Residential Treatment Services

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Residential Treatment Services

General Information

Introduction

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider “HELPLINE” at:

804-786-6273 Richmond Area

1-800-552-8627 All other areas

Program Background

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical

Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1

(as defined in the State Plan and subject to certain limitations)

- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam
    - Appropriate immunizations according to age and health history
    - Laboratory tests (including blood lead screening)

    - Health education

- Home health services

- Eyeglasses for all members younger than 21 years of age according to medical necessity

- Hearing services

- Inpatient psychiatric services for members under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section “transplant services”

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity

criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:

- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment
- Case Management
- Opioid Treatment

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- “Organ and disease” panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor’s prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.
- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary
- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent
- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners
- Unkept or broken appointments
- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in

the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

  To get the free mobile app, search for Virginia Managed Care on the Apple App Store

or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

  Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient’s age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO’s contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows: o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

  of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

  o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)

- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)

- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:

- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.

- Future month information is only available in the last week of the current month.

- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber’s last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute

990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card*. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.

- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.

- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);

- Immunizations (member under age 21);

- Family planning services;

- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;

- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service

methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (RTS)

PROVIDER PARTICIPATION REQUIREMENTS

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS. Providers are responsible for adhering to this manual, available on the DMAS website portal, and all DMAS policies, their Magellan of Virginia provider contract and policies, and related state and federal regulations.

Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. The provider network is managed and maintained by Magellan of Virginia. Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers into the network based upon DMAS regulatory requirements and geographical access needs. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/provide.

All calls related to the FFS behavioral health services should go to the Magellan of Virginia Call Center. Magellan of Virginia staff is available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution,
- grievances and
- complaints.

MANAGED CARE ENROLLED MEMBERS

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm whether an individual is enrolled in a Medicaid MCO and which particular MCO.

DMAS OFFERS A WEB-BASED INTERNET OPTION TO ACCESS INFORMATION REGARDING MEDICAID OR FAMIS MEMBER ELIGIBILITY AND MCO ENROLLMENT. PROVIDERS MUST REGISTER THROUGH THE VIRGINIA MEDICAID WEB PORTAL IN ORDER TO ACCESS THIS INFORMATION. THE VIRGINIA MEDICAID WEB PORTAL CAN BE ACCESSED BY GOING TO: WWW.VIRGINIAMEDICAID.DMAS.VIRGINIA.GOV. IF YOU HAVE ANY QUESTIONS REGARDING THE VIRGINIA MEDICAID WEB PORTAL, PLEASE CONTACT THE CONDUENT GOVERNMENT HEALTHCARE SOLUTIONS SUPPORT HELP DESK TOLL FREE, AT 1-866-352-0496 FROM 8:00 A.M. TO 5:00 P.M. MONDAY THROUGH FRIDAY, EXCEPT HOLIDAYS. THE MEDICALL AUDIO RESPONSE SYSTEM PROVIDES SIMILAR INFORMATION AND CAN BE ACCESSED BY CALLING 1-800-884-9730 OR 1-800-772-9996. BOTH OPTIONS ARE AVAILABLE AT NO COST TO THE PROVIDER.

Even if the individual is enrolled with an MCO, some services, such as therapeutic group home (TGH) services, continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the Fee-for-Service rules in these instances where services are "carved-out." Refer to each program's website for detailed information and the latest updates. While youth residing in TGHs remain in managed care, youth who enter a psychiatric residential treatment facility (PRTF) are disenrolled from managed care.

There are several different Medicaid managed care programs (Medallion 4.0, CCC Plus, and PACE). For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- Medallion 4.0:

  http://www.dmas.virginia.gov/#/med4

- Commonwealth Coordinated Care Plus (CCC Plus):

  http://www.dmas.virginia.gov/#/cccplus

- Program of All-Inclusive Care for the Elderly (PACE)

http://www.dmas.virginia.gov/#/longtermprograms

Provider Qualifications (RTS)

Provider Credentials for Mental Health Services Staff:

Residential treatment service providers (PRTFs and TGHs) must ensure that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider. All provider sites must be credentialed by Magellan of Virginia, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) and in compliance with all DMAS requirements as defined in the residential treatment service regulations.

"ADL Supervisor" means a child care supervisor with a baccalaureate degree in social work or psychology and two years of professional experience working with children one year of which must have been in a residential facility for children; or a high school diploma or General Education Development Certificate (G.E.D.) and a minimum of five years professional experience working with children with at least two years in a residential facility for children; ADL supervisors shall work under supervision of the Program Director.

"ADL Technician" means a child care worker at least 21 years of age who has a baccalaureate degree in human services; has an associate's degree and three months experience working with children; or is a high school graduate or has a G.E.D. and has six months of experience working with children. A trainee with a high school diploma or a G.E.D may gain experience working with children by working directly alongside a staff member who is, at a minimum, an ADL technician with at least one year of professional experience with children. These trainees must be within sight and sound of the supervising staff member and may not work alone. ADL technicians must be supervised by an ADL supervisor, QMHP-C, LMHP, LMHP-R, LMHP-RP or LMHP-S.

"Institution for Mental Disease" or **"IMD"** means a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Licensed assistant behavior analyst" or **"LABA"** means a person who has met the licensing requirements for an assistant behavior analyst as defined in 18VAC85-150-10 et

seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed behavior analyst" or **"LBA"** means a LMHP who has met the licensing requirements for a behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

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

"LMHP-resident" or **"LMHP-R"** means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"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.

"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.

"Program Director" means the same as defined in 12VAC35-46-350.

"Qualified mental health professional-child" or **"QMHP-C"** means the same as the term is defined in § 54.1-3500.

"Qualified mental health professional-eligible" or **"QMHP-E"** means the same as the term "qualified mental health professional - trainee" as defined in § 54.1-3500.

The QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP-RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

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

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by PRTFs. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) PRTFs. PRTFs must be:

- licensed by The Department of Behavioral Health and Developmental Services (DBHDS);
- 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 by any other accrediting organization with comparable standards that is recognized by the state; and
- fully in compliance with (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G regarding the use of restraint and seclusion.

Each admission must be service authorized and the treatment must meet DMAS

requirements for clinical necessity as outlined in Chapter IV of this manual.

THERAPEUTIC GROUP HOME (TGH)

TGH service providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46). Service Providers must be credentialed and contracted with Magellan of Virginia. Licensed practitioners providing professional services separately from the TGH per diem shall also be credentialed and contracted with the youth's MCO. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TGHs.

- 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 subsection are not eligible for reimbursement.
- DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds regardless of the funding source. DMAS shall not reimburse for TGH services provided in any facility that meets the definition of an Institution for Mental Disease (IMD).
- TGH services may only be rendered by a LMHP, LMHP-S, LMHP-R, LMHP-RP, a QMHP-C, a QMHP-E, a QPPMH, an ADL Supervisor or an ADL Technician.
- Treatment Team/Team Responsible for the Plan of Care must contain an LMHP, LMHP-R, LMHP-RP, or LMHP-S and a family member or legally authorized representative.
- The clinical director must be a LMHP. The caseload of the clinical director must not exceed 16 total clients including all sites for which the clinical director is responsible;
- The program director must be full time and meet the requirements for a program director as defined in 12VAC35-46-350.
- Assessment, treatment planning, crisis management, and individual, group and family therapy must be provided by a LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-C or higher.
- ADL restoration must be provided by a: LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP-C; or, a QMHP-E, QPPMH, ADL Supervisor or ADL Technician under the supervision of a QMHP-C or higher.
- At least 50% of the direct care staff onsite at the group home must meet a minimum of DBHDS QPPMH criteria.
- Services provided by QPPMHs require supervision by a QMHP-C or higher. Supervision is demonstrated by the supervisor's review of progress notes, the member's progress towards achieving Comprehensive Individual Plan of Care (CIPOC) goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.

- Direct staff who do not meet the minimum QPPMH requirements may provide services for Medicaid reimbursement if they meet qualifications to be an ADL Supervisor or ADL Technician, are working directly with at least a QPPMH on-site and being supervised by a QMHP-C or higher. Supervision must include on-site observation of services, face-to-face consultation with the direct staff member, a review of the progress notes, the youth's progress towards achieving CIPOC goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.
- If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications. The provider who subcontracts services is responsible for ensuring that the subcontracted employees meet all psychiatric service requirements and psychiatric services staffing requirements.

EPSDT PRTFs and TGHs

For Applied Behavior Analysis (ABA) services delivered in EPSDT PRTFs and TGHs, the following requirements apply:

- Applied Behavior Analysis (ABA) Services must be provided by either:
    1. An LMHP practicing within the scope of their practice as defined by the applicable Virginia Health Professions Regulatory Board or an agency that employs a LMHP, or
    2. An LBA meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq. or an agency that employs a LBA.

- Direct ABA interventions must be provided by either:
    1. A LMHP acting within the scope of their practice;
    2. A LMHP, LMHP-R, LMHP-RP or LMHP-S;
    3. A LBA;
    4. A LABA under the supervision of a LBA; or
    5. Personnel under the supervision of a LBA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations.

- EPSDT PRTF and TGH providers practicing ABA must meet all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.

Independent Assessment, Certification and Coordination Teams (IACCT)

a. The independent certification team shall certify the need for PRTF or TGH services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with Magellan of Virginia.

b. The independent certification team shall be approved by DMAS through a Memorandum of Understanding with a locality or be approved under contractual agreement with Magellan of Virginia. The team shall initiate and coordinate referral to the FAPT (as defined in Va. Code 2.2-5207 and 2.2-5208) to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

For additional information on the IACCT process and IACCT team requirements, please refer to the IACCT supplement to this manual.

Level A Group Home Level of Care (Service ended April 30, 2018)

As of May 1, 2018, DMAS ceased reimbursement for TGH services provided by a DSS licensed facility. Level A providers who were contracted with Magellan of Virginia had until April 30, 2018 to obtain a conditional license as defined by DBHDS in 12VAC35-46-90.

Freedom of Choice (RTS)

The individual has the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services. Fee for service providers must have a signed provider contract with Magellan of Virginia, meet the appropriate credentialing requirements, and adhere to Magellan of Virginia policies and procedures.

Provider Enrollment (RTS)

Each provider of TGH and PRTF services must be credentialed and contracted with Magellan of Virginia prior to billing for any services provided to Medicaid enrolled individuals.

DMAS is informing the provider community that National Provider Identifier numbers (NPIs) may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share a provider's NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

As part of the supporting documentation for a PRTF provider, Magellan of Virginia must receive 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 of restraint and seclusion in PRTFs (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted. Letters are required at enrollment and annually thereafter. A sample letter of attestation can be found in the Exhibits section at the end of this chapter. Letters are due by 5 PM on July 1 or the first business day thereafter each year.

Adherence to the regulations regarding restraint & seclusion, including the reporting of any serious incident involving any individual, is a condition of continued participation as a Medicaid provider. If the letter of attestation is not received by Magellan of Virginia by the due date, approval of new authorizations will not occur. Also, DMAS Utilization Review Audits will monitor for compliance with the provider contract with Magellan of Virginia.

For further information on requirements related to restraint and seclusion, refer to Chapter IV of this manual.

Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Providers must comply with all sections of this manual, their contracts, and related state and federal regulations to maintain continuous participation in the Medicaid Program.

Out-of-State Facilities

Enrollment of providers for PRTFs and TGHs are generally limited to those located in Virginia or within 50 miles of the state line. If a youth requires this level of service that is not available in Virginia, an out-of-state provider may enroll for a specific youth only for the duration of the admission. Out-of-state providers or Children's Services Act Coordinators who are interested in obtaining Virginia Medicaid reimbursement for a specific youth may contact Magellan of Virginia and provide information.

Specific information required for out-of-state placement consideration:

- Referral source and contact person
- Name and contact information, such as website, of the proposed placement
- Basic demographics of the youth (age, sex, current location, family involvement, Medicaid number)
- Description of the youth's current need for intensive PRTF services, such as planned focus of treatment, problem behaviors, DSM diagnosis, medications, court involvement, previous treatments-successful or not, discharge summaries (within the past 6 months)
- Virginia Medicaid providers approached to access services for the youth and the outcomes (provide specific reasons for denial of admission)
- Discharge plan

Specific Information for Out-of-State Providers

Out of state providers are held to the same service authorization processing rules as in-state providers and must have an agreement with Magellan of Virginia prior to submitting a request for out of state services for a specific youth which will cover enrollment only for the duration of the admission to Magellan of Virginia. If the provider is not enrolled as a participating provider, the provider is encouraged to submit the request to Magellan of Virginia as timeliness of the request will be considered in the review process. Magellan of Virginia will complete the service authorization review and will request the completion of enrollment documentation.

If Magellan of Virginia receives the information in response to the provider's enrollment, the request will be completed and the provider will be informed of the status of their enrollment to serve the individual youth.

If Magellan of Virginia does not receive the information to complete the processing of enrollment within 12 business days, Magellan of Virginia will reject the service authorization request and will not enroll the provider. It may take up to 10 business days after the receipt of required documentation to become a participating provider that is only serving a specific youth during the duration of admission.

Requests for Enrollment (RTS)

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only

accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Providers that wish to serve fee for service members for behavioral health services must contract with Magellan of Virginia.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider

categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

Revalidation Requirements (RTS)

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via DMAS' web portal or notice from Magellan for providers that are contracted with Magellan Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS and Magellan may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS (RTS)

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not

been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS (RTS)

To be a network provider of FFS behavioral health services with Magellan of Virginia to serve members in the Virginia Medicaid/FAMIS programs, you or your agency must be credentialed and enrolled according to Magellan of Virginia and DMAS standards, and must be contracted with Magellan of Virginia. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with Magellan of Virginia prior to rendering services. To initiate the application process, providers can visit www.magellanofvirginia.com and click the “Join the Network” link under the *For Providers* tab on the homepage. Additional information regarding the credentialing criteria and contracting process can be reviewed in the Provider Handbook Supplement for Virginia Behavioral Health Service Administrator located at www.magellanofvirginia.com and click “Provider Handbook” link under the *For Providers* tab on the homepage.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to Magellan of Virginia.

For any additional questions about credentialing and contracting, providers may contact a Magellan of Virginia Provider Network Coordinator at 1-800-424-4536, or send an email to VAProviderQuestions@MagellanHealth.com

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Behavioral Health providers approved for participation in the Magellan of Virginia provider network must perform the following activities as well as any others specified by DMAS. Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify Magellan of Virginia in writing whenever there is a change in the information that the provider previously submitted, including adding new services, new service locations or changes in licensure. For a change of address, notify Magellan of Virginia prior to the change and include the effective date of the change;

- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as Magellan of Virginia requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Send updated staff rosters no less than quarterly;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Charge Magellan of Virginia for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 provides that a "State Plan must provide

that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency ….” The provider should not attempt to collect from the individual or the individual’s responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid’s allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge DMAS, Magellan of Virginia or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- Reimburse the individual or any other party for any monies contributed toward the individual’s care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;

- Use DMAS or Magellan of Virginia designated billing forms for submission of charges;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS or its contractor, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members;

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public; and

- Serious incidents involving any youth must be reported to Magellan of Virginia, DBHDS Licensing, and the Disability Law Center of Virginia (DLCV), the protection and advocacy system for persons with disabilities in the Commonwealth of Virginia. Serious incidents include a youth's death, suicide attempt, or a serious injury that requires medical attention. The incident does not need to be related to a restraint or seclusion. If a youth must go to the emergency room to address an injury while a resident of the facility, the report must be sent to Magellan of Virginia. Providers contracted with Magellan of Virginia should send incident reports by fax at 1-888-656-5396.

  The fax must include the following information:

  - Youth's name and Medicaid number;
  - Facility name, address, and NPI number;
  - Names of staff involved;
  - Detailed description of the incident, including the date and location
  - of the incident;
  - Outcome, including the persons notified; and
  - Current location of the youth.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an

excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219

E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider’s programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates their attestation of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office

of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

Utilization of Insurance Benefits

Virginia Medical Assistance Programs are “last pay” programs. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers’ Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medical Assistance Program will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers’ Compensation** - No Virginia Medical Assistance Program payments shall be made for a patient covered by Workers’ Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Virginia Medical Assistance Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of Medicaid/FAMIS/FAMIS MOMS recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and DMAS is billed for this treatment, DMAS should be notified promptly so action can be initiated by DMAS to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.
- If there is an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid/FAMIS/FAMIS MOMS is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the

Third Party Liability Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

(To obtain a copy of this form, see the “Replenishment of Billing Materials” section in Chapter V of this manual.)

ASSIGNMENT OF BENEFITS (RTS)

If an individual enrolled in the Virginia Medical Assistance Program is the holder of an

insurance policy which assigns benefits directly to the individual, the facility must require that benefits be assigned to the facility or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION (RTS)

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

FRAUD (RTS)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals reenrolled in Medicaid. A provider participation agreement or contract will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V, “Billing Instructions,” and Chapter VI, “Utilization Review and Control” of this manual.

TERMINATION OF PROVIDER PARTICIPATION (RTS)

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 30 days prior to the

effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid –PES

PO Box 26803

Richmond, Virginia 23261-6803

DMAS or the BHSA may terminate a provider's agreement to participate with Virginia Medicaid with thirty (30) days written notification prior to the effective date**.** Such action precludes further payment by the BHSA for services provided to customers subsequent to the date specified in the termination notice. The MCOs have different rules for terminating providers and shall adhere to the contract rules regarding notification.

Any provider losing JCAHO accreditation will be notified of DMAS termination if their eligibility as an enrolled provider of a specific service required JCAHO accreditation. DMAS can rescind the termination of the provider agreement if accreditation is restored; however, Medicaid reimbursement will not be available for any period during which the provider does not meet DMAS provider participation standards.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a BHSA/Medicaid agreement or contract is terminated or denied to a provider pursuant to the Code of Virginia §32.1-325D and E. The provider may appeal the decision in accordance with the Virginia Administrative Process Act (APA), Code of Virginia §2.2-4000 *et seq.*, the State Plan for Medical Assistance provided for in the Code of Virginia § 32.1-325 *et seq.* and the DMAS appeal regulations at the Virginia Administrative Code 12 VAC 30-20-500 *et seq.* Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the

notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

   b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Member Appeals

Member Appeals (MCO)

Members, their attorneys, or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

Any member, member's attorney, or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here, a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.
- By downloading a Medicaid/FAMIS Appeal Request form from the internet at https://www.dmas.virginia.gov/ or by writing a letter. The appeal request must identify the issues being appealed. The form or letter can be submitted by:
    - Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
    - Email to appeals@dmas.virginia.gov, or
    - Fax to (804) 452-5454.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an attorney or authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights

that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.
- The appeal request form or letter and any additional documentation can be submitted by:
  - Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
  - Email to appeals@dmas.virginia.gov, or
  - Fax to (804) 452-5454.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action

is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request

can be submitted by:

- Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
- Email to appeals@dmas.virginia.gov; or
- Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

CLIENT APPEALS (RTS)

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal, the member must follow an oral appeal with a written, signed appeal. Information about the appeal process must be made accessible to individuals with limited English proficiency and individuals with disabilities.

A member may request continuation of services during the MCO's internal appeal and

DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at the Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be faxed to (804) 452-5454, emailed to appeals@dmas.virginia.gov, or mailed.. If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq*. and the Rules of Court.

Member Appeals (FFS)

Members receiving FFS services through a DMAS Contractor may be required to file an internal appeal with the DMAS Contractor before appealing to DMAS. Providers under

contract with a DMAS Contractor seeking to file an appeal on behalf of their client should consult their contract with the DMAS Contractor.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Information about the appeal process must be made accessible to individuals with limited English proficiency and individuals with disabilities.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. The member or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be faxed to (804) 452-5454 or emailed to appeals@dmas.virginia.gov .

If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Exhibits (RTS)

SAMPLE ATTESTATION LETTER

(Submit on Facility Letterhead)

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Date

Name of the Psychiatric Residential Treatment Facility

Facility Address

City, State, Zip Code

Telephone Number

Fax Number (if applicable)

Provider Number/NPI

To the Virginia Department of Medical Assistance Services:

The above listed facility has [insert total number of facility beds]. As of the date of this attestation, the facility has [insert number of Medicaid residents in the facility]. Of this total, [insert number of residents for whom the psych under 21 is paid for by another state].

Below is a list of all states from whom the facility has ever received Medicaid payment for the provision of psych under 21 benefit:

[include list]

By this letter, I attest that this facility, a residential treatment facility providing inpatient psychiatric services to individuals under the age of 21, is in compliance with Part 483, Subpart G of CMS's standards governing the use of restraint and seclusion. In the event that there is a new facility director, the facility will submit a new attestation of compliance.

