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1. Inpatient Hospital Services.

Inpatient hospital services may be provided in accordance with 42 CFR 440.10.

General

The provision of the following medically necessary services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician. Inpatient acute hospitalizations will be reimbursed only if the stay has been authorized.

Inpatient hospital services provided at general acute care hospitals and free standing psychiatric hospitals.

A. Service Authorizations

1. Service authorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and free-standing psychiatric hospitals. Non-authorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS) or its contractor. Service authorization shall be based on criteria specified by DMAS.

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B. Out-of-state inpatient general acute care hospitals and freestanding psychiatric hospitals, enrolled providers. In addition to meeting all of the service authorization requirements specified in subsection A above, out-of-state hospitals must further demonstrate that the requested admission meets at least one of the following additional standards. Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

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4. It is general practice for recipients in a particular locality to use medical resources in another state.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to the life of the mother if the fetus were carried to term.

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E. Mandatory lengths of stay.

a. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

b. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and service authorized until the Diagnosis Related Grouping methodology is fully implemented. Nothing in this regulation shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

F. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64 except as allowed under 42 CFR §438.3 (e)(2). Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section.

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G. Addiction and recovery treatment services shall be covered in inpatient facilities.

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H. The admission and length of stay must be medically justified and service authorized via the admission and concurrent review processes. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

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I. Mandatory lengths of stay.

1. Coverage for normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and service authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

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B. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of the life to the mother if the fetus were carried to term.

C. Coverage of outpatient observation beds. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds.

1. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment, or;

2. Non-routine observation for underlying medical complications, as explained in documentation attached to the provider's claim for payment, after surgery or diagnostic services shall be covered. Routine use of an observation bed shall not be covered. **Non-covered routine use shall be**:

(a) Routine preparatory services and routine recovery time for outpatient surgical or diagnostic testing services, (e.g., services for routine postoperative monitoring during a normal recovery period (four to six hours)).

(b) Observation services provided in conjunction with emergency room services, unless, following the emergency treatment, there are clear medical complications which must be managed by a physician other than the original emergency physician.

(c) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

3. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient pre-certification where applicable.

4. When inpatient admission is required following observation services and prior approval has been obtained for the inpatient stay, observation charges must be combined with the appropriate inpatient admission and be shown on the inpatient claim for payment. Observation bed charges and inpatient hospital charges shall not be reimbursed for the same day.

D. Comprehensive Outpatient Rehabilitation Facilities (CORF) Services are provided in accordance with 42 CFR, Subpart B., 485.50 – 485.74 and shall meet medical necessity requirements.

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1. All providers of CORFs shall be enrolled as a Medicaid provider. CORFs shall enroll via the Comprehensive Outpatient Rehabilitation Facility Participation Agreement.

2. Service Limitations: CORF services shall be considered for termination based on medical necessity.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. _

A. The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with §4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

A. The same service limitations apply to FQHCs as to all other services.

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3. Other laboratory and x-ray services. (12 VAC 30-50-120)

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

B. Prior authorization is required for the following non-emergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computer Axial Tomography (CAT) scans, including computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering the scan must obtain the prior authorization in order for the servicing provider to be reimbursed for the scan. Non-emergency outpatient MRI, CAT, and PET scans that are not prior authorized will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS).

4. Skilled nursing facility services, EPSDT and family planning. (12 VAC 30-50-130)

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

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

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I. Local Education Agencies (LEAs) are Virginia school divisions that operate local public primary and secondary schools in Virginia, and the Virginia School for the Deaf and Blind (VSDB). LEAs may enroll with DMAS as providers of LEA School Based Services. LEA School Based Services are covered for individuals up to age 21 under the EPSDT benefit.

II. LEA School Based Services are services listed in a recipient's Individualized Education Program (IEP) or services for which medical necessity has otherwise been established, and are covered under one or more of the service categories described in Section 1905(a) of the Social Security Act. These services are necessary to correct or ameliorate physical or behavioral illnesses or conditions.

Individual providers that order or refer students for services must be licensed under the applicable State practice act or comparable licensing criteria by the Virginia Department of Education, and shall meet applicable qualifications under 42 CFR Part 440. Identification of illnesses or conditions, and services necessary to correct or ameliorate such conditions is done by practitioners qualified to make those determinations within their licensed scope of practice.

III. Individual service rendering providers must be employed by the LEA or under contract to the LEA. Covered services include:

- Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders provided by licensed practitioners within the scope of practice as defined under state law and regulations and staff under the supervision of a licensed healthcare professional in accordance with state law and covered under 42 CFR §440.110.
- Nursing services provided by licensed nurses within the scope of practice as defined under state law and regulations, and covered under 42 CFR §440.60.

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- Behavioral health services provided by licensed practitioners within the scope of practice as defined under state law and regulations and staff under the supervision of a licensed healthcare professional in accordance with state law, and covered as physicians' services under 42 CFR §440.50, or medical or other remedial care under §440.60.
- Personal care services covered under 42 CFR §440.167 and performed by persons under supervision of a licensed health care professional acting within the scope of practice as defined under state law and regulations. This licensed professional develops a written plan for meeting the needs of the child, and provides training and direct supervision to the personal care assistant based on the plan of care.
- Medical evaluation services provided by licensed physicians, nurse practitioners and physician assistants within the scope of practice as defined under state law and regulations and covered as physicians' services under 42 CFR §440.50 or medical or other remedial care under §440.60.
- Transportation services are covered as school-based services as allowed under 42 CFR §431.53 and described at State Plan Attachment 3.1-D. To be covered as school-based services, transportation must be listed as a needed service within the child's individualized education program (IEP) plan. Transportation must be provided by the school division or an entity contracted by the school division. Transportation is covered for a child who requires transportation on a specially adapted school vehicle to or from a school or school-contracted provider, on days when the student is receiving a billed Medicaid covered service. Children requiring an aide during transportation on a specially adapted vehicle shall have this stated in the IEP.

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4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found. (12 VAC 30-50-130)

A. 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.

B. RESERVED.

C. 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.

D. 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).

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E. Community mental health services.

1. Staff Qualification Definitions:

"ADL supervisor" means the same as set forth in Attachment 3.1A&B, Supplement 1, page 30.

"ADL technician" means the same as set forth in Attachment 3.1A&B, Supplement 1, page 30.

"Licensed Mental Health Professional" or "LMHP" means the same as set forth in Attachment 3.1 A&B, Supplement 1, page 31.

"Licensed Mental Health Professional-Resident" or LMHP-R" means the same as "Licensed Mental Health Professional-Eligible" in Attachment 3.1 A&B, Supplement 1, page 31.

"Licensed Mental Health Professional-Resident in Psychology" or LMHP-RP" means the same as "Licensed Mental Health Professional-Eligible" in Attachment 3.1 A&B, Supplement 1, page 31.

"Licensed Mental Health Professional-Supervisee" or LMHP-S" means the same as "Licensed Mental Health Professional-Eligible" in Attachment 3.1 A&B, Supplement 1, page 31.

"QMHP-C means the same as "Qualified Mental Health Professional" in Attachment 3.1 A&B, Supplement 1, page 31.2.

"QMHP-E means the same as "Qualified Mental Health Professional-Eligible" in Attachment 3.1 A&B, Supplement 1, page 31.3.

"QPPMH" means the same as "Qualified Paraprofessional in Mental Health" in Attachment 3.1A&B, Supplement 1, page 31.2.

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2. Intensive in-home services

a. Service Definition: Intensive in-home services (IIH) are intensive therapeutic interventions provided to children and adolescents under age 21 in the individual's residence or other community settings as medically necessary, to improve family functioning and significant functional impairments in major life activities that have occurred due to the individual's mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the individual, and gradually transition the individual to less restrictive level(s) of care and supports. These services include assessment; crisis treatment; individual and family counseling; communication skills restoration (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services, and 24-hour emergency response.

b. Service Components and Provider Qualifications. Definitions of staff qualifications are provided in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.3.

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Service Component Definitions – Intensive In-Home	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent, guardian, or other family member or members, as appropriate, about the child's or adolescent's mental health status and behaviors. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-R LMHP-RP LMHP-S
"Crisis treatment" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.	LMHP LMHP-R LMHP-RP LMHP-S
"Counseling" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.	LMHP LMHP-R LMHP-RP LMHP-S
"Communication skills restoration" is available only to parents and guardians when it is for the direct benefit of the child and means skills training, guidance and assistance to the individual and his parents or guardians, as appropriate, to understand, voice, and practice appropriate problem solving, anger management, and interpersonal interaction. The child must be present for parents and guardians to receive the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, or LMHP-S.
"Care coordination" means locating and coordinating services across multiple providers to include collaborating and sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-C/ QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, or LMHP-S.

Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

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3. Therapeutic day treatment.

a. Service Definition.
Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to children/adolescents with mental, emotional, or behavioral illnesses and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement to school day or year. This service includes assessment, assistance with medication management, restorative facilitation, and individual and group counseling, family counseling, and care coordination.

b. Service Components and Provider Qualifications. Definitions of staff qualifications are provided in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.3.

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Service Component Definitions- Therapeutic Day Treatment	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent, guardian, or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-S LMHP-R LMHP-RP
"Assistance with medication management" means counseling to the child and parents or guardians on the role of prescription medications and their effects including side effects;- the importance of compliance and adherence; and monitoring the use and effects of medications. Assistance with medication management is only available to parents and guardians when it is for the direct benefit of the child and that the child must be present for parents and guardians to receive this service.	LMHP LMHP-S LMHP-R LMHP-RP
"Restorative Facilitation" means structured skills training and coaching to increase the individual's and, as appropriate, their family's interpersonal relations such as communication, problem solving, and coping skills.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-C/QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, or LMHP-S.
"Counseling" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.	LMHP, LMHP-R, LMHP-RP, or LMHP-S
"Care coordination" means locating and coordinating services across multiple providers to include collaborating and sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-C/QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, or LMHP-S

c. Limits on amount, duration, and scope. Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

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F. Therapeutic Group Home Services

Service Definition: Therapeutic group home services for children and adolescents younger than the age of 21 years shall provide therapeutic services to restore appropriate skills necessary to promote prosocial behavior and healthy living to include the restoration of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills. Therapeutic services also engage families and reflect family-driven practices that correlate to sustained positive outcomes post- discharge for youth and their family members. Each component of therapeutic group home services is provided for the direct benefit of the beneficiary, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. These services are provided under 42 CFR 440.130(d) in accordance with the rehabilitative services benefit.

Service Component Definitions – Therapeutic Group Homes	Staff That Provide Service Components*
Each component of therapeutic group home services is provided for the direct benefit of the beneficiary individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care and for the purpose of assisting in the individual's recovery.	
Assessment: the face-to-face interaction in which the provider obtains information from the child or adolescent, and parent, guardian, or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-S LMHP-R LMHP-RP
Treatment Planning: development of a person-centered plan of care that is specific to the individual's unique treatment needs and acuity levels and includes: (a) individual and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance; (b) diagnoses , symptoms, complaints, and complications indicating the need for admission; (c) a description of the functional level of the individual; (d) treatment objectives with short-term and long-term goals; (e) orders for medications , psychiatric, medical, dental and any special healthcare needs whether or not provided in the group home, treatments, restorative and rehabilitative services, activities, therapies, therapeutic/asses, social services, community integration, diet, an special procedures recommended for the health and safety of the mdividual; (f) plans for continuing care, including review and modification to the plan of care; and (g) plans for discharge.	LMHP LMHP-S LMHP-R LMHP-RP

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Crisis Management: activities and interventions designed to rapidly manage a crisis. The activities and interventions include behavioral health care to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity. Activities shall include assessment and short term counseling designed to stabilize the individual. Individuals will be referred to long term services once crisis has been stabilized.	LMHP LMHP-S LMHP-R LMHP-RP
Individual and Group Therapy: application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating plans of care using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.	LMHP LMHP-S LMHP-R LMHP-RP
Family Therapy: counseling services involving the child's family and significant others to advance the treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals. Family therapy shall be aligned with the goals of the child's plan of care. All family therapy services furnished are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's plan of care, and for the purpose of assisting in the beneficiary's recovery.	LMHP LMHP-S LMHP-R LMHP-RP
Skills Restoration: Skills restoration is a face-to-face service to assist beneficiaries in the restoration of lost skills that are necessary to achieve the goals established in the beneficiary's plan of care. Services include assisting the beneficiary in restoring self- management, interpersonal, communication, and problem solving skills through modeling, coaching, and cueing.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-C, QMHP-E, or a QPPMH under the supervision ofa QMHP-C.
Activities of Daily Living (ADL) Restoration: ADL restoration is a face-to-face interaction provided on an individual and group basis to assist beneficiaries in the restoration of lost ADL skills that are necessary to achieve the goals established in the beneficiary's plan of care. ADL Restoration restores and strengthens the beneficiaries' personal skills to complete ADLs themselves. Services address performance deficits related to a lack of physical, cognitive or psychosocial skills which hinder the ability of the beneficiary to complete ADLs. Services include (i) restoring acceptable habits, behaviors and attitudes related to daily health activities and personal care/hygiene and (ii) assisting the beneficiary restoring and regaining functional ADL skills and appropriate behavior related to health and safety.	LMHP, LMHP-R, LMHP-RP, LMHP-S, or QMHP-C. QMHP-E, QPPMH, ADL supervisor or ADL technician under the supervision of a QMHP-C or higher.

