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

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

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

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

1. Payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.
2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.
3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.
4. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, early and periodic screening, diagnostic, and treatment services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act §1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the State Plan and notwithstanding the limitations, applicable to recipients ages 21 and over, provided for by the Act §1905(a).
5. Community mental health services.

a. **Intensive in-home services to children and adolescents under age 21** shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. These services shall be limited annually to 26 weeks.

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

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

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

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

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

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

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

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

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-50-226. Community mental health services.

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

“Certified pre-screener” means an employee of the local community services board or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DMHMRSAS."

“Clinical experience” means practical experience in providing direct services to individuals with mental illness or mental retardation or the provision of direct geriatric services or special education services. Experience may include supervised internships, practicums, and field experience.

"Code" means the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DMHMRSAS" means Department of Mental Health, Mental Retardation and Substance Abuse Services consistent with Chapter 1 (§37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

“Human services field” means social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, and human services counseling or other degrees deemed equivalent by DMAS.

"Individual" means the patient, client, or recipient of services set out herein.

"Individual service plan" or "ISP" means a comprehensive and regularly updated statement specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, and estimated timetable for achieving the goals and objectives. ~~Such~~ The provider shall include the individual in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be ~~maintained up to date~~ updated as the needs and progress of the individual changes.

"Licensed Mental Health Professional" (LMHP) means an individual licensed in Virginia as a physician, a clinical psychologist, a professional counselor, a clinical social worker, or a psychiatric clinical nurse specialist.

"Qualified Mental Health Professional" (QMHP) means a clinician in the [~~health professions~~ human services field] who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. If the QMHP is also one of the defined licensed mental health professionals, the QMHP may perform the services designated for the Licensed Mental Health Professionals unless it is specifically prohibited by their licenses. These QMHPs may be either a:

1. Physician who is a doctor of medicine or osteopathy and is licensed in Virginia;

2. Psychiatrist who is a doctor of medicine or osteopathy, specializing in psychiatry and is licensed in Virginia;

3. Psychologist who has a master's degree in psychology from an accredited college or university with at least one year of clinical experience;

4. Social worker who has a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education and has at least one year of clinical experience;

5. Registered nurse who is licensed as a registered nurse in the Commonwealth and has at least one year of clinical experience; OR

6. Mental health worker who has at least:

(a) A bachelor degree in human services or related field from an accredited college and who has at least one year of clinical experience;

(b) Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as of January 1, 2001;

(c) A bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field. The individual must also have three years clinical experience;

(d) A bachelor's degree from an accredited college and certification by the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP);

(e) A bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field. The individual must also have three years clinical experience, OR;

(f) Four years clinical experience.

"Qualified para-professional in mental health" (QPPMH) means an individual who meets at least one of the following criteria:

(a) Registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as an Associate Psychiatric Rehabilitation Provider (APRP), as of January 1, 2001;

(b) Has an associate's degree in one of the following related fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of experience providing direct services to persons with a diagnosis of mental illness;

(c) An associate's or higher degree, in an unrelated field and at least three years experience providing direct services to persons with a diagnosis of mental illness, gerontology clients, or special education clients. The experience may include supervised internships, practicums and field experience.

(d) A minimum of 90 hours classroom training in behavioral health and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of clinical experience (including the 12 weeks of supervised experience).

(e) College credits (from an accredited college) earned toward a bachelor's degree in a human service field that is equivalent to an associate's degree and one year's clinical experience.

(f) Licensure by the Commonwealth as a practical nurse with at least one year of clinical experience.

(g) Certification by the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP).

B. Mental health services. The following services, with their definitions, shall be covered: Day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health supports. Staff travel time shall not be included in billable time for reimbursement.

1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.

a. Day treatment/partial hospitalization services shall be time limited interventions which are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit behavior that requires repeated interventions or monitoring by the mental health, social services, or judicial system; OR

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

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

2. Psychosocial rehabilitation shall be provided ~~in sessions of~~ at least two or more ~~consecutive~~ hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about ~~his~~ the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness which results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the

community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; OR

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

3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, ~~limited annually to 180 hours~~, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the

individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that he is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are necessary; OR

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

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

4. Intensive community treatment (ICT), initially covered for a maximum of 26 weeks based on an initial assessment with continuation re-authorized for an additional 26 weeks annually based on written assessment and certification of need by a qualified mental health provider (QMHP), shall be defined as medical psychotherapy, psychiatric assessment, [~~and~~]medication management[, and case management activities] offered to outpatients outside the clinic, hospital, or office setting for individuals who ~~[will not or cannot be served in the clinic setting~~ are best served in the community.] The annual unit limit shall be 130 units with a unit equaling one hour. To qualify for ICT, the individual must meet at least one of the following criteria:

a. The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.

b. The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for [co-occurring] serious mental illness and [substance use

disorder ~~chemical addiction~~]and demonstrates a resistance to seek out and utilize appropriate treatment options.

(1) An assessment that documents eligibility and the need for this service must be completed prior to the initiation of services. This assessment must be maintained in the individual's records.

(2) A service plan must be initiated at the time of admission and must be fully developed within 30 days of the initiation of services.

5. Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. Authorization may be for up to a 15-day period per crisis episode following a documented face-to-face assessment by a QMHP which is reviewed and approved by ~~a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or a certified psychiatric registered nurse~~ a LMHP within 72 hours. The maximum limit on this service is up to eight hours (with a unit being one hour) per day up to 60 days annually. The goals of crisis stabilization programs shall be to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and

rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement. The crisis stabilization program shall provide to recipients, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of a recipient who lives with family or other primary caregiver; (ii) the home of a recipient who lives independently; or (iii) community-based programs licensed by DMHMRSAS to provide residential services but which are not institutions for mental disease (IMDs). This service shall not be reimbursed for (i) recipients with medical conditions which require hospital care; (ii) recipients with primary diagnosis of substance abuse; or (iii) recipients with psychiatric conditions which cannot be managed in the community, i.e., recipients who are of imminent danger to themselves or others. Services must be documented through daily notes and a daily log of times spent in the delivery of services. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(a) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that he is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(b) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(c) Exhibit such inappropriate behavior that immediate interventions by the mental health, social services, or judicial system are necessary; OR

(d) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior.