Sincerely,

Name of Individual

Facility Director [insert position name]

Member Eligibility

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)

- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See "Exhibits" at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual's eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

  - Assistive technology

  - Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services

furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician’s office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician’s office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as

recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under “Exhibits” at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier
The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person
An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number
The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a “key” in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth
The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex
The member's gender is indicated on the card.

Card #
The sequential number of the member’s card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic “swipe” mechanism.

Cardholder’s Signature (signature line on back)
The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in

the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.

Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department’s managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:
  http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus):
  ttp://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/#/longtermprograms

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant’s situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant’s legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant’s behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated “his/her mark” and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the

individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link "E213". Any hospital staff that have approval from their hospital and have access to the portal may report the newborn's birth and receive the newborn's Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: General Information for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a TDO
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person's date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer's decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer's decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (RTS)

The Virginia Medicaid Program covers a variety of behavioral health treatment services under the Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitation and Psychiatric Services benefits for eligible members. This chapter describes these services and the requirements for the provision of psychiatric residential treatment and therapeutic group home services.

All psychiatric residential treatment facility and therapeutic group home providers are responsible for adhering to this manual, available on the DMAS website portal, their

provider contract with the MCOs, MMPs and the BHSA and state and federal regulations.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at: https://www.magellanprovider.com/MagellanProvider.

Behavioral Health Services Administrator (RTS)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424- 4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

All Residential Treatment Service providers are responsible for adhering to the residential treatment regulations defined in 12 VAC 30-50, 12VAC30-60, 12VAC30-130, this manual, their provider contract with the BHSA, and state and federal regulations.

Commonwealth Coordinated Care Plus (CCC Plus) Program (RTS)

CCC Plus is a managed long term services and supports (LTSS) program. This mandatory Medicaid managed care program will serve individuals with disabilities and complex care needs.

Target Population –

1. Individuals who receive Medicare benefits and full Medicaid benefits (dual eligible), including members enrolled in Commonwealth Coordinated Care (CCC). CCC members will transition as of January 1, 2018.

2. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver except Alzheimer's Assisted Living waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for- service.
3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program. Medallion ABD members who are not enrolled in the CCC Plus Waiver (per 2 above) will transition as of January 1, 2018.

Medallion 3.0 (RTS)

Medallion 3.0 is a statewide mandatory managed care program for Medicaid and FAMIS members. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver.

Additional information about the Medallion 3.0 program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

For Medallion MCO members, assessment and evaluation, and outpatient psychiatric therapy services (individual, family, and group) are handled through the member's MCO. MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service 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. MCO contact information is available on the DMAS website at https://www.virginiamanagedcare.com.

Certain services, however, are carved out of Medallion 3.0 managed care and will continue to be obtained through fee-for-service (e.g., dental and community mental health rehabilitation services). A complete list of carved out services are located online at: http://www.dmas.virginia.gov/Content_atchs/mc/MCRG_Member_2015_04262016_v2.pdf.

Residential Treatment Coverage for Managed Care Enrollees (RTS)

The following Residential Treatment Services are carved-out of the CCC Plus and Medallion 3.0 MCO contracts and are covered for Medicaid enrollees through fee-for-service, in accordance with DMAS fee-for-service established coverage criteria and

guidelines. Medicaid MCOs receive data on the Residential Treatment Services utilized by their members. Providers of Residential Treatment Services may be contacted by the MCOs to discuss the care of these individuals.

Please note that FAMIS and FAMIS MOMS enrollees covered by Medallion 3.0 Managed Care are not eligible for Residential Treatment Services including TGHs and PRTFs.

Medicaid MCO enrollees seeking Residential Treatment Services shall follow the assessment and certification process for individuals. The Independent Assessment, Certification and Coordination Team (IACCT) will complete the independent certification process as described in this chapter.

Managed Care Coverage, Eligibility and TGH Admissions

If a Medicaid enrollee in a MCO is eligible for and chooses TGH services, the individual will remain enrolled in their MCO after admission. If the individual transfers to a TGH after a PRTF stay, the eligible individual will be enrolled into a MCO. Professional services are covered by the MCOs thus the individual practitioners will need to be enrolled with the MCO. The TGH services are covered by Magellan of Virginia.

Managed Care Coverage, Eligibility and PRTF and EPSDT TGH Admissions

Medicaid members who are placed in an PRTF or EPSDT TGH setting are not eligible to participate in the Medicaid MCO programs. If the Medicaid enrollee is admitted to a PRTF or EPSDT TGH, they will be removed from the MCO effective on the day of admission to the PRTF or EPSDT TGH. The PRFT or EPSDT TGH services and most professional services will be covered by Magellan of Virginia. There are certain laboratory services that will be covered by DMAS.

Qualified Medicare Beneficiaries (QMBs) - Coverage Limitations

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the member's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with the MMP should contact the MMP directly for more information.

Client Medical Management (CMM) Program

As described in Chapters I and VI, the Medicaid Program may designate certain members to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the member's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these members only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

Transportation (RTS)

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 http://dmas.virginia.gov/#/nemtservices.

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 http://www.dmas.virginia.gov/#/nemtservices.

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 (RTS)

TELEMEDICINE SERVICES

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014: "Updates to Telemedicine Coverage". Medicaid Memos are posted at: https://www.virginiamedicaid.dmas.virginia.gov under Provider Services. For managed care enrolled members, the member's plan may cover additional telemedicine/telehealth services and have different requirements. Providers should direct specific telemedicine/telehealth coverage questions to the member's MCO.

Service Criteria and Requirements (RTS)

Residential Treatment Services are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances.

Residential Treatment Services as defined by this program manual consist of two levels of care: Psychiatric Residential Treatment Facility (PRTF) services and Therapeutic Group Home (TGH) services. Each level of care is defined as a distinct program with all applicable program rules grouped according to the level of care. The services available under the Early and Periodic Screening, Diagnosis and Treatment use the same level of care descriptions and are described under the EPSDT heading which describes the required activities that are distinct in each level of care setting.

The requirements for certification of need processes and the Independent Assessment, Certification and Coordination Teams (IACCT) are defined in this chapter as they apply to both levels of care.

Residential Treatment Services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

All services must be described with sufficient detail in a Plan of Care based on assessed needs of the individual defined in the assessment, the plan of care, most recent

treatment team review and clinical review of the individual's treatment needs. These services are person-centered with emphasis on the delivery of youth guided and family driven principles. The individuals who are receiving these services shall be included in all service planning activities.

Level A Group Home Level of Care

Prior to revisions associated with Residential Treatment Services regulations established three levels of residential care, i.e., Level A Group Home, Level B Group Home, and Level C Psychiatric Residential Treatment Facility. Research of the licensing requirements of Department of Behavioral Health and Developmental Services (DBHDS), Department of Social Services (DSS) and Medicaid regulations indicates that DSS licensed Level A Group Homes will not be eligible for continued Medicaid reimbursement. Medicaid regulations require therapeutic group home programs to provide counseling services and therapeutic interventions. The therapeutic interventions are not an allowable service under the DSS licensure for Level A Group Homes.

Level A Group Home Transition Process (effective July 1, 2017)

Revised regulations establish two levels of residential care: PRTF and TGH. Both levels of care require licensure by DBHDS.

In order to better align service delivery with federal mandates and licensing requirements, Level A group home service providers who wish to provide continued Medicaid covered services and be reimbursed by Medicaid must obtain a TGH license from DBHDS. As instructed in the DMAS Program Manual update issued on December 9, 2016, Level A service providers were to contact DBHDS and indicate their interest in applying for licensure by February 1, 2017. On January 20, 2017, DBHDS conducted an information session to Level A providers, outlining the transition process to become licensed as a TGH. As of February 1, 2017, Magellan of Virginia stopped enrolling new Level A providers with licenses issued by DSS.

As of May 1, 2018, DMAS and Magellan of Virginia will no longer reimburse for therapeutic group home services provided by a DSS licensed facility.

Level A Transition Summary:

Current Level A group home service providers who wish to transition and obtain a DBHDS TGH license must apply by June 30, 2017. The DBHDS application process can take up to one year to complete. Magellan of Virginia will continue to authorize and reimburse TGH care to Level A providers transitioning to TGH until May 1, 2018 if Level A providers have evidence of completing the following steps of the process:

1. submitted their notice of intent to DBHDS;
2. attended the DBHDS training on January 20, 2017;
3. provided Magellan of Virginia a copy of DSS license by February 1, 2017; and
4. submitted their application and policy and procedures to DBHDS by June 30, 2017.

To assist with a smooth transition, current Level A providers who have not completed the DBHDS application by June 30, 2017 will be able to enroll as a TGH, however their program participation status will be limited if the provider is not able to meet the TGH enrollment criteria. Providers who did not apply to DBHDS by June 30, 2017 will not be reimbursed for any new admissions with a certificate of need dated after September 30, 2017. For providers who did not apply for a license, reimbursement will be allowed only for initial and concurrent authorizations for anyone admitted on or prior to September 30, 2017.

Current providers of Community-Based Residential Services for Children and Adolescents under 21 (Level A) will no longer be eligible for continued Medicaid reimbursement as of May 1, 2018 For providers that applied to DBHDS after June 30, 2017 and have not obtained a Therapeutic Group Home license by April 30, 2018, Magellan of Virginia will terminate the Level A service provider agreement and contract effective on May 1, 2018. By terminating the Level A provider contract, Magellan of Virginia will prevent future submissions and reimbursement for CPT code H2022, for those providers.

Level A providers who have applied to DBHDS for a TGH license by June 30, 2017 will be able to do the following:

- Continue to accept new Level A admissions via the IACCT process using TGH medical necessity criteria (MNC); and

- Continue receiving reimbursement for authorized services through April 30, 2018.

Level A providers who have not applied to DBHDS for a TGH license by June 30, 2017 will be able to do the following:

- Accept new Level A admissions via the IACCT process through September 30, 2017 using TGH medical necessity criteria;

- Receive reimbursement for previously authorized admissions through April 30, 2018; and
- May begin the DBHDS licensure process after June 30, 2017 but will not be able to receive reimbursement after April 30, 2018 until a DBHDS license is issued.

Based on data received from DBHDS related to application status, beginning March 1, 2018, Magellan of Virginia will identify those providers with open authorizations that extend beyond April 30, 2018. For providers who have not obtained a TGH license, Magellan of Virginia will provide care coordination for those members that remain in placement prior to May 1, 2018. Care coordination will include reaching out to the providers and the legal guardian of the member to provide notice and assist in identifying alternative placements for youth that continue to meet medical necessity criteria for TGH services. For members who do not continue to meet TGH medical necessity criteria, Magellan of Virginia can assist in linking member to community based services. Legal guardians may choose to seek alternative funding for the child to remain in the DSS facility. This process will begin in March 2018 in order to allow Magellan of Virginia and providers sixty (60) days to work collaboratively on appropriately transitioning these children by May 1, 2018.

Definitions (RTS)

DEFINITIONS

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC. Each plan of care shall be designed to improve the youth's condition and to achieve the youth's safe discharge from residential care at the earliest possible time.

"Activities of Daily Living (ADL) Restoration" means a face-to-face interaction provided on an individual or group basis to assist youth in the restoration of lost ADL skills that are necessary to achieve the goals established in the youth's plan of care. Services address performance deficits related to a lack of physical, cognitive or psychosocial skills which hinder the ability of the youth to complete ADLs. Services include (i) restoring acceptable habits, behaviors and attitudes related to daily health activities and personal care/hygiene and (ii) assisting the youth restoring and regaining functional ADL skills and appropriate behavior related to health and safety.

"Assessment" means the face-to-face interaction by an LMHP, LMHP-R, LMHP-RP or LMHP-S to obtain information from the youth and parent, guardian or other family member, as appropriate, utilizing a tool or series of tools to provide a comprehensive evaluation and review of the youth's mental health status. The assessment shall include a documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.

"Certificate of need" or "CON" means a written statement by an independent certification team that services in a TGH or PRTF are or were needed.

"Comprehensive Individual Plan of Care" or "CIPOC" means a person-centered plan of care that meets all of the requirements of this subsection, is specific to the youth's unique treatment needs and acuity levels as identified in

the clinical assessment and information gathered during the referral process.

"Crisis" means a deteriorating or unstable situation, often developing suddenly that produces an acute, heightened emotional, mental, physical, medical, or behavioral event.

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis. The activities and interventions include behavioral health care to provide immediate assistance to youth experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short term counseling designed to stabilize the youth.

"Daily supervision" means the supervision provided in a PRTF through a resident-to-staff ratio as approved by the Department of Behavioral health and Developmental Services (DBHDS) Office of Licensure, with documented supervision checks every 15 minutes throughout the 24-hour period.

"Discharge planning" means family and locality-based care coordination that begins upon admission to a PRTF or TGH with the goal of transitioning the youth out of the PRTF or TGH to a less restrictive care setting with continued, clinically-appropriate services as soon as possible upon discharge. Discharge plans shall be recommended by the treating physician, psychiatrist, or treating LMHP responsible for the overall supervision of CIPOC and shall be approved by the BHSA.

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

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” **EPSDT** is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of youth’s health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the member. 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 DMAS or its agent as medically necessary.

"Family engagement" means a family-centered and strengths-based approach to partnering with families in making decisions, setting goals, achieving desired outcomes, and promoting safety, permanency, and well-being for youth and families. Family engagement requires ongoing opportunities for a youth to build and maintain meaningful relationships with family members, e.g. frequent, unscheduled, and non-contingent phone calls and visits between a youth and family members. Family engagement may also include enhancing or facilitating the development of the youth’s relationship with other family members and supportive adults responsible for the youth’s care and well-being upon discharge.

"Family engagement activity" means an intervention, which may be provided either in person or on the phone, consisting of family psychoeducational training or coaching; transition planning with the family; family and independent living skills; and training on accessing community supports as identified in the IPOC and CIPOC. Family engagement activity does not include and is not the same as family therapy.

“Family therapy” means counseling services involving the youth’s family and significant others to advance the treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the youth, (2) the counseling is not aimed at addressing treatment needs of the youth’s family or significant others, and (3) the youth is present except when it is clinically appropriate for the youth to be absent in order to advance the youth’s treatment goals. Family therapy shall be aligned with the goals of the youth’s treatment plan. All family therapy services furnished are for the direct benefit of the youth, in accordance with the youth’s needs and treatment goals identified in the youth’s treatment plan, and for the purpose of assisting in the youth’s recovery.

“IACCT” or “Independent Assessment, Certification, and Coordination Team” means a team that consists of various professionals who will collaborate to provide assessments or assist in gathering medical and behavioral health treatment records that will be used to fully assess the youth and family needs in order to formulate a preliminary plan of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family including preferences related to provider location, specialties, spoken languages, gender, and cultural aspects. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

"Independent certification team" means a team that has competence in diagnosis and treatment of mental illness, preferably in child and adolescent psychiatry, and has knowledge of the youth’s situation, and is composed of at least one physician and one LMHP, LMHP-R, LMHP-RP or LMHP-S. The independent certification team shall be a DMAS-authorized contractor with contractual or employment relationships with the required team members. Effective July 1, 2017 certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT).

"Initial plan of care" or "IPOC" means a person-centered plan of care established at admission that meets all of the requirements of this manual, is specific to the youth’s unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

“Institution for Mental Disease (IMD)” means a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Intervention" means scheduled therapeutic treatment included in the IPOC and CIPOC to help the youth achieve his or her plan of care goals and objectives. Interventions include, but are not limited to: skills restoration; ADL restoration; individual, group, and family therapy; individual or group psychoeducation; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the youth's ability to acquire coping and functional or self-regulating behavior skills; therapeutic passes and family engagement activities. Interventions shall not include medical or dental appointments, physician services, medication evaluation or management provided by a licensed clinician or physician, and shall not include school attendance. Interventions shall be provided in the TGH or PRTF and, when clinically necessary, in a community setting, or as part of a therapeutic pass activity. All interventions and settings of the intervention shall be established in the IPOC and CIPOC.

“LDSS” means Local Department of Social Services

"Licensed Assistant Behavior Analyst" or “LABA” means an individual who has met the licensing requirements for an assistant behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed behavior analyst" or “LBA” means a LMHP who has met the licensing requirements for a behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

“Licensed Mental Health Professional” or “LMHP” means the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"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. "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.

"Physician" means an individual licensed to practice medicine or osteopathic medicine in Virginia, as defined in Va. Code §54.1-2900.

“Non-psychotherapy interventions” means those interventions other than individual, group or family therapy.

"Psychiatric residential treatment facility (PRTF)," means the same as defined in 42 CFR 483.352, and is a 24-hour, supervised, clinically and medically-necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of a youth in order to prevent or minimize the need for more intensive inpatient treatment.

“Psychotherapy” or “therapy” means the use of psychological methods in a professional relationships to assist a person or persons to acquire great human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive. Psychotherapy may only be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.

"Recertification" means a certification other than the initial certification of need for each applicant or recipient for whom PRTF or TGH services are needed.

"Room and board" means a component of the total daily cost for placement in a licensed PRTF. Residential room and board costs are maintenance costs associated with placement in a licensed PRTF, and include a semi-private room, three meals and two snacks per day, and personal care items. Room and board costs are reimbursed only for PRTF settings.

“Skills Restoration” means a face-to-face service to assist youth in the restoration of lost skills that are necessary to achieve the goals established in the youth’s plan of care. Services include assisting the youth in restoring self-management, interpersonal, communication and problem solving skills through modeling, coaching and cueing.

"Therapeutic group home (TGH)" means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents. TGH providers must meet all requirements in DBHDS Regulations for Children’s Residential Facilities (12VAC 35-46).

"Therapeutic pass” means time at home or time with family consisting of partial or entire days away from the TGH or PRTF as clinically indicated in the plan of care and as paired with facility-based and community-based interventions to promote discharge planning, community integration, and family engagement activities. Therapeutic passes are not solely recreational but are a therapeutic component of the plan of care and are designed for the direct benefit of the youth.

“Therapeutic services” means the structured therapeutic program designed to restore appropriate skills necessary to promote prosocial behavior and healthy living to include: the restoration of coping skills; family living and health awareness; interpersonal skills; communication 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 include but are not limited to assessment, individualized treatment planning and interventions.

"Treatment planning" means development, implementing, monitoring and updating the person-centered IPOC and CIPOC, that is specific to the youth's unique treatment needs and acuity levels.

"Youth" means the individual under 21 years of age.

Residential Treatment Services (RTS)

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.

Noted below are two (2) concepts that should be reflected in all providers' service delivery practices.

Recovery and Resiliency

DMAS encourages providers to integrate individualized, recovery based behavioral health services into their practices and service delivery operations. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Cultural and Linguistic Competency

DMAS encourages providers to demonstrate an understanding and respect for each individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to

value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over time as cultures change.

Providers licensed by the DBHDS should refer to DBHDS for guidance in this area.

PRTF and TGH Program Requirement Changes

The 2017 revision to the regulations governing residential treatment services establish practices promoting the creation of strong and closely coordinated partnerships and collaborations between families, youth, and community/residential based treatment service providers. These partnerships help to ensure that comprehensive services and supports are family-driven, youth-guided, strengths-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. The goal is to promote medically appropriate services, shorter lengths of stay, and reunification with the family unit to include support systems to maintain the youth successfully in the community.

Highlights of the program requirement changes included:

- Integrate Building Bridges Initiatives Core Values into program policy. Information on Building Bridges Initiatives is available on the Magellan of Virginia website at https://www.magellanofvirginia.com/for-providers/residential-program-process/;
- Establish treatment planning that is family driven and youth guided;
- Establish daily rather than weekly minimum interventions;
- Establish family engagement activities as allowable interventions, and establish minimum requirement for family engagement activity;
- Require ongoing opportunities for youth to build and maintain meaningful relationships with family members to include frequent, unscheduled, and non-contingent phone calls and visits between youth and family members;
- Allow “time at home” consisting of therapeutic passes home and family engagement activities and more types of residential service structures as allowed interventions;
- Allow exceptions to daily intervention requirements to support activities to transition back to the community;
- Require provider’s discharge plan to be approved by Magellan of Virginia; and
- Establish new program coverage and medical necessity criteria for EPSDT Residential Treatment Services to be administered by Magellan of Virginia.

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 Magellan of Virginia and the youth's MCO as applicable to achieve effective family engagement strategies. Magellan of Virginia residential 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.