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*Provider qualifications are defined in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.3.
Limits:

1. Service authorization shall be required.

2. Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary.

3. At least fifty percent of direct care staff must meet a minimum of QPPMH criteria.

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H. Inpatient psychiatric services shall be covered for individuals younger than age 21, for medically necessary stays in inpatient psychiatric facilities described in 42 CFR 440.160(b)(1) and (b)(2), for the purpose of diagnosis and treatment of mental health and behavioral disorders identified under EPSDT when such services are rendered by:

1. A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

2. A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the commission on Accreditation or Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

3. Inpatient psychiatric hospital admissions at general acute care hospitals and freestanding psychiatric hospitals shall also be subject to the requirements of 12 VAC 30-50-100, 12 VAC 30-50-105, and 12 VAC 30-60-25. Inpatient psychiatric admissions to residential treatment facilities shall also be subject to the requirements of 12 VAC 30-130-850 et seq.

4. a. The inpatient psychiatric services benefit for individuals younger than 21 years of age shall include services defined at 42 CFR 440.160, provided under the direction of a physician, pursuant to a certification of medical necessity and plan of care developed by an interdisciplinary team of professionals, and shall involve active treatment designed to achieve the child's discharge from inpatient status at the earliest possible time. The inpatient psychiatric services benefit shall include the following services provided under arrangement furnished by Medicaid enrolled providers other than the inpatient psychiatric facility, as long as the inpatient psychiatric facility: (i) arranges for and oversees the provision of all services; (ii) ensures that the services are furnished under the direction of a physician. Services provided under arrangement shall be documented by a written referral from the inpatient psychiatric facility. For purposes of pharmacy services, a prescription ordered by an employee or contractor, of the facility, who is licensed to prescribe drugs shall be considered the referral.

a. Eligible services provided under arrangement with the inpatient psychiatric facility shall vary by provider type as described in this section. For purposes of this section, emergency services means the same as is set out in 12 VAC 30-50-310 B.

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1) State freestanding psychiatric hospitals shall arrange under contract for, maintain records of and ensure that physicians order these services (i) pharmacy services, and ; (ii) emergency services.

2) Private freestanding psychiatric hospitals shall arrange under contract for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) outpatient hospital services; (iii) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (iv) laboratory and radiology services; (v) vision services; (vi) dental, oral surgery, and orthodontic services; (vii) transportation services; and (viii) emergency services.

3) Residential treatment centers, as defined at 42 CFR 483.352, shall arrange for, maintain records of, and ensure that physicians order these services: (i) medical and psychological services, including those furnished by physicians, licensed mental health professionals, and other licensed or certified health professionals (i.e., nutritionists, podiatrists, respiratory therapists, and substance abuse treatment practitioners); (ii) pharmacy services; (iii) outpatient hospital services; (iv) physical therapy, occupational therapy, and therapy for individuals with speech, hearing, or language disorders; (v) laboratory and radiology services; (vi) durable medical equipment;(vii) vision services; (viii) dental, oral surgery, and orthodontic services; (ix) transportation services; and (x) emergency services.

5. Inpatient psychiatric services, as defined at 42 CFR 483.352, are reimbursable only when the treatment program is fully in compliance with i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically, 42 CFR § 441.151(a), (b) and §§ 441.152 through 441.156, and ii) the Conditions of Participation in 42 CFR Part 483 Subpart G. Each admission must be preauthorized and the treatment must meet DMAS requirements for clinical necessity.

6. Service limits may be exceeded based on medical necessity for individuals eligible for EPSDT.

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I. Hearing aids shall be reimbursed for individuals younger than 21 years of age according to medical necessity when provided by practitioners licensed to engage in the practice of fitting or dealing in hearing aids under the Code of Virginia. (12 VAC 30-50-130(B)(7))

J. 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.

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K. Personal care services under EPSDT.

1. Service definition. EPSDT Personal Care Services are designed to assist eligible children under the age of 21 with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These services may be provided either through an agency-directed or consumer-directed (CD) model. Services are provided in accordance with 42 CFR 440.167.

2. Service components may include: (i) Assistance with ADLs: bathing, dressing, toileting, transferring, eating/feeding, ambulation and bowel and bladder incontinence. Assistance can include hands on care, prompting, verbal cueing, multiple reminders and/or supervision of these tasks.

The individual's need for medically necessary personal care services shall be documented by a physician, physician's assistant or nurse practitioner in the Plan of Care, and updated as the individual's need for assistance changes or at a minimum of once every 12 months.

The state assures compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 in accordance with section 12006 of the 21st Century CURES Act.

Individuals choosing to receive services through the consumer-directed model shall choose a Consumer Directed Services Facilitator (SF) to provide training and guidance to the individual or their designee so that they can serve as an Employer of Record (EOR). An EOR is responsible for hiring, training, supervising, and firing personal care assistants. If the individual is under 18 years of age, the parent or responsible adult shall serve as the EOR. An EOR cannot be the paid caregiver, personal care assistant, or SF. An EOR can only serve on behalf of one individual. The only exception to this is that an EOR can serve on behalf of multiple individuals if the individuals reside at the same address, but only if these individuals do not receive services from the EOR at the same time.

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3. Provider qualifications – agency directed.

a. Personal Care services shall be provided by an agency that has a current signed participation agreement with DMAS to provide Personal Care; and is (i) licensed by the Virginia Department of Health (VDH), or (ii) certified by the Virginia Department of Health under provisions of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, or (iii) accredited either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Community Health Accreditation Program (CHAP) established by the National League of Nursing,.

b. A personal care agency shall also meet the following requirements:
(1) Demonstrate a prior successful health care delivery;
(2) Operate from a business office; and
(3) The provider agency shall be responsible for assuring all staff who are assigned to an individual are competent in the care needs of that individual.

c. The provider shall employ (or subcontract) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care assistants and licensed practical nurses (LPN).

(1) The RN must possess the following qualifications:
(a) a license to practice in the Commonwealth of Virginia or multi-state privileges that include Virginia;
(b) at least one (1) year of related clinical experience as a RN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility;
(c) a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable; and
(d) shall submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider shall not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry.

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(2) As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 calendar days to ensure both quality and appropriateness of personal care services to assess the individual's and the individual's representative's satisfaction with the services being provided, to review the plan of care and to update and verify the most current physician signed orders are in the home. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made. Additional supervisory visits may be required under the following circumstances:
(i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff. The RN is responsible for documentation of the visit's date, time and evaluation.

d. Personal care assistants shall:

(1) Have the physical ability to perform the work;
(2) Be age 18 years or older;
(3) Have the ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
(4) Have the ability to create and maintain required documentation;
(5) Have the documentation of any relevant training program and/or of competency in skills required to perform the services;
(6) Have a valid social security number;
(7) Receive tuberculosis (TB) screening, as specified in criteria used by the Virginia Department of Health http://www.vdh.virginia.gov/TB/Policies/screening.htm#c; and
(8) Meet one of the following qualifications:

(i) Have licensure as a Nurse Aide issued by the Virginia Board of Nursing;
(ii) Have satisfactorily completed a nurse aide education program approved by the Virginia Board of Nursing
(iii)Have satisfactorily completed a nursing education program preparing for registered nurse licensure or practical nurse licensure;
(iv) Be successfully enrolled in a nursing education program preparing for registered nurse or practical nurse licensure and have currently completed at least one nursing course that includes clinical experience involving direct client care; or
(v) Have satisfactorily passed a competency evaluation program that meets the criteria of 42 CFR 484.36 (b). Personal care assistants need only be evaluated on the tasks in 42 CFR 484.36 (b) as those tasks relate to the personal care services to be provided.

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(9) Complete a minimum of 12 hours of training annually.

(10) Have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If the assistant has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

(11) Submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

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4. Provider qualifications – consumer directed.

a. Services facilitator. The Services Facilitator (SF) shall have a current signed participation agreement with DMAS to provide consumer directed services facilitation. The SF must possess a combination of work experience and the following knowledge, skills, and abilities:

Knowledge of:
(1) Types of functional limitations and health problems that are common to individuals with disabilities, as well as strategies to reduce limitations and health problems;
(2) Child development and developmental disabilities;
(3) Physical assistance typically required by individuals who have physical and developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
(4) Equipment and environmental modifications that are commonly used and required by individuals who have physical and developmental disabilities which reduce the need for human assistance and improve safety;
(5) Various long-term care program requirements, including nursing facility level of care criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care and respite services;
(6) Various behavioral health program requirements;
(7) DMAS consumer-directed personal care program requirements, as well as the administrative duties for which the individual will be responsible;
(8) Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in care planning;
(9) Interviewing techniques;
(10) The individual's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care assistant;
(11) The principles of human behavior and interpersonal relationships; and
(12) General principles of record documentation.

Skills in:
(1) Negotiating with individuals, family/caregivers, and service providers;
(2) Assessing, supporting, observing, recording, and reporting behaviors;
(3) Identifying, developing, and providing services to individuals who have disabilities; and
(4) Identifying services within the established services system to meet the individual's needs.

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Ability to:
(1) Report findings of the assessment or onsite visit, either in writing or in an alternative format for individuals who have visual impairments;
(2) Demonstrate a positive regard for individuals and their families;
(3) Be persistent and remain objective;
(4) Work independently, performing position duties under general supervision;
(5) Communicate effectively both orally and in writing; and
(6) Develop a rapport and communicate with different types of persons from diverse cultural Backgrounds.

Service facilitators shall also complete required training and competency assessments.

b. Consumer-directed personal care assistants shall:
(1) be 18 years of age or older;
(2) be able to read and write in English and possess basic math skills to the degree necessary to perform the tasks expected;
(3) have the required skills to perform care as specified in the individual's person-centered Plan of Care;
(4) possess a valid Social Security Number;
(5) submit to a criminal history record check and a child protective services central registry check for assistants that care for minor children. The Personal Care assistant will not be compensated for services provided to the individual once the records check verifies the Personal Care assistant has been convicted of any of the crimes that are described in the Code of Virginia;
(6) be willing to attend or receive training at the EOR's/family's/individual's request;
(7) understanding and agree to comply with the CD Personal Care services program requirements;
(8) receive periodic tuberculosis (TB) screening as specified in criteria used by the Virginia Department of Health, and;
(9) not be the parent (biological, step parent, adoptive, legal guardian) of the minor child or spouse of the individual receiving personal care services.

5. Service limits. Individuals under 21 years of age qualifying under EPSDT shall receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

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M. Medical Supplies, Equipment, and Appliances under EPSDT.

1. Service definition. To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for specialized medical equipment, supplies, devices, controls, and appliances not otherwise available under other sections of the Virginia State Plan for Medical Assistance. Services are provided in accordance with 42 CFR 440.70.

