided Under Arrangement and Medically Necessary EPSDT Services

States must make available any services coverable under the EPSDT benefit and under 1905(a) of the Act for youth residing in a PRTF and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These EPSDT services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility. Please see Chapter 5 for additional information.

Medically necessary EPSDT services are not required to be included in the youth's IPOC or CIPOC prior to initiation, however, all services provided to the youth shall be included in the CIPOC no later than the next 30 day plan of care review.

Service Authorization

All TGH and PRTF services, including EPSDT TGH and EPSDT PRTF services, require an IACCT recommendation and service authorization. Refer to the IACCT Appendix and Appendix C for details.

CARE COORDINATION

The purpose of care coordination is to ensure that the individual receives all needed services and supports in the most effective and efficient manner, to provide informed and congruent treatment planning, to ensure open communication among all treating providers, and to ensure that these resources are well-coordinated and integrated.

To ensure that youth at risk of or receiving residential treatment services receive the benefits of effective care coordination, the FFS service authorization contractor provides residential care coordination through care managers and family support coordinators. See the Residential Care Coordination and Independent Assessment Certification and Care Coordination Team (IACCT) Appendix for additional information on care coordination for youth in residential settings provided by the FFS service authorization contractor.

The Medicaid MCOs are required to establish policies and procedures to deliver care and coordinate services for all members regardless of risk or need and adhere to the provisions noted in 42 CFR § 438.208.

If the individual is receiving targeted case management (TCM) services, the care coordinator will work collaboratively with, and not duplicate the services provided by, the TCM. TCM includes case management for Addiction and Recovery Treatment Services (ARTS), mental health, developmental disabilities, treatment foster care, early intervention, and high risk prenatal and infant services.

Care Coordination Requirements of Residential Treatment Services Providers

Service Provider Care Coordination is done in the spirit of collaboration with the treatment team and is meant to support the youth on his or her path of recovery**.**

Service Provider Care Coordination includes:

- Assisting the individual to access and appropriately utilize needed services and supports;
- Assisting them to overcome barriers to being able to maximize the use of these resources;
- Actively collaborating with all internal and external service providers;
- Coordinating the services and supports provided by these individuals (including family members and significant others involved in the individual's life);
- Assessing the effectiveness of these services/supports;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the CIPOC as clinically indicated to ensure that service planning is consistent with other services being provided to the individual.

Care coordination between different providers is required and must be documented in the IPOC, CIPOC and Progress Notes. Care coordination serves to help align services to prevent duplication and is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and share information among other health care providers and individuals who routinely come in contact with the individual, i.e. PCPs, case managers, probation officers, teachers, etc. and who are involved with the individual's health care and overall wellbeing in order to improve care.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COVERED SERVICES

PRTF services are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of a youth in order to prevent or minimize the need for more intensive inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for youth, these services shall meet DMAS approved psychiatric medical necessity criteria or be approved as an EPSDT service, based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of their license; and

be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. Failure to perform any of the covered services as described below up until the discharge of the youth shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of non-compliance.

PRTF services are therapeutic services provided under the direction of a physician and shall include assessment and re-assessment; room and board; daily supervision; treatment planning; family engagement; therapeutic passes; crisis management; individual, family, and group therapy; care coordination; interventions; general or special education (not covered by the Medicaid program); medical treatment (including medication, coordination of necessary medical services, and 24-hour onsite nursing availability); specialty services; and discharge planning that meets the medical and clinical needs of the youth.

PRTF Service Requirements

The following clinical activities shall be required for each PRTF resident:

1) A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 calendar days prior to admission and weekly thereafter, and shall document a DSM-5 or ICD-10 diagnosis.

2) A certificate of need shall be completed by the IACCT according to the requirements of 12VAC30-50-130(D)(4) or by the appropriate team in accordance with the emergency, retro, transfer or inpatient IACCT process. Please refer to the IACCT Appendix of this manual for details. Recertification by the team responsible for the CIPOC shall occur at least every 30 calendar days and be approved by a physician acting within their scope of practice.

3) The initial plan of care (IPOC) shall be completed within 24 hours of admission by the treatment team. The initial plan of care shall include:

    a. Youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

    b. diagnoses, symptoms, complaints, and complications indicating the need for admission;

    c. A description of the functional level of the youth;

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

    e. any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services,

activities, therapies, social services, diet, and special procedures recommended for the health and safety of the youth;

f. plans for continuing care, including review and modification to the plan of care;

g. Plans for discharge; and

h. Signature and date by the youth, parent, or legally authorized representative, a physician and treatment team members.

4) The CIPOC shall be completed no later than 14 calendar days after admission by the treatment team. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

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

b. Be developed by an interdisciplinary team of physicians and other personnel specified in 12VAC30-50-130 and described further below who are employed by, or provide services to the youth in the facility in consultation with the youth, family member, or legally authorized representative, or appropriate others into whose care the youth will be released after discharge;

c. Shall state treatment objectives that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities, and the design of community-based aftercare with target dates for achievement;

d. Prescribe an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the youth and family treatment needs; and

e. Describe comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the youth's family, school, and community.

5) The CIPOC shall be reviewed every 30 calendar days by the team responsible for the CIPOC to determine that services being provided are or were required from a PRTF and to recommend changes in the plan as indicated by the youth's overall adjustment during the time away from home. The CIPOC shall include the signature and date from the youth, parent, or legally authorized representative, a physician and treatment team members.

The "treatment team" developing the CIPOC shall meet the following requirements:

a. At least one member of the team must have expertise in pediatric behavioral health. Based on education and experience, preferably including competence in child and adolescent psychiatry, the team must be capable of all of the following: assessing the youth's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the youth's family or legally authorized representative; setting treatment objectives; and prescribing therapeutic modalities to achieve the CIPOC's objectives.

b. The team shall include either:

   1. a board-eligible or board-certified psychiatrist;

   2. a licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or

   3. a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a licensed clinical psychologist.

c. The team shall also include one of the following: an LMHP, LMHP-S, LMHP-R, LMHP-RP

6) Individual therapy shall be provided three times per week (or more frequently based upon the youth's needs) by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the requirements in this manual. A week is defined as Sunday through Saturday.