~~6.~~ 5. Mental health support services shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services may be authorized for six consecutive months. ~~Continuation of services may be authorized at six-month intervals or following any break in service by a QMHP based on a documented assessment and documentation of continuing need. The monthly limit on services shall be 31 units.~~ This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness which results in significant functional impairments in major life activities. Services are provided to individuals who without these services would be unable to remain in the community. The individual must have two of the following criteria on a continuing or intermittent basis:

(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports;

(2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; OR

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

b. The individual must demonstrate functional impairments in major life activities. This may include individuals with a dual diagnosis of either mental illness and mental retardation, or mental illness and substance abuse disorder.

c. The yearly limit for mental health support services is 372 units. [~~A unit equals one hour.~~ One unit is one hour but less than three hours.]

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

Case management services for seriously mentally ill adults and emotionally disturbed children.

A. Target Group: The Medicaid eligible individual shall meet the DMHMRSAS definition for "serious mental illness", or "serious emotional disturbance in children and adolescents".

1. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90 days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services ~~except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge~~. Case management ~~for institutionalized individuals may be billed for no more than two predischarge periods in 12 months~~. shall not be billed for individuals who are in institutions for mental disease.

B. Services will be provided to the entire State.

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

D. Definition of Services: Mental health services. Case management services assist individual children and adults, in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the individualized service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual.

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts with the individuals' significant others to promote implementation of the service plan and community adjustment;

7. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of Providers:

1. Services are not comparable in amount, duration, and scope. Authority of §1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and individuals with serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of §1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental health case management, the provider of the services must meet certain criteria. These criteria shall be:

~~a. The provider must guarantee that clients have access to emergency services on a 24 hour basis;~~

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

~~c.~~ a. The provider must have the administrative and financial management capacity to meet state and federal requirements;

~~d.~~ b. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

~~e.~~ c. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

~~f.~~ d. The provider must be licensed as a provider of case management services ~~certified as a mental health case management agency~~ by the DMHMRSAS.

e. Persons providing case management services must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

(2) The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;

(3) Different types of assessments, including functional assessments, and their uses in service planning;

(4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(5) The service planning process and major components of a service plan;

(6) The use of medications in the care or treatment of the population served; and

(7) All applicable federal and state laws, state regulations, and local ordinances.

f. Persons providing case management services must have skills in:

(1) Identifying and documenting an individual's needs for resources, services, and other supports;

(2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;

(3) Identifying services and resources within the community and established service system to meet the individual's needs; and documenting how resources, services, and natural supports,

such as family, can be utilized to achieve an individual's personal habilitative/rehabilitative, and life goals; and

(4) Coordinating the provision of services by public and private providers.

g. Persons providing case management services must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently, performing position duties under general supervision; and

(3) Engage and sustain ongoing relationships with individuals receiving services.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. ~~The case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).~~

~~a. Knowledge of:~~

~~(1) the nature of serious mental illness in adults and serious emotional disturbance in children and adolescents~~

~~(2) treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination~~

~~(3) different types of assessments, including functional assessment, and their uses in service planning~~

~~(4) consumers' rights~~

~~(5) local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups)~~

~~(6) types of mental health programs and services~~

~~(7) effective oral, written and interpersonal communication principles and techniques~~

~~(8) general principles of record documentation~~

~~(9) the service planning process and major components of a service plan~~

~~b. Skills in:~~

~~(1) interviewing~~

~~(2) observing, recording and reporting on an individual's functioning~~

~~(3) identifying and documenting a consumer's needs for resources, services and other supports~~

~~(4) using information from assessments, evaluations, observation and interviews to develop service plans~~

~~(5) identifying services within the community and established service system to meet the individual's needs~~

~~(6) formulating, writing and implementing individualized service plans to promote goal attainment for persons with serious mental illness and emotional disturbances~~

~~(7) negotiation with consumers and service providers~~

~~(8) coordinating the provision of services by diverse public and private providers~~

~~(9) identifying community resources and organizations and coordinating resources and activities~~

~~(10) using assessment tools (e.g. level of function scale, life profile scale)~~

~~c. Abilities to:~~

~~(1) demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of people with mental illness, respecting consumers' and families' privacy, believing consumers are valuable members of society)~~

~~(2) be persistent and remain objective~~

~~(3) work as a team member, maintaining effective inter- and intra-agency working relationships~~

~~(4) work independently, performing position duties under general supervision~~

~~(5) communicate effectively, verbally and in writing~~

~~(6) establish and maintain ongoing supportive relationships~~

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

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

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

G. Payment for case management services under the plan ~~does~~ shall not duplicate payments made to public agencies ~~of~~ or private entities under other program authorities for this same purpose.

H. Case management services may not be billed concurrently with intensive community treatment services, treatment foster care case management services or intensive in-home services for children and adolescents.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-50-430. Case management services for youth at risk of serious emotional disturbance.

A. Target Group: Medicaid eligible individuals who meet the DMHMRSAS definition of youth at risk of serious emotional disturbance.

1. An active client shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90-days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services ~~except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge~~. Case management ~~for institutionalized individuals may be billed for no more than two predischarge periods in 12 months.~~ services must not be billed for individuals who are in institutions for mental disease.