As defined in 42 CFR 440.70, supplies are "health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury." Equipment and appliances are "items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable."

2. Service components. To meet the definition of Assistive Technology, requested items must meet all of the following requirements. Assistive Technology must:

- meet the definition of medical supplies, equipment, or appliances as defined in 42 CFR 440.70;

- be appropriate for use anywhere normal life activities take place;

- be ordered by a physician to correct or ameliorate physical or mental conditions identified during EPSDT screening services;

- constitute a reasonable and medically necessary part of a treatment plan;

- be consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;

- be consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and

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3. Provider qualifications. Medical supplies, equipment and appliances must be ordered by a physician.

4. Service limits. Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

Items not covered under this service include:

- Items furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;

- Items covered under the Individuals with Disabilities Act (IDEA) when requested for use during school hours;

- Items that may provide duplicate coverage in that they are otherwise covered under other sections of the Virginia *State Plan for Medical Assistance;* and

- Items that are experimental or investigational.

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L. Private duty nursing services under EPSDT.

This section applies to private duty nursing services for eligible individuals on fee-for-service programs. Individuals enrolled with managed care health plans receive private duty nursing services through their plans.

1. Service description.
Private duty nursing services consists of individual skilled nursing care to eligible individuals with complex medical needs. Private duty nursing services consists of individual and continuous skilled nursing care to eligible individuals with complex medical needs which cannot be managed within the scope of intermittent home health services. Private duty nursing provides individualized, medically necessary nursing treatment to correct, ameliorate or maintain the member's health condition. The care provided will be based in the individual's home, or any setting in which normal life activities take place. Congregate private duty nursing is defined as private duty nursing provided to two or more individuals who require private duty nursing in the same setting. Services are provided in accordance with 42 CFR 440.80.

2. Service components.

a. Skilled nursing service is the management and administration of the treatment and care of an individual by a licensed nurse, within the scope of practice as outlined by the Virginia Board of Nursing, but is not limited to:

(1) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management, etc.);

(2) Administration of treatment related to technological dependence (e/g. ventilator, tracheotomy, bi-level positive airway pressure (BiPAP), intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines, etc.)

(3) Monitoring and maintaining parameters/machinery (e.g. oximetry, blood pressure, lab draws, end tidal CO2s, ventilator settings, humidification systems, fluid balance, etc.);

(4) Interventions (e.g. medications, suctioning, IV's, hyper alimentation, enteral feeds, ostomy care, tracheostomy care, etc.); and
(5) May include consultation and training for the primary caregiver for up to 30 days following a transition in level of care. Transition services shall be covered in 2 ways: (i) to provide for applicants to move from institutional placements to community private homes and shall be service authorized by DMAS or the designated service authorization contractor in order for reimbursement to occur, and (ii) for applicants who have already moved from an institution to the community within 30 days of their transition. The applicant's transition from an institution to the community shall be coordinated by the facility's discharge planning team.

(6) Exclusions from DMAS' coverage of skilled PDN services:
(a) Not custodial or personal care delivered for the purpose of helping with activities of daily living (ADLs), including dressing, feeding, bathing or transferring from a bed to a chair, and which can safely and effectively be performed by trained non-medical personnel.
(b) Monitoring for medically-controlled disorders as part of "maintenance of care".
(c) Respite skilled nursing services

3. Provider qualifications.
a. Private duty nursing providers shall meet the following requirements:
(1) Demonstrate a prior successful health care delivery;
(2) Operate from a business office;
(3) Disclose ownership, if requested;
(4) Attest to the ability to document and maintain individual case records in accordance with state and federal requirements.

b. Private duty nursing must be provided by a registered nurse (RN) or licensed practical nurse (LPN) employed by (or subcontracted with) and supervised by a private duty nursing provider enrolled with DMAS.
(1) The RN must possess the following qualifications:
(a) a license to practice in the Commonwealth of Virginia;
(b) at least one (1) year of related clinical experience as a RN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility;
(c) a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable; and

shall submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider shall not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry.

(2) Licensed Practical Nurses shall meet the following requirements:
(a) licensed to practice in the Commonwealth of Virginia;
(b) have at least one (1) year of related clinical experience as a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility;
(c) have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable; and
(d) submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

(3) The RN or LPN must have (i) a documented provider training program or (ii) at least six months of related clinical nursing experience meeting the needs of the individual to receive care. Regardless of whether a nurse has six months of experience or completes a provider training course, the provider agency shall be responsible for assuring all nurses who are assigned to an individual are competent in the care needs of that individual.

(4) Nursing services must be provided under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse in the Commonwealth.
(a) As part of direct supervision, the RN supervisor shall make, at a minimum, a visit every 30 days to ensure both quality and appropriateness of nursing services to assess the individual's and the individual's representative's satisfaction with the services being provided, to review the plan of care and to update and verify the most current physician signed orders are in the home. When a delay occurs in the RN supervisor's visits because the individual is unavailable, the reason for the delay shall be documented in the individual's record, and the visit shall occur as soon as the individual is available. Failure to meet this standard may result in DMAS' recovery of payments made. Additional

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supervisory visits may be required under the following circumstances: (i) at the provider's discretion; (ii) at the request of the individual when a change in the individual's condition has occurred; (iii) any time the health, safety, or welfare of the individual could be at risk; and (iv) at the request of the DMAS staff. The RN is responsible for documentation of the visit's date, time and evaluation.

(b) The Supervising RN shall:

- Use and foster a person centered planning team approach to nursing services;
- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate EPSDT PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify the primary care provider if the individual no longer meets criteria for PDN;
- Complete the Plan of Care (POC) and update as necessary for revisions;
- Assure provision of those services requiring substantial and specialized nursing skill and that assigned nurses have the necessary licensure;
- Initiate appropriate preventive and rehabilitative nursing procedures;
- Perform an assessment, at least every 30 days (the monthly nursing assessment cannot be made by the nurse providing care in the home); RN Monthly Supervisory Visits shall be completed in the primary residence at least every other visit. Visits may be conducted at school every other visit if necessary;
- Coordinate PDN services;
- Inform the physician and case manager as appropriate of changes in the individual's condition and needs;
- Educate the individual and family/caregiver in meeting nursing and related goals;
- Supervise and educate other personnel involved in the individual's care;
- Ensure that required documentation is in the individual's agency record;
- Ensure that all employees are aware of the requirements to report suspected abuse, neglect, or exploitation immediately to Adult Protective Services or Child Protective Services, as appropriate. A civil penalty may be imposed on mandated reporters who do not report suspected abuse, neglect or exploitation to VDSS as required;
- Ensure services are provided in a manner that is in the best interest of the individual and does not endanger the individual's health, safety, or welfare;
- Recommend staff changes when needed;

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- Report to DMAS or it's contractor any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to individuals, including household issues that may jeopardize the safety of the PDN; and

- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is Medicaid fraud.

c. Parents (natural, adoptive, legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual shall not provide skilled PDN services for the purpose of Medicaid reimbursement for the individual.

4. Service limits.

Private duty nursing services are limited to the hours of skilled nursing care and medically-necessary supervision as specified in the Plan of Care signed by the child's physician, and limited to the number of hours approved by DMAS or its contractor. Individuals under 21 years of age qualifying under EPSDT shall receive the services described in excess of any State Plan limit, up to 24 hours per day, if services are determined to be medically necessary and are prior authorized by the Department or its contractor.

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N. Autism spectrum disorder (ASD) services, including applied behavior analysis (ABA) provided under EPSDT.

Service Definition: ASD services including ABA are a preventative services benefit provided according to 42 CFR 440.130(c). These services are covered for individuals younger than 21 years of age under EPSDT. ASD services including ABA include the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ASD services including ABA address deficient adaptive behaviors (e.g., instruction following, verbal and nonverbal communication, self-care, personal safety skills) or maladaptive behaviors (e.g., repetitive and stereotypic behaviors; behaviors that risk physical harm to the patient, others, and/or property) by identifying the deficient behaviors and engaging in treatment in individual, family, and group settings. Family adaptive behavior treatment is provided for the direct benefit of the beneficiary and may be provided with or without the beneficiary present. Family adaptive behavior treatment service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service."

Provider qualifications: These services shall be provided by licensed healthcare professionals and staff under the supervision of a licensed healthcare professional in accordance with state law. Providers of Applied Behavior Analysis may include any of the following: LMHP, LMHP-S, LMHP-R, LMHP-RP (all of which are defined in 3.1A&B, pages 31 and 31.1) LABA, or RBTs (defined below).

"Licensed Assistant Behavioral Analyst" or "LABA" means a Board Certified Assistant Behavior Analyst licensed by the Virginia Board of Medicine in accordance with state law.

"Registered behavior technician" or "RBT" means a paraprofessional certified by the Behavior Analyst Certification Board.

Assessment and Family Adaptive Behavior Treatment must be provided by a LMHP. LABAs, LMHP-Rs, LMHP-RPs and LMHP-Ss may assist with these activities in accordance with state law

Limits:

1. ASD services including ABA shall be covered for individuals younger than 21 years of age when determined by DMAS or its contractor to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities.

2. Service authorization shall be required for these services. (Service authorization is not required for assessment.)

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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12 VAC 30-50-131. Early Intervention services under EPSDT.

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

“DBHDS” means the Department of Behavioral Health and Developmental Services, the lead State agency for Early Intervention services appointed by the Governor in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

“Early Intervention services” means services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42CFR440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

"Individualized family service plan" or "IFSP" means a comprehensive and regularly updated statement specific to the child being treated containing, but not necessarily limited to, treatment or training needs, measurable outcomes expected to be achieved, services to be provided with the recommended frequency to achieve the outcomes, and estimated timetable for achieving the outcomes. The IFSP is developed by a multidisciplinary team which includes the family, under the auspices of the local lead agency.

“Local lead agency” means an agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local Early Intervention system as described in Chapter 53 of Title 2.2 (§ 2.2-5304.1) of the Code of Virginia.

“Primary care provider” means a practitioner who provides preventive and primary health care and is responsible for providing routine Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and referral and coordination of other medical services needed by the child.

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B. Coverage for Early Intervention services.

1. Early Intervention services shall be reimbursed for individuals younger than 21 years of age who meet criteria for Early Intervention services established by DBHDS in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

2. Early Intervention services shall be recommended by the child's primary care provider or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition.

3. Early Intervention services shall be provided in settings that are natural or normal for an infant or toddler without a disability, such as the home, unless there is justification for an atypical location.

4. Except for the initial and periodic assessments, Early Intervention services shall be described in an IFSP developed by the local lead agency and designed to prevent or ameliorate developmental delay within the context of the Early Intervention services system defined by Chapter 53 of Title 2.2 of the Code of Virginia.

5. Medical necessity for Early Intervention shall be defined by the IFSP. The IFSP shall describe service needs in terms of amount, duration, and scope. The IFSP shall be approved by the child's primary care provider.

6. Covered Early Intervention services include the following functions provided with the infant or toddler and the child's parent or other authorized caregiver by a certified Early Intervention professional:

a. Assessment, including consultation with the child's family and other service providers, to evaluate:

(1) the child's level of functioning in the following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development;

(2) the family's capacity to meet the developmental needs of the child; and

(3) services needed to correct or ameliorate developmental conditions during the infant and toddler years.

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b. Participation in a multidisciplinary team review of assessments to develop integrated, measurable outcomes for the IFSP.

c. The planning and design of activities, environments, and experiences to promote the normal development of an infant or toddler with a disability, consistent with the outcomes in the IFSP.

7. Covered Early Intervention services include the following functions when included in the IFSP and provided with an infant or toddler with a disability and the child's parent or other authorized caregiver by a certified Early Intervention professional or by a certified Early Intervention specialist under the supervision of a certified Early Intervention professional:

a. Providing families with information and training to enhance the development of the child.

b. Working with the child with a disability to promote normal development in one or more developmental domains.

c. Consulting with the child's family and other service providers to assess service needs, plan, coordinate, and evaluate services to ensure that services reflect the unique needs of the child in all developmental domains.

C. The following functions shall not be covered under this section:

1. Screening to determine if the child is suspected of having a disability. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as an Early Intervention service under this section.