7) Group therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the requirements in this manual.

8) Family therapy shall be provided as clinically indicated by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in the IPOC and CIPOC and progress notes in accordance with the youth and family or legally authorized representative's goals and the requirements in this manual.

9) Family engagement shall be provided in addition to family therapy/counseling. To promote and prepare the youth and family for reunification, family engagement shall be provided at least weekly as outlined in the IPOC and CIPOC and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the IPOC and CIPOC.

   For each service authorization period when family engagement is not possible, the PRTF shall identify and document the specific barriers to the youth's engagement with his family or legally authorized representatives. The PRTF shall document on a weekly basis, the reasons why family engagement is not occurring as required. This information will be required on the updated service authorization form for these

services. The PRTF shall document alternative family engagement strategies to be used as part of the interventions in the CIPOC and include documentation of the revised CIPOC for review at the next service authorization submitted to the FFS service authorization contractor. The PRTF shall develop individualized family engagement strategies and document the revised strategies in the CIPOC. The revised CIPOC should include documentation of instances where family engagement did not occur.

In instances where the family or legal guardian has disengaged from treatment and routinely not participating in the weekly family engagement activities, the facility should document the communication and care coordination with the youth's Local Department of Social Services (LDSS) Worker.

Transportation benefits may be used to support family engagement. The PRTF is encouraged to contact the DMAS designated transportation contractor for assistance in coordinating services. Refer to the Transportation section in this chapter for more coverage information.

10) Three non-psychotherapy interventions shall be provided per 24-hour period including nights and weekends in addition to individual, group and family therapies as specified in the IPOC or CIPOC. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Daily interventions are not required when there is documentation to justify clinical or medical reasons for the youth's deviations from the service plan. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation based on the needs of the youth.

11) Therapeutic passes shall be provided as clinically indicated in the plan of care and as paired with community and facility-based interventions and therapeutic services to promote discharge planning, community integration, and family engagement. Therapeutic passes should consist of collaboration with the family, legal guardian and/or supportive adults and involve consideration for what is clinically appropriate for the youth and family within the family's structure, culture and goals for engagement with the youth as they receive residential services.

The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass. Preparing the youth and the family for the therapeutic pass includes a meeting with the youth and the family in which the facility staff (i) reviews CIPOC goals and objectives for the pass; (ii) develops and reviews the safety and crisis plan that will be in effect while the youth is on the pass; (iii) instructs the youth, family, and facility staff on what skills learned during therapy will be practiced and applied during the pass; (iv) if facility staff will not be accompanying the youth on the pass, the facility staff will

instruct the youth and the family that the facility will contact the youth and the family on a daily basis during the pass, and that the facility is on-call to answer questions and concerns that the youth or the family may have during the pass; and (v) instructs the youth and the family that there will be a family meeting at the conclusion of the pass to review treatment plan and recovery related accomplishments and challenges that arose during the pass.

- Activities that occur during the pass are individualized and based upon what skills were learned during individual, group, family therapy, and daily therapeutic services and set forth in the CIPOC goals and objectives for the pass. Facility staff may accompany the youth to the family home during the pass, if indicated in the CIPOC, to assist the youth and the family with practicing and applying skills learned during therapy. If a facility staff member does not accompany the individual on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

- The family meeting at the conclusion of the therapeutic pass will involve a discussion of the accomplishments and challenges during the pass, as well as progress or lack of progress toward CIPOC goals and objectives, and any needed updates to the CIPOC. The family meeting shall occur no later than seven calendar days from the end date of the therapeutic pass. In the event that a family therapy session is needed to address any issues that arose during the pass, facility staff will schedule a family therapy session as soon as possible.

Twenty-four therapeutic passes shall be permitted per youth, per admission, without authorization as approved by the treating physician and documented in the CIPOC. Additional therapeutic passes shall require service authorization and can be requested during continued authorization requests. Any unauthorized therapeutic passes shall result in retraction for those days of service.

One pass equals any instance of time away from the facility campus to include short trips such as dinner with family or guardians and passes that include overnight stays at home.

12) A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

13) Discharge planning. Beginning at admission and continuing throughout the youth's placement at the PRTF, the parent or legally authorized representative, the Community Services Board (CSB), FAPT case manager, if applicable, and the FFS service authorization contractor care manager shall be involved in treatment planning and shall identify the anticipated needs of the youth and family upon discharge and identify the available services in the community.

Prior to discharge, the PRTF shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to the FFS service authorization contractor for review with its service authorization request. Once the FFS service authorization contractor approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for comprehensive needs assessments as needed The PRTF shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the youth has been enrolled in school, and shall provide Individualized Education Program (IEP) recommendations to the school if necessary.

The PRTF shall inform the FFS service authorization contractor of all scheduled appointments within 30 calendar days of discharge, and shall notify the FFS service authorization contractor within one business day of the youth's discharge date from the PRTF. Failure to notify the FFS service authorization contractor of discharges can delay or prevent the youth from accessing needed medical, behavioral health, dental and pharmacy benefits and prevents the FFS service authorization contractor from engaging in coordination of care upon discharge. Youth cannot have service authorizations for both PRTF and TGH at the same time and a delay in notifying the FFS service authorization contractor of a PRTF discharge for a youth who is transitioning to TGH will delay the service authorization for TGH.

PRTF Medical Necessity Criteria

The following admission criteria requirements for severity of need and intensity and quality of service shall be met to satisfy the criteria for admission:

Severity of Need

The following criteria shall be met to satisfy the criteria for severity of need.