B. Services will be provided in the entire State.

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

D. Definition of Services: Mental health services. Case management services assist youth at risk of serious emotional disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan;

2. Linking the individual directly to services and supports specified in the treatment/services plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts which are non-therapy contacts with an individual's significant others to promote treatment and/or community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of Providers

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(1) of the Act is invoked to limit case management providers, to the Community Services Boards only, to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of § 1902(a)(10)(B) of the Act. To qualify as a provider of case management services to youth at risk of serious emotional disturbance, the provider of the services must meet ~~certain~~ the following criteria~~. These criteria shall be~~:

~~a. The provider must guarantee that clients have access to emergency services on a 24 hour basis;~~

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

~~c.~~a. The provider must ~~have the administrative and financial management capacity to meet state and federal requirements~~ meet state and federal requirements regarding its capacity for administrative and financial management;

~~d~~b. The provider must have ~~the ability to~~ document and maintain individual case records in accordance with state and federal requirements;

~~e.~~c. The provider must provide services ~~shall be~~ in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

~~f.~~d. The provider must be licensed as a provider of case management services ~~certified as a mental health case management agency~~ by the DMHMRSAS.

e. Persons providing case management services must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

(2) The nature of serious mental illness, mental retardation and/or substance abuse depending on the population served, including clinical and developmental issues;

(3) Different types of assessments, including functional assessments, and their uses in service planning;

(4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(5) The service planning process and major components of a service plan;

(6) The use of medications in the care or treatment of the population served; and

(7) All applicable federal and state laws, state regulations, and local ordinances.

f. Persons providing case management services must have skills in:

(1) Identifying and documenting an individual’s need for resources, services, and other supports;

(2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;

(3) Identifying services and resources within the community and established service system to meet the individual’s needs; and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/ rehabilitative and life goals; and

(4) Coordinating the provision of services by diverse public and private providers.

g. Persons providing case management services must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently performing position duties under general supervision; and

(3) Engage and sustain ongoing relationships with individuals receiving services.

~~2.~~ F. Providers may bill Medicaid for mental health case management to youth at risk of serious emotional disturbance only when the services are provided by qualified mental health case managers. ~~The case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).~~

~~a. Knowledge of:~~

~~(1) The nature of serious mental illness in adults and serious emotional disturbance in children and adolescents~~

~~(2) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination~~

~~(3) Different types of assessments, including functional assessment, and their uses in service planning~~

~~(4) Consumer's rights~~

~~(5) Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, self-help groups)~~

~~(6) Types of mental health programs and services~~

~~(7) Effective oral, written and interpersonal communication principles and techniques~~

~~(8) General principles of record documentation~~

~~(9) The service planning process and major components of a service plan~~

~~b. Skills in:~~

~~(1) Interviewing~~

~~(2) Observing, recording and reporting on an individual's functioning~~

~~(3) Identifying and documenting a consumer's needs for resources, services and other supports~~

~~(4) Using information from assessments, evaluations, observation and interviews to develop service plans~~

~~(5) Identifying services within the community and established service system to meet the individual's needs~~

~~(6) Formulating, writing and implementing individualized service plans to promote goal attainment for persons with serious mental illness and emotional disturbances~~

~~(7) Negotiating with consumers and service providers~~

~~(8) Coordinating the provision of services by diverse public and private providers~~

~~(9) Identifying community resources and organizations and coordinating resources and activities~~

~~(10) Using assessment tools (e.g. level of function scale, life profile scale)~~

~~c. Abilities to:~~

~~(1) Demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of people with mental illness, respecting consumers' and families' privacy, believing consumers are valuable members of society)~~

~~(2) Be persistent and remain objective~~

~~(3) Work as a team member, maintaining effective inter- and intra- agency working relationships~~

~~(4) Work independently, performing position duties under general supervision~~

~~(5) Communicate effectively, verbally and in writing~~

~~(6) Establish and maintain ongoing supportive relationships~~

~~F.~~ G. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

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

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

~~G.~~ H. Payment for case management services under the plan [~~does~~ must] not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Case management may not be billed concurrently with intensive community treatment services, treatment foster care case management services, or intensive in-home services for children and adolescents.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-50-510. Requirements and limits applicable to specific services: expanded prenatal care services.

A. Comparability of services: Services are not comparable in amount, duration and scope. Authority of §9501(b) of COBRA 1985 allows an exception to provide service to pregnant women without regard to the requirements of § 1902(a)(10)(B).

B. Definition of services: Expanded prenatal care services will offer a more comprehensive prenatal care services package to improve pregnancy outcome. The expanded prenatal care services provider may perform the following services:

1. Patient education. Includes six classes of education for pregnant women in a planned, organized teaching environment including but not limited to topics such as body changes, danger signals, substance abuse, labor and delivery information, and courses such as planned parenthood, Lamaze, smoking cessation, and child rearing. Instruction must be rendered by Medicaid certified providers who have appropriate education, license, or certification.

2. Homemaker. Includes those services necessary to maintain household routine for pregnant women, primarily in third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation. Must be rendered by Medicaid certified providers.

3. Nutrition. Includes nutritional assessment of dietary habits, and nutritional counseling and counseling follow-up. All pregnant women are expected to receive basic nutrition information from their medical care providers or the WIC Program. Must be provided by a Registered Dietitian (R.D.) or a person with a master's degree in nutrition, maternal and child health, or

clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

4. Blood glucose meters. Effective on and after July 1, 1993, blood glucose test products shall be provided when they are determined by the physician to be medically necessary for pregnant women suffering from a condition of diabetes which is likely to negatively affect their pregnancy outcomes. The women authorized to receive a blood glucose meter must also be referred for nutritional counseling. Such products shall be provided by Medicaid enrolled durable medical equipment providers.

5. Residential substance abuse treatment services for pregnant and postpartum women. Includes comprehensive, intensive residential treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent with standards established to assure high quality of care in 12VAC30-60~~-10 et seq~~. Residential substance abuse treatment services for pregnant and postpartum women shall provide intensive intervention services in residential facilities other than inpatient facilities and shall be provided to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse disorders, for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The woman may keep her infant and other dependent children with her at the treatment center. The daily rate is inclusive of all services which are provided to the pregnant woman in the program. A unit of service shall be one day. The maximum number of units to be covered ~~for one adult in her lifetime is 330 days of~~

~~continuous~~ per pregnancy is 300 days~~service~~, not to exceed 60 days postpartum. ~~The lifetime limit may only be provided during one course of treatment.~~ These services must be reauthorized every 90 days and after any absence of less than 72 hours which was not first authorized by the program director. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. An unauthorized absence of more than 72 hours shall terminate Medicaid reimbursement for this service. Unauthorized hours absent from treatment shall be included in this lifetime service limit.