2. Administration and coordination activities related to the development, review, and evaluation of the IFSP and procedural safeguards required by Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.).

3. Services other than the initial and periodic assessments that are provided but are not documented in the child's IFSP or linked to a service in the IFSP.

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

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5. Services provided by a relative who is legally responsible for the child's care.

6. Services rendered in a clinic or provider's office without justification for the location.

7. Services provided in the absence of the child and a parent or other authorized caregiver identified in the IFSP with the exception of multidisciplinary team meetings, which need not include the child.

D. Qualifications of providers:

1. Individual practitioners of Early Intervention must be certified by DBHDS as a qualified Early Intervention professional or Early Intervention specialist.

2. Certified individuals or service agencies or groups who employ or contract with certified individuals may enroll with DMAS as Early Intervention providers. In accordance with 42 CFR 431.51, recipients may obtain Early Intervention services from any willing and qualified Medicaid provider who participates in this service, or for individuals enrolled with a Managed Care Organization (MCO), from such providers available in their MCO network.

3. Certified EI practitioners are qualified to provide a specialized rehabilitative service for young children with developmental delays. Certified individuals and agencies will enroll with DMAS and bill for this specialized rehabilitative service as an EPSDT Early Intervention provider rather than as a speech therapist, rehabilitation facility, or other designation. EI providers are certified or licensed to provide services within the scope of their practice as defined under state law. All licensed physical therapy and occupational therapy providers, and those providing services for individual with speech, hearing, and language disorders shall comply with requirements of 42 CFR 440.110.

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4c. Family planning services and supplies for individuals of child-bearing age.

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

B. 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.

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PHYSICIAN'S SERVICES WHETHER FURNISHED IN THE OFFICE, THE PATIENT'S HOME, A HOSPITAL, A SKILLED NURSING FACILITY OR ELSEWHERE.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program prior approval.

C. Routine physicals and immunizations are covered.

D. Outpatient psychiatric services.

1. Psychiatric services can be provided by or under the supervision of an individual licensed under state law to practice medicine or osteopathy. Only the following licensed or registered providers are permitted to provide psychiatric services under the supervision of an individual licensed under state law to practice medicine or osteopathy: an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a licensed school psychologist. Medically necessary psychiatric services shall be covered by DMAS or its designee and shall be directly and specifically related to an active written plan designed and signature dated by one of the healthcare professionals listed in this subdivision.

2. Psychiatric services shall be considered appropriate when an individual meets the following criteria:

a. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels which have been impaired;

b. Exhibits deficits in peer relations, dealing with authority, is hyperactive, has poor impulse control, is clinically depressed or demonstrates other dysfunctional clinical symptoms having an adverse impact on attention and concentration, abilities to learn, and/or ability to participate in employment, educational, or social activities;

c. Is at risk for developing or requires treatment for maladaptive coping strategies; and

d. Presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress.

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E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of life to the mother if the fetus was carried to term.

G. Physician visits to inpatient psychiatric hospital patients are restricted to medically necessary authorized (for enrolled providers)/approved (for non-enrolled providers) inpatient hospital days as determined by DMAS or its contractor.

H. [Reserved.]

I. Reimbursement shall not be provided for physician services provided to recipients in the inpatient setting whenever the facility is denied reimbursement.

J. [Reserved.]

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K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require service authorization by DMAS. Cornea transplants do not require service authorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant.

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Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere (continued)

L. Breast reconstruction/prostheses following mastectomy and breast reduction.

1. If serviced authorized, breast reconstruction surgery and prostheses may be covered following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions may be covered, if serviced authorized, for medically necessary indications. Such procedures shall be considered non-cosmetic.

2. Breast reconstruction or enhancements for cosmetic reasons shall not be covered. Cosmetic reasons shall be defined as those which are not medically indicated, or are intended solely to preserve, restore, confer or enhance the aesthetic appearance of the breast.

M. Admitting physicians shall comply with the requirements for coverage of out-of-state inpatient hospital services. Inpatient hospital services provided out of state to a Medicaid recipient who is a resident of the state of Virginia shall only be reimbursed under at least one of the following conditions. It shall be the responsibility of the hospital, when requesting service authorization for the admission, to demonstrate that one of the following conditions exists in order to obtain authorization. Services provided out-of-state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;

2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;

3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or

4. It is the general practice for recipients in a particular locality to use medical resources in another state.

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N. In compliance with 42 CF441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review of the required DMAS forms corresponding to the procedures. The claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

O. Service authorization is required for the following nonemergency outpatient procedures: Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA), Computer Axial Tomography (CAT) scans, including Computed Tomography Angiography (CTA), or Positron Emission Tomography (PET) scans performed for the purpose of diagnosing a disease process or physical injury. The referring physician ordering non-emergency outpatient Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) scans, or Positron Emission Tomography (PET) scans must obtain service authorization from the Department of Medical Assistance Services (DMAS) for those scans. The servicing provider will not be reimbursed for the scan unless proper service authorization is obtained from DMAS by the referring physician.

P. Addiction and recovery treatment services shall be covered in physician services.

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6. Medical care by other licensed practitioners within the scope of their practice as defined by State Law.

A. Podiatrists' Services.

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

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

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

B. Optometrists' Services.

1. Diagnostic examination and optometric treatment procedures and services by licensed optometrists and opticians acting within their scope of practice as defined under state law are covered. Routine refractions are limited to once in 24 months. This limitation may be exceeded based on medical necessity.

C. Chiropractors' Services

1. Not provided.

D. In accordance with 42 CFR 440.60, licensed practitioners may provide medical care or any other type of remedial care or services, other than physician services, within the scope of practice as defined under state law. These practitioners are limited to the following:

Licensed Practitioners:
1. Nurse practitioners
2. Physician assistants
3. Nurse anesthetists
4. Clinical nurse specialists
5. Respiratory therapists
6. Licensed midwives/certified professional midwives

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7. Licensed clinical psychologists
8. Licensed professional counselors
9. Licensed clinical social workers
10. Licensed substance abuse treatment practitioners
11. Licensed marriage and family therapists
12. Licensed behavior analysts
13. Licensed school psychologists

Non-Licensed Practitioners:

1. Residents/supervisees working under the supervision of a licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner or licensed marriage and family therapist in accordance with state law.

E. Pharmacist, Pharmacy Intern and Pharmacy Technician Services

Services provided by licensed pharmacists, and pharmacy interns and pharmacy technicians supervised by pharmacists, are covered when those services are provided by pharmacists, and pharmacy interns and pharmacy technicians supervised by pharmacists, who are acting within their scope of practice or in a collaborative agreement with a provider licensed in Virginia or are specified in Board of Pharmacy protocols for licensure that have been reviewed and accepted by DMAS and are services covered by Medicaid. Collaborative agreements can be with any licensed podiatrist or licensed advanced practice registered nurse or physician assistant. The scope of services that are covered under a collaborative agreement are limited to those under the licensed provider's scope of practice.

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6.5 Substance abuse treatment services provided by other licensed practitioners within the scope of their practice as defined by state law (12 VAC 30-50-150 and at 42 CFR 440.60)

1. Outpatient substance abuse services are limited to an initial availability of 26 sessions, without prior authorization during the first treatment year. An additional extension of up to 26 sessions is available during the first treatment year and must be prior authorized by DMAS or its designee. The availablity is further restricted to no more than 26 sessions each succeeding year when prior authorized by DMAS or its designee. Outpatient substance abuse services are further restricted to no more than three sessions in any given seven-day period. Consistent with § 6403 of the Omnibus Budget Reconciliation Act of 1989, medically necessary substance abuse services shall be covered when prior authorized by DMAS or its designee for individuals younger than 21 years of age when the need for such services has been identified in an EPSDT screening, and the above limits have been exceeded.

2. Outpatient substance abuse services shall be provided by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, or a licensed substance abuse treatment practitioner.

   The provider must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

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

4. Psychological or psychiatric substance abuse services shall be considered appropriate when an individual meets criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence shall not be covered. The Axis I substance-related disorder shall meet American Society of Addiction Medicine (ASAM) Level of Care Criteria.

5. Psychological or psychiatric services may be provided in an office or a clinic.

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7. Home Health Services.

A. Services must be ordered or prescribed by a physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Home health services shall be provided in accordance with 42 CFR 440.70 and the guidelines found in the Virginia Medicaid Home Health Manual. All home health services rendered under this authority shall comply with the requirements of section 12006 of the 21st Century CURES Act, with regard to electronic visit verification (EVV), beginning July 1, 2023.

B. Nursing services provided by a home health agency.

1. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

2. Patients may receive up to five visits by a licensed nurse annually. Limits are per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the practitioner, as defined in paragraph A of this section to be required, then the provider shall request prior authorization from DMAS for additional services. Payment shall not be made for additional services unless authorized by DMAS.

C. Home health aide services provided by a home health agency.

1. Home Health Aides must function under the supervision of a registered nurse.

2. Home Health Aides must meet the certification requirements specified in 42 CFR 484.80.

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3. For home health aide services, patients may receive up to 32 visits annually. Limits shall be per recipient, regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. The state assures that this limit is sufficient to meet the service needs of recipients.

D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility in accordance with 42 CFR 440.110.

1. Service covered only as part of a plan of care developed by a practitioner, as defined in paragraph A of this section.

2. Patients may receive up to five visits for each rehabilitative therapy service ordered annually without authorization. Limits shall apply per recipient regardless of the number of providers rendering services. "Annually" shall be defined as July 1 through June 30 for each recipient. If services beyond these limitations are determined by the practitioner, as defined in paragraph A of this section to be required, then the provider shall request prior authorization from DMAS for additional services.

E. The following services are not covered under the home health services program:

1. Medical social services;
2. Services or items which would not be paid for if provided to an inpatient of a hospital, such as private-duty nursing services, or items of comfort which have no medical necessity, such as television;
3. Community food service delivery arrangements;
4. Domestic or housekeeping services which are unrelated to patient care and which materially increase the time spent on a visit;
5. Custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care; and
6. Services related to cosmetic surgery.

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§ 7.5. Durable medical equipment (DME) and supplies suitable for use. (12 VAC 30-50-165)

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

"Affirmative contact" means speaking, either face-to-face or by phone, with either the individual or caregiver in order to ascertain that the DME and supplies are still needed and appropriate. Such contacts shall be documented in the individual's medical record.

"Certificate of Medical Necessity" or "CMN" means the DMAS-352 form that operates as a plan of care, and that must be completed and submitted in order for DMAS to provide coverage.

"Designated agent" means an entity with whom DMAS has contracted to perform functions such as provider audits and prior authorizations of services.

"DMAS" means the Department of Medical Assistance Services.

"DME provider" means those entities enrolled with DMAS to render DME services.

"Durable medical equipment" or “DME” means medical supplies, equipment, and appliance suitable for use consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

"Enteral nutrition" refers to any method of feeding that uses the gastrointestinal tract to deliver part or all of an individual's caloric requirements. "Enteral nutrition" may include a routine oral diet, the use of liquid supplements, or delivery of part or all of the daily requirements by use of a tube, which is called a tube feeding.

"Expendable supply" means an item that is used and then disposed of.

"Frequency of use" means the rate of use by the individual as documented by the number of times per day, week, or month, as appropriate, a supply is used by the individual. Frequency of use must be recorded on the face of the CMN in such a way that reflects whether a supply is used by the individual on a daily, weekly, or monthly basis. Frequency of use may be documented on the CMN as a range of the rate of use. By way of example and not limitation, at the frequency of use of a supply may be expressed as a range, such four to six adult diapers per day. However large ranges shall not be acceptable documentation of frequency of use (for example, the range of one to six adult diapers per day shall not be acceptable.) The frequency of use provides the justification for the total quantity of supplies ordered on the CMN.

"Functional limitation" means the inability to perform a normal activity.

"Physician" means a provider of physician services as defined in 42 CFR 440.50.

"Prior authorization" or "PA" means the process of approving either by DMAS or its prior authorization contractor for the purposes of DMAS reimbursement for the service for the individual before it is rendered or reimbursed.