Magellan of Virginia Care Management (RTS)

Care Management is provided by Magellan of Virginia employed clinical staff who are licensed behavioral health clinicians. Care Management includes provider service coordination and coordination with CSA Coordinators/CSA Case Managers, LDSS Social Workers, CSB and Treatment Foster Care Case Managers. The central purpose of Care Management is to help individuals receive quality services in the most cost-effective manner. The primary activities of Care Management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care

transition, quality management, and independent review.

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals:

1. To improve the health and wellness of individuals with complex and special needs; and
2. To integrate services around the needs of the individual at the local level by working to make sure members receive appropriate services and experience desirable treatment outcomes.

Examples when Magellan of Virginia may provide care management to assist individuals and families include:

- Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management;
- An MCO liaison at Magellan of Virginia will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care;
- Care coordination with Primary Care Physicians (PCPs); and
- Assistance with transferring cases from one provider to another.

Care Coordination

"Care coordination" in the regulations defined in 12VAC30-50-130 means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

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.

According to the National Technical Assistance Center for Children's Mental Health, "intensive family involvement, meaningful discharge planning, and deliberate strategies to reintegrate back into the community are the essential components to the assurance of effective psychiatric treatment for youth. National research provides evidence that care coordination including these components improves child and family outcomes and results in positive return on investment." Through the focus groups and workgroups described above, DMAS received universal feedback that effective care coordination of services for youth with severe behavioral health needs is lacking across the Commonwealth.

To ensure that youth at risk of or receiving residential treatment services receive the

benefits of effective care coordination, Magellan of Virginia will provide residential care coordination through Intensive Care Managers and Family Support Workers. These individuals will ensure the engagement of families, youth, and community- and residential-based treatment service providers in the comprehensive assessment of youth and family needs, determination of the most appropriate and least restrictive level of care, service planning, service delivery, and post- discharge follow-up. Emphasis on family-driven and youth-guided care will be a key hallmark of Magellan of Virginia's residential care coordination.

Service Provider Care Coordination is done in the spirit of collaboration with the treatment team and is meant to support the member 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 consumer's life);
- Assessing the effectiveness of these services/supports;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the service plan 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.

Residential Services for Substance Use and Behavioral Health (RTS)

Effective April 1, 2017, DMAS implemented the Addiction and Recovery Treatment Services (ARTS) program for all members. For more information on the services, criteria, and staffing requirements, refer to the ARTS Provider Manual.

Addiction and Recovery Treatment Services (ARTS) Residential Treatment Services

ARTS residential services for adolescents 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 adolescent's primary diagnosis is a substance use disorder, please submit an ARTS residential service request to the MCO for managed care enrolled members or Magellan of Virginia for fee-for-service enrolled members. For assistance or a list of ARTS residential providers, contact the adolescent's MCO or Magellan of Virginia. Providers can also be contacted directly for services.

Behavioral Health Residential Treatment Services

Behavioral health residential services include: Therapeutic Group Home (TGH) and Psychiatric Residential Treatment Facility (PRTF) Each child seeking admission to behavioral health residential services (TGH or PRTF) will first receive the support of the local Independent Assessment, Certification and Coordination Team (IACCT) to assess the child's needs. If the youth's primary diagnosis is a mental health diagnosis, please submit a Residential Inquiry form to Magellan of Virginia to begin the process. This form can be found on the Magellan of Virginia website in the Residential Program Process section. For additional information on the IACCT process, please refer to IACCT overview guides on the Magellan of Virginia website in the Residential Program Process section.

Interaction between ARTS and IACCT

If the youth is in a PRTF or TGH and it is determined that ARTS Residential services are needed, please notify the Magellan of Virginia Residential Care Manager (RCM) who will assist with identifying appropriate ARTS resources for the youth.

If the youth is in an ARTS Residential facility and needs to transition to a PRTF or a TGH, please submit an IACCT Inquiry form as soon as the need is identified.

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. Individuals 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 individuals 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 member to an appropriate service provider.

For persons with co-occurring psychiatric and substance abuse 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. Providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment

Independent Certification Process (RTS)

Medical Necessity Review Process Changes

Beginning on July 1, 2017 PRTF and TGH services will begin using different medical necessity criteria. Changes in the service authorization process was implemented on July 1, 2017 when Magellan of Virginia will stop using the current medical necessity criteria for Level A and Level B Group Home Services and will instead make authorization decisions in the new TGH Services using new medical necessity criteria and IACCT review process.

Both initial and concurrent authorizations will be issued using a maximum duration of 30 days based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. Initial EPSDT cases will be authorized for a maximum duration of 60 calendar days based on medical necessity requirements. Concurrent EPSDT cases will be authorized for a maximum duration of 90 days based on medical necessity requirements.

The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination.

The service review process used by Magellan of Virginia will assess the plan of care and treatment plan to determine if the services are adequate to treat the individual's needs in the residential or group home setting. The Magellan review will focus more intensively on the quality of care for the member while in the residential service setting.

Independent Assessment, Certification and Coordination Teams (IACCT)

CMS requires, per §441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in

§441.153. Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services. Effective January 1, 2017 DMAS will require that all certification teams are credentialed and contracted with Magellan of Virginia in order to administer the independent certification process on behalf of DMAS. DMAS will also allow localities to enter into a partnership agreement with DMAS to administer the IACCT process in collaboration with Magellan of Virginia. The new certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

- Ensuring care coordination and higher probability for improved outcomes;
- Following strict turnaround timeframes for assessing the need for treatment and level of care requirements;
- Accessing the established Medicaid grievance process as mandated by CMS;
- Ensuring freedom of choice in service providers as mandated by CMS; and
- Implementing Medical Necessity Criteria for all members who request residential care.

All Medicaid-eligible youth must be referred to Magellan of Virginia who will make referral to the IACCT team for PRTF and TGH services. In addition, all inpatient providers and residential treatment providers must refer to Magellan of Virginia to initiate the IACCT certification process to assess and certify an appropriate level of care prior to being transferred to PRTF or TGH care from an inpatient setting. All IACCT decisions are due within 10 business days of the referral to Magellan of Virginia. A licensed mental health professional (LMHP) who is part of the IACCT will conduct a diagnostic assessment through a face-to-face meeting and the IACCT will determine the appropriate level of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

IACCT Oversight and Support

Magellan of Virginia, as the DMAS Behavioral Health Administrator, will provide oversight to the IACCT process and facilitate implementation of best practices.

Magellan of Virginia will support the IACCT process through activities including:

- Ensure that all appropriate community services are explored in lieu of residential placement;

- Make the final medical necessity determination for residential placement;
- Handle all grievances and appeals per the established DMAS appeals process; and
- Provide freedom of choice of providers to youth and families.

Magellan of Virginia's Role

The Magellan of Virginia certification and care coordination model, i.e., IACCT, will utilize a single team for the assessment of care needs and care coordination. Magellan of Virginia will support the IACCT through Magellan of Virginia employed positions including Intensive Care Managers (ICM) and Family Support Coordinators (FSC).

The roles of these positions are described below:

Magellan of Virginia Residential Care Manager (RCM)

The RCM will notify the IACCT serving a locality of any youth from that locality referred to Magellan of Virginia for consideration of residential treatment.

In all circumstances, the RCM will:

a. Support the IACCT process by facilitating the collection of required assessments and behavioral and physical health histories;
b. Review the results from the assessments and recommendations of the IACCT and apply the established medical necessity criteria to determine Medicaid funding authorization; and
c. If residential treatment is initiated, the RCM will provide continued oversight around:
    - Treatment plan of care development,
    - Progress toward treatment goals including cans outcomes, and
    - Transition planning for return to the community. The RCM will remain involved with the IACCT following discharge as a coordination resource to ensure the outlined community plan with any necessary service authorizations is in place.

Magellan of Virginia Family Support Coordinator (FSC)

The FSC will perform outreach to the family or guardian to coordinate any face-to-face assessments, encourage and facilitate family engagement in any treatment option decisions, provide education for informed decision making regarding treatment, and offer any other support or assistance to the family throughout the course of treatment. The FSC's primary role is to provide support to the family, helping them to stay involved while their child is in care and preparing for a successful reunification upon the youth's

discharge.

IACCT Staffing Requirements

- Each IACCT team[1] will include at a minimum:
    - A Licensed Mental Health Professional (LMHP) or an approved LMHP Resident or Supervisee (LMHP-resident; LMHP-resident in psychology; or LMHP- supervisee in social work) who performs the required diagnostic assessment, i.e., psychosocial history. The LMHP OR LMHP Resident/Supervisee will collect, review, and/or complete the Child and Adolescent Needs and Strengths Tool (CANS) and Adverse Childhood Experiences (ACEs) screening tool (note, only the Whole Child Assessment-ACEs only or the Center for Youth Wellness ACEs Questionnaire are allowed to be utilized for this required screening).
    - A physician, who either 1) actively sees this member for medical care2) can be accessed through the youth's MCO or 3) is identified by the locality as physician willing to engage in this process with identified youth. Physicians engaged in this process need to have knowledge of the service delivery system and are able to assess the youth's medical history and current status through either a face to face contact scheduled during the IACCT process or via their current health related knowledge of this youth including having seen the youth face to face in the last 13 months; and
    - The youth and family/legally authorized representative who are active participants in the assessment and decision-making process.

It is expected that the team will also include representatives of local agencies and other supports involved in the child's plan of care who will provide information to the team regarding the youth's service history and current level of functioning.

IACCT Required Activities

- Receive and respond to Residential Inquiry requests and IACCT Referrals from Magellan of Virginia of youth[2] to be considered for residential treatment services;
- Determine each youth's appropriate level of care and certify, as appropriate, the need for residential treatment services. Assessment must include psychosocial history, CANS, approved ACEs tool (Center for Youth Wellness-Adverse Childhood Experiences Questionnaire as completed by an MD, PA, of CNP or the Whole Child Assessment – Adverse Childhood Experiences- Only completed by a LMHP or LMHP Supervisee/Resident), medical history and current status; and
- If the youth has had a CANS (including the Magellan of Virginia 2016 CANS or

the Virginia Comprehensive CANS) completed within the last 30 days, the LMHP/LMHP Supervisee/Resident can utilize this CANS for the assessment.

For **contracted IACCT providers** completing the VA CANS Comprehensive, the contracted IACCT provider LMHP or LMHP Resident/Supervisee must transfer the ratings to the Magellan of Virginia CANS 2016 system to submit the CANS 2016 Youth Report with the IACCT SRA.

For **identified IACCT locality partners (MOU with DMAS)**, the LMHP or LMHP Resident/Supervisee will submit the VA CANS Youth Report from CANVaS with the IACCT SRA.

- Adhere to IACCT procedures established by DMAS regulations, provider manuals, and Magellan of Virginia contractual agreements including:
    - Meet all specified timeframes;
    - Assess the youth and family's needs;
    - Apply medical necessity criteria in accordance with DMAS regulations;
    - Ensure the youth is served in the least restrictive environment in accordance with the Department of Justice Settlement Agreement; and
    - Ensure family engagement throughout the assessment process.

- Assume responsibility for assessment of youth in inpatient facilities who are referred for consideration of transfer to a residential treatment facility.[3]
    - The LMHP OR LMHP Resident/Supervisee will assess the youth (expedited, if possible) through either a face-to-face or telemedicine contact. For youth who are currently in an inpatient setting where telemedicine is not available and distance is a barrier for the IACCT LMHP or LMHP Resident/Supervisee, a telephonic interview with the youth may be conducted while the IACCT LMHP or LMHP Resident/Supervisee conducts a face to face with the legal guardian.
    - The LMHP OR LMHP Resident/Supervisee will coordinate with the inpatient facility to gather diagnostic and clinical assessments completed during the youth's inpatient treatment.
    - The LMHP OR LMHP Resident/Supervisee will partner with the inpatient

facility to complete the CON with the facility physician[4] and to make sure all viable options, including community based options, have been explored.

- Participate in care coordination with Magellan of Virginia, the family, the youth's primary physician, the local CSB, the local DSS (as appropriate), the youth's school, and community-based service providers serving the youth and family.
- Ensure family engagement throughout the course of treatment.

[1] Team members may participate in person or by teleconference

[2] Each IACCT will receive referrals for a contracted catchment area. All youth shall be referred to the IACCT serving the city/county of the youth's legal residence.

[3] As an alternative, the responsible IACCT may opt to coordinate with an IACCT in close geographic proximity to the facility to conduct the assessment.

[4] The facility physician cannot be referring to an affiliated residential program. If this is a conflict, Magellan of Virginia will assist in engaging the MCO physician.

IACCT Timeframes (RTS)

1. When a residential inquiry is received by Magellan of Virginia, a Magellan of Virginia Residential Care Manager (RCM) will conduct the education session[5] to the youth and the parent/legally authorized representative.
2. After all education sessions, the parent(s)/legally authorized representatives' wishes for community based services or for engaging in the IACCT process shall be documented. The parent(s)/legally authorized representatives' verbal response for community based services or engaging in the IACCT process shall be documented. Magellan of Virginia will initiate a referral to the identified locality partner or the contracted IACCT provider to begin the IACCT process.

3. The IACCT shall assess the treatment needs of the individual and recommend a level of care ***within 10 business days from the referral*** from Magellan of Virginia.

    a. The LMHP or LMHP Resident/Supervisee will conduct the face to face assessment within two business days of the referral from Magellan of Virginia.

    b. If the youth and parent/legally authorized representative are unable to

attend the face to face appointment ***within two business days***, the LMHP OR LMHP Resident/Supervisee must notify the Magellan of Virginia Residential Care Manager (RCM) of this missed appointment and request a ***3 business day extension***.

c. ***Up to two 3 day extensions*** can be offered due to the youth and parent/legally authorized representative being unable to attend a scheduled appointment.

d. ***Up to two 3 day extensions*** can be offered for challenges engaging a physician in completing a review of a known client or face to face meeting with an unknown client and making Certificate of Need (CON) recommendations.

NOTE: No more than a total of two 3 business day extensions can be given during the IACCT process which allows for a possible 16 business day timeline.

4. If the child has been referred to community based service options via the IACCT process, the IACCT in collaboration with the youth's legal guardian will develop a community based plan of care.

- For **contracted IACCT providers**, the Magellan of Virginia RCM will assist with a referral list for community providers and the RCM and FSC are available to the youth and legal guardian for up to 90 days after the IACCT process is completed so that they can provide ongoing support and care coordination.
- For **identified IACCT locality partners (MOU with DMAS)**, the Magellan of Virginia RCM will assist with a referral list for community providers. The locality partner will be responsible for providing ongoing support and care coordination for the youth and legal guardian.

NOTE: In all cases, when the youth's legal guardian is the LDSS all coordination will occur with the identified LDSS foster care worker as

required by the court.

If a residential treatment level of care has been determined, then the following steps will occur:

a. The CON shall be effective for ***thirty calendar days*** prior to admission.

b. The IACCT shall provide the completed CON to Magellan of Virginia ***within one calendar day*** of completing the CON.

c. The IACCT shall provide the completed CON to the facility ***within one calendar day*** of the facility being identified. Note, if the youth is in an inpatient or residential treatment facility during the IACCT process AND the IACCT process results in determining the youth meets DMAS medical necessity requirements for residential treatment services, the facilities' current CON may be utilized or a facility-based physician engaged in the youth's treatment can complete Magellan of Virginia's Retroactive CON.

5. If the youth has been authorized for residential treatment service options via the IACCT process and medical necessity determination, the RCM will provide a listing of credentialed residential facilities to the youth's legal guardian so that the legal guardian and youth can begin to make their selection of facility based care. The RCM will continue to engage in care coordination at a minimum of every 30 days.

   The RCM and FSC are available to the youth and family throughout the youth's placement in a residential treatment facility.

   When the youth is discharged from a residential facility, the RCM and FSC are available to the youth and (foster care worker) for up to 90 days after discharge from a residential facility to provide ongoing support and care coordination.

6. If the child receives residential treatment services, the IACCT LMHP or LHMP Resident/Supervisee will conduct a reassessment at 90-days or earlier as deemed clinically appropriate. The 90-day reassessment will include a CANS and a psychosocial addendum when there has been a significant life change for the youth or family. The reassessment process with include a review of CANS outcomes as it relates to treatment recommendations via the completion of the Magellan of Virginia Re-Assessment Clinical CANS grid.

- For **contracted IACCT providers,** the Magellan of Virginia System will produce individualized CANS outcome reports that the LMHP or LMHP Supervisee/Resident can utilize to complete the Magellan of Virginia Re-Assessment Clinical CANS grid.
- For **identified IACCT locality partners (MOU with DMAS)**, all CANs will be submitted via attachment and therefore the Magellan of Virginia System cannot produce individualized CANS outcome reports. The LMHP or LMHP Supervisee/Resident will need to compare the initial and 90 day CANS items submission to complete the required Magellan of Virginia Re-Assessment Clinical CANS grid.

For youth with a Certificate of Need (CON) completed prior to July 1 2017, Magellan will require the following from the PRTF or TGH provider when submitting a continued stay request:

- Youth connected with Children's Services Act (CSA):

  i. Service Authorization Request form (Continued Stay), Comprehensive Individual Plan of Care (CIPOC), Rate Sheet, Child and Adolescent Needs and Strengths Assessment (CANS); and
  ii. Attach the CANS to the Facility Service Authorization Request Form versus inputting into Managed Outcomes for the IACCT process at www.MagellanProvider.com.

- Youth not connected with CSA:

  i. Service Authorization Request form (Continued Stay), CIPOC; and

  ii. Continued stay criteria for these members with a CON completed prior to July 1, 2017 shall be met as defined in the Criteria for Continued Stay sections for PRTF and TGH in Chapter 4 of the Residential Treatment Services Manual.

[5] Education Session will ensure that the parent(s)/legally authorized representative(s) is aware of community resources and understands the IACCT process so that they can consider the least restrictive mental health services available that best meet the needs of their child.

IACCT Processes (RTS)

Members Eligible for Medicaid at the Time of Admission

For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP. An individual's parent or legally authorized representative shall be included in the certification process.

Emergency Placements for Foster Care Youth

DMAS and the LDSS have completed final edits on the Residential Treatment Regulations to defer to DSS for guidance on defining emergency placements for foster care youth. The emergency placements for both Medicaid eligible and non-Medicaid eligible foster care youth will be allowed to be admitted to a PRTF or a TGH immediately according to DSS protocol that will ensure all potential community placement options are not viable prior to placing a child into services. The IACCT will receive notice of all emergency placements from the PRTF or the TGH within five days of admission to care or five days from the date that Medicaid eligibility and coverage begins. For emergency admissions, the certification must be made by the team responsible for the comprehensive individual plan of care (CIPOC) within 14 calendar days after admission. These certifications of need for these “emergency admissions” shall be made by the team responsible for the CIPOC and the certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid. After processing an emergency admission, the PRTF or TGH shall notify Magellan of Virginia of the individual's status as being under the care of the facility within 5 days.

The Facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children’s residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the individual is Medicaid eligible at the time of admission and is referred to the IACCT within 5 days of admission or within 5 days of being determined eligible for Medicaid.

Individuals Not Medicaid Eligible at Admission to Residential Treatment Services

For individuals who apply and become eligible for Medicaid while admitted to PRTF or TGH, the certification shall be made by the team responsible for the CIPOC and certification of need (CON), within 14 calendar days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children's residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the individual is Medicaid eligible at the time of admission and is referred to the IACCT within 5 calendar days of admission or within 5 calendar days of being determined eligible for Medicaid.

All individuals entering a PRTF or TGH utilizing private medical insurance who will become eligible for enrollment in Medicaid within 30 days following the facility admission are required to have an independent certification of need completed by the team responsible for the plan of care at the facility will provide the certificate of need using the facilities treatment team within 14 calendar days from admission. The team providing the certificate of need must include the following professionals:

- In IACCT Special Considerations, the CON is completed by the team responsible for the plan of care in emergency and retroactive placements.

The team responsible for the plan of care shall include in TGH, as a minimum must include:

1. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
2. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify Magellan of Virginia of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

The LMHP must sign off on the CON for the TGH settings.

The team responsible for the plan of care shall include in PRTF, as a minimum must

include:

1. A Board-eligible or Board-certified psychiatrist; or
2. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
3. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify Magellan of Virginia of the individual's status as being under the care of the facility within five calendar days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

The Psychiatrist must sign off on the CON for the PRFT settings.

Inpatient Transfer to Residential Services

1. Upon a member's admission to an inpatient facility, the facility will assess for viable discharge treatment options and develop an initial discharge plan.
2. If residential services are recommended as an option for the discharge plan, the inpatient facility will submit an online residential inquiry form to Magellan of Virginia within one business day. Alternatively, this form can be completed telephonically with Magellan of Virginia during a concurrent review.
3. When the legal guardian gives permission to move forward with the residential referral, Magellan of Virginia will contact the IACCT LMHP to begin the IACCT assessment process. The IACCT LMHP will schedule a face-to-face or telemedicine assessment (expedited, if possible), and will coordinate with the inpatient facility to gather any diagnostic and clinical assessments that were completed during the member's inpatient treatment.