(a) There is clinical evidence that the youth has a DSM-5 disorder that is amenable to active psychiatric treatment.

(b) There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

(c) Either

(i) there is clinical evidence that the youth would be at risk to self or others if the individual was not participating in PRTF services, or
(ii) as a result of the youth's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

(d) The youth requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow the youth to live outside of a PRTF setting.

(e) The youth's current living environment does not provide the support and access to behavioral health services needed.

(f) The youth is medically stable and does not require the 24 hour medical/nursing monitoring or procedures provided in a hospital level of care.

Intensity and Quality of Service

The following criteria shall be met to satisfy the criteria for intensity and quality of service:

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

(b) The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the youth to live outside of a PRTF setting.

(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes:

(i) at least once-a-week psychiatric reassessments;

(ii) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible;

(iii) psychotropic medications, when used, are to be used with specific target symptoms identified;

(iv) evaluation for current medical problems;

(v) evaluation for concomitant substance use issues;

(vi) linkage and/or coordination with the youth's community resources, including the local school division and FAPT case manager with the goal of returning the youth to his or her regular social environment as soon as possible, unless contraindicated.

Continued Stay Criteria

The following criteria shall be met to satisfy the criteria for continued stay:

(a) Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

(i) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs);

(ii) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs);

(iii) that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued PRTF treatment. Subjective opinions without objective clinical information or evidence are not sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

(b) There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the youth can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment resources, including the local school division and FAPT case manager as appropriate, and housing in anticipation of discharge, with alternative housing contingency plans also being addressed.

(c) There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the youth's ability to return to a less-intensive level of care.

(d) The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion in (a) above and this is documented in weekly progress notes, written and signed by the provider.

(e) There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

(f) A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-PRTF resources including the local school division and FAPT case manager as appropriate.

(g) All applicable elements in "Admission Criteria" and "Intensity and Quality of Service Criteria" are applied as related to assessment and treatment, if clinically relevant and appropriate.

Discharge Criteria

Discharge shall occur if any of the following applies:

- the level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably be expected to maintain these gains at a lower level of treatment;

- the youth no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 30 calendar days; or

- other less intensive services may achieve stabilization

Seclusion and Restraint

PRTFs must comply with federal requirements regarding restraint and seclusion. Providers should refer to 42 CFR § 483.350 – 483.376 for detailed information regarding definitions, the protection of youth; orders for the use of restraint or seclusion; consultation with the treatment team physician; monitoring of the youth in and immediately after restraint or seclusion; notification of the youth's parent or legal guardian; application of time out; post emergency safety intervention debriefings; medical treatment for injuries resulting from an emergency safety intervention; facility reporting; and, education and training of staff.

Each year providers must submit to DMAS a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation for the use of restraint or seclusion in psychiatric residential treatment facilities. Detailed information regarding this requirement can be found in Chapter II of this manual.

The use of Seclusion and Restraint in an IMD shall be in accordance with 42 CFR § 483.350 through 42 CFR § 483.376.

Facilities must report each instance of restraint or seclusion as defined in 42 CFR §483.352 involving a resident to the FFS service authorization contractor within one business day of the occurrence.

Facilities must report any serious incident involving a resident to the FFS service authorization contractor within one business day of the occurrence.

Please submit the serious incident information to the FFS service authorization contractor by completing the required questionnaire within the existing case submission in the Atrezzo Next Generation (ANG) portal.

Service Exclusions

- PRTF services may not be billed concurrently with Mental Health Services with the exception of Mobile Crisis Response. Short-term overlaps with other Mental Health services to assist with care coordination as a youth is transitioning between services is permissible as service authorized by the FFS service authorization contractor.

- Providers may not bill another payer source for any supervisory services including daily supervision and one-on-one support when provided as PRTF services.

- PRTF services do not include reimbursement for activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the youth.

THERAPEUTIC GROUP HOME SERVICES

TGH services for youth shall provide therapeutic services to restore, develop, or maintain appropriate skills necessary to promote prosocial behavior and healthy living including skills restoration, family living and health awareness, interpersonal skills, communication skills, community integration skills, coping skills and stress management skills. Therapeutic services also engage families and reflect family-driven practices that correlate to sustained positive outcomes post-discharge for youth and their family members. Therapeutic services may occur in group settings, in one-on-one interactions, or in the home setting during a therapeutic pass. Each component of TGH services is provided for the direct benefit of the youth, in accordance with the youth's needs and treatment goals identified in the IPOC and CIPOC, and for the purpose of assisting in the youth's recovery. TGH services are provided under 42 CFR § 440.130(d) in accordance with the rehabilitative services benefit. Treatment for substance use disorders shall be addressed as clinically indicated.

Failure to perform any of the items described in the service requirements section below shall result in a retraction of the per diem for each day of non-compliance.

TGH Service Requirements

The following clinical activities shall be required for each TGH resident:

1) An assessment shall be performed by an LMHP, LMHP-R, LMHP-RP, or LMHP-S upon admission.

2) A face-to-face evaluation shall be performed by an LMHP, LMHP-R, LMHP-RP or LMHP-S within 30 calendar days prior to admission with a documented DSM-5 or ICD-10 diagnosis.

3) A certificate of need shall be completed by the IACCT according to the requirements of 12VAC30-50-130, or by the appropriate team in accordance with the emergency, retro, transfer or inpatient IACCT process. Please see the IACCT supplement to this manual for additional information. Recertification shall occur at least every 60 calendar days by a LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within their scope of practice.