"Quantity" means the total number of supplies ordered on a monthly basis as reflected on the CMN. The monthly quantity of supplies ordered for the individual shall be dependent upon the individual's frequency of use.

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B. General requirements and conditions.

1. a. All medically necessary medical supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost-effective by DMAS, payment may be made for rental of the equipment in lieu of purchase.
   b. No provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity, when there is an error in the ordering practitioner's CMN, or when the equipment is rented.

2. DME providers shall adhere to all applicable federal laws and regulations, including the face-to-face requirements in 42 CFR 410.38. DME providers shall also adhere to all applicable state laws and regulations and DMAS' policies for DME and supplies. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations that are required by such licensing agency or agencies shall result in denial of coverage for DME or supplies which are regulated by a licensing agency. Upon post payment review, DMAS or its designated contractor may deny coverage for any DME products or supplies that have not been provided and billed in accordance with these regulations and DMAS policies.

3. DME and supplies must be furnished pursuant to a properly completed Certificate of Medical Necessity (CMN) (DMAS-352). In order to obtain Medicaid coverage, specific fields of the DMAS-352 form shall be completed as specified in Attachment 3.1-C, p. 17.1 (12 VAC 30-60-75).

4. DME and supplies shall be ordered by the physician and shall be related to medical treatment of the Medicaid individual. The complete DME order shall be recorded on the CMN for Medicaid individuals to receive such services. In the absence of a different effective period determined by DMAS or its designated agent, the CMN shall be valid for a maximum period of six months for Medicaid individuals younger than 21 years of age. In the absence of a different effective period determined by DMAS or its designated agent, the maximum valid time period for CMNs for Medicaid individuals 21 years of age and older shall be 12 months. The validity of the CMN shall terminate when the individual's medical need for the prescribed DME or supplies no longer exists as determined by the physician.

5. DME shall be furnished exactly as ordered by the physician who signed the CMN. The CMN and any supporting verifiable documentation shall be fully completed, signed and dated by the physician, and in the DME provider's possession within 60 days from the time the ordered DME and supplies are initially furnished by the DME provider. Each component of the DME shall be specifically ordered on the CMN by the physician. The order shall not be backdated to cover prior dispensing of all DME products and supplies. If the order is not signed within 60 days of the service initiation, then the date the order is signed becomes the effective date.

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6. The CMN shall not be changed, altered, or amended after the attending physician has signed it. If individual's condition indicates that changes in the ordered DME or supplies are necessary, the DME provider shall obtain a new CMN. All CMNs shall be signed and dated by the physician within 60 days from the time the ordered supplies are furnished by the DME provider.

7. DMAS or its designated agent shall have the authority to determine a different length of time from those specified in subdivisions 4, 5, and 6 of this subsection that a CMN may be valid based on medical documentation submitted on the CMN. The CMN may be completed by the DME provider or other appropriate health care professionals, but it shall be signed and dated by the physician, as specified in subdivision 5 of this subsection. Supporting documentation may be attached to the CMN but the attending physician's entire order shall be on the CMN.

8. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for purposes of the DMAS post payment audit review. DME providers shall not create or revise CMNs or supporting documentation for this service after the initiation of the post payment review audit process. Physicians shall not complete, nor sign and date CMNs once the post payment audit review has begun.

9. The DME provider shall be responsible for knowledge of items requiring prior authorization and the limitation on the provision of certain items as described in the Virginia Medicaid Durable Medical Equipment and Supplies Manual, Appendix B. (This limitation may be exceeded based upon medical necessity.) Appendix B shall be the official listing of all items covered through the Virginia Medicaid DME program and lists the service limits, items that require prior authorization, billing units, and reimbursement rates.

10. The DME provider shall be required to make affirmative contact with the individual or his caregiver and document the interaction prior to the next month's delivery and prior to the recertification CMN to assure that the appropriate quantity, frequency, and product are provided to the individual.

11. Supporting documentation, added to a completed CMN, shall be allowed to further justify the medical need for DME but shall not replace the requirement for a properly completed CMN.

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12. DMAS shall deny payment to the DME provider if any of the following occur:

    a. Absence of a current, fully completed CMN appropriately signed and dated by the practitioner;
    b. Documentation does not verify that the item was provided to the individual;
    c. Lack of medical documentation, signed by the practitioner to justify the DME products or supplies; or
    d. Item is non-covered or does not meet DMAS criteria for coverage.

13. If coverage is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

C. The billing unit for incontinence supplies (such as diapers, pull-ups, and panty liners) shall be by each product. For example, if the incontinence supply being provided is diapers, DMAS will cover them by each individual diaper, rather than a case of diapers. Prior authorization shall be required for incontinence supplies requested in quantities greater than the allowable service limit per month. This service shall be provided as a sole source contract.

D. All medically necessary supplies and equipment shall be covered; unusual types shall be preauthorized based on a medical necessity determination. Individuals shall be notified of their right to appeal any denial determination. Supplies, equipment, or appliances that are generally not covered include, but are not limited to, the following:

1. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners

2. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, and bathroom scales)

3. Items that are only for the recipient's comfort and convenience or for the convenience of those caring for the recipient (e.g., a hospital bed or mattress because the recipient does not have a decent bed; wheelchair trays used as a desk surface;) mobility items used in addition to primary assistive mobility aide the convenience of the individual or his caregiver (i.e., an electric wheelchair plus a manual chair); and cleansing wipes.

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4. Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (for example, dentifrices; toilet articles; shampoos which do not require a physician's prescription; dental adhesives; electric toothbrushes; cosmetic items, soaps, and lotions which do not require a practitioner's prescription; sugar and salt substitutes; and support stockings;
5. Home or vehicle modifications;
6. Equipment for which the primary function is vocationally or educationally related (i.e., computers, environmental control devices, speech devices, etc.);
7. Diapers for routine use by children younger than three years of age who have not yet been toilet trained.

E. For coverage of blood glucose meters for pregnant women, refer to Supplement 3 to Attachment 3.1 A & B.

F.

1. Coverage of home infusion therapy. Home infusion therapy shall be defined as the administration of fluids, drugs, chemical agents, or nutritional substances to individuals through intravenous (I.V.) therapy or an implantable pump in the home setting. The therapies to be covered under this policy shall be: hydration therapy, chemotherapy, pain management therapy, drug therapy, and total parenteral nutrition (TPN). All the therapies which meet criteria shall be covered and do not require prior authorization.

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2. The following limitations shall apply to this service:

   a. This service must be medically necessary to treat an individual's medical condition. The service must be ordered and provided in accordance with accepted medical practice. The service must not be desired solely for the convenience of the recipient or the recipient's caregiver.

   b. In order for Medicaid to reimburse for this service, the individual shall:

      (a) Reside in either a private home or a domiciliary care facility;

      (b) Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy.

      (c) Have body sites available for peripheral intravenous catheter or needle placement or have a central venous access; AND

      (d) Be capable of either self-administering such therapy or have a caregiver who can be adequately trained, is capable of administering the therapy, and is willing to safely and efficiently administer and monitor the home infusion therapy. The caregiver must be willing to and be capable of following appropriate teaching and adequate monitoring. In those cases where the individual is incapable of administering or monitoring the prescribed therapy and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

G. The DME vendor shall provide the equipment and supplies as prescribed by the physician on the CMN. Orders shall not be changed unless the vendor obtains a new CMN, which includes the physician's signature, prior to ordering the equipment or supplies or providing the equipment or supplies to the individual.

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H. Medicaid shall not provide coverage to the DME and supply vendor for services that are provided (i) prior to the date prescribed by the physician; (ii) prior to the date of the delivery; (iii) or when services are not provided in accordance with DMAS published regulations and guidance documents. If coverage is denied for one of these reasons, the medical equipment and supply vendor shall not bill the Medicaid individual for the service that was provided.

I. The following criteria shall be satisfied through the submission of adequate and verifiable documentation on the CMN satisfactory to DMAS. Medically necessary DME and supplies shall be:

1. Ordered by the licensed practitioner on the CMN;
2. A reasonable and necessary part of the individual's treatment plan;
3. Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
4. Not furnished solely for the convenience, safety, or restraint of the individual, the family or caregiver, attending physician, or other licensed practitioner or supplier;
5. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
6. Furnished at a safe, effective, and cost-effective level suitable for the individual's use.

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J. Enteral nutrition products. Coverage of enteral nutrition (EN) drug shall be limited to when the nutritional supplement is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. DMAS shall provide coverage for nutritional supplements for enteral feeding only if the nutritional supplements are not available over the counter. Additionally, DMAS shall cover medical foods that are (i) specific to inherited diseases and metabolic disorders; (ii) not generally available in grocery stores, health food stores, or the retail section of a pharmacy; and (iii) not used as food by the general population. Coverage of EN shall not include the provision of routine infant formula or feedings as meal replacement only. Coverage of medical foods shall not extend to regular foods prepared to meet particular dietary restrictions, limitations, or needs, such as meals designed to address the situation of individuals with diabetes or heart disease. A nutritional assessment shall be required for all individuals for whom nutritional supplements are ordered.

1. General requirements and conditions.

a. Enteral nutrition products shall only be provided by enrolled DME providers.

b. DME providers shall adhere to all applicable DMAS policies, law, and regulations. DME providers shall also comply with all other applicable Virginia Laws and regulations requiring licensing, registration, or permitting. Failure to comply with such laws and regulations shall result in denial of coverage for enteral nutrition that is regulated by such licensing agency.

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2. Service units and service limitations.
   a. DME and supplies shall be furnished pursuant to the Certificate of Medical Necessity (DMAS 352).
   b. The DME provider shall include documentation related to the nutritional evaluation findings on the CMN and may include supplemental information on any supportive documentation submitted with the CMN.
   c. DMAS shall reimburse medically necessary formulae and medical foods when used under a licensed practitioner's direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.
   d. The CMN shall contain a licensed practitioner's order for the enteral nutrition products that are medically necessary to treat the diagnosed condition and the individual's functional limitation. The justification for enteral nutrition products shall be demonstrated in the written documentation either on the CMN or on the attached supporting documentation. The CMN shall be valid for a maximum period of six months.
   e. Regardless of the amount of time that may be left on a six-month approval period, the validity of the CMN shall terminate when the individual's medical need for the prescribed enteral nutrition products ends, as determined by the licensed practitioner.
   f. A face-to-face nutritional assessment completed by trained clinicians (e.g., physician, physician assistant, nurse practitioner, registered nurse, or a registered dietitian) shall be completed as required documentation of the need for enteral nutrition products.
   g. Prior authorization of enteral nutrition products shall not be required. The DME provider shall assure that there is a valid CMN (i) completed every six months in accordance with subsection B of this section and (ii) on file for all Medicaid individuals for whom enteral nutrition products are provided.

   (1) The DME provider is further responsible for assuring that enteral nutrition products are provided in accordance with DMAS reimbursement criteria in 12VAC30-80-30 A 6.

   (2) Upon post payment review, DMAS or its designated contractor may deny reimbursement for any enteral nutrition products that have not been provided and billed in accordance with this section and DMAS policies.

   h. DMAS shall have the authority to determine that the CMN is valid for less than six months based on medical documentation submitted.

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3. Provider responsibilities.

a. The DME provider shall provide the enteral nutrition products as prescribed by the licensed practitioner on the CMN. Physician orders shall not be changed unless the DME provider obtains a new CMN prior to ordering or providing the enteral nutrition products to the individual.

b. The licensed practitioner's order on the CMN shall specify either a brand name of the enteral nutrition product being ordered or the category of enteral nutrition products that must be provided. If a licensed practitioner orders a specific brand of enteral nutrition product, the DME provider shall supply the brand prescribed. The licensed practitioner order shall include the daily caloric intake and the route of administration for the enteral nutrition product. Supporting documentation may be attached to the CMN, but the entire licensed practitioner's order shall be on the CMN.

c. The CMN shall be signed and dated by the licensed practitioner within 60 days of the CMN begin service date. The order shall not be backdated to cover prior dispensing of enteral nutrition products. If the CMN is not signed and dated by the licensed practitioner within 60 days of the CMN begin service date, the CMN shall become valid on the date of the licensed practitioner's signature.

d. The CMN shall include all of the following elements:

(1) Height of individual (or length for pediatric patients);

(2) Weight of individual. For initial assessments, indicate the individual's weight loss over time;

(3) Tolerance of enteral nutrition product (e.g., is the individual experiencing diarrhea, vomiting, constipation). This element is only required if the individual is already receiving enteral nutrition products;

(4) Route of administration; and

(5) The daily caloric order and the number of calories per package or can

e. Medicaid reimbursement shall be recovered when the enteral nutrition products have not been ordered on the CMN. Supporting documentation is allowed to justify the medical need for enteral nutrition products. Supporting documentation shall not replace the requirement for a properly completed CMN. The dates of the supporting documentation shall coincide with the dates of service on the CMN, and the supporting documentation shall be ~~fully~~ signed and dated by the licensed practitioner.