This type of treatment shall provide the following types of services or activities in order to be eligible to receive reimbursement by Medicaid:

a. Substance abuse rehabilitation, counseling and treatment must include, but is not necessarily limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes if needed; education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but is not necessarily limited to, the impact of alcohol and other drugs on fetal development, normal physical changes associated with pregnancy as well as training in normal gynecological functions, personal nutrition, delivery expectations, and infant nutrition.

c. Initial and ongoing assessments shall be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including medication management and ongoing psychological treatment.

e. Personal health care training and assistance shall be provided. Such training shall include:

(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC §300x-24(b)(6)(A) and (B), including early intervention services as defined in 42 USC §300x-24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;

(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC §300x-24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and

(3) Education services and referral services for testing, counseling, and management of hepatitis.

f. Case coordination with providers of primary medical care shall be provided, including obstetrical/gynecological services for the recipient.

g. Training in decision-making, anger management and conflict resolution shall be provided.

h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, and representatives of appropriate service agencies.

6. ~~Day substance~~ Substance abuse day treatment for pregnant and postpartum women. Includes comprehensive, intensive day treatment for pregnant and postpartum women to improve pregnancy outcomes by eliminating the substance abuse problem. Must be provided consistent

with the standards established to assure high quality of care in 12VAC30-60-10 et seq. Substance abuse day treatment services for pregnant and postpartum women shall provide intensive intervention services at a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week, to pregnant and postpartum women (up to 60 days postpartum) with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug-free lifestyle. The pregnant woman may keep her infant and other dependent children with her at the treatment center. One unit of service shall equal two but no more than 3.99 hours on a given day. Two units of service shall equal at least four but no more than 6.99 hours on a given day. Three units of service shall equal seven or more hours on a given day. The ~~lifetime~~ limit on this service shall be ~~440~~ 400 units per pregnancy, not to exceed 60 days post partum ~~in a 12-month period. The lifetime limit may only be provided during one course of treatment~~. Services must be reauthorized every 90 days and after any absence of five consecutive days from scheduled treatment without staff permission. More than two episodes of five-day absences from scheduled treatment without prior permission from the program director or one absence exceeding seven days of scheduled treatment without prior permission from the program director shall terminate Medicaid funding for this service. The program director must document the reason for granting permission for any absences in the clinical record of the recipient. Unauthorized hours absent from treatment shall be included in the lifetime service limit. In order to be eligible to receive Medicaid payment the following types of services shall be provided:

a. Substance abuse rehabilitation, counseling and treatment shall be provided, including education about the impact of alcohol and other drugs on the fetus and on the maternal relationship, smoking cessation classes if needed; relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

b. Training about pregnancy and fetal development shall be provided at a level and in a manner comprehensible by the participating women to include, but not necessarily be limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy, as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

c. Initial and ongoing assessments shall be provided specifically for substance abuse, including psychiatric and psychological assessments.

d. Symptom and behavior management as appropriate for co-existing mental illness shall be provided, including medication management and ongoing psychological treatment.

e. Personal health care training and assistance shall be provided. Such training shall include:

(1) Educational services and referral services for testing, counseling, and management of HIV, provided as described in 42 USC §300x-24(b)(6)(A) and (B), including early intervention services as defined in 42 USC §300x-24(b)(7) and in coordination with the programs identified in 45 CFR 96.128;

(2) Educational services and referral services for testing, counseling, and management of tuberculosis, including tuberculosis services as described in 42 USC §300x-24(a)(2) (1992) and in coordination with the programs identified in 45 CFR 96.127; and

(3) Educational services and referral services for testing, counseling, and management of hepatitis.

f. Case coordination with providers of primary medical care shall be provided, including obstetrics and gynecology services for the recipient.

g. Training in decision-making, anger management and conflict resolution shall be provided.

h. Extensive discharge planning shall be provided in collaboration with the recipient, any appropriate significant others, as well as representatives of appropriate service agencies.

C. Qualified providers.

1. Any duly enrolled provider which the department determines to be qualified who has signed an agreement may provide expanded prenatal care services.
2. The qualified providers will provide prenatal care services regardless of their capacity to provide any other services under the Plan.
3. Providers of substance abuse treatment services must be licensed and approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). Substance abuse services providers shall be required to meet the standards and criteria established by DMHMRSAS and the following additional requirements:

a. The provider shall ensure that recipients have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.

b. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the following professionals who must not be the same individual providing non-medical clinical supervision:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals, as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. A provider of Substance Abuse Treatment services for pregnant and postpartum women must meet the following requirements for day treatment services for pregnant and postpartum women:

(1) Medical care must be coordinated by a nurse case manager who is a registered nurse licensed by the Board of Nursing and who demonstrates competency in the following areas:

(a) Health assessment;

(b) Mental health;

(c)[~~Addiction~~Substance abuse] ;

(d) Obstetrics and gynecology;

(e) Case management;

(f) Nutrition;

(g) Cultural differences; and

(h) Counseling.

(2) The nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003 **/s/ P. W. Finnerty**
Date Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

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

1. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from ~~a condition due to~~ mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

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

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

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

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

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

assessment and ISP. ~~Some services may be delivered while accompanying family members to community agencies or in other locations.~~

4. These services ~~Services~~ shall be ~~used~~ provided when ~~out-of-home placement due to~~ the clinical needs of the child put the child at risk for out-of-home placement and ~~is a risk and either~~:

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

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

5. Services ~~are not appropriate for~~ may not be billed when provided to a family while the child is ~~absent from~~ not residing in the home.

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

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

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

9. Services must be provided by a LMHP or a QMHP as defined in 12 VAC 30-50-226. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in 12 VAC 30-50-226.

~~9~~. 10. The billing unit for intensive in-home service is one hour. Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of ~~five~~ three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of ~~five~~ three hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter weeks of service. ~~Intensive in-home services below the five hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan.~~ Service plans must incorporate a discharge plan which identifies transition from intensive in-home to less intensive or nonhome based services.

~~10. The intensity of service dictates that caseload sizes should be six or fewer cases at any given time. If on review caseloads exceed this limit, the provider will be required to submit a corrective action plan designed to reduce caseload size to the required limit unless the provider can demonstrate that enough of the cases in the caseload are moving toward discharge so that the caseload standard will be met within three months by attrition. Failure to maintain required caseload sizes in two or more review periods may result in termination of the provider agreement unless the provider demonstrates the ability to attain and maintain the required caseload size.~~

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

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

~~11~~. 13. Emergency assistance shall be available 24 hours per day, seven days a week.