4) An IPOC that is specific to the youth's unique treatment needs and acuity levels shall be completed on the day of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall include all of the following: (i) youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance; (ii) diagnoses, symptoms, complaints, and complications indicating the need for admission; (iii) a description of the functional level of the youth; (iv) treatment objectives with short-term and long-term goals; (v) orders for medications, psychiatric, medical, dental and any special healthcare needs whether or not provided in the facilities, treatments, restorative and rehabilitative services, activities, therapies, therapeutic passes, social services, community integration, diet, and special procedures recommended for the health and safety of the youth; (vi) plans for continuing care, including review and modification to the plan of care; and (vii) plans for discharge. The IPOC shall be signed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth and a family member or legally authorized representative.

5) The CIPOC shall be completed no later than 14 calendar days after admission and shall meet all of the following criteria: (i) be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the youth's situation and shall reflect the need for TGH care; (ii) be based on input from school, home, other healthcare providers, FAPT if necessary, the youth, and the family or legal guardian; (iii) shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement; (iv) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and (v) include a comprehensive discharge plan with clear action steps and target dates including necessary, clinically appropriate community services to ensure continuity of care upon discharge with the youth's family, school, and community.

6) The CIPOC shall be reviewed, signed, and dated every 30 calendar days by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth or a family member or primary caregiver. The review shall include all of the following: (i) the youth's response to the services provided; (ii) recommended changes in the plan as indicated by the youth's overall response to the CIPOC interventions; and (iii) determinations regarding whether the services being provided continue to be required. Updates shall be signed and dated by the LMHP, LMHP-R, LMHP-RP, or LMHP-S and the youth or a family member or legally authorized representative.

7) Crisis management, clinical assessment, and individualized therapy shall be provided as indicated in the IPOC and CIPOC to include both mental health and substance use disorder needs as indicated in the IPOC and CIPOC to address intermittent crises and challenges within the TGH setting or community settings as defined in the plan of care and to avoid a higher level of care.

8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the youth as included in the IPOC and CIPOC; The facility/group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility or group home in the youth's record. The documentation shall include who was contacted, when the contact occurred, what information was transmitted and recommended next steps.

9) The program shall include individualized activities provided in accordance with the IPOC and CIPOC including a minimum of one non-psychotherapy intervention per 24-hour period in addition to individual, group, and family therapies as specified in the IPOC and CIPOC.

    - Daily interventions are not required when there is documentation to justify clinical or medical reasons for the youth's deviations from the service plan.

    - Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC.

    - Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation in the progress note.

10) Weekly individual therapy shall be provided in the TGH, or other settings as appropriate for the youth's needs, by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61. A week is defined as Sunday through Saturday.

11) Group therapy shall be provided at a minimum of weekly and as documented in the IPOC or CIPOC by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, and shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61.

12) Family involvement begins immediately upon admission to the TGH. Family therapy shall be provided as clinically indicated and as documented in the IPOC or CIPOC by an LMHP, LMHP-R, LMHP-RP, or LMHP-S and shall be documented in progress notes in accordance with the definition of the term "progress note" in 12VAC30-60-61. One family therapy session per week is recommended.

13) Family engagement activities shall be provided in addition to family therapy. To promote and prepare the youth and family for reunification, family engagement activities shall be provided at least weekly as outlined in the IPOC and CIPOC and daily communication with the family or legally authorized representative and the treatment team representative shall be part of the family engagement strategies in the IPOC or CIPOC.

    For each service authorization period when family engagement is not possible, the TGH provider shall identify and document the specific barriers to the youth's engagement with his family or legally authorized representatives. At each treatment team meeting the facility team should be actively discussing the family involvement and planning for family engagement strategies. The TGH provider shall document on a weekly basis, the reasons why family engagement is not occurring as required. This information will be required on the updated service authorization form for these services. The TGH provider shall document alternative family engagement strategies to be used as part of the interventions in the CIPOC and include documentation of the revised CIPOC for review at the next service authorization submitted to the FFS service authorization contractor. The TGH provider shall develop individualized family engagement strategies and document the revised strategies in the CIPOC. The revised CIPOC should include documentation of instances where family engagement did not occur.

    In instances where the family or legal guardian has disengaged from treatment and routinely not participating in the weekly family engagement activities, the facility should document the communication and care coordination with the youth's Local Department of Social Services (LDSS) Worker.

    Transportation benefits may be used to support family engagement. The TGH provider is encouraged to contact the DMAS designated transportation contractor for assistance in coordinating services. Refer to the Transportation section in this chapter for more coverage information.

14) Therapeutic passes shall be provided as clinically indicated in the IPOC and CIPOC, and as paired with facility- and community-based interventions to promote discharge planning, community integration, and family engagement activities. The provider shall document how the family was prepared for the therapeutic pass to include a review of the plan of care goals and objectives being addressed by the planned interventions and the safety and crisis plan in effect during the therapeutic pass. Preparing the youth and the family for the therapeutic pass includes a meeting with the youth and the family in which the facility staff (i) reviews ISP goals and objectives for the pass; (ii) develops and reviews the safety and crisis plan that will be in effect while the youth

is on the pass; (iii) instructs the youth, family, and facility staff on what skills learned during therapy will be practiced and applied during the pass; (iv) if facility staff will not be accompanying the youth on the pass, the facility staff will instruct the youth and the family that the facility will contact the youth and the family on a daily basis during the pass, and that the facility is on-call to answer questions and concerns that the youth or the family may have during the pass; and (v) instructs the youth and the family that there will be a family meeting at the conclusion of the pass to review treatment plan and recovery related accomplishments and challenges that arose during the pass.

- Activities that occur during the pass are individualized and based upon what skills were learned during individual, group, family therapy, and daily therapeutic services and set forth in the IPOC and CIPOC goals and objectives for the pass. Facility staff may accompany the youth to the family home during the pass, if indicated in the IPOC and CIPOC, to assist the youth and the family with practicing and applying skills learned during therapy. If a facility staff member does not accompany the youth on the therapeutic pass and the therapeutic pass exceeds 24 hours, the provider shall make daily contacts with the family and be available 24 hours per day to address concerns, incidents, or crises that may arise during the pass.