K. Reimbursement denials.

1. DMAS shall deny payment to the DME provider if any of the following occur:

a. Absence of a current, fully completed CMN appropriately signed and dated by the licensed practitioner;

b. Documentation does not verify that the item was provided to the individual;

c. Lack of medical documentation, signed by the licensed practitioner to justify the DME; or

d. Item is non-covered or does not meet DMAS criteria for reimbursement.

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2. If reimbursement is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

L. Replacement DME following a disaster.

1. Medicaid individuals who (i) live in areas that have been declared by the Governor to be subject to a state of emergency in accordance with § 44-146.16 of the Code of Virginia, (ii) live in Virginia and were present in an area of the state that has been declared by the Governor to be subject to a state of emergency in accordance with § 44-146.16 of the Code of Virginia, or (iii) live in Virginia and can prove they were present in a state or federally declared disaster or emergency area in another state when the disaster occurred, and who need to replace DME previously approved by Medicaid that were damaged as a result of the disaster or emergency, may contact a DME provider (either enrolled in fee-for-service Medicaid or a Medicaid health plan) of their choice to obtain a replacement.

a. If the individual's DME provider has gone out of business or is unable to provide replacement DME, the individual may choose another provider who is enrolled as a DME provider with Medicaid or the Medicaid health plan. The original authorization will be canceled or amended and a new authorization will be provided to the new DME provider.

b. The DME provider shall submit a signed statement from the Medicaid individual requesting a change in DME provider in accordance with the declaration by the Governor as a state of emergency due to a disaster and giving the Medicaid individual's current place of residence.

c. The individual can contact the state Medicaid office or the Medicaid health plan to get help finding a new DME provider.

2. For Medicaid enrolled providers, the provider shall make a request to the service authorization contractor; however, a new CMN and medical documentation is not required unless the DME is beyond the service limit (e.g., the individual has a wheelchair that is older than five years). The provider shall keep documentation in the individual's record that includes the individual's current place of residence and states that the original DME was lost due to the disaster.

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§8 Private duty nursing services.

A. Not provided.

§9 Clinic services.

A. Reserved.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;
2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
3. except in the case of nurse-midwife services, as specified in 42 CFR §440.165, are furnished by or under the direction of a physician or dentist.

C. Reimbursement to community mental health clinics for psychotherapy services is provided only when performed by a qualified therapist. For purposes of this section, a qualified therapist is:

1. A licensed physician who has completed three years of post-graduate residency training in psychiatry;

2. An individual licensed or registered by one of the boards administered by the Department of Health Professions to provide psychotherapy services including an LMHP, LMHP-R, LMHP-RP, or LMHP-S, as defined in Attachment 3.1A&B, Supplement 1, pages 31 and 31.1.

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10. Dental services.

A. Dental services shall be covered for individuals younger than 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

1. The state agency will provide any medically necessary dental service to individuals younger than 21 years of age.

2. Certain dental services for individuals under the age of 21 shall require preauthorization or prepayment review by the state agency or its designee.

3. Dental services for individuals under the age of 21 that do not require preauthorization or prepayment review are: initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; pre-treatment evaluations for deep sedation or general anesthesia, dental prophylaxis; fluoride treatments; routine amalgam and composite restorations; stainless steel crowns, prefabricated steel post, temporary (polycarbonate crowns) and stainless steel bands; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping, sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure.

B. Dental services, determined by the dental provider to be appropriate for a woman during the term of her pregnancy, shall be provided to Medicaid-enrolled pregnant woman age 21 and older. The dental services that shall be covered are: (i) diagnostic x-rays and exams; (ii) preventive cleanings; (iii) restorative fillings; (iv) endodontics (root canals); (v) periodontics (gum related treatments); (vi) prosthodontics, both removable and fixed (crown, partial plates,); (vii) oral surgery (tooth extractions and biopsies, alveoloplasty); (viii) pre-treatment evaluations for deep sedation or general anesthesia; and (ix) adjunctive general services (all covered services that do not fall into specific professional categories). These services require prepayment review by the state agency or its designee.

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C. For the dental services covered for Medicaid-enrolled adult pregnant women, the same limits described in paragraph D.2 for adults shall apply.

D. Dental services shall be provided to individuals with full-benefit Medicaid coverage, aged 21 and over.

1. The following services shall be covered: 1) dental exams, routine cleanings, x-rays; 2) fillings and crowns; 3) root canals and pulpal debridement; 4) scaling and root planning, gingivectomies, and periodontal maintenance procedures; 5) extractions and alveoplasty; and 6) anesthesia services, including pre-treatment evaluations for deep sedation or general anesthesia.

2. The following limits shall apply: 1) Prophylaxis shall be covered up to three times per year; 2) Non-routine x-rays such as imaging and cone beam technology require service authorization; 3) 3) bridges are not covered; 4) endodontic retreatment, apexification and apicoectomy are not covered; 5) periodontal flap procedures, crown lengthening procedures, and bone replacement grafts are not covered; 6) oral antral fistulation procedures, closures of sinus perforations and dislocation and management of TMJ dysfunctions are not covered; 7) surgical trauma procedures that require CPT codes are not covered; 8) implants are not covered; 9) non-anesthesia adjunctive services may require service authorization.

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), and described in Agency guidance documents, are covered for all recipients, and require preauthorization or prepayment review by the state agency or its designee as described in Agency guidance documents.

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11. Physical therapy, occupational therapy, services for individuals with speech, hearing, and language disorders.

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

"Actively participate" means the individual regularly, as may be ordered by the physician, attends planned therapeutic activities and demonstrates progress towards goals established in the plan of care.

"Acute conditions" means conditions that are expected to be of brief duration (less than 12 months) and in which progress toward established goals is likely to occur frequently.

"Admission certification statement" means that the physician signs and dates an initial written statement in the individual's medical record of the need for intensive rehabilitation services. This statement shall be documented at the time of the rehabilitation admission.

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

"Evaluation" means a thorough assessment completed by a licensed therapist that is signed and fully dated and includes the following components: a medical diagnosis, clinical signs and symptoms, medical history, current functional status, summary of previous rehabilitative treatment and the result, and the therapist's recommendation for treatment.

"Non-acute conditions" means conditions that are of long duration (greater than 12 months) and in which progress toward established goals is likely to occur slowly.

"Plan of care" means a treatment plan developed by a licensed therapist, which shall include medical diagnosis; current functional status; individualized, measurable, participant-oriented goals (long-term and short-term goals) that describe the anticipated level of functional improvement; achievement timeframes for all goals; therapeutic interventions or treatments to be utilized by the therapist; frequency and duration of the therapies; and a discharge plan and anticipated discharge date.

"Recertification" means that the physician shall sign and date at least every 60 days a written statement in the individual's medical record of the continuing need for intensive rehabilitation services.

"Reevaluation" means an assessment that contains all of the same components as an evaluation and that shall be completed when an individual has a significant change in his condition or when an individual is readmitted to a rehabilitative service.

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"SLP" means speech-language pathology.

"Therapist plan of care" means a written treatment plan, developed by each licensed therapist involved with the individual's care, to include measurable long-term and short-term goals, interventions or modalities, frequency and duration, and a discharge disposition. These therapist plans of care shall be written, signed, and dated by either a licensed physical or occupational therapist, speech-language pathologist, cognitive rehabilitative therapist, psychologist, social worker, or certified therapeutic recreational specialist

11.a Physical Therapy Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of physical therapy services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed physical therapist.
2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy or a physical therapy assistant licensed by the Virginia Board of Physical Therapy and who is under the direct supervision of a licensed physical therapist.
3. When physical therapy services are provided by a qualified physical therapy assistant, such services shall be provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days and documents the findings of the visit in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable physical therapy:

1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.
2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.
3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for non-acute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.

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4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.

5. Physical therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress

b. Lack of participation on the part of the individual is evident.

c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.

d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.

e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.

f. The service no longer requires the skills of a qualified therapist.

g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

11.b Occupational Therapy Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of occupational therapy services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed occupational therapist.

2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by an occupational therapist certified by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine or an occupational therapy assistant certified by the National Board for Certification in Occupational Therapy who is under the direct supervision of a licensed occupational therapist.

3. When occupational therapy services are provided by a qualified occupational therapy assistant, such services shall be provided under the supervision of a qualified occupational therapist who makes an onsite supervisory visit at least once every 30 days and documents the visit findings in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable occupational therapy:

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1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.
2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.
3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for non-acute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.
4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.
5. Occupational therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress.
b. Lack of participation on the part of the individual is evident.
c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.
d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.
e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.
f. The service no longer requires the skills of a qualified therapist.
g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

11.c Speech-Language Pathology Services are provided in accordance with 42 CFR 440.110 and shall meet medical necessity requirements.

A. The provision of speech-language pathology services shall meet all of the following conditions:

1. The services that the individual needs shall be directly and specifically related to a written plan of care developed, signed, and dated by a licensed speech-language pathologist.
2. The services shall be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Virginia Board of Audiology and Speech-Language Pathology or who, if exempted from licensure by statute, meets the requirements in 42 CFR 440.110(c).

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3. DMAS shall reimburse for the provision of speech-language pathology services when provided by a person considered by DMAS as a speech-language assistant (i.e., has a bachelor's level or a master's level degree without licensure by the Virginia Board of Audiology and Speech-Language Pathology and who does not meet the qualifications required for billing as a speech-language therapist). Speech-language assistants shall work under the direct supervision of a licensed professional therapist holding a Certificate of Clinical Competence (CCC) in SLP or a speech-language pathologist who meets the licensing requirements of the Virginia Board of Audiology and Speech-Language Pathology.

4. When services are provided by a therapist who is in his Clinical Fellowship Year (CFY) of an SLP Program or a speech-language assistant, a licensed professional therapist holding a CCC in SLP or a speech-language pathologist who shall make a supervisory visit at least every 30 days while therapy is being conducted and document the findings in the medical record. The supervisory visit shall not be reimbursable.

B. Service Limitations. The following general conditions shall apply to reimbursable speech-language pathology therapy:

1. The individual must be under the care of a physician or other licensed practitioner who is legally authorized to practice and who is acting within the scope of his license.

2. The orders for elevauation of the need for therapy services identify the specific therapy discipline and must be personally signed and dated prior to the initiation of rehabilitative services.

3. The plan of care shall include the specific procedures and modalities to be used and indicate the frequency and duration for services. A written plan of care shall be reviewed by the physician or licensed practitioner every 60 days for acute conditions or annually for non-acute conditions. The requested services shall be necessary to carry out the plan of care and shall be related to the individual's condition. The plan of care shall be signed and dated, as specified in this section, by the physician or other licensed practitioner who reviews the plan of care.

4. Quality management reviews, in accordance with VA regulations, shall be performed by DMAS or its contractor.

5. Speech-language pathology therapy services are to be considered for termination regardless of the service authorized visits or services when any of the following conditions are met:

a. No further potential for improvement is demonstrated and the individual has reached his maximum progress.

b. Lack of participation on the part of the individual is evident.

c. The individual has an unstable condition that affects his ability to actively participate in a rehabilitative plan of care.

d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time as determined by the licensed therapist.