B. Therapeutic day treatment for children and adolescents.

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

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

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

(1) This programming during the school day; or

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

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

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

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

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

~~2.~~ 3. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

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

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

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

~~3~~. 4. The enrolled provider of therapeutic day treatment for child and adolescents services must be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services to provide day support services.

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

~~4.~~ 6. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.

~~5.~~ 7. The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before ~~and/or~~ or after school ~~and/or~~ or during the summer). One unit of service is

defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

~~6.~~ 8. Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.

~~7~~ 9. Services shall be provided following a diagnostic assessment ~~when~~ that is authorized ~~by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker or certified psychiatric nurse~~ by a LMHP. ~~and~~ Services must be provided in accordance with an ISP which must be fully completed within 30 days of initiation of the service.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

A. Utilization reviews shall include determinations that providers meet the following requirements ~~all the requirements of Virginia state regulations found in 12VAC30-50-95 through 12VAC30-50-310.~~

1. The provider shall meet the federal and state requirements for administrative and financial management capacity.

2. The provider shall document and maintain individual case records in accordance with state and federal requirements.

3. The provider shall ensure eligible recipients have free choice of providers of mental health services and other medical care under the Individual Service Plan.

B. Day treatment/partial hospitalization services shall be provided following a diagnostic assessment ~~when~~ and be authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or ~~certified~~ ~~psychiatric nurse~~ licensed clinical nurse specialist-psychiatric. ~~and in accordance with an~~ An ISP ~~which~~ shall be fully completed by either the LMHP or the QMHP as defined at 12 VAC 30-50-226 within 30 days of service initiation.

1. The enrolled provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS as providers of day treatment services.

2. Services shall be provided by a LMHP, QMHP, or a qualified paraprofessional under the supervision of a QMHP or LMHP as defined at 12 VAC 30-50-226.

~~2.~~ 3. The program shall operate a minimum of two continuous hours in a 24-hour period. ~~One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.~~

~~3.~~4. Individuals shall be discharged from this service ~~when they are no longer in an acute psychiatric state or~~ when other less intensive services may achieve or maintain psychiatric stabilization. ~~Admission and services longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.~~

~~4. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:~~

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

b. Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.

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

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

C. Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who ~~lack daily living skills~~ experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

1. ~~Services~~ Psychosocial rehabilitation services shall be provided following an assessment which clearly documents the need for services. The assessment shall be completed by a LMHP, or a QMHP and approved by a LMHP within 30 days of admission to services. ~~and in accordance with an~~ An ISP ~~which~~ shall be ~~fully~~ completed by the LMHP or the QMHP within 30 days of service initiation. Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP.

2. ~~Services~~ Psychosocial rehabilitation services of any individual that continue more than six months must be reviewed by an LMHP who must document the continued need for the service. The ISP shall be rewritten at least annually.

~~2.~~ 3. The enrolled provider of psychosocial rehabilitation services shall be licensed by DMHMRSAS as a provider of psychosocial rehabilitation or clubhouse services.

4. ~~Services~~ Psychosocial rehabilitation services may be provided by a LMHP, QMHP, or qualified paraprofessional under the supervision of a QMHP or LMHP.

~~3.~~5. The program shall operate a minimum of two continuous hours in a 24-hour period. ~~One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.~~

~~4.~~ 6. Time allocated for field trips may be used to calculate time and units for service delivery if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.

~~5. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:~~

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

~~b. Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.~~

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

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

D. Admission to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. ~~Crisis intervention may be the initial contact with a client.~~

1. The ~~provider of~~ crisis intervention services provider shall be licensed as a provider of ~~an~~ Outpatient ~~Program~~ services by DMHMRSAS.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out-of-clinic services is clinically/programmatically appropriate.

Travel by staff to provide out-of-clinic services is not reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

7. An LMHP, a QMHP, or certified prescreener must conduct a face-to-face assessment. If the QMHP performs the assessment, it must be reviewed and approved by a LMHP or certified prescreener within 72 hours of the face-to-face assessment. The assessment shall document the need for and the anticipated duration of the crisis service. Crisis intervention will be provided by an LMHP, certified prescreener, or QMHP.

8. Crisis intervention shall not require an ISP.

9. For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations (42 CFR § 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. Preadmission screenings cannot be billed unless the requirement for an independent team, with a physician's signature, is met.

10. Services must be documented through daily notes and a daily log of time spent in the delivery of services.

E. Case management services (pursuant to 12 VAC 30-50-226).

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DMHMRSAS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.

4. The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

5. The ISP shall be updated at least annually.

6. The provider of case management services shall be licensed by DMHMRSAS as a provider of case management services.

F. Intensive community treatment (ICT) for adults.

1. An assessment which documents eligibility and need for this service shall be completed by the LMHP or the QMHP prior to the initiation of services. This assessment must be maintained in the individual's records.

2. ~~A~~ An individual service plan, based on the needs as determined by the assessment, must be initiated at the time of admission and must be fully developed by the LMHP or the QMHP and approved by the LMHP within 30 days of the initiation of services.

3. ICT may be billed if the client is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present to support this intervention.

4. The enrolled ICT provider shall be licensed by the DMHMRSAS as a provider of intensive community services or as a program of [~~assistive~~ assertive] community treatment, and must provide and make available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on-call.

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

G. Crisis stabilization services.

1. This service must be authorized following a face-to-face assessment by an LMHP, a certified prescreener, or a QMHP. This assessment must be reviewed and approved by a licensed mental health professional within 72 hours of the assessment.

2. The assessment ~~documents~~ must document the need for crisis stabilitation services, ~~service~~ and anticipated duration of need.

3. The Individual Service Plan (ISP) ~~is~~ must be developed or revised within ~~24 hours~~ 10 business days of the approved assessment or reassessment. The LMHP, certified prescreener, or QMHP shall develop the ISP.