4. If the member is clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will arrange community-based services to maintain member's stability during IACCT process.
5. If the member is not clinically stable enough to return to the community during

the IACCT assessment process, the inpatient facility will complete the certificate of need and engage in an acute discharge planning process.

Additional information about the IACCT process is available on the Magellan of Virginia website at: Residential Service Changes.

Questions about the IACCT process may be directed by email to: RTCChange@dmas.virginia.gov.

Psychiatric Residential Treatment Facility Covered Services (RTS)

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. Signature and date by the youth, parent, or legally authorized representative, a physician and treatment team members.
b. Plans for discharge; and
c. plans for continuing care, including review and modification to the plan of care;
d. 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;
e. Treatment objectives with short-term and long-term goals;
f. A description of the functional level of the youth;
g. diagnoses, symptoms, complaints, and complications indicating the need for admission;
h. Youth and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;

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.

b. 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.
c. 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
d. 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;
e. 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;
f. 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;

5.

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.

a. The team shall also include one of the following: an LMHP, LMHP-S, LMHP-R, LMHP-RP
    1. 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.
    2. a licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or
    3. a board-eligible or board-certified psychiatrist;
b. The team shall include either:
c. 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.

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 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.
9. 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.

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 Magellan of Virginia. 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.

- 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.
- 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.

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 either the MCO or Magellan of Virginia 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 Magellan of Virginia for review with its service authorization request. Once Magellan of Virginia 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 Magellan of Virginia of all scheduled appointments within 30 calendar days of discharge, and shall notify Magellan of Virginia within one business day of the youth's discharge date from the PRTF. Failure to notify Magellan of Virginia of discharges can delay or prevent the youth from accessing needed medical, behavioral health, dental and pharmacy benefits and prevents Magellan 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 Magellan of Virginia 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 he or she were not in a PRTF, 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 Magellan of Virginia 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 Magellan of Virginia within one business day of the occurrence.

Facilities must report any serious incident involving a resident to Magellan of Virginia within one business day of the occurrence.

Please submit the following information to Magellan of Virginia via fax (888-656-5396):

- Youth's name and Medicaid number;
- Facility name, address, and NPI number;
- Name(s) of staff members and ordering physician involved;
- Detailed description of the incident and the staff debriefing that occurred following the incident;
- Dates and location of the incident;
- Outcome, including all persons notified; and

- Current location of the youth.

Service Exclusions

- PRTF services may not be billed concurrently with any Community Mental Health Rehabilitative Services, with the following exception: Intensive In-Home Services for Children and Adolescents may be billed for up to seven days immediately prior to discharge from a PRTF, to transition the youth from the PRTF to home.

- 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 (RTS)

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 Magellan of Virginia. 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 either the MCO or Magellan of Virginia care manager 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 Magellan of Virginia 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 Magellan of Virginia of all scheduled appointments within 30 calendar days of discharge, and shall notify Magellan of Virginia 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 Community Mental Health Rehabilitative Services (CMHRS), with the following exceptions:

- Intensive In-Home Services for Children and Adolescents may be billed for up to seven days immediately prior to discharge from a TGH, to transition the youth from the TGH to home, as applicable.
- School based Therapeutic Day Treatment.
- 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 Chapter IV of the CMHRS Manual for additional details.

Early Periodic Screening, Diagnosis and Treatment (RTS)

Residential Treatment Facility and Therapeutic Group Home Services

Background Discussion

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT fosters the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the

problem becomes complex and treatment more costly and has more of an impact on the individual and the family. Examination and treatment services are provided at no cost to the Medicaid member.

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 child 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 individual.

EPSDT Service Definition

EPSDT residential treatment services includes, but is not limited to clinically directed programming including applied behavior analysis and other evidence based/evidence informed 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 individual and family becomes able to more effectively manage the individual'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 individual.

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 therapeutic group homes, and residential treatment facilities on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS, the DMAS contractor, or Magellan of Virginia.

All service requirements including but not limited to independent certification team,

interventions, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT residential treatment, or therapeutic group home services.

The psychiatric, psychological and behavioral therapies that the individual 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 children 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. Children must exhibit intensive behavioral challenges to be authorized for services.

- EPSDT Residential Treatment services are available to individuals who: are under 21 years of age and enrolled in Medicaid.

- EPSDT Residential Treatment services for Medicaid eligible children with developmental disabilities are service authorized and billed through Magellan of Virginia.

Covered Services

- Behavioral modification services to increase the individual's adaptive functioning and communication skills;
- Training of family members to improve the child'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 as noted earlier in the chart earlier in this chapter for services provided under arrangement, provided that the requirements discussed in this section are met;

- Behavioral modification services and direct consultation by the Licensed Behavior Analyst (LBA) or LBA - Assistant with direct services staff, and other professionals and paraprofessionals involved in the child's overall treatment and/or implementation of the behavior modification 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

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

Ancillary services such as assessment and counseling will be delivered using evidence based and evidence informed treatment approaches specific to the needs of the individual receiving the residential treatment service. Specific reimbursement coding options are **available on the Magellan of Virginia website at: Process Changes: Psychiatric Residential Treatment Facility.**

Questions about the EPSDT services may be directed by email to: RTCChange@dmas.virginia.gov.

Limitations

- All services require authorization for reimbursement.

- Certain EPSDT DD Waiver Services are not allowed simultaneously with EPSDT

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.

I. 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 an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual 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 individual'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 individual would be at risk to self or others if he or she were not in a residential treatment program,

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

F. The individual 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, C, and D 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 individual 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 individual's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the individual to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. 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.

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:
   a. 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
   b. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), or
   c. 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 individual 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 individual'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 IIIA, 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 covered when one or more of the following exists.

A. The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting.

B. The required treatment, Activity of Daily Living supports and behavioral supports can be provided in a less restrictive environment.

C. There is documented evidence, from the use of day and overnight pass that the individual has been able to function safely and satisfactorily with the community:

D. There has been no documented evidence of a change in treatment or behavioral support plan when the member has not responded for a 30 day period.

E. Reimbursement shall not be made for this level of care if any of the following applies:
    1. The level of functioning has improved with respect to the goals outlined in the CIPOC and the member can reasonably expected to maintain these gains at a lower level of treatment; or
    2. The member no longer benefits from services as determined by the oversight physician.

EPSDT Medical Necessity Treatment for TGH (RTS)

The child must require services from multiple disciplines. Behavioral modifications strategies must require the clinical oversight of a Licensed Mental Health Provider, or a Board Certified Behavioral Analyst.

Individuals 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 an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual 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 individual'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 therapeutic group home services.
C. There is clinical evidence that the individual would be at risk to self or others if he or she were not in a therapeutic group home.

D. The individual 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 therapeutic group home setting.

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

F. The individual 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 (Must meet A-F):

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

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

C. The individual'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 individual would be at risk for hospitalization or a higher level of care without such placement.

D. It has been documented that the individual 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 individual 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 individuals with DD/ASD in order to ensure member and milieu safety.

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

Admission - Intensity and Quality of Service

Criteria A, B, C, and D 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 individual 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 individual's community resources, including the local school division and FAPT case manager as appropriate, with the goal of returning the individual to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

D. 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.

Continued Stay Criteria (Must Meet All)

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 member's CIPOC or the member 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 member has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.
2. The member 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 member is not making progress, and the CIPOC has been modified to identify more effective interventions.
4. There are current indications that the member requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

C. As member 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 member to less intensive behavioral intervention and a less intensive level of care.

Discharge Criteria (Must Meet One)

Continued residential level of care is not appropriate and will not be covered when one or more of the following exists.

A. The stabilization of presenting symptoms and behavioral/mental health conditions with demonstrated ability to function appropriate within residential environment and community setting.

B. The required treatment, ADL supports and behavioral supports can be provided in a less restrictive environment.

C. There is documented evidence, from the use of day and overnight pass that the individual has been able to function safely and satisfactorily with the community.

D. There has been no documented evidence of a change in treatment or behavioral support plan when the member has not responded for a 30 day period.

E. Reimbursement shall not be made for this level of care if any of the following applies:
    1. The level of functioning has improved with respect to the goals outlined in the CIPOC and the member can reasonably expected to maintain these gains at a lower level of treatment; or

    2. The member no longer benefits from services as determined by the oversight physician.

EPSDT 1:1 Services Criteria

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

- The treatment team must document the need for 1:1 support in the individualized assessment of the member. 1:1 supports must be included in the plan of care and be ordered by a physician.

- 1:1 supports may be appropriate in the following situations; when a member demonstrates:

  - Serious suicidal intent;

  - The member verbalizes, gestures, or otherwise expresses an intent to inflict, or attempts to inflict, self-injury that would pose a threat to life;

  - High risk for imminent attempts at elopement, evidenced by elopement attempt, or clear plan to elope;

  - Severe physical aggression towards staff and/or other individual; active or recent homicidal threat to staff and/or other individuals; unpredictable physical aggression; or

  - A severe health risk; the individual's behaviors are a severe health and safety risk to self or others. Accommodations (consisting of support for activities of daily living) for physical disabilities are not an appropriate use of 1:1 supports.

- The need for 1:1 supports must be reviewed at least weekly by the treatment team and the physician to determine if the member continues to meet criteria for this level of monitoring. Daily progress notes shall include the member's response to the intensive treatment supervision.

- The staff providing 1:1 supports must be no more than an "arm's length" away from the member at all times unless the individual is actively transitioning to a lesser level of supervision and 1:1 supports are "fading" as the individual 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.

- Should the member continue to pose a threat to self or others, the treating physician needs to be notified. Member shall be assessed for possible acute hospitalization.

- 1:1 supports is not appropriate during nighttime hours if the member typically is sleeping. However, staff continues to be responsible for monitoring member activity during any interrupted sleep.

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

- 1:1 supports will be authorized based on the individual needs of the member at the time of the authorization request.

Criteria for Discontinuing 1:1 Supports

1:1 Supports shall be discontinued if the following occurs:

- No incidences of severe physical aggression or homicidal threats in the previous 7 days.

- No attempts to elope in the previous 7 days.
- No serious attempts to harm self or others in the previous 7 days.
- No verbalization, gestures or expressions of intent to hurt self or others in the previous 7 days.
- Verbal or written safety contract between member and staff addressing issues which necessitated 1:1 supports is developed, dated and signed.

The provider must submit documentation supporting the need for continued 1:1 supports, an approximate schedule of 1:1 hours, the updated comprehensive plan of care, 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 member from meeting their treatment goals.

- Special consideration should be given to individuals 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 member.

Billing (RTS)

INTRODUCTION

Behavioral Health Services Administrator (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and

is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Utilization Review and Control (RTS)

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of care and services paid by Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts

455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS or its contractor, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction. DMAS and the MCOs will perform the financial review and verification of services for their contracted providers to ensure that the provider bills for services consistent with the DMAS policy as well as with the provider's contract with the MCO.

Utilization Review (UR) - General Requirements

Utilization reviews of enrolled providers of residential treatment services are conducted by DMAS or it designated contractor. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

UR is comprised of desk audits, on-site record review, and may include observation of service delivery. It may include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may be asked to bring program and billing records to a central location within their organization.

DMAS and/or Magellan shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations.

Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Upon completion of a UR, DMAS staff or its designated contractor(s) may be available to meet either face to face or telephonically with provider staff. The purpose of the Exit Conference is to provide a general overview of the UR procedures and expected timetables. DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be outlined and DMAS will cite federal or state regulations and policy and procedures that were not followed. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. Their request notice is considered filed when it is received by DMAS. The provider’s response and any additional information provided will be reviewed. At the conclusion of the review, DMAS staff will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the facility address on record.

If a billing adjustment is needed, it will be specified in the final audit findings report. If a Plan of Correction is also offered and requested, the provider will have 30 days (unless otherwise indicated) from receipt of the final audit findings report to submit the plan to DMAS or its designated contractor(s) for approval.

Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

If DMAS requests a corrective action plan, the provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review.

Appeals

If the provider disagrees with the final audit findings report they may appeal the findings by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of this letter. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be Sent to:

Appeals Division

Department of Medical Assistance
Services 600 East Broad
Street Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be considered untimely.

Documentation Requirements for Residential Treatment Services Including Psychiatric Residential Treament Facilities (PRTF) and Therapeutic Group Homes (RTS)

The Provider Agreement and Magellan contract requires that records fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical or clinical necessity and document how the individual's service needs match the level of care criteria for the service. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered. Psychiatric Residential Treatment Facility Services that fail to meet Medicaid criteria are not reimbursable. If the required components are not present or do not comply with

the documentation criteria, reimbursement will be retracted.

Some Medicaid covered services require an approved service authorization prior to service delivery in order for reimbursement to occur. To obtain service authorization, all providers' information supplied to the DMAS service authorization contractor, or the behavioral health service authorization contractor shall be fully substantiated throughout individuals' medical records.

To describe the service, review the service description, select the procedure code in accord with your Magellan contract which describes the service rendered and documented, and enter the appropriate procedure code in the record. Providers must have the correct service license from the Department of Behavioral Health and Developmental Services (DBHDS) in order to secure service authorizations and registrations, provide the service and be reimbursed for the service. The service descriptions will be used to evaluate the documentation during audits of records. The following elements are a clarification of Medicaid policy regarding documentation:

- The individual must be referenced on each page of the record by full name or Medicaid ID number.
- The provider must maintain a copy of the entire certificate of need and any psychosocial assessment, Independent Assessment. Certification and Coordination Team (IACCT) assessments and re-assessments to include any clinical assessment documentation conducted while the individual received residential treatment services.
- There must be documentation indicating that the individual was included in the development of the Initial Plan of Care (IPOC) and Comprehensive Individual Plan of Care (CIPOC). The IPOC and CIPOC shall be signed by the individual. The IPOC AND CIPOC shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal competency, is unable or unwilling to sign the IPOC AND CIPOC.

- The CIPOC shall be a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment and as the needs and progress of the individual changes.
- The CIPOC contains treatment or training needs, goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services.
- All interventions and the planned and allowable settings of the intervention shall be defined in the Initial and Comprehensive Plan of Care. Documentation shall

include how all identified intervention and settings meet the treatment needs of the individual.

- All CIPOCs shall be completed, signed, and contemporaneously dated by the team responsible for the plan of treatment. The child's or adolescent's CIPOC shall also be signed by the parent/legal guardian and the adult individual shall sign his own. If the individual, whether a child, adolescent, or an adult, is unwilling to sign the CIPOC, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the CIPOC. Signatures shall be obtained unless there is a medical or clinical reason that renders the individual unable to sign the CIPOC.
- The CIPOC must be reviewed at a minimum, every 30 days by a PRTF treatment team and every 60 days by a TGH treatment team to determine if the goals and objectives meet the needs of the individual based on the most recent clinical review of the service documentation and assessment of functioning. The provider must evaluate and update the member's progress toward meeting the objectives and document the outcome of this review. The CIPOC shall be rewritten at least annually.
- If an individual receiving TGH services is also receiving case management services the provider shall collaborate with the case manager by notifying the case manager of the provision of residential treatment services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the case manager within 30 calendar days of the discontinuation of services.
- Any drugs prescribed as a part of the treatment, including the prescribed quantities and the dosage, must be entered in the record.
- If the service being provided allows the utilization of paraprofessional staff, then the documentation of supervision must meet criteria set forth in Chapters II and IV of this manual.

- A member-signed document verifying freedom of choice of provider was offered and this provider was chosen.
- All medical record entries must include the dated signature of the author.
- A member signed document verifying that the individual was notified of their appeal rights in the event of an adverse outcome.
- Care coordination between all health care service providers who are involved in the individual’s care is required and must be documented in the CIPOC and Progress Notes.

Daily Service Documentation and Medical Record Entries for PRTF and TGH (RTS)

DAILY SERVICE DOCUMENTATION AND MEDICAL RECORD ENTRIES FOR PRTF AND TGH

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid members who are in providers' care. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. Daily service documentation shall support the medical necessity criteria and how the youth's needs for the service match the level of care criteria. **This documentation shall be written, signed, and dated at the time the services are rendered or within one business day from the time the services were rendered.**

The daily 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;
- The amount of time or units/hours spent in the delivery of service. The content of each progress note shall corroborate the time/units billed;
- Specific interventions used;
- How the intervention relates to the youth's stated goals and objectives as contained in the plan of care;
- The youth's response to the intervention;
- Reasons for missed interventions to include: when the intervention was scheduled, the barrier to providing the intervention, how this barrier was addressed and any necessary adjustments to the plan of care to address the barrier;
- Documentation of therapeutic passes and related interventions;
- Family engagement activities and routine family contact or attempts at providing the activity and related follow up coordination with LDSS, Magellan of Virginia and others involved in the treatment team and family engagement process.
- For instances where there is a lack of family engagement with the identified family, documentation shall include: dates of scheduled family engagement; any barriers to family engagement; steps to overcome barriers; plans for future family engagement; and, adjustments to the plan of care based on the family engagement plan; and
- Care coordination documentation.

Medical Record Entries:

The facility or agency must maintain medical records on all youths in accordance with accepted professional standards and practice. The records must be completely and

accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

Each psychiatric treatment session must be written on the date when the service is rendered or within one business day from the time the services were rendered and must include the dated signature of the professional rendering the service.

All psychiatric treatment medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used. For additional information on physician signatures, refer to the Medicaid *Physician Manual*.

Progress Notes

DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-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.

- Progress notes must contain 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 case-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 CIPOC.

Utilization Review of Psychiatric Residential Treatment Services and Therapeutic Group Homes (RTS)

Medicaid criteria for reimbursement of residential treatment services are found throughout the provider manual. Utilization review will include, but is not limited

to review of:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed as Medicaid providers of residential treatment services.
- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009);
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.);
- The appropriateness of the admission to service and for the level of care based upon the service definition, the service specific provider intake, and medical necessity criteria.
- The medical or clinical necessity of the delivered service;
- A copy of the provider's license/certification, staff licenses, and qualifications for Licensed Mental Health Professional (LMHP, LMHP-R, LMHP-S and LMHP-RP), Qualified Mental Health Professional (QMHP), and paraprofessionals to ensure that the services were provided by appropriately qualified individuals as defined in Chapter II of this manual;
- Certificate of Need signed by the required team members, with a recommendation to admit the individual to inpatient services and an indication of why community resources do not meet the individual's needs;
- Written IPOC and CIPOC completed by specified professionals and addressing the components listed in Chapter IV of this manual;
- Timely review of the written Plan of Care;
- Dated signatures of qualified service providers on all medical documentation;
- Ensure documentation supports QMHP supervision of QPPMH staff as set forth in Chapter 2 and that staff who do not meet the minimum QPPMH are working directly with a minimum QPPMH who is supervised by a QMHP;
- A current, signed initial plan of care (IPOC) and Comprehensive Plan of Care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC;

- Documentation that the individual is involved, to the extent of his/her ability, in the development of the IPOC and CIPOC;
- A determination that the delivered services as documented are consistent with the individual's Initial and Comprehensive Individual Plan of Care(CIPOC), invoices

submitted, and specified service limitations;

- A determination that the delivered services are provided by qualified staff that meet the minimum requirement for the service being delivered and the provision of all ordered services in the individual's written treatment plan by qualified professionals;
- As indicated, supervision of QPPMH staff is documented and included in the clinical record;
- A determination that for residential treatment services requiring service authorization, the medical record content corroborates information provided to Magellan;
- The reviewer determines whether appropriate activities are billed under the assessment code, that all required data elements are met, and that the assessment code is otherwise being used appropriately;
- The reviewer determines that all documentation is specific to the individual. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services;
- The reviewer determines whether the provider has maintained medical records sufficient to document fully and accurately the nature, scope and details of the health care provided;
- The reviewer determines whether all required aspects of treatment are being provided, and also determines whether there is any inappropriate overlap or duplication of services;
- The reviewer determines whether all required activities/service requirements (as set forth in the appropriate sections of the residential treatment manual and related regulations) have been performed;
- The reviewer determines whether inappropriate items (i.e. staff travel time tutoring, mentoring) have been billed; and
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

Specific Utilization Review for Psychiatric Residential Treatment:

- Validation that after admission the team responsible for the CIPOC recertified that the individual continues to require inpatient services in a psychiatric facility at least every 30 days and the certificate of need was approved by a physician acting

within their scope of practice as defined by state law;
- Validation of documentation received during the preauthorization process;
- Validation that all required provision of services are be fully documented in the medical record; and
- Verify compliance with restraint and seclusion regulations (42 CFR §§ 483.350 – 483.376) including the reporting of serious incidents and each instance of seclusion and restraint including the communication to family members or legally authorized representatives.