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e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.
f. The service no longer requires the skills of a qualified therapist.
g. A home maintenance program has been established to maintain the individual's function at the level to which it has been restored.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

A. Prescribed drugs.

1. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of §1927 of the Social Security Act (OBRA '90 §4401), shall not be covered.

2. a. Selective non legend drugs shall be covered by Virginia Medicaid and published in Chapter 4 of the Pharmacy Provider Manual.

b. Designated drugs prescribed by a licensed prescriber to be used as less expensive therapeutic alternatives to covered legend drugs. A list of specific covered drug categories is published in Chapter 4 of the Pharmacy Provider Manual.

3. Contraceptives may be covered for up to a 12-month supply.

4. Select maintenance legend and non-legend drugs may be covered for a maximum of a 90-day supply per prescription per patient after two 34-day or shorter duration fills. The drugs or classes of drugs identified in Supplement 5 to Attachment 3.1 A&B and all other covered drugs are covered for a maximum of a 34-day supply per prescription. FDA- approved drug therapies and agents for weight loss, when preauthorized, will be covered for recipients who meet the strict disability standards for obesity established by Social Security Administration in effect on April 7, 1999, and whose condition is certified as life threatening, consistent with the Department of Medical Assistance Services' medical necessity requirements, by the treating physician.

5. Prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other practitioner so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written or unless the drug class is subject to the Preferred Drug List.

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6. New drugs shall be covered pursuant to the Social Security Act of §1927(d) (OBRA '90 §4401).

7. The number of refills shall be limited pursuant to the Drug Control Act, Code of Virginia Title 54.1, §54.1-3411.

8. Drug Prior Authorization.

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

"Clinical data" means drug monographs as well as any pertinent clinical studies, including peer review literature.

"Complex drug regimen" means treatment or course of therapy that typically includes multiple medications, co-morbidities and or caregivers.

"Department" means the Department of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§54.1-3400 et seq.).

"Drug Utilization Review" means the process for the retrospective and prospective review and approval of drug use based on criteria and standards employed by the agency to evaluate the medical necessity of reimbursing for covered outpatient drugs.

"Emergency supply" means 72-hour supplies of the prescribed medication that is dispensed if the prescriber cannot readily obtain authorization, or if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays and the pharmacist, in his professional judgment consistent with current standards of practice, feels that the patient's health would be compromised without the benefit of the drug, or other criteria defined by theP & T Committee and DMAS.

"Non-preferred drugs" means those drugs that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Non-preferred drugsmay be prescribed but require prior authorization prior to dispensing to the patient.

"Pharmacy and Therapeutics Committee (P&T Committee)" or "Committee" means the Committee formulated to review therapeutic classes, conduct clinical

reviews of specific drugs, recommend additions or deletions to the preferred drug list, and perform other functions as required by the Department.

"Polypharmacy program" means a retrospective review program for recipients receiving a set number of unique prescriptions (refills and OTC excluded) in a period of one calendar quarter. These outlier reviews are initiated based upon standard clinical and medical utilization practices.

"Preferred drug list (PDL)" means the list of drugs that meet the safety, clinical efficacy, and pricing standards employed by the P&T Committee and adopted by the Department for the Virginia Medicaid fee-for-service program. Most drugs on the PDL may be prescribed and dispensed in the Virginia Medicaid fee-for-service program and Managed Care Plans without prior authorization; however, some drugs as recommended by the Pharmacy and Therapeutics Committee may require authorization prior to dispensing to the patient.

"Prior authorization" as it relates to the PDL, means the process of review by a clinical pharmacist or pharmacy technician of legend and non-legend drugs that are not on the preferred drug list or other drugs as recommended by the Pharmacy and Therapeutics Committee, to determine if medically justified.

"State supplemental rebate" means any cash rebate that offsets Virginia Medicaid expenditure and that supplements the Federal rebate. State supplemental rebate amounts shall be calculated in accordance with the National Medicaid Pooling Initiative (NMPI).

"Therapeutic class" means a grouping of medications sharing the same Specific Therapeutic Class Code (GC3) within the Federal Drug Data File published by First Data Bank, Inc.

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b. Medicaid Pharmacy and Therapeutics Committee.

(1) The Department shall utilize a Pharmacy and Therapeutics Committee (the "P & T Committee") to assist in the development and ongoing administration of the preferred drug list and other pharmacy program issues. The Committee may adopt bylaws that set out its make-up and functioning. A quorum for action of the Committee shall consist of nine members.

(2) Vacancies on the Committee shall be filled in the same manner as original appointments. The Department shall appoint individuals for the Committee that assures a cross-section of the physician and pharmacy community.

(3) Duties of the Committee. The Committee shall receive and review clinical and pricing data related to the drug classes. The Committee's medical and pharmacy experts shall make recommendations to DMAS regarding various aspects of the pharmacy program. For the preferred drug list program, the Committee shall select those drugs to be deemed preferred that are safe, clinically effective, as supported by available clinical data, and meet pricing standards. Cost-effectiveness or any pricing standard shall be considered only after a drug is determined to be safe and clinically effective.

(4) As the United States Food and Drug Administration (FDA) approves new drug products, the Department shall ensure that the Pharmacy and Therapeutics Committee will evaluate the drug for clinical appropriateness. Based on clinical information and pricing standards, the P&T Committee will determine if the drug will be included in the PDL or require prior authorization.

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(a) Except as noted in subsection (b) below, if the new drug product falls within a drug class previously reviewed by the P&T Committee, until the review of the new drug is completed, it will be classified as non-preferred, requiring prior authorization in order to be dispensed. The new drug will be evaluated for inclusion in the PDL no later than at the next review of the drug class.

(b) New non-branded generic drugs that fall within a generic class listed on the PDL as preferred shall be classified as preferred.

(5) To the extent feasible, the Pharmacy and Therapeutics Committee shall review all drug classes included in the preferred drug list at least every 12 months and may recommend additions to and deletions from the PDL.

(6) In formulating its recommendations to the Department, the Committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia).

(7) Immunity. The members of the Committee and the staff of the Department and the contractor shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, Committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

c. Pharmacy prior authorization program. Pursuant to § 1927 of the Act and 42 CFR § 440.230, the Department shall require the prior authorization of certain specified legend drugs. For those therapeutic classes of drugs subject to the PDL program, drugs with non-preferred status included in the DMAS preferred drug list shall be subject to prior authorization. The Department also may require prior authorization of other drugs only if recommended by the P&T Committee. Providers who are licensed to prescribe legend drugs shall be required to obtain prior authorization for all non-preferred drugs or other drugs as recommended by the P&T Committee.

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(1) Prior authorization shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria, as established by the P&T Committee relative to each therapeutic class, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate clinicians, or through written or electronic communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of 72-hour emergency supplies of the prescribed drug shall be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.

(2) The preferred drug list program shall include: (i) provisions for an expedited review process of denials of requested prior authorization by the Department; (ii) consumer and provider education, (iii) training and information regarding the preferred drug list both prior to implementation as well as ongoing communications, to include computer and website access to information and multilingual material.

(3) Exclusion of protected groups from pharmacy preferred drug list prior authorization requirements. The following groups of Medicaid eligibles shall be excluded from pharmacy prior authorization requirements: individuals enrolled in hospice care, services through PACE or pre-PACE programs; persons having comprehensive third party insurance coverage; minor children who are the responsibility of the juvenile justice system; and refugees who are not otherwise eligible in a Medicaid covered group.

d. (Repealed with SPA 12-05, effective 4/1/2012)

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e. State supplemental rebates. The Department has the authority to seek supplemental rebates from pharmaceutical manufacturers. In addition to collecting supplemental rebates for fee-for-service claims, the Department may, at its option, also collect supplemental rebates for Medicaid Member utilization through MCOs under an agreement. Supplemental rebate agreements shall be separate from the federal rebates and in compliance with federal law, §§ 1927(a)(1) and 1927(a)(4) of the *Social Security Act* (Act). All rebates collected on behalf of the Commonwealth shall be collected for the sole benefit of the state share of the costs.

f. Pursuant to 42 U.S.C. § 1396r-8(b)(3)(D), information disclosed to the Department or to the Committee by a pharmaceutical manufacturer or wholesaler which discloses the identity of a specific manufacturer or wholesaler and the pricing information regarding the drugs by such manufacturer or wholesaler is confidential and shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§2.2-3700 *et seq.* of the Code of Virginia).

g. Appeals for denials of prior authorization shall be addressed pursuant to 12VAC30-110, Part I, Client Appeals.

12b. Dentures.

A. Medically necessary dentures, partials, and repair procedures are subject to service authorization and are covered under EPSDT for individuals under the age of 21.

Individuals aged 21 and over may receive coverage for medically necessary dentures, partials, and repair procedures only as a part of a definitive treatment plan, after a course of preventive and periodontal maintenance treatment, and after service authorization.

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12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

A. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

C. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye.

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12d. Eyeglasses.

A. Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan. (12 VAC 30-50-220)

13a. Diagnostic services.

A. Provided, but only when necessary to confirm a diagnosis.

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13b. Screening services.

A. Screening PSA (meaning prostate specific antigen) and the related DRE (meaning digital rectal examination) for males shall be covered, consistent with the guidelines of the American Cancer Society.

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13c. Preventive services.

A. Maternity length of stay and early discharge.

1. If the mother and newborn, or the newborn alone, is discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care" as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (1992, as amended). The mother and newborn, or the newborn alone, if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of their choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

B. All services otherwise provided according to the United States Preventive Services Task Force (USPSTF) A and B recommendations along with approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP) pursuant to section 4106 of the Patient Protection and Affordable Care Act (PPACA) for adult, full Medicaid individuals. Changes to USPSTF A and B recommendations and ACIP recommendations are incorporated into coverage and billing codes as necessary.

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Doula Services

Doula services will be used to provide support for pregnant individuals throughout the perinatal period, which may improve birth-related outcomes. Pursuant to 42 C.F.R. Section 440.130(c), doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complications and/or promote the physical and mental health of the beneficiary.

Service Description:
Virginia intends to provide doula services for pregnant individuals during the prenatal period, childbirth and the postpartum period. Doulas support the pregnant individual throughout the pregnancy, childbirth and postpartum experience, with the goal of improving outcomes for birthing parents and infants. Doulas offer support, guidance, evidence-based education, practical support during childbirth, and linkages to community-based resources. Service components include:

- Perinatal support services, including newborn care, to prevent adverse outcomes;
- Labor support; and
- Coordination with community-based services, to improve beneficiary outcomes

Qualified Provider Specifications:
Doula services shall be provided by qualified individuals who are at least 18 years of age. Doulas must:

- Complete doula training, which must include core competencies (perinatal support services, labor support), community-based/cultural competency training, and care coordination. Doula trainings must be approved by the Virginia Department of Health (VDH); and
- Be certified by a state certifying entity designated by VDH.

Limits:

- Any service limits may be exceeded based upon medical necessity.
- Service authorization is required if more than four prenatal visits and/or more than six postpartum visits during the 12 months after birth are required.

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13d. Rehabilitative services provided in accordance with 42 CFR § 440.110. (12 VAC 30-50-225)

A. Intensive physical rehabilitation:

1. Medicaid covers intensive inpatient rehabilitation services as defined in §A.4 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient physical rehabilitation services as defined in §A.4 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).

3. These facilities are excluded from the 21 day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive physical rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech-language pathology, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of physical medicine and rehabilitation.

5. Nothing in this regulation is intended to preclude DMAS from negotiating individual contracts with in-state intensive physical rehabilitation facilities for those individuals with special intensive rehabilitation needs.

6. To receive continued intensive rehabilitation services, the patient must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team. This shall be evidenced by regular attendance in planned activities and demonstrated progress toward the established goals.

7. Intensive rehabilitation services shall be considered for termination regardless of the preauthorized length of stay when any of the following conditions are met:

a. No further potential for improvement is demonstrated. The patient has reached his maximum progress and a safe and effective maintenance program has been developed.