4. Room and board, custodial care, and general supervision are not components of this service.

5. Clinic option services are not billable at the same time ~~as~~ crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

6. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization. ~~Individuals must meet at least two of the following criteria at the time of admission to the service:~~

~~a. Experiencing difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community;~~

~~b. Experiencing difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized;~~

~~c. Exhibiting such inappropriate behavior that immediate interventions by mental health and other agencies are necessary; or~~

~~d. Exhibiting difficulty in cognitive ability such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior.~~

7. Providers of crisis stabilitzation shall be licensed by DMHMRSAS as providers of outpatient services.

H. Mental health support services.

~~1. The individual receiving mental health support services must have an active case management plan in effect which includes monitoring and assessment of the provision of mental health support services. The individual responsible for the case management plan and for the provision of case management services shall not be the provider of mental health support services nor the immediate supervisor of the staff person providing mental health support services.~~

1. At admission, an appropriate face-to-face assessment must be made and documented by the LMHP or the QMHP, indicating that service needs can best be met through mental health support services. The assessment must be performed by the LMHP, or the QMHP and approved by the LMHP, within 30 days of the date of admission. The LMHP or the QMHP will complete the ISP within 30 days of the admission to this service. The ISP must indicate the specific

supports and services to be provided and the goals and objectives to be accomplished. The LMHP or QMHP will supervise the care if delivered by the qualified paraprofessional.

~~2. There shall be a documented assessment/evaluation prior to the initiation or reauthorization of services. The assessment/evaluation must have been completed by a QMHP no more than 30 days prior to the initiation or reauthorization of services.~~

~~3. The ISP must be developed within 30 days of the initiation of services and must indicate the specific supports and services to be provided and the goals and objectives to be accomplished.~~

~~4. The ISP must be reviewed every three months, modified as appropriate, and must be updated and rewritten at least annually.~~

2. Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

~~5.~~ 3. Only direct face-to-face contacts and services to individuals shall be reimbursable.

~~6.~~ 4. Any services provided to the client ~~which~~ that are strictly academic in nature shall not be ~~reimbursable~~ billable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

~~7.~~ 5. Any services provided to clients ~~which~~ that are strictly vocational in nature shall not be ~~reimbursable~~ billable. However, support activities and activities directly related to assisting a client to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be ~~reimbursable~~ billable.

~~8.~~ 6. Room and board, custodial care, and general supervision are not components of this service.

~~9.~~ 7. This service is not ~~reimbursable~~ billable for individuals who reside in ~~any domiciliary care facilities such as ACRs or group homes or nursing~~ facilities where staff are expected to provide such services under facility licensure requirements.

~~10. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:~~

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

~~b. Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.~~

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

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

8. Provider qualifications. The enrolled provider of mental health support services must be licensed by DMHMRSAS as a provider of supportive in-home services[, Intensive Community Treatment, or as a program of Assertive Community Treatment.] Individuals employed or contracted by the provider to provide mental health support services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.

9. Mental health support services, which continue for six consecutive months, must be reviewed and renewed at the end of the six month period of authorization by an LMHP who must document the continued need for the services.

10. Mental health support services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

A. ~~Utilization reviews shall include a determination that providers meet all the requirements of Part VIII (12VAC30-130-540 et seq.) of 12VAC30-130.~~ REPEALED.

B. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

1. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in ~~Part VIII (12VAC30-130-540 et seq.) of 12VAC30-130.~~ 12VAC 30-50-510.

a. To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ~~1996~~ Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders,

Second Edition, ~~1996~~ Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

b. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

c. Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

d. The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

e. The ISP shall be reviewed and updated every two weeks.

f. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

g. Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

h. While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently rendered to her.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

2. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions. ~~The contract must include a provision for medical supervision of the nurse case manager~~.

b. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.

c. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(1) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(2) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide residential substance abuse services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance

Abuse Treatment Professionals of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.

C. Substance abuse day treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to women, linkages to other programs tailored to specific needs, and program and staff qualifications.

1. The following services must be rendered and documented in case files in order for this day treatment service to be reimbursed by Medicaid:

a. Services must be authorized following a face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed professionals as specified in ~~12VAC30-130-540 through 12VAC30-130-590.~~ 12VAC 30-50-510.

b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.1 (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ~~1996~~ Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II.1 (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, ~~1996~~ Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without

staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.

c. Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations, as well as the appropriate reauthorizations after absences.

d. Documented assessment regarding the woman's need for the intense level of services; the assessment must have occurred within 30 days prior to admission.

e. The Individual Service Plan (ISP) shall be developed within 14 days of admission and an obstetric assessment completed and documented within a 30-day period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

f. The ISP shall be reviewed and updated every four weeks.

g. Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

h. Face-to-face therapeutic contact with the woman which is directly related to her ISP shall be documented at least once per week.

i. Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning shall seek to begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service

agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

j. While participating in this substance abuse day treatment program, the only other mental health, mental retardation or substance abuse rehabilitation services which can be concurrently reimbursed shall be mental health emergency services or mental health crisis stabilization services.

2. Linkages to other services or programs. Access to the following services shall be provided and documented in the woman's record or program documentation.

a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor. ~~The contract must include provisions for medical supervision of the nurse case manager.~~

b. The program must have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the women and ongoing training and consultation to the staff of the program.

c. In addition, the program must provide access to the following services (either by staff in the day treatment program or through contract):

(1) Psychiatric assessments, which must be performed by a physician licensed to practice by the Board of Medicine of the Virginia Department of Health Professions.

(2) Psychological assessments, as needed, which must be performed by clinical psychologist licensed to practice by the Virginia Board of Psychology.

(3) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Virginia Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(4) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(5) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

3. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide either substance abuse outpatient services or substance abuse day treatment services.

b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following appropriately licensed professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Virginia Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals or as a certified addictions counselor by the Substance

Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. The minimum ratio of clinical staff to women should ensure that adequate staff are available to address the needs of the women in the program.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-130-570.-Provider qualification requirements. Repealed.