For Services Provided Under Arrangement (PRTF Only):

- Services provided under arrangement, needed while residing in a PRTF, must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of a service provided under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Inpatient Psychiatric Facilities (IPFs) should begin preparations now to include routine or expected services provided under arrangement in each plan of care.
- Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.
- Each IPF must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. As a provider of services under arrangement, the prescribing provider must be employed or have a contract with the facility. Referrals should not be documented unless the provider has accepted the referral.

- Providers of services under arrangement must either be employees of the IPF or, if they are not employees of the IPF, they must have a fully executed contract with the IPF in advance of provision of the service, with the exception of emergency services. For emergency services, the contract must be executed before the provider of emergency services bills DMAS for the emergency services. IPFs

should begin preparations now to contract with usual providers of services under arrangement who are not employees of the IPF.

- The contract must include the following: 1) if the provider of services under arrangement accepts a referral, it agrees to include the NPI of the referring IPF on its claim for payment; and 2) the provider of services under arrangement agrees to provide medical records related to the member residing in the IPF upon request. A fully executed contract requires that a representative of the IPF and a representative of the provider of services under arrangement signs the contract and includes their name, title, and date. A letter of understanding or letter of agreement will meet the requirement for a contract, provided that both the IPF and provider of services under arrangement sign the letter.
- Each IPF must maintain medical records from the provider of services under arrangement in the individual's medical record at the facility. These may include admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings. These records must be requested in writing by the IPF within seven (7) calendar days of discharge from or completion of the service provided under arrangement. If the records are not received from the provider of services under arrangement within 30 days of the initial request, they must be re-requested.
- If there is the potential for retroactive Medicaid eligibility, the IPF should comply with these requirements so that the provider of services under arrangement can bill Medicaid after eligibility is confirmed.
- The referral from the IPF shall be documented in the records of the provider of services under arrangement.

Medical Records and Record Retention (RTS)

MEDICAL RECORDS AND RECORD RETENTION

The provider must recognize the confidentiality of individuals' medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The individual's written consent is required for the release of information not authorized by law. Documentation in all current individual medical records and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of all outpatient psychiatric services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the individual to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). ***Refer to 42 CFR***

485.721 for additional requirements.

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment and the supervisor of the MHUR/Hospital Utilization Review Unit in writing within 30 calendar days of the effective date of the change. Information required concerning the change includes, but is not restricted to, the effective date of the change and who will have custody of the files/records. Send notice to:

Department of Medical Assistance Services

Hospital Utilization Review Supervisor

600 E. Broad Street, Suite 1300

Richmond, Virginia 23219

Or

Department of Medical Assistance Services

Provider Enrollment

600 E. Broad Street, Suite 1300

Richmond, Virginia 23219

Fee- for-service providers must notify Magellan of Virginia via VAProviders@MagellanofVirginia.com.

Fraudulent Claims (Psych)

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law. Some examples of falsifying records include, but are not limited to:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Writing over, or adding to existing documentation (except as described in late entries, addendums or corrections, which would include the dated signature of the amendments)

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The Virginia Medicaid Program, DMAS, maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations, Medicaid Memos, the provider agreement, Magellan of Virginia and MCO contract if applicable, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee or business contractor providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 692-0480

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit Office of
the Attorney General

900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Reports may be made to Magellan of Virginia via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

Member Fraud

Allegations about fraud or abuse by individuals are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Recipient Audit Unit at (804)786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804)

786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Program Manager, Recipient Audit Unit Program
Integrity Division

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Referrals To the Client Medical Management (CMM) Program

DMAS providers may refer individuals receiving Medicaid/FAMIS Plus or FAMIS benefits who are suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services. Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Division

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

To contact by telephone, 1-804-786-6548, or the CMM HELPLINE AT 1-888-323-0589. When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his/her name and telephone number in case DMAS has

questions regarding the referral.

Appendix C: Procedures Regarding Service Authorization of Residential Treatment Services

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Introduction

Service authorization is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some require service registration.

Service Registration

Registration is a key element to the success of a care coordination model. Registering a service with Magellan of Virginia as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

When registration is required, the preferred method is to log into www.MagellanofVirginia.com and follow the protocol for registering the requested service. Please note that registration is necessary for claims to be paid.

Registration is a means of notifying Magellan of Virginia that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should register the start of any new service within two (2) business days of the service start date. Registration is required for Mental Health Case Management

services effective December 1, 2013. Registration is required for Crisis Intervention and Crisis Stabilization Services effective April 1, 2014.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan of Virginia include: (1) the individual's name and Medicaid/FAMIS identification number; (ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address. The provider should also have at least a provisional behavioral health related diagnosis for the individual being served.

Claims payments will be delayed if the registration is not completed.

Service Authorizations

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS and Magellan of Virginia criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorizations for Psychiatric Residential Treatment Facilities (PFTF) and Therapeutic Group Home (TGH) services are performed by Magellan of Virginia.

Service Authorization is required for the following services:

- Therapeutic Group Home Services: H2020 HW (CSA); H2020 HK (non-CSA)
- Psychiatric Residential Treatment Facility: Revenue Code 1001 (CSA); Revenue Code 1001 (non-CSA)

- EPSDT Therapeutic Group Home Services: H0019
- EPSDT Psychiatric Residential Treatment Facility: T2048 Revenue Code 0961
- EPSDT One-to-One Services: H2027

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

When a service authorization is required, follow the Magellan of Virginia's service authorization process by completing the applicable authorization request methodology [i.e., Request Higher Level of Care, Service Request Application (SRA), or Treatment Request Form]. Specifics regarding service authorization requests can be located at www.MagellanofVirginia.com.

Magellan of Virginia will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the service authorization entity notifies the youth and the provider in writing of the status of the request.

Magellan of Virginia will make an authorization determination based upon the information provided and, if approved, will address the type of service(s), number of sessions or days authorized, and a start- and end-date for authorized services in the authorization determination;

Retrospective review will be performed when a provider is notified of a youth's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service

authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the youth's Medicaid eligibility determination.

Once authorization is obtained, if the youth is discharged from the service and there are dates of service and units that have not been used, the provider must contact Magellan of Virginia to notify them of discharge from service so that the remaining dates or units may be available at a later date, or by another provider.

Magellan's of Virginia MIS system has edits that do not allow the same service to be authorized for different providers for the same dates. In the case where a second provider makes a request for dates that overlap, with the first provider on file, the second provider should contact the previous provider to advise that the service authorization needs to be ended. Should the second provider not be successful in obtaining release of the initial service authorization, Magellan of Virginia will then make one attempt to contact the previous provider to obtain an end date. If there is no response by the prior provider, the service authorization and the second provider's request is processed.

Providers should request a cancellation of a service authorization when there has been no service utilization within the authorized date span. Canceling a service authorization means that it never should have existed and no claims will be or have been billed against the service authorization.

If the initial period you requested is denied and the youth later meets criteria a new request may be submitted for the current dates of service as long as that request is not a retro-request for service. The new request must explain how and why they now meet criteria.

Providers are responsible to keep track of utilization of services, regardless of the number of providers. Magellan of Virginia has provided various methods for the providers to research utilization.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at

https://www.magellanprovider.com/MagellanProvider.

Retro Medicaid Eligibility

Retroactive requests for authorizations will not be approved with the exception of retroactive Medicaid eligibility for the youth. When retroactive eligibility is obtained, the request for authorization must be submitted no later than 30 calendar days from the date that the youth's Medicaid was activated; if the request is submitted later than 30 calendar days from the date of activation, the request will be authorized beginning on the date it was received.

Changes in Medicaid Assignment

Service authorization decisions by Magellan of Virginia are based upon clinical review and apply only to youth enrolled in Medicaid fee-for-service on dates of service requested. Magellan of Virginia's decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify the youth's eligibility and to check for MCO enrollment. For MCO enrolled youth, the provider must follow the MCO's service authorization policy and billing guidelines.

Youth Who Are Enrolled With DMAS Contracted Managed Care Organizations (MCOs)

Many Medicaid youth are enrolled with one of DMAS' contracted MCOs. In order to be reimbursed for services provided to an MCO enrolled youth that are included in the MCO contract, providers must contract with and follow their respective contract with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service youth. For detailed information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Additional information about the CCC Plus program can be found at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Youth who are authorized by Magellan of Virginia into PRTFs and EPSDT PRTFs will be

disenrolled from the MCO as PRTF services are reimbursed for all Medicaid youth through the Medicaid fee-for-service program. TGH services and EPSDT TGH services are carved-out of the MCO contracts and are reimbursed directly through Medicaid fee-for-service. See the table below for additional information. TGH providers should contact the youth's MCO to arrange for services that are allowed to be reimbursed outside the TGH per diem and that are included in the managed care contract.

Service	**In MCO Contract?**	**Comments**
Therapeutic Group Home	No	For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines.
EPSDT Therapeutic Group Home	No	For MCO enrolled youth, the provider must follow the DMAS coverage rules and guidelines
Psychiatric Residential Treatment Facility	No	MCO Exclusion-Disenrollment
EPSDT Psychiatric Residential Treatment Facility	No	MCO Exclusion-Disenrollment

Communication

Provider manuals are located on the DMAS website and Provider Handbooks are located on the Magellan of Virginia websites. Magellan of Virginia's website has information related to the service authorization processes for programs identified in this manual. Providers under contract with Magellan of Virginia should consult the Magellan National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider for additional information.

Magellan of Virginia provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the Residential Treatment Services manual and the Magellan of Virginia Handbooks.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION/REGISTRATION

Medical Necessity Review Process Changes

Effective July 1, 2017, PRTF and TGH services began using different Medical Necessity Criteria and the IACCT review process.

Authorizations will be issued using a maximum duration of 30 calendar days per admission based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care.

The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination. See the IACCT appendix to this manual for additional information.

The service review process used by Magellan of Virginia will assess the plan of care and treatment plan to determine if the services are adequate to treat the youth's needs in the PRTF or TGH setting. The Magellan of Virginia review will focus more intensively on the quality of care for the youth while in the residential service setting.

Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Service Authorization requirements applicable to both TGHs and PRTFs:

1. Authorization shall be required and shall be conducted by Magellan of Virginia using medical necessity criteria specified in this manual.
2. Youth shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this manual to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the youth will require a mental health evaluation by an LMHP, LMHP-R, LMHP-RP or LMHP-S employed or contracted with the independent certification team to establish a diagnosis, recommend and coordinate referral to the available treatment options.
3. At authorization, an initial length of stay shall be agreed upon by the youth and parent or legally authorized representative with the treating provider and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement and obtaining authorization for continued stay.
4. Information that is required to obtain authorization for these services shall include:
    a. A completed state-designated uniform assessment instrument approved by DMAS completed no more than 30 calendar days prior to the date of submission;
    b. A certificate of need completed by an independent certification team specifying all of the following:
        i. the ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the youth;
        ii. alternative community-based care was not successful;
        iii. proper treatment of the youth's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and
        iv. the services can reasonably be expected to improve the youth's condition or prevent further regression so that a more intensive level of care will not be needed;
    c. Diagnosis, as defined in the most current Diagnostic Statistical Manual (DSM), and based on an evaluation by a LMHP, LMHP-R, LMHP-RP or LMHP-S

completed within 30 days of admission or if the diagnosis is confirmed, in writing, by an LMHP, LMHP-R, LMHP-RP or LMHP-S after reviewing a previous evaluation completed within one year of admission;

d. A description of the youth's behavior during the seven days immediately prior to admission;

e. A description of alternate placements and CMHRS and traditional behavioral health services pursued and attempted and the outcomes of each service;

f. The youth's level of functioning and clinical stability;

g. The level of family involvement and supports available; and

h. The initial plan of care (IPOC).

5. For a continued stay authorization or a reauthorization to occur, the youth shall meet the medical necessity criteria as defined in this manual to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS or its contractor. A current Comprehensive Individual Plan of Care (CIPOC) and a current (within 30 calendar days) summary of progress related to the goals and objectives of the CIPOC shall be submitted to DMAS or its contractor. The service provider shall also submit:
   a. A state uniform assessment instrument if updated since the last service authorization request;

   b. Documentation that the required services have been provided as defined in the CIPOC;

   c. Current (within the last 14 calendar days) information on progress related to the achievement of all treatment and discharge-related goals; and

   d. A description of the youth's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

6. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services requirements applicable to TGH and PRTFs: Service limits may be exceeded based on medical necessity for youth eligible for EPSDT. EPSDT services may involve service modalities not available to other youth, 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 DMAS or its contractor. In unique EPSDT cases, DMAS or its contractor 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 youth. 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 CIPOC and approved for reimbursement by DMAS or its contractor. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT PRTF or TGH.

7. Both initial and concurrent authorizations will be issued using a maximum duration of 30 calendar days based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. Initial EPSDT cases will be authorized for a maximum duration of 60 calendar days based on medical necessity requirements. Concurrent EPSDT cases will be authorized for a maximum duration of 90 days based on medical necessity requirements.

8. If a youth requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 7 days in a PRTF or 10 days in a TGH, for Medicaid purposes, the authorization will be end-dated and addressed as a discharge. Any subsequent admission to a PRTF or TGH is considered a new admission. If a youth requires acute psychiatric admission, the authorization will be end-dated and addressed as a discharge, Any subsequent admission to a PRTF or TGH would also be considered a new admission.

Note: None of the days away from the PRTF or TGH for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS authorization for PRTF or TGH.

Timeliness of Submission by Providers

All initial requests for services must be submitted within one business day of admission and continued stay requests must be submitted by the requested start date. This means that if a provider is untimely submitting the request, Magellan of Virginia will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Specific Information for Out of State Providers

Out of state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to Magellan of Virginia. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to Magellan of Virginia, as timeliness of the request will be considered in the review process. Magellan of Virginia will redirect the request back to the provider to allow the provider to become successfully enrolled.

Out of State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of PRTF, TGH and EPSDT services in those levels of care. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period. Additional information may be found in Chapter II of this manual.

EPSDT Service Authorization Process

The EPSDT service is Medicaid's comprehensive and preventive child health program for youth under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the youth receiving services.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the

service/item is physician ordered will correct a medical condition, make it better, or prevent the child's health status from worsening.

All Medicaid, FAMIS (FFS) and FAMIS Plus services that are currently authorized by the service authorization contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, MagellanofVirginia.com

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the youth's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all service authorization reviews of Medicaid services.

EPSDT Review Process:

Individuals under 21 years of age qualify under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by DMAS or its contractor. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

Appendix D: Independent Assessment, Certification, and Coordination Team (IACCT)

Introduction

Each youth seeking admission to a Therapeutic Group Home (TGH) or Psychiatric

Residential Treatment Facility (PRTF) will first receive the support of the local Independent Assessment, Certification and Coordination Team (IACCT) to assess the youth's needs. If the youth's primary diagnosis is a mental health diagnosis, please submit a Residential Inquiry form to Magellan of Virginia to begin the process. This form can be found on the Magellan of Virginia website, www.magellanofvirginia.com, in the Residential Program Process section.

The IACCT team will gather relevant information from which Magellan of Virginia will use to render a medical necessity determination.

Independent Assessment, Certification and Coordination Teams (IACCT)

CMS requires, per §441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in §441.153.

For individuals who are already eligible for Medicaid at the time of admission, the independent certification team shall be a DMAS-authorized contractor with competence in the diagnosis and treatment of mental illness, preferably in child and adolescent psychiatry, and have knowledge of the individual's situation and service availability in the individual's local service area. The team shall be composed of at least one physician and one LMHP, LMHP-R, LMHP-RP or LMHP-S. A youth's parent or legally authorized representative shall be included in the certification process.

Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services. Effective January 1, 2017 DMAS requires that all certification teams are credentialed and contracted with Magellan of Virginia in order to administer the independent certification process on behalf of DMAS. DMAS also allows localities to enter into a partnership agreement with DMAS to administer this process in collaboration with Magellan of Virginia. These certification teams are called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

- Ensuring care coordination and higher probability for improved outcomes;
- Following strict turnaround timeframes for assessing the need for treatment and level of care requirements;
- Accessing the established Medicaid grievance process as mandated by CMS;
- Ensuring freedom of choice in service providers as mandated by CMS; and
- Implementing Medical Necessity Criteria for all youth who request residential care.

All Medicaid-eligible youth must be referred to Magellan of Virginia who will make referral to the IACCT team for PRTF and TGH services. In addition, all inpatient providers and residential treatment providers must refer to Magellan of Virginia to initiate the IACCT certification process to assess and certify an appropriate level of care prior to being transferred to PRTF or TGH care from an inpatient setting. All IACCT decisions are due within 10 business days of the referral to Magellan of Virginia. A licensed mental health professional (LMHP), LMHP-resident (LMHP-R), LMHP-resident in psychology (LMHP-RP) or LMHP-supervisee (LMHP-S) who is part of the IACCT will conduct a diagnostic assessment through a face-to-face meeting and the IACCT will determine the appropriate level of care. The IACCT is essential in ensuring the most clinically appropriate, least restrictive setting, and that care is provided in a manner that best suits the needs of each youth and family. The IACCT will also ensure family engagement in the decision making process and throughout the course of treatment.

Magellan of Virginia's Role

The Magellan of Virginia certification and care coordination model, i.e., IACCT, will utilize a single team for the assessment of care needs and care coordination. Magellan of Virginia will support the IACCT through Magellan of Virginia employed positions including Residential Care Managers (RCM) and Family Support Coordinators (FSC).

The roles of these positions are described below:

Magellan of Virginia Residential Care Manager (RCM)

The RCM will notify the IACCT serving a locality of any youth from that locality referred to Magellan of Virginia for consideration of residential treatment.

In all circumstances, the RCM will:

a. Support the IACCT process by facilitating the collection of required assessments and behavioral and physical health histories;
b. Review the results from the assessments and recommendations of the IACCT and apply the established medical necessity criteria to determine Medicaid funding authorization; and
c. If residential treatment is initiated, the RCM will provide continued oversight around:
    - Treatment plan of care development,
    - Progress toward treatment goals including CANS outcomes, and
    - Transition planning for return to the community. The RCM will remain involved with the IACCT following discharge as a coordination resource to ensure the outlined community plan with any necessary service authorizations is in place. In situations where a youth transfers to another facility and an IACCT is not required, the RCM will alert the IACCT that the youth is at a new facility.

Magellan of Virginia Family Support Coordinator (FSC)

The FSC will perform outreach to the family or guardian to coordinate any face-to-face assessments, encourage and facilitate family engagement in any treatment option decisions, provide education for informed decision making regarding treatment, and offer any other support or assistance to the family throughout the course of treatment. The FSC's primary role is to provide support to the family, helping them to stay involved while their youth is in care and preparing for a successful reunification upon the youth's discharge.

IACCT Oversight and Support

Magellan of Virginia, as the DMAS Behavioral Health Administrator, will provide oversight to the IACCT process and facilitate implementation of best practices.

Magellan of Virginia will support the IACCT process through activities including:

- Ensure that all appropriate community services are explored in lieu of residential placement;
- Make the final medical necessity determination for residential placement;
- Handle all grievances and appeals per the established DMAS appeals process; and
- Provide freedom of choice of providers to youth and families.

IACCT Staffing Requirements

- Each IACCT team[1] will include at a minimum:
    - A LMHP, LMHP-R, LMHP-RP or LMHP-S who performs the required diagnostic assessment, i.e., psychosocial history. The LMHP, LMHP-R, LMHP-RP or LMHP-S will collect, review, and/or complete the Child and Adolescent Needs and Strengths Tool (CANS).
    - A physician, who either 1) actively sees this youth for medical care 2) can be accessed through the youth's managed care organization (MCO) or 3) is identified by the locality as physician willing to engage in this process with identified youth. Physicians engaged in this process need to have knowledge of the service delivery system and are able to assess the youth's medical history and current status through either a face to face contact scheduled during the IACCT

process or via their current health related knowledge of this youth including having seen the youth face to face in the last 13 months; and

- The youth and family/legally authorized representative who are active participants in the assessment and decision-making process.

It is expected that the team will also include representatives of local agencies and other supports involved in the youth's plan of care who will provide information to the team regarding the youth's service history and current level of functioning.