- The family meeting at the conclusion of the therapeutic pass will involve a discussion of the accomplishments and challenges during the pass, as well as progress or lack of progress toward ISP goals and objectives, and any needed updates to the ISP. The family meeting shall occur no later than seven calendar days from the end date of the therapeutic pass. In the event that a family therapy session is needed to address any issues that arose during the pass, facility staff will schedule a family therapy session as soon as possible.

Twenty-four therapeutic passes shall be permitted per youth, per admission, without authorization as approved by the treating LMHP, LMHP-R, LMHP-RP or LMHP-S and documented in the CIPOC. Additional therapeutic passes shall require service authorization and can be requested at the time of the continued service authorization. Any unauthorized therapeutic passes shall result in retraction for those days of service.

One pass equals any instance of time away from the facility campus to include short trips such as dinner with family or guardians and passes that include overnight stays at home.

15) A Urine Drug Screen (UDS) is considered at the time of admission, when progress is not occurring, when substance misuse is suspected, or when substance use and medications may have a potential adverse interaction. After a positive screen, additional random screens are considered and referral to a substance use disorder provider is considered.

16) Discharge planning. Beginning at admission and continuing throughout the youth's stay at the TGH, the family or guardian, the CSB, the FAPT case manager, and the FFS service authorization contractor care manager and the MCO care manager for youth enrolled in Managed Care shall be involved in treatment planning and shall identify the anticipated needs of the youth and family upon discharge and available services in the community. Prior to discharge, the TGH shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to Magellan of Virginia for review with its service authorization request. Once the FFS service authorization contractor reviews the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for a comprehensive needs assessment as needed. The TGH shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities have begun, shall establish that active transition planning has begun, the youth has been enrolled in school, and shall provide IEP recommendations to the school if necessary. The TGH shall inform the FFS service authorization contractor of all scheduled appointments within 30 calendar days of discharge, and shall notify the FFS service authorization contractor within one business day of the youth's discharge date from the TGH.

TGH Medical Necessity Criteria

The following admission criteria requirements for severity of need and intensity and quality of service shall be met to satisfy the criteria for admission:

Severity of Need

The following criteria shall be met to satisfy the criteria for severity of need:

(a) The youth's behavioral health condition can only be safely and effectively treated in a 24 hour therapeutic milieu with onsite behavioral health therapy due to significant impairments in home, school and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

(b) The Certificate of Need must demonstrate all of the following:

(i) ambulatory care and Medicaid or FAPT-funded resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the youth;

(ii) proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(iii) the services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed.

(c) An assessment which demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool must be completed. A moderate impairment is evidenced by, but not limited to:

(i) frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the youth's age and developmental level;

(ii) frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community;

(iii) severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions;

(iv) impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community;

(v) limited ability to consider the effect of one's inappropriate conduct on others; and,

(vi) interactions consistently involving conflict, which may include impulsive or abusive behaviors.

(d) Less restrictive community based services have been given a fully adequate trial, and were unsuccessful or, if not attempted, have been considered, but in either situation were determined during the IACCT to be to be unable to meet the youth's treatment needs and the reasons for that are discussed in the certificate of need.

(e) The youth's symptoms, and/or the need for treatment in a 24/7 level of care, are not primarily due to any of the following:

(i) intellectual disability, developmental disability or autistic spectrum disorder;

(ii) organic mental disorders, traumatic brain injury or other medical condition; or

(iii) the youth doesn't require a more intensive level of care.

(f) The youth doesn't require primary medical or surgical treatment.

Intensity and Quality of Service

All of the following criteria shall be met to satisfy the criteria for intensity and quality of service.

(a) TGH service has been prescribed by a psychiatrist, psychologist, or other LMHP, LMHP-R, LMHP-RP or LMHP-S who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the youth.

(b) The TGH service is not being used for clinically inappropriate reasons, including:

(i) an alternative to incarceration, and/or preventative detention;

(ii) an alternative to parents', guardian's or agency's capacity to provide a place of residence for the youth; or

(iii) a treatment intervention, when other less restrictive alternatives are available.

(c) The youth's treatment goals are included in the IPOC and CIPOC and include behaviorally defined objectives that require, and can reasonably be achieved within, a TGH setting.

(d) The TGH is required to coordinate with the youth's community resources, including schools and FAPT as appropriate, with the goal of transitioning the youth out of the program to a less restrictive care setting with continued, services as soon as possible and appropriate.

(e) The TGH program must incorporate nationally established, evidence based, trauma informed services and supports that promote recovery and resiliency.

Continued Stay Criteria

The following criteria shall be met in order to satisfy the criteria for continued stay.

(a) All of the admission guidelines continue to be met and continue to be supported by the written clinical documentation.

(b) The youth shall meet one of the following:

(i) the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the youth's IPOC and CIPOC or the youth continues to be at risk for relapse based on history; or

(ii) the nature of the functional gains is tenuous and use of less intensive services will not achieve stabilization.

(c) The youth shall meet one of the following:

(i) the youth has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care;

(ii) the youth is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care;

(iii) the youth is not making progress, and the CIPOC has been modified to identify more effective interventions;

(iv) there are current indications that the youth requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic passes.

(d) There is a written, up-to-date discharge plan that:

(i) identifies the custodial parent or custodial caregiver at discharge;

(ii) identifies the school the youth will attend at discharge, if applicable;

(iii) includes IEP and FAPT recommendations, if necessary;

(iv) outlines the aftercare treatment plan (discharge to another residential LOC is not an acceptable discharge goal); and

(v) lists barriers to community reintegration, and progress made on resolving these barriers since last review.

(e) The CIPOC includes structure for daily therapeutic services, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the CIPOC.