~~To qualify as a provider of services through DMAS for rehabilitative mental health services, mental retardation services, and substance abuse treatment services the provider of the services must meet certain criteria. These criteria shall be:~~

~~1. The provider shall guarantee that recipients have access to emergency services on a 24-hour basis.~~

~~2. The provider shall demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement.~~

~~3. The provider shall have the administrative and financial management capacity to meet state and federal requirements.~~

~~4. The provider shall have the ability to document and maintain individual case records in accordance with state and federal requirements.~~

~~5. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services.~~

~~6. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the following professionals:~~

~~a. A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists and Substance Abuse Treatment Professionals or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.~~

~~b. A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.~~

~~c. A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.~~

~~This individual must not be same individual providing nonmedical clinical supervision in the program.~~

~~7. In addition to those requirements stated in subdivisions 1 through 6 of this section, a provider shall meet the following requirements specific to each disability area:~~

~~a. Mental health.~~

~~(1) Intensive in-home: licensure by DMHMRSAS as an intensive in-home services program.~~

~~(2) Therapeutic day treatment for children/adolescents: licensure by DMHMRSAS as a day support program.~~

~~(3) Day treatment/partial hospitalization: licensure by DMHMRSAS as a day support program.~~

~~(4) Psychosocial rehabilitation: licensure by DMHMRSAS as a day support program.~~

~~(5) Crisis intervention: licensure by DMHMRSAS as an outpatient program.~~

~~(6) Case management: certified by DMHMRSAS.~~

~~(7) Intensive community treatment: Licensure by DMHMRSAS to provide outpatient services.~~

~~(8) Crisis stabilization services: Licensure by DMHMRSAS to provide outpatient services.~~

~~(9) Mental health support services: Licensure by DMHMRSAS as a provider of supported living residential services or supportive residential services. Individuals employed or contracted by the provider agency to implement mental health support services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.~~

~~b. Mental retardation.~~

~~(1) Case management: certified by DMHMRSAS.~~

~~(2) Mental retardation crisis stabilization community services. The provider agency must be licensed by DMHMRSAS as a provider of outpatient services or of supportive residential services or residential services. The provider agency must employ or utilize qualified mental retardation professionals, licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to recipients with mental retardation who are experiencing serious psychiatric/behavioral problems.~~

~~8. In addition to those requirements stated in subdivisions 1 through 7 of this section, a provider shall meet the following requirements for residential and day treatment services for pregnant and postpartum women. For programs to be eligible to be reimbursed by Medicaid, they must meet all of the following standards:~~

~~a. Medical care must be coordinated by a nurse case manager who is a registered nurse licensed by the Board of Nursing and who demonstrates competency in the following areas:~~

~~(1) Health assessment;~~

~~(2) Mental health;~~

~~(3) Addiction;~~

~~(4) Obstetrics and gynecology;~~

~~(5) Case management;~~

~~(6) Nutrition;~~

~~(7) Cultural differences; and~~

~~(8) Counseling.~~

~~b. The nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.~~

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-130-565. Substance abuse treatment services.

A. Substance abuse treatment services shall be provided consistent with the criteria and requirements of 12VAC30-50-510.

B. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse residential treatment services for pregnant and postpartum women can occur:

1. The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the plan of care; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2. The woman must be pregnant at admission and intend to complete the pregnancy.

3. The woman must:

a. Have used alcohol or other drugs within six weeks of referral to the program~~;~~ . If the woman was in jail or prison prior to her referral to this program, the alcohol or drug use must have been within six weeks prior to jail or prison.

b. Be participating in less intensive treatment for substance abuse and be assessed as high-risk for relapse without more intensive intervention and treatment; or

c. Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital which is an approved Virginia

Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

C. The following criteria must be met and documented in the woman's record before Medicaid reimbursement for substance abuse day treatment services for pregnant and postpartum women can occur:

1. The woman must agree to participate in developing her own treatment plan, to comply with the treatment plan, to utilize appropriate measures to negotiate changes in her treatment plan, to fully participate in treatment, to comply with program rules and procedures, and to complete the treatment plan in full.

2. The woman must be pregnant at admission and intend to complete the pregnancy.

3. The woman must:

a. Have used alcohol or other drugs within six weeks of referral to the program~~;~~ . If the woman was in jail or prison prior to her referral to this program, the alcohol or drug use must have been within six weeks prior to jail or prison.

b. Be participating in less intensive treatment for substance abuse and assessed as high-risk for relapse without more intensive intervention and treatment; or

c. Within 30 days of admission, have been discharged from a more intensive level of treatment for substance abuse, such as hospital-based or jail- or prison-based inpatient treatment or residential treatment.

4. The woman must be under the active care of a physician who is an approved Virginia Medicaid provider and who has obstetrical privileges at a hospital which is an approved Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician and the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services

12VAC30-130-550. ~~Mental health services~~. REPEALED.

~~A. The following services shall be covered: intensive in-home services, therapeutic day treatment, day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, intensive community treatment, crisis stabilization, and support services. These covered services are further defined below. For purposes of this part, staff travel time shall not be included in billable time for reimbursement.~~

~~B. Intensive in-home services for children and adolescents under age 21 shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services rendered solely to an eligible child provide crisis treatment, individual and family counseling, communication skills, case management activities and coordination with other required services, and 24-hour emergency response. These services shall be limited annually to 26 weeks. General program requirements shall be as follows:~~

~~1. The provider of intensive in-home services shall be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.~~

~~2. An appropriate assessment is made and documented that service needs can best be met through intensive in-home services; service shall be recommended on an Individual Service Plan (ISP).~~

~~3. Intensive in-home services shall be used when out-of-home placement is a risk, when services that are far more intensive than outpatient clinic care are required to stabilize the family situation, and when the recipient's residence as the setting for services is more likely to be successful than a clinic.~~

~~4. Intensive in-home services shall also be used to facilitate the return from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful.~~

~~5. At least one parent or responsible adult with whom the child is living must be willing to participate in in-home services.~~

~~6. Since case management services are an integral and inseparable part of this service, case management services will not be reimbursed separately for periods of time when intensive in-home services are being reimbursed.~~

~~C. Therapeutic day treatment for children and adolescents shall be provided in sessions of two or more hours per day to children and adolescents who have diagnosed developmental and social functioning levels which are significantly disabling. This determination of significant disability should be based upon consideration of the social~~

~~functioning of most children their age and which has become more disabling over time and requires significant intervention through services that are supportive and intensive offered over a protracted period of time in order to provide therapeutic interventions. Day treatment programs, limited annually to 780 units, provide evaluation; individual, group and family counseling; medication education and management; and opportunities to learn and use daily living skills and to enhance social and interpersonal skills. General program requirements shall be as follows:~~