IACCT Required Activities

- Receive and respond to Residential Inquiry requests and IACCT Referrals from Magellan of Virginia of youth[2] to be considered for residential treatment services;

- Determine each youth's appropriate level of care and certify, as appropriate, the need for residential treatment services. Assessment must include psychosocial history, CANS, medical history and current status; and

- If the youth has had a CANS (including the Magellan CANS 1.0 or the Virginia CANS Comprehensive) completed within the last 30 calendar days, the LMHP, LMHP-R, LMHP-RP or LMHP-S can utilize this CANS for the assessment.

  For **contracted IACCT providers** completing the VA CANS Comprehensive, the contracted IACCT provider LMHP, LMHP-R, LMHP-RP or LMHP-S must transfer the ratings to the Magellan CANS 1.0 system to submit the CANS 2016 Youth Report with the IACCT SRA.

- Adhere to IACCT procedures established by DMAS regulations, provider manuals, and Magellan of Virginia contractual agreements including:
    - Meet all specified timeframes;
    - Assess the youth and family's needs. If the LMHP, LMHP-R, LMHP-RP or LMHP-S determines that the youth is in immediate need for access to more intensive services, the youth shall be referred to an appropriate crisis intervention provider, crisis stabilization provider, inpatient psychiatric provider or referred for emergency admission to a PRTF or TGH for foster care youth. The LMHP, LMHP-R, LMHP-RP, LMHP-S shall coordinate with the youth's MCO as appropriate;
    - Apply medical necessity criteria in accordance with DMAS regulations;
    - Ensure the youth is served in the least restrictive environment in accordance with the Department of Justice Settlement Agreement; and
    - Ensure family engagement throughout the assessment process. The youth and the youth's parent or legally authorized representative shall have the right to freedom of choice of service providers. If the youth or the youth's parent or legally authorized representative disagrees with the IACCT recommendation, the parent or legally authorized representative may appeal the decision.
- Assume responsibility for assessment of youth in inpatient facilities who are referred for consideration of transfer to a PRTF or TGH.[3]
    - The LMHP, LMHP-R, LMHP-RP or LMHP-S will assess the youth (expedited, if possible) through either a face-to-face or telemedicine contact. For youth who are currently in an inpatient setting where telemedicine is not available and distance is a barrier for the IACCT LMHP, LMHP-R, LMHP-RP or LMHP-S, a telephonic interview with the youth may be conducted while the IACCT LMHP,

LMHP-R, LMHP-RP or LMHP-S conducts a face to face with the legal guardian.

- The LMHP, LMHP-R, LMHP-RP or LMHP-S will coordinate with the inpatient facility to gather diagnostic and clinical assessments completed during the youth's inpatient treatment.

- The LMHP, LMHP-R, LMHP-RP or LMHP-S will partner with the inpatient facility to complete the Certificate of Need (CON) with the facility physician and to make sure all viable options, including community based options, have been explored.

- Participate in care coordination with Magellan of Virginia, the family, the youth's primary physician, the local CSB, the local DSS (as appropriate), the youth's school, and community-based service providers serving the youth and family.
- Ensure family engagement throughout the course of treatment.

IACCT Timeframes

1. When a residential inquiry is received by Magellan of Virginia, a Magellan of Virginia RCM will conduct the education session[4] to the youth and the parent/legally authorized representative.

2. After all education sessions, the parent(s)/legally authorized representatives' wishes for community based services or for engaging in the IACCT process shall be documented. The parent(s)/legally authorized representatives' verbal response for community based services or engaging in the IACCT process shall be documented. Magellan of Virginia will initiate a referral to the identified locality partner or the contracted IACCT provider to begin the IACCT process.

3. The IACCT shall assess the treatment needs of the youth and recommend a level of care ***within 10 business days from the referral*** from Magellan of Virginia.

   a. The LMHP, LMHP-R, LMHP-RP or LMHP-S will conduct the face to face assessment within two business days of the referral from Magellan of Virginia to

begin the process to certify the need for an out of home placement.

b. If the youth and parent/legally authorized representative are unable to attend the face to face appointment ***within two business days***, the LMHP, LMHP-R, LMHP-RP or LMHP-S must notify the Magellan of Virginia RCM of this missed appointment and request a ***3 business day extension***.

c. ***Up to two 3 day extensions*** can be offered due to the youth and parent/legally authorized representative being unable to attend a scheduled appointment.

d. ***Up to two 3 day extensions*** can be offered for challenges engaging a physician in completing a review of a known client or face to face meeting with an unknown client and making CON recommendations.

NOTE: No more than a total of two "3 business day" extensions can be given during the IACCT process which allows for a possible 16 business day timeline.

4. If the youth has been referred to community based service options via the IACCT process, the IACCT in collaboration with the youth's legal guardian will develop a community based plan of care.

For **contracted IACCT providers**, the Magellan of Virginia RCM will assist with a referral list for community providers and the RCM and FSC are available to the youth and legal guardian for up to 90 calendar days after the IACCT process is completed so that they can provide ongoing support and care coordination.

NOTE: In all cases, when the youth's legal guardian is the Local Department of Social Services (LDSS) all coordination will occur with the identified LDSS foster care worker as required by the court.

If a residential treatment level of care has been determined, then the following steps

will occur:

a. The CON shall be effective for ***30 calendar days*** prior to admission.

b. The IACCT shall provide the completed CON to Magellan of Virginia ***within one calendar day*** of completing the CON.

c. The IACCT shall provide the completed CON to the facility ***within one calendar day*** of the facility being identified.

5. If the youth has been authorized for residential treatment service options via the IACCT process and medical necessity determination, the RCM will provide a listing of credentialed residential facilities to the youth's legal guardian so that the legal guardian and youth can begin to make their selection of facility based care. The RCM will continue to engage in care coordination at a minimum of every 30 calendar days.

   The RCM and FSC are available to the youth and family throughout the youth's placement in a PRTF or TGH.

   When the youth is discharged from a TGH or PRTF, the RCM and FSC are available to the youth and (foster care worker) for up to 90 calendar days after discharge from a residential facility to provide ongoing support and care coordination.

6. If the youth receives residential treatment services, the IACCT LMHP, LMHP-R, LMHP-RP or LMHP-S will conduct a reassessment at 90 calendar days or earlier as deemed clinically appropriate. The 90 calendar day reassessment will include a CANS and a psychosocial addendum when there has been a significant life change for the youth or family. The reassessment process with include a review of CANS outcomes as it relates to treatment recommendations via the completion of the Magellan of Virginia Re-Assessment Clinical CANS grid.

   For **contracted IACCT providers,** the Magellan of Virginia System will produce

individualized CANS outcome reports that the LMHP, LMHP-R, LMHP-RP or LMHP-S can utilize to complete the Magellan of Virginia Re-Assessment Clinical CANS grid.

For youth with a Certificate of Need (CON) completed prior to July 1 2017, Magellan will require the following from the PRTF or TGH provider when submitting a continued stay request:

- Youth connected with Children's Services Act (CSA):

    i. Service Authorization Request form (Continued Stay), Comprehensive Individual Plan of Care (CIPOC), Rate Sheet, Child and Adolescent Needs and Strengths Assessment (CANS); and

    ii. Attach the CANS to the Facility Service Authorization Request Form.

- Youth not connected with CSA:

    i. Service Authorization Request form (Continued Stay), CIPOC; and

    ii. Continued stay criteria for these youth with a CON completed prior to July 1, 2017 shall be met as defined in the Criteria for Continued Stay sections for PRTF and TGH in Chapter 4 of the Residential Treatment Services Manual.

Exceptions to the IACCT Processes

Emergency Placements for Foster Care Youth

DMAS follows LDSS guidance on defining emergency placements for foster care youth. The

emergency placements for both Medicaid eligible and non-Medicaid eligible foster care youth will be allowed to be admitted to a PRTF or a TGH immediately according to DSS protocol that will ensure all potential community placement options are not viable prior to placing a youth into services. Emergency admissions means admissions for youth in the custody of social services that are made when, pending a review for the certificate of need, it appears that the youth is in need of an immediate admission to a TGH or PRTF and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization or acute psychiatric inpatient services.

The IACCT will receive notice of all emergency admissions from the PRTF or the TGH within five calendar days of admission to care or five calendar days from the date that Medicaid eligibility and coverage begins. For emergency admissions, the certification must be made by the team responsible for the comprehensive individual plan of care (CIPOC) within 14 calendar days after admission. These certifications of need for these emergency admissions shall be made by the team responsible for the CIPOC and the certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid. After processing an emergency admission, the PRTF or TGH shall notify Magellan of Virginia of the youth's status as being under the care of the facility within five calendar days.

The Facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children's residential services care management staff. All reimbursement approvals will cover the dates of admission and afterward if the youth is Medicaid eligible at the time of admission and is referred to the IACCT within five calendar days of admission or within five calendar days of being determined eligible for Medicaid. Inquiries that are not submitted within the required timeframe will result in facilities not receiving DMAS reimbursement approval for the days prior to the submission.

Individuals Not Medicaid Eligible at Admission to Residential Treatment Services

For youth who apply and become eligible for Medicaid while admitted to a PRTF or TGH, the certification shall be made by the team responsible for the CIPOC and certification of need (CON), within 14 calendar days from admission. The certification shall cover any period of time before the application for Medicaid eligibility for which claims are made for reimbursement by Medicaid. The facility will not receive DMAS reimbursement approval until the certification of need is received by Magellan of Virginia and assessed by the children's residential services care management staff. All reimbursement approvals will

cover the dates of admission and afterward if the youth is Medicaid eligible at the time of admission and is referred to the IACCT within five calendar days of admission or within five calendar days of being determined eligible for Medicaid.

All youth entering a PRTF or TGH utilizing private medical insurance who will become eligible for enrollment in Medicaid within 30 calendar days following the facility admission are required to have an independent certification of need completed by the team responsible for the plan of care at the facility. The certificate of need should be completed by the treatment team within 14 calendar days from admission.

The team responsible for the plan of care in TGH, at a minimum, shall include:

1. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
2. The team shall also include one of the following: LMHP, LMHP-R, LMHP-RP or LMHP-S.

The LMHP, LMHP-R, LMHP-RP or LMHP-S must sign off on the CON for the TGH settings. Upon the youth's enrollment into the Medicaid program, the TGH shall notify Magellan of Virginia of the youth's status as being under the care of the facility within five calendar days of the youth becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

The team responsible for the plan of care in PRTF, at a minimum, shall include:

1. A Board-eligible or Board-certified psychiatrist; or
2. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and
3. The team shall also include one of the following: LMHP, LMHP-R, LMHP-RP or LMHP-S.

   The Psychiatrist must sign off on the CON for the PRTF settings. Upon the youth's enrollment into the Medicaid program, the PRTF shall notify Magellan of Virginia of the youth's status as being under the care of the facility within five calendar days of the youth becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

Inpatient Transfer to Residential Services

1. Upon a youth's admission to an inpatient facility, the facility will assess for viable

discharge treatment options and develop an initial discharge plan.

2. If residential services are recommended as an option for the discharge plan, the inpatient facility will submit an online residential inquiry form to Magellan of Virginia within one business day. Alternatively, for children not enrolled in a MCO, this form can be completed telephonically with Magellan of Virginia during a concurrent review.

3. When the legal guardian gives permission to move forward with the residential referral, Magellan of Virginia will contact the IACCT LMHP, LMHP-R, LMHP-RP or LMHP-S to begin the IACCT assessment process. The IACCT LMHP, LMHP-R, LMHP-RP or LMHP-S will schedule a face-to-face or telemedicine assessment (expedited, if possible), and will coordinate with the inpatient facility to gather any diagnostic and clinical assessments that were completed during the youth's inpatient treatment.

4. If the youth is clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will arrange community-based services to maintain member's stability during IACCT process.

5. If the youth is not clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will complete the certificate of need and engage in an acute discharge planning process.

Effective July 10, 2019, an IACCT is no longer required to be completed in the following situations:

1. The youth is transitioning to a TGH from PRTF. The IACCT process is not required if the PRTF is willing to complete and sign the CON indicating a TGH is necessary and the youth goes directly to the TGH. The IACCT process will be required if the PRTF does not support the discharge to a TGH or is unwilling or unable to complete and sign the CON. If the PRTF completes the CON, the PRTF shall forward the CON to the TGH. The TGH is required to submit the CON at the Initial Service Request Authorization (SRA)

2. The youth is transitioning to another provider of the same level of care within 30 calendar days of the original CON. If a youth is admitted to a PRTF or TGH after completing the IACCT process and transfers to another provider of the same level of care within 30 calendar days of the CON being signed, an IACCT is not required. The CON must be dated within 30 calendar days of the new admission.

3. The youth transitions from a PRTF or TGH to psychiatric inpatient and back to the same level of care within 30 calendar days of the original CON being signed. If a youth is admitted to a PRTF or TGH after completing the IACCT process and transitions to psychiatric inpatient, a new IACCT is not required if the youth transitions back to the same level of care (PRTF or TGH) within 30 calendar days of the original CON being signed. The youth must transition back to the same level of care initially recommended by the IACCT but does not need to transfer back to the same provider.

Transition between PRTF or TGH and ARTS Residential

If the youth is in a PRTF or TGH and it is determined that Addiction and Recovery Treatment Services (ARTS) Residential services are needed, please notify the Magellan of Virginia RCM who will assist with identifying appropriate ARTS resources for the youth.

If the youth is in an ARTS Residential facility and needs to transition to a PRTF or a TGH, please submit an IACCT Inquiry form as soon as the need is identified.

Additional information about the IACCT process is available on the Magellan of Virginia website at: https://www.magellanofvirginia.com/for-providers/residential-program-process/

[1] Team members may participate in person or by teleconference

[2] Each IACCT will receive referrals for a contracted catchment area. All youth shall be referred to the IACCT serving the city/county of the youth's legal residence.

[3] As an alternative, the responsible IACCT may opt to coordinate with an IACCT in close geographic proximity to the facility to conduct the assessment.

[4] Education Session will ensure that the parent(s)/legally authorized representative(s) is aware of community resources and understands the IACCT process so that they can consider the least restrictive mental health services available that best meet the needs of their youth.

Peer Recovery Support Services Supplement (ARTS)

This supplement defines program requirements for Peer Recovery Support Services, which includes Peer Support Services and Family Support Partners.. The provision of Peer Support Services and Family Support Partners facilitates recovery from both serious mental health conditions and substance use disorders. Recovery is a process in which people are able to live, work, learn and fully participate in their communities. Peer Recovery Support Services are delivered by trained and certified peer recovery specialists who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an member's community and natural environment to support and assist an member with staying engaged in the recovery process. Peer recovery support services are an evidence-based model of care which consists of a qualified peer recovery specialist assisting members with their recovery. The experiences of peer recovery specialists, as consumers of mental health and substance use services, can be an important component in the delivery of a comprehensive mental health and substance use service delivery system.

Effective July 1, 2017, the Department of Medical Assistance Services (DMAS) expanded the Medicaid benefit to allow for credentialing and reimbursement of Peer Recovery Support Services to include Peer Support Services and Family Support Partners. This was in response to a legislative mandate to implement peer recovery support services to eligible children and adults who have mental health conditions and/or substance use disorders. Peer Support Services shall target members 21 years or older with mental health or substance use disorders or co-occurring mental health and substance use disorders. Family Support Partners may be provided to eligible members under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their families or caregivers. Members 18-20 years-old who meet the medical necessity criteria, may choose to receive Peer Support Services or Family Support Partners.

Peer Support Services and Family Support Partners shall be an added service under Mental Health (MH) service settings for members with mental health

disorders and under the Addiction and Recovery Treatment Services (ARTS) settings for members with substance use disorders and co- occurring substance use and mental health disorders.

Background/Discussion (ARTS)

Medicaid coverage for the provision of Peer Support Services to adults and Family Support Partners to the caregivers of youth a necessary component for a comprehensive, person-centered and recovery focused program for the treatment of addiction and mental health conditions. The Centers for Medicare & Medicaid Services (CMS) recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, is an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services."

To address the emphasis on recovery from mental health conditions and substance use disorders and the recommendations from CMS, members 21 years or older and families or caregivers of youth 21 and under who participate in Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) are eligible to receive Peer Recovery Support Services to include Peer Support Services and Family Support Partners. Peer Support Services and Family Support Partners are covered by DMAS or its contractor for members enrolled in fee for service and the Managed Care Organization (MCO) for members enrolled in Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus.

Definitions (ARTS)

"Behavioral Health Service" means treatments and services for mental and/or substance use disorders.

"Certified substance abuse counselor" or "CSAC" means the same as defined in 18VAC115-30- 10 and in accordance with 54.1-3507.1.

"Certified substance abuse counseling-assistant" or "CSAC-A" means the same as defined in 18VAC115-30-10 and in accordance with §54.1-3507.2.

"Credentialed addiction treatment professionals" or "CATP" means an member licensed or registered with the appropriate Board in the following roles: (i) an addiction-credentialed physician or physician with experience or training in addiction medicine; (ii) physician extenders with experience in or training in addiction medicine (iii) a licensed psychiatrist; (iv) a licensed clinical psychologist; (v) a licensed clinical social worker; (vi) a licensed professional counselor; (vii) a registered psychiatric clinical nurse specialist; (viii) a licensed psychiatric nurse practitioner; (ix) a licensed marriage and family therapist; (x) a licensed substance

abuse treatment practitioner; (xi) residents under supervision of a licensed professional counselor (18VAC115-20-10), licensed marriage and family therapist (18VAC115-50-10), or licensed substance abuse treatment practitioner (18VAC115-60-10) and registered with the Virginia Board of Counseling; (xii) residents in psychology under supervision of a licensed clinical psychologist and registered with the Virginia Board of Psychology (18VAC125-20-10); or (xiii) supervisees in social work under the supervision of a licensed clinical social worker and registered with the Virginia Board of Social Work (18VAC140-20-10).

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

“Direct Supervisor” in ARTS is the person who provides direct supervision to the Peer Recovery Specialist (PRS). The direct supervisor: 1) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification as a PRS under a certifying body approved by Department of Behavioral Health and Developmental Services (DBHDS), and have completed the DBHDS PRS supervisor training; or 2) shall be a CATP or a CSAC who has documented completion of the DBHDS PRS supervisor training The CSAC shall be acting under the supervision or direction of a licensed substance use treatment practitioner or licensed mental health professional (LMHP). If a practitioner referenced in item 2 of this paragraph or a CSAC referenced in item 3 of this paragraph provides services before April 1, 2018, they had until April 1, 2018 to complete the DBHDS PRS supervisor training.

“Direct Supervisor” in a Mental Health setting is the person who provides direct supervision to the PRS. The direct supervisor: 1) shall have two consecutive years of documented practical experience rendering peer support services or family support services, have certification as a PRS under a certifying body approved by Department of Behavioral Health and Developmental Services (DBHDS) , and have completed the DBHDS PRS supervisor training; or 2) shall be a qualified mental health professional (QMHP) as defined in 12VAC30-105-20 with at least two consecutive years of experience as a QMHP, and who has completed the DBHDS PRS supervisor training; or 3) shall be an LMHP, LMHP-resident (LMHP-R), LMHP-resident in psychology (LMHP-RP), or LMHP-supervisee in social work (LMHP-S) who has documented completion of the DBHDS PRS supervisor training who is acting within their scope of practice under state law. An LMHP, LMHP-R, LMHP-RP, or LMHP-S providing services before April 1, 2018 had until April 1, 2018 to complete the DBHDS PRS supervisor training.

“Family Support Partners” means a peer recovery support service by a PRS that is a person- centered strength-based and recovery oriented rehabilitative service provided to the caregiver of Medicaid-eligible member under age 21, with a mental health or substance use disorder or co- occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver must be directed exclusively toward the benefit of the Medicaid-eligible youth.

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

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

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

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

their signatures to indicate such status.

"Peer recovery specialist" or “PRS” means a person who has the qualifications, education, and experience established by the DBHDS as set forth in 12VAC35-250-10 through 12VAC35-250- 50 and who has received certification in good standing by a certifying body recognized by DBHDS as set forth in 12VAC35-250-40. A PRS is professionally qualified and trained (i) to provide collaborative services to assist members in achieving sustained recovery from the effects of mental health, substance abuse disorders , or both (ii) to provide peer support as a self-identified member successful in the recovery process with lived experience with mental health or substance use disorders, or co-occurring mental health and substance use disorders, and (iii)to offer support and assistance in helping others in the recovery and community-integration process. A PRS may be a parent of a minor or adult child with a similar mental health or substance use disorder or co- occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. PRS includes both Peer Support Services and Family Support Partners.

“Peer recovery support services” – means the same as defined in 12VAC35-250-10. Collaborative, nonclinical, peer-to-peer services that engage, educate, and support an member’s self-help efforts to improve his health, recovery, resiliency, and wellness to assist members in achieving sustained recovery from the effects of mental illness, addiction or both.