(f) There is evidence of intensive family or support system involvement occurring at least once per week, unless there is an identified valid reason why it is not clinically appropriate or feasible.

(g) Less restrictive treatment options have been considered, but cannot yet meet the youth's treatment needs. There is sufficient current clinical documentation/evidence to show that TGH LOC continues to be the least restrictive level of care that can meet the youth's mental health treatment needs.

Discharge Criteria

Reimbursement shall not be made for this level of care if any of the following discharge criteria applies:

- the level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably be expected to maintain these gains at a lower level of treatment; or

- the youth no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 calendar days.

- less intensive services may achieve stabilization.

Service Exclusions

1. Room and board costs shall not be reimbursed. Facilities that only provide independent living services or non-clinical services that do not meet the requirements of this manual are not eligible for reimbursement.

2. TGH services shall not be covered when treatment goals are met or less intensive services may achieve stabilization.

3. Services that are based upon incomplete, missing, or outdated assessments, IPOCs or CIPOCs shall be denied reimbursement.

4. TGH services may not be billed concurrently with any Mental Health Service, with the following exceptions:

    - School based Therapeutic Day Treatment, Mobile Crisis Response and Community Stabilization with no limitations (see the Mental Health Services Manual for service requirements).

    - Mental Health Skill-Building (MHSS) with the following limitations: the TGH may not serve as the MHSS provider for individuals residing in the provider's respective facility; MHSS is limited to 8 units per week, with at least half of each week's services provided outside of the TGH; MHSS is limited to a maximum of 2 units per day; and, the MHSS Individual Service Plan (ISP) shall not include activities that contradict or duplicate those in the treatment plan established by the TGH. Limits may be exceeded based on medical necessity under EPSDT. See the Mental Health Services Manual for additional details.

- For other Mental Health Services not listed above, short term overlaps to assist with transitions as a youth moves between services is permissible as service authorized by the FFS service authorization contractor or MCO.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

PRTF and TGH

Federal law requires that any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a youth through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary for the specific youth.

Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT in TGHs and PRTFs. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by a DMAS contractor. In unique EPSDT cases, DMAS may authorize specialized services beyond the standard TGH or PRTF medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in TGHs and PRTFs on behalf of a Medicaid-enrolled youth shall adhere to the individualized interventions and evidence-based progress measurement criteria described in the plan of care and approved for reimbursement by DMAS.

EPSDT Service Definition

EPSDT residential treatment services includes, but is not limited to clinically directed programming including applied behavior analysis and other evidence based behavior modification models. Services are 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 is to ensure the youth and family becomes able to more effectively manage the youth's behavior using behavioral modification strategies.

EPSDT residential treatment services shall focus on increasing adaptive behavioral function in communication skills, managing safety and aggressive behaviors, assessment and training in activities of daily living is also provided if the skill deficit impacts the clinical treatment needs of the youth.

EPSDT residential treatment services are intended to be a temporary rehabilitative, structured environment that fosters the use of evidence based behavioral strategies such as applied behavioral analysis and other evidence informed behavior modification

strategies. EPSDT residential treatment services are expected to increase appropriate social - communicative interactions and pivotal responses within a social framework, increase adaptive functioning and produce beneficial changes in pivotal responses that result in more widespread behavioral change across a number of other non-targeted behaviors.

Treating service providers authorized to deliver medically necessary EPSDT services in TGHs and residential treatment facilities on behalf of a Medicaid-enrolled youth shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC.

All service requirements including but not limited to documentation, IACCT, interventions, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or TGH services.

The psychiatric, psychological and behavioral therapies that the youth requires must have clinical oversight from a licensed physician, psychiatrist, neurologist, licensed clinical social worker, licensed professional counselor, psychologist, or licensed behavior analyst along with coordination between other facility-employed or contracted licensed professionals in the fields of speech pathology, occupational therapy and physical therapy or audiology.

EPSDT Residential Treatment Services are not appropriate for youth who have attained behavioral control and who only require services such as social skills enhancement.

EPSDT Eligibility Criteria for Residential Treatment Services

EPSDT Residential Treatment Services may be provided to persons with developmental delays such as autism and intellectual disabilities. Youth must exhibit intensive behavioral challenges to be authorized for services. EPSDT Residential Treatment services for Medicaid eligible youth with developmental disabilities are service authorized and billed through the FFS service authorization contractor.

Covered Services

- Applied behavior analysis and other evidence based behavioral modification services under the supervision of a Licensed Behavior Analyst (LBA), Licensed Assistant Behavior Analyst (LABA) or LMHP acting within their scope of practice to increase the youth’s adaptive functioning and communication skills;

- Training of family members to improve the youth’s adaptive skills in the home and community;

- Care coordination;

- Assessment and behavior analysis encounters are permitted to be billed separately to the per diem reimbursement (see Chapter V for details)

- Direct consultation by the Licensed Behavior Analyst (LBA), Licensed Assistant Behavior Analyst (LABA) or LMHP acting within their scope of practice with direct services staff, and other professionals and paraprofessionals involved in the youth's overall treatment and/or implementation of the behavior plan;

- Documentation and analysis of quantifiable behavioral data related to treatment objectives;

- Assistive technology related services (such as instruction or training on use of assistive technology or development of communication methods and materials related to the functional use of assistive communication and assistive technology devices);

Service Requirements and Exclusions

EPSDT residential treatment services must follow the service requirements and service exclusion sections as defined in the PRTF and TGH sections of this manual.

Medical Necessity Criteria for EPSDT PRTF

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

Admission - Severity of Need

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. There must be a diagnosed developmental disability and mental health condition that is amenable to active psychiatric treatment and behavioral modification strategies and behavioral supports.

"Developmental disability" means a severe, chronic disability of a youth that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the youth attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the youth's need for a combination and sequence of special, interdisciplinary, or generic services, individualized

supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization in the absence of residential treatment.