~~1. The provider of therapeutic day treatment for child and adolescent services shall be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.~~

~~2. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP.~~

~~3. The program shall operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service are defined as a minimum of three but less than five hours in a given day, and three units of service shall be defined as five or more hours of service in a given day.~~

~~4. When day treatment occurs during the school day, time solely for academic instruction (i.e., when no treatment activity is going on) cannot be included in the billing unit.~~

~~D. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. General program requirements shall be as follows:~~

~~1. The provider of day treatment/partial hospitalization shall be licensed by DMHMRSAS.~~

~~2. The program shall operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day.~~

~~3. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state or when other less intensive services may achieve stabilization. Admission and services longer than 90 calendar days must be authorized based upon a~~

~~face-to-face evaluation by a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or certified psychiatric nurse.~~

~~E. Psychosocial rehabilitation for adults shall be provided in sessions of two or more consecutive hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education about mental illness and appropriate medication to avoid complications and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, within a supportive and normalizing program structure and environment.~~

~~1. The provider of psychosocial rehabilitation shall be licensed by DMHMRSAS.~~

~~2. The program shall operate a minimum of two continuous hours in a 24-hour period. A unit of service is defined as a minimum of two but less than four hours on a given day. Two units of service are defined as at least four but less than seven hours in a given day. Three units are defined as seven or more hours in a given day.~~

~~3. Time allocated for field trips may be used to calculate time and units of service if the goal is to provide training in an integrated setting, and to increase the recipient's understanding or ability to access community resources.~~

~~F. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the recipient or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities, limited annually to 180 hours, shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual or the family unit, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include, but are not limited to, office visits, home visits, preadmission screenings, telephone contacts, and other recipient-related activities for the prevention of institutionalization. General program requirements are as follows:~~

~~1. The provider of crisis intervention services shall be licensed by DMHMRSAS.~~

~~2. Recipient-related activities provided in association with a face-to-face contact shall be reimbursable.~~

~~3. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.~~

~~4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised to reflect the short-term counseling goals by the fourth face-to-face contact.~~

~~5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.~~

~~6. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed provided the provision of out-of-clinic services is clinically/programmatically appropriate. Crisis intervention may involve the family or significant others.~~

~~G. Intensive community treatment (ICT) shall be provided consistent with the criteria and requirements of 12VAC30-50-95 through 12VAC30-50-540.~~

~~1. The individual shall meet two or more of the following criteria, as documented by the individual's record, in order to be eligible for Medicaid coverage of this service:~~

~~a. The individual cannot or will not be served in the clinic setting.~~

~~b. The individual is at high risk for psychiatric hospitalization or for becoming or remaining homeless, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.~~

~~c. The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for serious mental illness and chemical addiction (MICA) and demonstrates a resistance to seek out and utilize appropriate treatment options.~~

~~2. The recipient is certified by a licensed mental health professional as being in need of the services as defined by the Individual Service Plan.~~

~~3. The provider shall be licensed by the DMHMRSAS to provide outpatient services in order to be reimbursed for the provision of these services. In order to qualify for a provider agreement, emergency services must be available and provide services 24 hours per day, seven days per week, 365 days per year, either directly or on call.~~

~~4. ICT may be provided based on an initial assessment. This service may be provided for a maximum of 26 weeks with a limit of 130 units available. A unit shall equal one hour. Continuation of service may be reauthorized at 26-week intervals based on written assessment and certification of need by a qualified mental health professional (QMHP).~~

~~5. Services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a~~

~~weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.~~

~~H. Crisis stabilization services shall be provided consistent with the criteria and requirements of 12VAC30-50-95 through 12VAC30-50-540. These services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.~~

~~1. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:~~

~~a. Experiencing difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.~~

~~b. Experiencing difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.~~

~~c. Exhibiting such inappropriate behavior that immediate interventions by mental health and other agencies are necessary.~~

~~d. Exhibiting difficulty in cognitive ability such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior.~~

~~2. This service shall not be appropriate nor reimbursed for (i) recipients with medical conditions which require hospital care; (ii) recipients with primary diagnosis of substance abuse; or (iii) recipients with psychiatric conditions which cannot be managed in the community, i.e., recipients who are of imminent danger to themselves or others.~~

~~3. Mental health crisis stabilization services is limited to nonhospitalized individuals and may be provided in any of the following settings, but shall not be limited to: (i) the home of a recipient who lives with family or other primary caregiver; (ii) the home of a recipient who lives independently; or (iii) community based programs licensed by DMHMRSAS to provide residential services.~~

~~4. In order to be reimbursed for this service by Medicaid, providers shall be licensed by DMHMRSAS to provide outpatient services. If any of these services are subcontracted by the CSB, the subcontractor shall be appropriately licensed by DMHMRSAS to provide the subcontracted services.~~

~~5. Services must be documented through daily notes and a daily log of times spent in the delivery of services.~~

~~I. Mental health support services shall be provided consistent with the criteria and requirements of 12VAC30-50-95 through 12VAC30-50-540.~~

~~1. In order for Medicaid reimbursement to occur:~~

~~a. The individual must have a history of psychiatric hospitalization.~~

~~b. The individual must demonstrate functional impairments in major life activities. This may include individuals with a dual diagnosis of either mental illness and mental retardation, or mental illness and substance abuse disorder.~~

~~c. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:~~

~~(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.~~

~~(2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.~~

~~(3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.~~

~~(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.~~

~~2. Provider qualifications. The provider agency must be licensed by DMHMRSAS as a provider of supported living residential services or supportive residential services. Individuals employed or contracted by the provider agency to provide mental health support services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.~~

~~3. Mental health support services may be authorized for six consecutive months. Continuation of services may be authorized at six month intervals or following any break in service by a QMHP based on a documented assessment and documentation of continuing need. The monthly limit on services shall be 31 units.~~

~~4. Services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.~~

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

10/6/2003
Date

/s/ P. W. Finnerty
Patrick W. Finnerty, Director
Dept. of Medical Assistance Services