“Peer Support Services” means a peer recovery support service that is a person centered, strength- based, and recovery oriented rehabilitative service for members 21 years or older provided by a Peer Recovery Specialist (PRS) successful in the recovery process with lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support.

“Person Centered” means a collaborative process where the member participates in the development of their treatment goals and make decisions on the services provided.

“Recovery-oriented services” means supports and assistance to members with mental health or substance use disorders or both so that the member (i) improves their health, recovery, resiliency and wellness; (ii) lives a self-directed life; and (iii)

strives to reach the member's full potential.

"Recovery Resiliency and Wellness Plan" means a written set of goals, strategies, and actions to guide the member and the healthcare team to move the member toward the maximum achievable independence and autonomy in the community. The comprehensive documented wellness plan shall be developed by the member, caregiver as applicable, the PRS, and the direct supervisor within 30 days of the initiation of services and shall describe how the plan for peer support services and activities will meet the member's needs. This document shall be updated as the needs and progress of the member changes and shall document the member's or family's, as applicable, request for any changes in peer support services. The Recovery, Resiliency and Wellness Plan is a component of the member's overall plan of care and shall be maintained by the enrolled/credentialed provider in the member's medical record.

"Resiliency" means the same as defined in 12VAC30-130-5160 and the ability to respond to stress, anxiety, trauma, crisis, or disaster.

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

"Self-Advocacy" means the same as defined in 12VAC30-130-5160 and is an empowerment skill that allows the member to effectively communicate preferences and choice.

"Supervision" means the same as defined in 12VAC30-130-5160 and is the ongoing process performed by a direct supervisor who monitors the performance of the PRS and provides regular documented consultation and instruction with respect to the skills and competencies of the PRS.

Provider Participation and Setting Requirements (ARTS)

Only a licensed and enrolled/credentialed provider of Peer Support Services and Family Support Partners shall be eligible to bill and receive reimbursement. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with DMAS or its contractor (s). Providers should refer to the specific Managed Care Organization (MCO) policies for information on single case agreements.

Provider Enrollment

ARTS Peer Support Services and Family Support Partners

Providers of ARTS Peer Support Services and Family Support Partners shall be enrolled/credentialed with Medicaid or its contractor (s) for one of the following:

1. Acute Care General Hospital level 4.0 licensed by Virginia Department of Health (VDH) as defined in 12VAC30-130-5150.

2. Freestanding Psychiatric Hospital or Inpatient Psychiatric Unit (Levels 3.7 and 3.5) licensed by DBHDS as defined in 12VAC30-130-5130 through 5140.

3. Residential Placements (Levels 3.7, 3.5, 3.3, and 3.1) licensed by DBHDS as defined in 12VAC30-130-5110 through 12VAC30-130-5140.

4. Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs) (Levels 2.5, 2.1) and licensed by DBHDS as defined in 12VAC30-130-5090 and 12VAC30-130-5100.

5. Outpatient Services (Level 1) as defined in 12VAC30-30-5080.

6. Opioid Treatment Program (OTP) as defined in 12VAC30-130-5050.

7. Preferred Office Based Opioid Treatment (OBOT) as defined in 12VAC30-130-5060.

8. Pharmacy Services licensed by VDH.

MH Peer Support Services

Providers of MH Peer Support Services shall be enrolled/credentialed with Medicaid or its contractor (s) for one of the following:

1. Acute Care General and Emergency Department Hospital licensed by VDH.
2. Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by the DBHDS.
3. Outpatient mental health clinic services licensed DBHDS
4. Outpatient psychiatric services provider.
5. Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).
6. Community Mental Health Rehabilitative Services provider licensed by the DBHDS as a provider of one of the following Community Mental Health Rehabilitative Services defined in 12VAC30-50-226 or 12VAC30-50-420 for which the member meets eligibility criteria:
    a. Day Treatment/ Partial Hospitalization;
    b. Psychosocial Rehabilitation;
    c. Crisis Intervention;
    d. Intensive Community Treatment*;
    e. Crisis Stabilization;
    f. Mental Health Skill-building Services; or
    g. Mental Health Case Management

*PRS who are serving within Intensive Community Treatment (ICT) interdisciplinary teams and provide peer recovery support services as a component of the ICT program do not have to follow the requirements set forth in the Peers Recovery Support Services Manual Supplement. There are no changes to the service delivery requirements or billing for ICT.

If a LMHP, LMHP-R, LMHP-RP and LMHP-S determines that a member receiving ICT meets the medical necessity criteria for additional Peer Recovery Support Services beyond the peer services that are embedded in ICT and the member agrees to the additional peer service, the provider would need to meet the requirements set in the Peers Recovery Support Services Manual Supplement and coordinate with the ICT provider to avoid duplication of services.

MH Family Support Partners

Providers of MH Family Support Partners shall be enrolled/credentialed with Medicaid or its contractor (s) for one of the following:

1. Acute Care General and Emergency Department Hospital Services licensed by VDH.

2. Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by DBHDS.

3. Psychiatric Residential Treatment Facility licensed by DBHDS.

4. Therapeutic Group Home licensed by DBHDS.

5. Outpatient mental health clinic services licensed by DBHDS.

6. Outpatient psychiatric services provider.

7. Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).

8. A Community Mental Health Rehabilitative Services provider licensed by the DBHDS as a provider of one of the following Community Mental Health Rehabilitative Services as defined in 12VAC30-50-130, 12VAC30-50-226, 12VAC30-50-420, or 12VAC30- 50-430 for which the youth under 21 meets eligibility criteria:
    a. Intensive In-Home;
    b. Therapeutic Day Treatment;
    c. Day Treatment/Partial Hospitalization;
    d. Crisis Intervention;
    e. Crisis Stabilization;
    f. Mental Health Skill-building Services; or

g. Mental Health Case Management.

Peer Recovery Specialists

A PRS is professionally qualified and trained to provide collaborative services to assist members in achieving sustained recovery from the effects of mental health, substance use disorders, or co- occurring disorders. A PRS who provides Peer Support Services is a self-identified person with lived experience with a mental health condition and/or substance use disorder who is in successful and ongoing recovery from mental health and/or substance use disorders and who is trained to offer support and assistance in helping others in the recovery and community-integration process.

A PRS who provides Family Support Partners may be a parent of a minor or adult child with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services.

Peer Support Services and Family Support Partners shall be rendered by an member who:

- Is sufficiently trained and certified to deliver services;
- Meets the definition of a Peer Recovery Specialist "PRS" as defined in 12VAC35-250;
- Has the qualifications, education and experience as established by DBHDS in 12VAC35- 250-30;
- Has a current certification by a certifying body approved by DBHDS;
- Is registered with the Board of Counseling at the Department of Health Professions; and,
- Is employed by or has a contractual relationship with a provider enrolled/credentialed with DMAS, its contractor, or a Medicaid MCO.

The PRS shall perform services within the scope of his knowledge, lived experience, and education. The caseload assignment of a full time PRS shall not

exceed 15 members at any one time allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-time PRS shall not exceed 9 members at any one time.

Referral for Peer Support Services and Family Support Partners

Peer Support Services and Family Support Partners are incorporated in many levels of care and DMAS encourages engagement of members into services. There are no limits to who can refer members for Peer Support Services and Family Support Partners.

Assessment and Recommendation for Services and Clinical Oversight ARTS Peer Support Services and Family Support Partners

ARTS Peer Support Services and Family Support Partners shall be rendered following a documented assessment from a referring provider. Referrals must be made by a practitioner who meets the definition of Credentialed Addiction Treatment Professional (CATP) acting within their scope of practice under state law and who is recommending PRS for the member. A certified substance abuse counselor (CSAC) may also provide a documented assessment and recommendation for services if they are acting under the supervision or direction of a CATP.

This practitioner shall be an enrolled/credentialed as a Medicaid provider or working in an agency or facility enrolled/credentialed as a provider. The documented recommendation within the assessment shall verify how the member will benefit from the service. The assessment recommending the service shall be valid for no longer than 30 calendar days.

The qualified practitioner for ARTS Peer Support Services and Family Support Partners shall provide clinical oversight of the services provided by the PRS and oversight of the member's Recovery, Resiliency, and Wellness Plan.

MH Peer Support Services and Family Support Partners

MH Peer Support Services and Family Support Partners shall be rendered following a documented assessment for service by a practitioner who is a LMHP, LMHP-R, LMHP-RP, LMHP-S. This practitioner shall be an enrolled/credentialed provider or working in an agency or facility enrolled/credentialed as a provider. The documented assessment shall verify how medically the member shall benefit from the service. The documented assessment shall be valid for no longer than 30 calendar days.

The qualified practitioner for MH Support Services and Family Support Partners shall provide clinical oversight of the services provided by the PRS and oversight of the member's Recovery, Resiliency, and Wellness Plan.

Supervision of Peer Recovery Specialists

Supervision of the PRS can be provided by the qualified practitioner who completes the assessment for services or by another provider within the same agency who meets the direct supervisor qualifications as defined in the definition section of this supplement.

Direct supervision of the PRS shall be provided as needed based on the level of urgency and intensity of service being provided. Supervisors shall maintain documentation of all supervisory sessions.

1. If the PRS has less than 12 months of experience delivering Peer Support Services or Family Support Partners, they shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. A direct supervisor must be available at least by telephone while the PRS is on duty. If the primary direct supervisor is not available, another direct supervisor meeting the qualifications is acceptable.

2. If the PRS has been delivering Peer Support Services or Family Support Partners over 12 months and fewer than 24 months, they must receive

monthly face-to-face, one-to- one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. A direct supervisor must be available by phone for consult within 24 hours of service delivery if needed for challenging situations. If the primary direct supervisor is not available, another direct supervisor meeting the qualifications is acceptable.

The Direct Supervisor shall have an employment (or contract) relationship with the same provider entity that employs/contracts with the PRS.

Documentation of all supervision sessions shall be maintained by the enrolled/credentialed provider in a supervisor's log or the PRS' personnel file.

Service Definitions: ARTS and MH Peer Recovery Support Services

Peer Support Services and Family Support Partners are Peer Recovery Support Services and are non-clinical, peer to peer activities that engage, educate, and support an member's, and as applicable the caregiver's, self-help efforts to improve health, recovery, resiliency and wellness. Supervision and care coordination are required components of Peer Recovery Support Services.

Peer Support Services

Peer Support Services for adults are person centered, strength-based, and recovery oriented rehabilitative service for members 21 years or older provided by a PRS successful in the recovery process with lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or co- occurring mental health and substance use disorder that is the focus of support. Services assist the member develop and maintain a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist members in achieving positive coping mechanisms for

the stressors and barriers encountered when recovering from their illness or disorder.

Family Support Partners

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

Service Delivery

Service delivery shall be based on the member's identified needs, established medical necessity criteria, consistent with the assessment of the practitioner who recommended services, and goals identified in the member Recovery Resiliency and Wellness Plan. The level of services provided and total time billed by the enrolled/credentialed provider for the week shall not exceed the frequency established in the Recovery, Resiliency, and Wellness Plan. As determined by the goal(s) identified in the Recovery, Resiliency and Wellness Plan, services may be rendered in the provider's office or in the community, or both. Peer Support Services and Family Support Partners shall be rendered on an member basis or in a group. Services shall be delivered in compliance with the following minimum contact requirements:

- Billing shall occur only for services provided with the member present. Telephone time is supplemental rather than replacement of face-to-face contact and is limited to 25% or less of total time per recipient per calendar year. Justification for services rendered with the member via telephone shall be documented. Any telephone time rendered over the 25% limit will be subject to retraction.

- Contact shall be made with the member receiving Peer Support Services or Family Support Partners a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact, subject to the 25% limitation described above, depending on the member's support needs and documented preferences.

- In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed two units. After two consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur.

- Peer Support Services or Family Support Partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space. Services shall not be delivered at the time within the same space of another service. Peer Support Services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting.

Covered Services (ARTS)

Specific strategies and activities shall be rendered and fully align with the Recovery, Resiliency, and Wellness Plan. Strategies and activities shall include at a minimum:

1. Person centered, strength based planning to promote the development of self-advocacy skills;
2. Empowering the member to take a proactive role in the development and

updating of their Recovery, Resiliency, and Wellness Plan;
3. Crisis support; and
4. Assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the Recovery Resiliency and Wellness Plan so that the member:
    a. Remains in the least restrictive setting;
    b. Achieves their goals and objectives identified in the Recovery Resiliency and Wellness Plan;
    c. Self-advocates for quality physical and behavioral health services; and
    d. Has access to strength-based behavioral health services, social services, educational services and other supports and resources.

Medical Necessity (ARTS)

ARTS Peer Support Services

In order to receive Peer Support Services, members 21 years or older shall meet the following requirements:

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

2. Have a documented substance use disorder or co-occurring mental health and substance use disorder diagnoses.

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

understanding his or her illness, living more independently).

ARTS Family Support Partners

Caregivers of youth under age 21 who qualify for Family Support Partners (i) have a youth with a substance use disorder or co-occurring mental health and substance use disorder, who requires recovery assistance, and (ii) meets two or more of the following:

1. Member and his caregiver need peer-based recovery oriented services for the maintenance of wellness and acquisition of skills needed to support the youth;

2. Member and his caregiver need assistance to develop self-advocacy skills to assist the youth in achieving self-management of the youth's health status;

3. Member and his caregiver need assistance and support to prepare the youth for a successful work/school experience; or

4. Member and his caregiver need assistance to help the youth and caregiver assume responsibility for recovery.

Members 18-20 years old who meet the medical necessity criteria for ARTS Peer Support Services stated above, who would benefit from receiving peer supports directly, and who choose to receive ARTS Peer Support Services directly instead of through ARTS Family Support Partners shall be permitted to receive ARTS Peer Support Services by an appropriate PRS.

MH Peer Support Services

Members 21 years or older qualifying for MH Peer Support Services shall meet the following requirements:

1. Have a documented mental health disorder diagnosis;

2. Require recovery oriented services for the acquisition of skills needed to engage in and maintain recovery; the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and increasing responsibilities, wellness potential, and shared accountability for the member's own recovery; and

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

MH Family Support Partners

Caregivers of youth under age 21 who qualify to receive MH Family Support Partners shall (i) have a youth with a mental health disorder, who requires recovery oriented services, and (ii) meets two or more of the following:

1. Member and his caregiver need peer-based recovery oriented services for the maintenance of wellness and the acquisition of skills needed to support the youth;

2. Member and his caregiver need assistance to develop self-advocacy skills to assist the youth in achieving self-management of the youth's health status;

3. Member and his caregiver need assistance and support to prepare the youth for a successful work/school experience;

4. Member and his caregiver need assistance to help the youth and caregiver assume responsibility for recovery.

Members 18-20 years old who meet the medical necessity criteria stated above for MH Peer Support Services, who would benefit from receiving peer supports directly, and who choose to receive MH Peer Support Services directly instead of through MH Family Support Partners shall be permitted to receive MH Peer Support Services by an appropriate PRS.

Continued Stay Criteria

To qualify for continued services for Peer Support Services and Family Support Partners for both MH and ARTS, medical necessity service criteria shall continue to be met, progress notes shall document the status of progress relative to the goals identified in the Recovery Resiliency and Wellness Plan, and the member continues to require the monthly minimum contact requirements.

Discharge Criteria

Discharge criteria for both MH and ARTS Peers Support Services and Family Support Partners shall occur when one or more of the following is met:

1. Goals of the Recovery Resiliency and Wellness Plan have been substantially met; or
2. The individual or as applicable for youth under 21, the caregiver, request discharge; or
3. The member or as applicable for youth under 21, the caregiver, fail to make the monthly minimum contact requirements or the member or caregiver, as applicable, discontinues participation in services.

Documentation of Required Activities (ARTS)

For both MH and ARTS Peer Support Services the enrolled/credentialed provider shall have oversight of the member's record and maintain member records in accordance with state and federal requirements. The enrolled/credentialed provider shall ensure documentation of all activities and shall ensure documentation of all relevant information about the Medicaid member receiving

services. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. Documentation shall support the medical necessity criteria and how the members needs for the service match the level of care criteria. This documentation shall be written, signed, and dated at the time the services are rendered or within one business day from the time the services were rendered.

Documentation of required activities shall include:

- Assessment for services
- Recovery, Resiliency, and Wellness Plan;
- Review of Recovery, Resilience, and Wellness Plan;
- Progress Notes;
- Supervision; and
- Collaboration of services.

Assessment for Services

Any person involved in the member's treatment, caregiver or community partner can make a referral for services. The member may also self-refer. Once a referral for services is received an assessment for Peer Support Services or Family Support Partners shall be completed and must include the dated signature of the LMHP, LMHP-R, LMHP-RP, or LMHP-S or practitioner making the recommendation and their credentials. The assessment for services shall be included as part of the Recovery, Resiliency, and Wellness Plan and medical record and may serve as verification that the member meets the medical necessity criteria for Peer Support Services or Family Support Partners.

Recovery, Resiliency, and Wellness Plan

Under the clinical oversight of a qualified practitioner making the recommendation for Peer Support Services or Family Support Partners, PRS in consultation with their direct supervisor shall develop a Recovery, Resiliency, and Wellness Plan. The plan shall be based on the members, and as applicable the caregiver's perceived recovery needs and any clinical assessment within 30 calendar days of the initiation of service. Development of the Recovery, Resiliency, and Wellness Plan shall include collaboration with the member and, as applicable, the caregiver. Individualized goals and strategies shall be focused on the member identified

needs for self-advocacy and recovery.

The Recovery, Resiliency, and Wellness Plan shall also include documentation of how many days per week and how many hours per week are required to carry out the services in order to meet the goals of the Plan. The Recovery, Resiliency, and Wellness plan shall be completed, signed, and dated by the qualitied practitioner making the recommendation, the PRS, the direct supervisor, the member, and as applicable the caregiver involved in the members recovery within 30 calendar days of the initiation of service. The PRS shall act as an advocate for the member, encouraging the member and as applicable the caregiver to take a proactive role in developing and updating goals and objectives in the ized recovery planning. The PRS shall be empowered to convene multidisciplinary team meetings regarding a participating member's needs and desires, and the PRS shall participate as an equal practitioner partner with all staff in multidisciplinary team meetings.

Services with a length of stay fewer than 30 calendar days still require a Recovery, Resiliency, and Wellness Plan. Members receiving Peer Support Services or Family Support Partners within a short-term program require a Recovery, Resiliency, and Wellness Plan as described above during the provision of services that focuses on the identified recovery goals. Providers are to ensure the timely completion of the Recovery, Resiliency, and Wellness Plan while a member is receiving services of durations that are fewer than 30 calendar days.

Upon discharge from a short-term program, if the member chooses to continue receiving Peer Recovery Support Services and still meets the medical necessity criteria for Peer Support Services or Family Support Partners, the provider shall be allowed to continue services as long as all of the reimbursement criteria outlined in this Peer Recovery Support Services Supplement are met. The Recovery, Resiliency, and Wellness Plan that was developed prior to discharge from the short- term program shall remain in effect and services shall continue to be delivered in accordance with the member's goals and objectives as identified in the Recovery, Resiliency, and Wellness Plan.

Services shall be delivered in accordance with the member's goals and objectives as identified in the Recovery, Resiliency, and Wellness Plan. As determined by the goal(s) identified in the Recovery, Resiliency, and Wellness Plan, services may be

rendered in the provider's office or in the community, or both. The level of services provided and total time billed for the week shall not exceed the frequency or intensity established in the Recovery, Resiliency, and Wellness Plan.

Review of Recovery, Resiliency, and Wellness Plan

Under the clinical oversight of the qualified practitioner making the recommendation for service, the PRS in consultation with their direct supervisor shall conduct and document a Review of the Recovery, Resiliency, and Wellness Plan every 90 calendar days with the member and family or caregiver as applicable. The review shall be signed by the PRS and the member, and as applicable the identified caregiver. Review of the Recovery Resiliency and Wellness Plan means the PRS evaluates and updates the member's progress every 90 calendar days toward meeting the Recovery, Resiliency, and Wellness Plan's goals and documents the outcome of this review in the member's medical record. For DMAS to determine that these reviews are complete, the reviews shall (i) update the goals and strategies as needed to reflect any change in the member's recovery as well as any newly identified needs; (ii) be conducted in a manner that enables the member to actively participate in the process; and (iii) be documented by the PRS in the member's medical record no later than 15 calendar days from the date of the review.

Progress Notes

Progress notes as defined in 12VAC30-50-130 shall be required and shall record the date, time, place of service, participants, face-to-face or telephone contact and circumstance of contact, regardless of whether or not a billable service was provided, and shall summarize the purpose and content of the Peer Support Services or Family Support Partner session along with the specific strategies and activities utilized as related to the goals in the Recovery, Resiliency, and Wellness Plan. Documentation of the specific strategies and activities rendered shall fully disclose the details of services rendered and align with the Recovery, Resiliency, and Wellness Plan.