C. There is clinical evidence that the youth would be at risk to self or others if the individual was not participating in a residential treatment program,

D. The youth requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a residential treatment setting.

E. The youth's current living environment does not provide the behavioral support and access to therapeutic services needed.

F. The youth is medically stable but may require consistent medical management by a nursing team and needs this level of care to comply with behavioral health and / or healthcare treatment.

II. Admission - Intensity and Quality of Service

Criteria A, B, and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision and behavioral modification training and supports seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the youth to live outside of a structured residential setting or lower level of care.

C. An individualized plan of active psychiatric treatment, behavioral modification training/supports and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical and nursing service availability.

This plan includes:

1) at least once-a-week psychiatric reassessments;
2) intensive family and/or support system involvement occurring at least once per week; or identifies valid reasons why such a plan is not clinically appropriate or feasible;

3) psychotropic medications, when used, are to be used with specific target symptoms identified;
4) evaluation for current medical problems;
5) evaluation for concomitant substance use issues, and
6) linkage and/or coordination with the youth's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the youth to their regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

Criteria for Continued Stay

Criteria A, B, C, D, E, F, and G must all be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic and supportive efforts, clinical and historical evidence indicates at least one of the following:

1. the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), or
2. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
3. that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness or functioning limitations to the degree that would necessitate continued residential treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be a decompensation.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical and behavioral functioning goals that must be met before the youth can return to a new or previous living situation. There is evidence that attempts are being made to secure timely access to treatment and support resources (including housing) in anticipation of discharge, with alternative housing contingency plans also being addressed.

C. There is evidence that the treatment and behavioral support plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial and/or environmental stressors that are interfering with the youth's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion A of this

section, and this is documented in weekly progress notes, written and signed by the provider.

E. There is evidence of intensive family and/or support system involvement occurring at least once per week, unless there is an identified, valid reason why it is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources including the local school division and FAPT case manager as appropriate.

G. All applicable elements in Admission-Intensity and Quality of Service Criteria are applied as related to assessment and treatment/supports, if clinically relevant and appropriate.

Discharge Criteria

Continued residential level of care is not appropriate and will not be reimbursed when one or more of the following discharge criteria applies:

- The level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably expected to maintain these gains at a lower level of treatment.
    - The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting; or
    - The required treatment, activity of daily living supports and behavioral supports can be provided in a less restrictive environment; or
    - There is documented evidence, from the use of day and overnight pass that the youth has been able to function safely and satisfactorily with the community.
- The youth no longer benefits from services as determined by the oversight physician and as evidenced by an absence of progress toward CIPOC goals for a period of 30 days:
- Other less intensive services may achieve stabilization

Services will not be reimbursed when there has been no documented evidence of a change in treatment or behavioral support plan when the youth has not responded for a 30 calendar day period.

Medical Necessity Criteria for EPSDT TGH

The youth must require services from multiple disciplines. Behavioral modifications strategies must require the clinical oversight of a LMHP, LMHP-R, LMHP-RP or LMHP-S.

Youth must demonstrate deficits in adaptive functioning and require treatment services that cannot be provided by another DMAS program or lower level of care.

Severity of Need Criteria

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for severity of need.

A. There must be a diagnosed developmental disability and mental health condition that is amenable to active psychiatric treatment and behavioral modification strategies and behavioral supports.

"Developmental disability" means a severe, chronic disability of a youth that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the youth attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the youth's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization or a higher level of care in the absence of TGH services.

C. There is clinical evidence that the youth would be at risk to self or others if the individual was not participating in in TGH services.

D. The youth requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a TGH setting.

E. The youth's current living environment does not provide the behavioral support and access to therapeutic services needed.

F. The youth is medically stable but requires consistent clinical management by multidisciplinary team and needs this level of care to comply with behavioral health and / or healthcare treatment.

Admission Criteria:

Criteria A, B, C, D, E, and F must be met to satisfy the criteria for admission.

A. The youth must demonstrate behaviors or symptoms which are expected to cause harm to self or others without immediate intervention.

B. The youth is medically stable, but needs systematic treatment interventions to increase adaptive behavioral functioning and increase communication abilities.

C. The youth's needs cannot be met in the home setting or a lower level of care because the behavioral modification strategies that were attempted in the home setting were not successful or the family members or caregivers are not able to or not willing to participate in the behavioral treatment process *and* it can be determined that the youth would be at risk for hospitalization or a higher level of care without such placement.

D. It has been documented that the youth would not achieve a demonstrable clinical or adaptive behavioral improvement if using similar treatment modalities in the home setting or within a less structured environment; The youth cannot be safely maintained or effectively treated at a less-intensive level of care.

E. These symptoms and behaviors present in increasing frequency, duration and intensity that require continual close monitoring and intervention by staff who are trained to treat youth with DD/ASD in order to ensure member and milieu safety.

F. TGH services must be reasonably be expected to increase the youth's functional autonomy or prevent regression so that the youth can engage with a lower level of care.

Admission - Intensity and Quality of Service

Criteria A, B, and C must be met to satisfy the criteria for intensity and quality of service.

A. The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.

B. The program provides supervision and behavioral modification training and supports seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the youth to live outside of a structured residential setting or lower level of care.

C. An individualized plan of active psychiatric treatment, behavioral modification training/supports and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical and nursing service availability. This plan includes:

1) at least monthly psychiatric reassessments;

2) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible, and

3) psychotropic medications, when used, are to be used with specific target symptoms identified;

4) evaluation for current medical problems;

5) evaluation for concomitant substance use issues;

6) linkage and/or coordination with the youth's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the youth to their regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

Continued Stay Criteria

Criteria A, B, C and D must be met to satisfy the criteria for continued stay.

A. One of the following:

1. The desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the youth's CIPOC or the youth continues to be at risk for relapse or regression based on history
2. The tenuous nature of the functional gains and use of less intensive services will not achieve stabilization.

B. One of the following:

1. The youth has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.
2. The youth is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.
3. The youth is not making progress, and the CIPOC has been modified to identify more effective interventions.
4. There are current indications that the youth requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic passes.

C. As youth makes progress evidenced by reduction in rates, intensity and duration of maladaptive behaviors and increase in skill acquisition, service authorization will reflect new presentation.

D. Coordination of care and discharge planning are ongoing with the goal of transitioning youth to less intensive behavioral intervention and a less intensive level of care.

Discharge Criteria

Continued TGH level of care is not appropriate and will not be reimbursed when one or more of the following discharge criteria applies:

- The level of functioning has improved with respect to the goals outlined in the CIPOC and the youth can reasonably expected to maintain these gains at a lower level of treatment
    - The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting.
    - The required treatment, ADL supports and behavioral supports can be provided in a less restrictive environment.
    - There is documented evidence, from the use of day and overnight pass that the youth has been able to function safely and satisfactorily with the community.
- The youth no longer benefits from services as determined by the oversight LMHP, LMHP-R, LMHP-RP or LMHP-S and as evidenced by an absence of progress toward CIPOC goals for a period of 60 calendar days; or
- Other less intensive services may achieve stabilization.

Services will not be reimbursed when there has been no documented evidence of a change in treatment or behavioral support plan when the youth has not responded for a 30 day period.

EPSDT 1:1 Services Criteria

EPSDT 1:1 Support is an intervention involving a specific level of monitoring for youth who require one dedicated staff person to personally monitor one youth in order to help ensure their health and safety.

The treatment team must document the need for EPSDT 1:1 support in the individualized assessment of the youth. EPSDT 1:1 supports must be included in the plan of care. In TGH settings a LMHP, LMHP-R, LMHP-RP or LMHP-S must recommend EPSDT 1:1 services and review the need for continued EPSDT 1:1 services. In PRTF settings, a physician must recommend EPSDT 1:1 services and review the need for continued EPSDT 1:1 services. The 1:1 services must be documented in the youth's plan of care. 1:1 supports will be authorized based on the individual needs of the youth at the time of the authorization request.

The following must be clearly documented in the youth's medical record:

- The member must demonstrate acute behavioral instability within 24 hours of the documented EPSDT 1:1 request. Acute behavioral instability includes at least one of the following:
  - serious suicidal intent;
  - verbalize, gesture or otherwise expresses an intent to inflict, or attempts to inflict, self-injury that would post a threat to life;
  - high risk for imminent attempts at elopement, evidenced by elopement attempt or clear plan to elope;
  - severe physical aggression toward staff or other individual;
  - homicidal threat to staff or other individual; unpredictable physical aggression; or
  - the individual's behaviors are a severe health and safety risk to self or others.

- The need for 1:1 supports must be reviewed and documented at least every 72 hours by the treatment team including the physician in PRTF settings and LMHP in TGH settings, to determine if the member continues to meet criteria for this level of intervention. The physician in PRTF settings and LMHP, LMHP-R, LMHP-RP or LMHP-S in TGH settings will also need to complete a face to-face re-assessment to determine updates needed to the member's plan of care including medication evaluations.

The staff providing 1:1 supports must be no more than an "arm's length" away from the youth at all times unless the youth is actively transitioning to a lesser level of supervision and 1:1 supports are "fading" as the youth transitions to a less intensive staffing ratio. The staff must not be performing any other duties or activities, and must not have any other assignments. Daily progress notes shall include the youth's response to the intensive treatment supervision.

Should the youth continue to pose a threat to self or others, the treating LMHP, LMHP-R, LMHP-RP, LMHP-S or physician needs to be notified. The youth shall be assessed for possible acute hospitalization.

Criteria for Discontinuing 1:1 Supports

1:1 Supports shall be discontinued when the clinical need for the service no longer exists. This may include but is not limited to the following:

- No incidences of severe physical aggression or homicidal threats in the previous 72 hours.

- No attempts to elope in the previous 72 hours.

- No serious attempts to harm self or others in the previous 72 hours.

- No verbalization, gestures or expressions of intent to hurt self or others in the previous 72 hours.

- Verbal or written safety contract between the youth and staff addressing issues which necessitated 1:1 supports is developed, dated and signed and the physician in the PRTF setting or the LMHP, LMHP-R, LMHP-RP or LMHP-S in the TGH setting determines the youth no longer requires the 1:1 support.

The provider must submit documentation supporting the need for continued 1:1 supports, an approximate schedule of 1:1 hours, the updated CIPOC, and a plan for reducing 1:1 hours. If the goals necessary to reduce or discontinue supports are not met within the requested timeframe, the provider must provide documentation to support additional/continued hours which includes describing the barriers preventing the youth from meeting their treatment goals.

* Special consideration should be given to youth with Intellectual Disability, Autism Spectrum Disorder, and Developmental Delays who may require 1:1 support when their behavior, either intentional or unintentional, may cause harm to self or others as their ability to fully understand the potential injury that may result may be limited due to their intellectual functioning or communicative ability. Along with the request for 1:1 support, a plan must be provided to further assess the function of the behaviors to provide behavioral modification or evaluation of other medical needs, working toward reaching the least restrictive treatment environment for the youth.

Service Exclusions

- Accommodations (consisting of support for activities of daily living) for physical disabilities are not an appropriate use of EPSDT 1:1 supports.

- EPSDT 1:1 supports are not reimbursed during nighttime hours if the youth typically is sleeping.

- EPSDT 1:1 supports are not reimbursed by EPSDT during school hours. The IPOC and CIPOC must identify how the youth’s safety will be monitored during school hours.