Progress notes shall reflect collaboration between the PRS and the member in the development of the progress note. If contact with the member cannot be made, the service is not billable. However, the progress note shall reflect attempts to contact the member. Progress notes shall contain the dated signature of the PRS who

provided the service.

Supervision Documentation

The enrolled/credentialed provider shall ensure that documentation of all supervision sessions be maintained in a supervisor's log or in the PRS' personnel file.

Care Coordination Documentation

Collaboration shall be required with all behavioral health service providers and shall include the PRS, the member, or caregiver as applicable and shall involve discussion regarding initiation of services and updates on the member's status. Documentation of all collaboration shall be maintained in the member's record. Plans for collaboration shall be included in the Recovery, Resiliency, and Wellness Plan and shall not be performed without properly signed release(s) of information. Collaboration rendered with other service providers without the member present shall not be billable.

The enrolled/credentialed provider may integrate an member's peer support record with the member's other records maintained within same provider agency or facility, provided the peer support record is clearly identified and logs and progress notes documenting the provision of Peer Support Services or Family Support Partners corroborate billed services.

Limitations: ARTS and MH Peer Recovery Support Services

An approved service authorization or registration submitted by the enrolled/credentialed provider shall be required prior to service delivery in order for reimbursement to occur. To obtain service authorization, all providers' information supplied to the DMAS or its contractor shall be fully substantiated throughout the member's record.

A unit of service shall be defined as 15 minutes. Peer Support Services and Family

Support Partners shall be limited to four hours per day (up to 16 units per calendar day) and nine hundred (900) hours per calendar year. Service delivery limits may be exceeded based upon documented medical necessity and service authorization approval. Providers should review the MCO contract requirements for specific requirements for registration or authorization.

PEER SUPPORT SERVICES & FAMILY SUPPORT PARTNERS	**UNIT VALUE**	**PROCEDURE CODE**	**RATE**	**DAILY LIMITS**	**ANNUAL LIMITS**
ARTS Member	1 unit=15 minutes	T1012	$6.50 per 15 minute unit	4 hours/16 units per calendar day	Up to 900 hours/3600 units per calendar year
ARTS Group		S9445	$2.70 per 15 minute unit		
Mental Health Member		H0024	$6.50 per 15 minute unit		Up to 900 hours/3600 units per calendar year
Mental Health Group		H0025	$2.70 per 15 minute unit		

If an assessment is completed for MH Peer Support Services or MH Family Support Partners as set forth in 12VAC 30-50-226 or 12VAC30-50-130 in addition to a completed assessment for ARTS Peer Support Services or ARTS Family Support Partners as set forth in 12VAC 30-130- 5160 through 12VAC30-130-5210, no more than a total of four hours (up to 16 units) of services shall be rendered per calendar day. An enrolled provider cannot bill DMAS separately for: i) MH Peer Recovery Support Services (MH Peer Support Services or MH Family Support Partners) and ii) ARTS Peer Recovery Support Services (Peer Support Services or ARTS Family Support Partners) rendered on the same calendar day unless the MH Peer Services and ARTS Peer Services are rendered at different times. The enrolled provider must coordinate services to ensure the four hour daily service

limit is not exceeded. No more than a total of four hours of one type of service, or a total of four hours of a combination of service types, up to 16 units of total service, shall be provided per calendar day. A separate annual service limit of up to 900 hours shall apply to MH Peer Support Services or MH Family Support Partners Service and ARTS Peer Support Services or Family Support Partners.

Service shall be initiated within 30 calendar days of the completed assessment and shall be valid for no longer, than 30 calendar days. If the time has exceeded 30 calendar days without service initiation, another assessment for services shall be required.

Peer Support Services and Family Support Partners rendered in a group setting shall have a ratio of no more than 10 members to one PRS and progress notes shall be included in each Medicaid member's record to support billing.

General support groups which are made available to the public to promote education and global advocacy do not qualify as Peer Support Services or Family Support Partners.

Non-covered activities include:

- Transportation;
- Record keeping or documentation activities (including but not limited to progress notes, tracking hours and billing and other administrative paperwork);
- Services performed by volunteers;
- Household tasks such as chores and grocery shopping;
- On the job training;
- Case management;
- Meals and breaks:
- Outreach to potential clients; and
- Room and board.

The PRS shall document each 15-minute unit in which the member was actively engaged in Peer Support Services or Family Support Partners. Non-covered activities listed in this section shall not be included in the reporting of units of

service delivered. Should a member receive other services during the range of documented time in/time out for Peer Recovery Support Service hours, the absence of or interrupted services must be documented.

Family Support Partners is not billable for siblings of the targeted youth for whom a need is specified unless there is applicability to the targeted youth/family. The applicability to the targeted youth must be documented.

Family Support Partners shall not be billed for youth who resides in a congregate setting in which the caregivers are paid (such as child caring institutions, or any other living environment that is not comprised of caregivers as defined above). An exception would be for youth actively preparing for transition back to a single-family unit, the caregiver is present during the intervention, and the service is directed to supporting the unification/reunification of the youth and his/her caregiver and takes place in that home and community. The circumstances surrounding the exception shall be documented.

Members with the following conditions are excluded from Peer Support Services and Family Support Partners unless there is clearly documented evidence and diagnosis of a substance use disorder or mental health disorder overlaying the diagnosis: developmental disability including intellectual disabilities, organic mental disorder including dementia or Alzheimer's, or traumatic brain injury. There must be documented evidence that the member is able to participate in the service and benefit from Peer Support Services or Family Support Partners.

Claims that are not adequately supported by appropriate up to date documentation may be subject to recovery of expenditures. Progress notes, as defined in 12VAC30-50-130, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes shall be subject to recovery of expenditures.

The enrolled/credentialed provider shall be subject to utilization reviews conducted by DMAS or its designated contractor. Reimbursement shall be subject to retraction for any billed service that is determined to not be in compliance with DMAS requirements.

Service Authorization and Billing Instructions (ARTS)

All providers must be under contract and enrolled/credentialed with the appropriate MCOs

for respective managed care enrolled members and DMAS or its contractor for fee-for-service members. Enrolled/credentialed providers must contact the MCO for managed care enrolled members or DMAS or its contractor for fee-for-service members directly for information regarding service authorization and claims processing instructions.

Peer Support Services and Family Support Partners shall be registered and providers can access registration forms here: http://www.dmas.virginia.gov/#/artsregistration.

Peer Support Services and Family Support Partners are billed separately from the per diem or Diagnostic Related Group (DRG) for the following ARTS and MH Settings. Peer Services claims should be submitted on a CMS-1500 for managed care and fee-for-service members:

- ARTS Residential Placements (Levels 3.7, 3.5, 3.3, and 3.1) licensed by DBHDS as defined in 12VAC30-130-5110 through 12VAC30-130-5140.
- Hospital Emergency Department Services licensed by VDH.
- Acute Care General Hospital licensed by VDH.
- Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by the DBHDS.
- Psychiatric Residential Treatment Facility licensed by DBHDS.
- Therapeutic Group Home licensed by DBHDS.

Telehealth Services Supplement

Definitions (TH)

Audio only

The use of real-time telephonic communication that does not include use of video.

Distant Site

The distant site is the location of the Provider rendering the covered service via telehealth.

Originating Site

The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates (i.e., where the data are

collected). Examples of originating sites include: medical care facility; Provider's outpatient office; the member's residence or school; or other community location (e.g., place of employment).

Provider

For purposes of this manual supplement, the term "Provider" refers to the billing provider – either a qualified, licensed practitioner of the healing arts or a facility – who is enrolled with DMAS.

Remote Patient Monitoring

Remote Patient Monitoring (RPM) involves the collection and transmission of personal health information from a beneficiary in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Store-and-Forward

Store-and-forward means the asynchronous transmission of a member's medical information from an originating site to a health care Provider located at a distant site. A member's medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are covered in the dental manuals.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

Virtual Check-In

A Virtual Check-In is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

Reimbursable Telehealth Services

Attachment A lists covered services that may be reimbursed when provided via telehealth. Specifically:

Table 1 –

- Table 3 list Telemedicine and Store-and-Forward services
- Table 4 lists Remote Patient Monitoring services
- Table 5 lists Virtual Check-In services
- Table 6 lists audio only services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 6 in this Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care Organization (MCO)-enrolled individuals, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at https://www.dmas.virginia.gov/#/cccplus and https://www.dmas.virginia.gov/#/med4.

Additional modality-specific conditions for reimbursement are provided, below.

Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.
- Telemedicine must not be used when in-person services are medically and/or clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.
- If, after initiating a telemedicine visit, the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange, in a timely manner, an alternative to meet the needs of the individual (e.g., services delivered in-person; services delivered via telemedicine when conditions allow telemedicine to meet requirements stipulated in the "Reimbursable Telehealth Services" section). In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
    - Medically complex patient under 21 years of age (6 months);
    - Transplant patient (6 months);
    - Post-surgical patient (up to 3 months following the date of surgery);
    - Patient with a chronic health condition who has had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months (6 months); and/or a
    - High-risk pregnant person (6 months).
- All service authorization criteria outlined in the DMAS Form "DMAS-P268" are met prior to billing the following CPT/HCPCS codes:
    - Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
    - Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
    - Self-Measured Blood Pressure: 99473, 99474

- Providers must meet the criteria outlined in the DMAS Form "DMAS-P268" and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.
- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form "DMAS-P268".

Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

Reimbursement and Billing for Telehealth Services

Telemedicine

Distant site Providers must include the modifier **GT** on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would *have normally been provided*, had interactions occurred in-person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Store-and-Forward

Distant site Providers must include the modifier **GQ**.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

Remote Patient Monitoring

No billing modifier is required on claims for services delivered via RPM.

Devices used to satisfy conditions for CPT 99453 and 99454 must automatically digitally upload patient data (i.e., not self-recorded or reported by patients) and automatically transmit either daily recordings of the beneficiary's physiologic data OR the device must record daily values and transmit an alert if the beneficiary's values fall outside predetermined parameters for 16 days in a 30-day period. Devices used to satisfy conditions for CPT 98975, 98976 and 98977 must be used to monitor data for 16 days in a 30-day period. These codes cannot be used for monitoring of parameters for which more specific codes are available (i.e., CPT 93296, 93264, 94760).

Services billed for using CPT 99457, 99458 and 99091 may involve review of data collected in conjunction with codes CPT 99453, 99454, or physiologic data manually captured and submitted by the patient/caregiver for billing providers to review. Services billed for using CPT 98980 and 98981 may involve review of data collected in conjunction with codes 98975, 98976, 98977, or therapeutic data (including self-reported data) manually captured and submitted by the patient/caregiver for billing providers to review.

Time requirements associated with CPT 99457, 99458, 98980, 98981, and 99091 can include time spent furnishing care management services, if not billed for under other reported services, as well as time spent on required direct interactive communication. Interactive communication is defined as real-time synchronous, two-way audio interaction. Time spent on a day when the billing provider reports an E/M service (office or other outpatient services) shall not be included. Time counted toward time requirements of other reported services must also not be counted toward the time requirements of the aforementioned codes.

Only providers eligible to bill CMS Evaluation & Management (E&M) services are eligible to bill for RPM services. Clinical staff members—who work under the supervision of the eligible billing provider and are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who do not individually report that professional service—are allowed to assist in delivery and satisfaction of appropriate RPM service requirements for 99453, 98975, 99457, 99458, 98980, and 98981, but not 99091.

Codes including the provision of RPM devices (99454, 98976, 98977) shall not be billed if patients supply their own device, or have been separately provided relevant durable medical equipment by DMAS.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, shall reflect the location in which patients would *normally be evaluated.* For example, if the member would have come to a private office to discuss management of the condition being monitored via RPM, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

An individual provider must not bill for more than one set of RPM services per patient at any given time.

Virtual Check-In

No billing modifier is required on claims for the covered Virtual Check-In codes listed, in Table 5 of Attachment A.

Virtual Check-In services do not require service authorization.

Only physicians and other qualified health care professionals – previously defined by the American Medical Association as being an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service – may furnish and bill for Virtual Check-In services.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which patients would have received services had the service occurred in-person and not virtually. For example, if the member would have come to a private office to discuss management of the condition being addressed via virtual check-in, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Originating Site Fee (TH)

Telemedicine

In the event it is medically necessary for a Provider to be present at the originating site at the time a synchronous telehealth service is delivered, said Provider may bill an originating site fee (via procedure code Q3014) when the following conditions are met:

- The Medicaid member is located at a provider office or other location where services can be received (this does not include the member's residence);
- The member and distant site Provider are not located in the same location; and
- The Provider (or the Provider's designee), is affiliated with the provider office or other location where the Medicaid member is located and attends the encounter with the member. The Provider or designee may be present to assist with initiation of the visit but the presence of the Provider or designee in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

All telehealth modalities

Originating site Providers, such as hospitals and nursing homes, submitting UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 ("Telemedicine-General") or 0789 ("Telemedicine-Other"). The use of these codes is currently not applicable for services administered by Magellan of Virginia.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider or originating site and bill under the encounter rate. The encounter rate methodology for FQHCs and RHCs is described in 12VAC30-80-25; the encounter rate for IHCs (including Tribal clinics) is the All Inclusive Rate set by Indian Health Services.

Service Limitations (TH)

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

Provider Requirements (TH)

All coverage requirements for a particular covered service described in the DMAS Provider

Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (888-829-5373) or the Medicaid MCOs for more information.

Documentation Requirements (TH)

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient’s medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site respectively to substantiate the services provided by each. When the originating site is the member’s residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

Member Choice and Education (TH)

Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);
- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member's benefits;
- That dissemination, storage, or retention of an identifiable member image or other information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;
- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine service and has the right to exclude anyone from either site; and
- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS's required documentation of patient consent.

Telehealth Equipment and Technology

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to in-person encounter for professional medical services.

Equipment utilized for Remote Patient Monitoring must meet the Food and Drug Administration (FDA) definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is

responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

Attachment A (TH)

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

Table 1. Medicaid-covered medical services authorized for delivery by telemedicine*

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Colposcopy		• 57452, 57454, 57455, 57456, 57460, 57461
Fetal Non-Stress Test		• 59025
Prenatal and Postpartum Visits	• Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person. • Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk.	• 59400, 59410, 59425, 59426, 59430, 59510, 59515
Radiology and Radiology-related Procedures		• 70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward**
Obstetric Ultrasound		• 76801, 76802, 76805, 76810, 76811-76817
Echocardiography, Fetal		• 76825, 76826
End Stage Renal Disease		• 90951 - 90970
Remote Fundoscopy		• 92250; TC if applicable; GQ modifier if store and forward • 92227, 92228; 26 if applicable; GQ modifier if store and forward
Speech Language Therapy/Audiology		• 92507†, 92508†, 92521, 92522, 92523, 92524
Diagnosis, analysis cochlear implant function		• 92601-92604, 95974
Cardiography interpretation and report		• 93010
Echocardiography		• 93307, 93308, 93320, 93321, 93325
Genetic Counseling		• 96040
Maternal Mental Health Screening		• 96127, 96160††, 96161††
Physical therapy / Occupational therapy		• 97110†, 97112†, 97150† • 97530†, S9129†
Medical Nutrition Therapy		• 97804
Evaluation & Management (Office/Outpatient)		• 99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Evaluation & Management (Hospital)		• 99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward
Evaluation & Management (Nursing facility)		• 99304-99306 • 99307-99310
Discharge planning (Nursing facility)		• 99315, 993169
Evaluation & Management (Assisted living facility)		• 99334, 99335, 99336
Respiratory therapy	• Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team. Restricted to outpatient respiratory therapy.	• 99503, 94664
Education for Diabetes, Smoking, Diet		• G0108, 97802, 97803
Early Intervention	• Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit. • Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. • Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.	• T2022 • w/ or w/o U1: T1023, T1024, T1027, G0151, G0152, G0153, G0495

Table 2. Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		• 90791-90792
Psychotherapy		• 90832, 90834, 90837
Psychotherapy for Crisis		• 90839-90840
Pharmacologic counseling		• 90863
Psychotherapy w/ E&M svc		• 90833, 90836, 90838
Psychoanalysis		• 90845
Family/Couples Psychotherapy		• 90846-90847
Group Psychotherapy		• 90853
Prolonged Service, in office or outpatient setting		• 99354-99357
Psychological testing evaluation		• 96130, 96131
Neuropsychological testing evaluation		• 96132, 96133

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Psychological or neuropsychological test administration & scoring		• 96136, 96137, 96138, 96139, 96146
Neurobehavioral Status Exam		• 96116, 96121
Add-on Interactive Complexity		• 90785
Health Behavior Assessment		• 96156
Health Behavior Intervention (Individual, group, family)		• 96158-96159 • 96164-96165 • 96167-96168 • 96170-96171
Evaluation & Management (Outpatient)		• 99202-99205, 99211-99215
Evaluation & Management (Inpatient)		• 99221-99223, 99231-99233
Smoking and tobacco cessation counseling		• 99406-99407
Alcohol/SA structured screening and brief intervention		• 99408-99409
OTP/OBOT Specific Services		• H0004, H0005, H0014*, G9012
SUD Case Management		• H0006
Mental Health Case Management Services		• H0023
IACCT Initial Assessment		• 90889 HK
IACCT Follow-Up Assessment		• 90889 TS
Mental Health Skill Building		• H0046
Crisis Stabilization		• H2019 (ended 11/30/2021)
Crisis Intervention		• H0036 (ended 11/30/2021)
Mobile Crisis Response	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• H2011 (effective 12/1/2021)
Community Stabilization	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• S9482 (effective 12/1/2021)
23 Hour Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• S9485 (effective 12/1/2021)
Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• H2018 (effective 12/1/2021)
Assertive Community Treatment		• H0040
Psychosocial Rehabilitation		• H2017
Intensive In-Home Services		• H2012
Therapeutic Day Treatment		• H2016
Behavioral Therapy Program		• H2033 (ended 11/30/2021)
Applied Behavior Analysis (ABA)	97151 and 97152 may be provided through telemedicine for reassessments only.	• 97151-97158 (effective 12/1/2021)
Multisystemic Therapy (MST)		• H2033 (effective 12/1/2021)
Functional Family Therapy (FFT)		• H0036 (effective 12/1/2021)
Foster Care Case Management		• T1016
Peer Recovery Support Services (PRSS)		• H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		• H0035
Mental Health Intensive Outpatient Program		• S9480
SUD Partial Hospitalization Program		• S0201
SUD Intensive Outpatient Program		• H0015

Table 3. Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage

Procedure Title (Reduced Length)	CPT Code
Fine needle aspiration; with imaging guidance	10022
Biopsy of breast; percutaneous, needle core, using image guidance	19102
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device	19103
Preoperative placement of needle localization wire, breast	19290
Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration	19295
Arthrocentesis, aspiration, and/or injection; major joint or bursa	20610
Transcatheter occlusion or embolization (eg, for tumor destruction, other)	37204
Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage	47011
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083
Electrocardiogram, routine ecg with at least 12 leads; with interpretation	93000
Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only	93010
Echocardiography, transthoracic, real-time with image documentation (2d)	93306
Duplex scan of extremity veins including responses to compression and other	93970
Duplex scan of extremity veins including responses to compression and other	93971
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93976

Table 4. Medicaid-covered services authorized for delivery via Remote Patient Monitoring

Procedure Title (Reduced Length)	Code
Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d	99091
Remote monitoring of physiologic parameter(s); set-up and education on use of equipment	99453
Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days	99454
Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes	99457
Each additional 20 minutes	99458
Remote therapeutic; initial set-up and patient education on use of equipment	98975
Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98976

Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98977
Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes	98980
Each additional 20 minutes	98981
Self-measured blood pressure; patient education/training and device calibration	99473
Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan	99474

Table 5. Virtual Check-In Services

Service	Code
Virtual check-in, E&M-eligible providers, 5-10 min	G2012
Virtual check-in, non-E&M-eligible providers, 5-10 min	G2251
Virtual check-in, E&M-eligible providers, 11-20 min	G2252
Remote evaluation of recorded video and/or images, E&M-eligible providers	G2010
Remote evaluation of recorded video and/or images, non-E&M-eligible providers	G2250

Table 6. Audio Only Services*

Service	Code
Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion	99443
Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion	98966
Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion	98968

* All fee-for-service claims for audio only codes should be billed directly to DMAS, including those delivered in the context of mental health and substance use disorder services. See Chapter V of the Physician/Practitioner Manual for detailed billing instructions.