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b. There is limited motivation on the part of the individual or caregiver.

c. The individual has an unstable condition that affects his or her ability to participate in rehabilitative plan.

d. Progress toward an established goal or goals cannot be achieved within a reasonable period of time.

e. The established goal serves no purpose to increase meaningful functional or cognitive capabilities.

f. The service can be provided by someone other than a skilled rehabilitation professional.

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Community mental health services. (12 VAC 30-50-226)
Definitions. The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

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

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

"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 DBHDS.

"Clinical experience" for Mental Health Therapeutic Day Treatment/Partial Hospitalization, Intensive Community Treatment, Psychosocial Rehabilitation, Mental Health Support, Crisis Stabilization, and Crisis Intervention 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.

"Clinical experience for Intensive In-Home, Therapeutic Day Treatment for Children and Adolescents, and Therapeutic Group Home Behavioral Services means providing direct clinical services to children and adolescents with mental illness. It includes supervised internships, practicums, and field experience.

"Code" means the Code of Virginia.

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

"DBHDS" means Department of Behavioral Health and Developmental Services, consistent with the Chapter 1 (§37.1-39 et seq.) of Title 37.1 of the Code of Virginia.

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"Human services field" means the same as defined by the Department of Health Professions in the document entitled Approved Degrees in Human Services and Related Fields for QMHP Registration, issued November 3, 2017, revised February 9, 2018.

"Individual" means the client or recipient of services described in Attachment 1.1-A&B, pages 30 through 31.10 (12VAC30-50-226).

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment. The ISP contains 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, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"LMHP" or "licensed mental health professional" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse Treatment practitioner , licensed marriage and family therapist, licensed psychiatric/mental health nurse practitioner, licensed behavior analyst or certified psychiatric clinical nurse specialist.

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"LMHP-Rs" or "LMHP-residents" are registered with the Virginia Board of Counseling and in the process of obtaining licensure in accordance with state law. Only a Licensed Substance Abuse Treatment Practitioner, Licensed Marriage and Family Therapist, or Licensed Professional Counselor who is fully licensed by the Board of Counseling may supervise LMHP-Rs.

"LMHP-RPs" or "LMHP-residents in psychology" are registered with the Virginia Board of Psychology and in the process of obtaining licensure in accordance with state law. Only a Licensed Clinical Psychologist who is fully licensed by the Board of Psychology may supervise LMHP-RPs .

"LMHP-Ss" or "LMHP-supervisees in social work ," or "LMHP-supervisees," are registered with the Virginia Board of Social Work and in the process of obtaining licensure in accordance with state law. Only a Licensed Clinical Social Worker who is fully licensed by the Board of Social Work may supervise LMHP-Ss.

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"QMHP-A" or "Qualified mental health professional-adult" is trained and experienced in providing mental health services to adults who have a mental illness. A QMHP-A must: (i) have a master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness; (ii) have a master's or bachelor's degree in human services or a related field from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration; (iii) have a bachelor's degree from an accredited college in an unrelated field that includes 15 semester credits or 22 quarter hour in a human services field with no less than 3,000 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration; (iv) be a registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration; (v) be a licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration. A QMHP-A must work under the supervision of a LMHP, LMHP-S, LMHP-R or LMHP-RP and shall be registered in accordance with state law.

"QMHP-C" or "Qualified mental health professional-child" means a registered QMHP who is trained and experienced in providing mental health services to children or adolescents who have a mental illness. QMHP-Cs must: (i) have a master's degree in psychology, social work, counseling, substance abuse, or marriage and family therapy from an accredited college or university with an internship or practicum of at least 500 hours of experience with persons who have mental illness; (ii) have a master's or bachelor's degree in human services or in special education from an accredited college with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration; (iii) be a registered nurse licensed in Virginia with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration; (iv) be a licensed occupational therapist with no less than 1,500 hours of supervised experience to be obtained within a five-year period immediately preceding application for registration. A QMHP-C must work under the supervision ofa LMHP, LMHP-S, LMHP-R or LMHP-RP and shall be registered in accordance with state law.

"QMHP-E" or "Qualified mental health professional-eligible" means a person who meets the education requirements of either a QMHP-C or QMHP-A and who is receiving supervised training in order to qualify as a QMHP-C or QMHP-A. A QMHP-E must work under the supervision of a QMHP-A, QMHP-C, LMHP, LMHP-S, LMHP-R or LMHP-RP and shall be registered in accordance with state law.

"QPPMH" or "qualified paraprofessional in mental health" means a person who must, at a minimum, meet one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation; human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; (iii) licensed as an occupational therapy assistant and supervised by a licensed occupational therapist, with at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iv) has a minimum of90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-Adult providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience). A QPPMH must work under the supervision ofa QMHP-A, QMHP-C, LMHP, LMHP- S, LMHP-R or LMHP-RP.

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Mental Health Partial Hospitalization

(1) Service definition. Mental Health Partial Hospitalization (MH-PHP) services are short-term, non-residential interventions that are more intensive than outpatient services and that are required to stabilize an individual's psychiatric condition. The service is delivered under physician direction to individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result in significant functional impairments in major life activities. The service is non-residential and is not an IMD. The service is provided in accordance with the rehabilitative services benefit requirements at 42 CFR 440.130(d).

This service includes assessment, assistance with medication management, individual and group therapy, skills restoration, and care coordination for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, and QMHP-E are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1. Provider qualifications for PRS are on page 55 of Attachment 3.1A&B, Supp. 1. Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP) shall hold an active license issued by the Virginia Board of Nursing. Physicians, Physician Assistants and Occupational Therapists shall hold an active license issued by the Virginia Board of Medicine.

Service Component Definitions –Mental Health Partial Hospitalization	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-R LMHP-RP LMHP-S Nurse Practitioner Physician Assistant
"Treatment Planning" means the development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.	LMHP LMHP-R LMHP-RP LMHP-S Nurse Practitioner, Physician Assistant

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"Health literacy counseling" means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP LMHP-R LMHP-RP LMHP-S Nurse Practitioner, Physician Assistant Occupational Therapist A RN or LPN with at least one year of clinical experience involving medication management
"Individual, group and family therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. The individual is present during family therapy except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals.	LMHP LMHP-R LMHP-RP LMHP-S

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"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: self- management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of at least a QMHP-A or QMHP-C.
"Crisis treatment" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and a higher level of acuity.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-A, QMHP-C, or QMHP-E
"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer recovery support services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.	PRS
"Care coordination" means locating and coordinating services across mental health providers to include sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of at least a QMHP-A or QMHP-C.

(3) Limits on amount, duration, and scope.

a. Mental Health Partial Hospitalization services are available to individuals who meet themedical necessity criteria for the service.

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c. Psychosocial rehabilitation

(1) Service definition. Psychosocial rehabilitation is a program of two or more consecutive hours per day provided to groups of adults in a community, nonresidential setting who require a reduction of mental disability and restoration to the best possible functional level in order to maintain community tenure. This service provides a consistent structured environment for conducting targeted exercises and coaching to restore an individual's ability to manage mental illness. These services include assessment, assistance with medication management, restorative facilitation, and care coordination. Individuals must demonstrate a medical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

(2) Service Components and Provider Qualifications. Definitions of staff qualifications are provided in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.3. LMHP-R, -RP, and -S are included in the term "Licensed Mental Health Professional-Eligible" on page 31. QMHP-A means the same as the term "Qualified Mental Health Professional" on page 31. QMHP-C means the same as the term "Qualified Mental Health Professional" on page 31.2. QMHP-E means the same as the term "Qualified Mental Health Professional" on page 31.3. QPPMH means the same as the term "Qualified Paraprofessional in Mental Health" on page 31.3.

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Service Component Definitions – Psychosocial Rehabilitation	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-R LMHP-RP LMHP-S
"Assistance with medication management" means counseling on the role of prescription medications and their effects including side effects; the importance of compliance and adherence; and monitoring the use and effects of medications.	LMHP LMHP-R LMHP-RP LMHP-S
"Restorative Facilitation" means facilitating improved communication, problem solving, coping skills, and stress management to increase the individual's continued adjustment to and management of mental illness.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, C, or E.
"Care coordination" means locating and coordinating services across multiple providers to include collaborating and sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, C, or E.

(3). Limits on amount, duration, and scope.
Services comparable to Psychosocial Rehabilitation can be found in Attachment 3.1A&B, Supplement 1, page 6.1. These services are available to individuals under 21 years of age who meet the medical necessity criteria for the service. Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

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Mobile Crisis Response:

Service Definition: Mobile Crisis Response is a rehabilitative services benefit provided according to 42 CFR 440.130(d). Mobile Crisis Response shall provide immediate behavioral health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing an acute behavioral health crisis 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. Mobile Crisis Response activities shall include assessment, short-term counseling designed to stabilize the individual, crisis intervention, health literacy counseling, peer recovery support services, and care coordination. Mobile Crisis Response is provided in a variety of settings including community locations where the individuals lives, works, attends school, participates in services and socializes, and includes temporary detention order preadmission screenings.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, and QMHP-E are on page 30, 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1.Provider qualifications for CSAC, CSAC-supervisee and CSAC-A are on page 42 of Attachment 3.1A&B, Supp. 1. PRS are on page 55 of Attachment 3.1A&B, Supp. 1.

Service Component Definitions – Mobile Crisis Response	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's behavioral health status. It includes documented history of the severity, intensity, and duration of behavioral health care problems and issues. Assessment services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Treatment Planning" means development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate. Treatment planning that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S QMHP-A, QMHP-C QMHP-E, CSAC, CSAC-supervisee

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"Individual, Family, and Group Therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate behavioral health disorders and associated distresses that interfere with behavioral health.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher levels of acuity.	LMHP, LMHP-R, LMHP-RP, LMHP-S QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, CSAC-A
"Health literacy counseling" means patient counseling on mental health, and, as appropriate, substance use disorder, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC, CSAC-supervisee
"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer Recovery Support Services are only available as a component of the service in community settings. Peer recovery support service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service."	PRS
"Care coordination" means locating and coordinating services across multiple providers to include sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, or CSAC-A

(3) Limits on amount, duration, and scope:
Mobile Crisis Response services are available to individuals who meet the medical necessity criteria for the service.

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Assertive Community Treatment

(1) Service definition. Assertive Community Treatment (ACT) is a rehabilitative benefit provided according to 42 CFR 440.130(d). ACT provides long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community. ACT services are offered to outpatients outside of clinic, hospital, or program office settings for individuals who are best served in the community. ACT services include assessment, therapy, assistance with medication management, crisis treatment, co-occurring substance use disorder treatment, skills restoration and care coordination activities through a designated multi-disciplinary team of mental health professionals.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, and QPPMH are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1. Provider qualifications for CSAC and CSAC-A are on page 42 of Attachment 3.1A&B, Supp. 1. PRS are on page 55 of Attachment 3.1A&B, Supp. 1. Registered Nurses (RN) and Nurse Practitioners (NP) shall hold an active license issued by the Virginia Board of Nursing and 1 year of experience working with individuals with serious mental illness. Licensed Practical Nurses (LPN) shall hold an active license issued by the Virginia Board of Nursing and three years of experience with individuals with serious mental illness. Physician Assistants shall hold an active license issued by the Virginia Board of Medicine and 1 year of experience working with individuals with serious mental illness. Psychiatrists shall hold an active license issued by the Virginia Board of Medicine.

Service Component Definitions – Assertive Community Treatment	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP LMHP-R LMHP-RP LMHP-S Nurse Practitioner Physician Assistant

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"Individual, Family and Group Therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. The individual is present during family therapy except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals.	LMHP LMHP-R LMHP-RP LMHP-S Credentialed addiction treatment professional excluding CSAC and CSAC-A
"Health literacy counseling" means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Credentialed addiction treatment professional A RN or LPN with at least one year of clinical experience involving medication management.
"Crisis treatment" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to prevent harm and a higher level of acuity.	LMHP LMHP-R LMHP-RP LMHP-S QMHP-A QMHP-E

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"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: personal care/hygiene, self-management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-E or a QPPMH under the supervision of at least a QMHP-A.
"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer recovery support services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.	PRS
"Care coordination" means locating and coordinating services across mental health providers to include sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-E, or a QPPMH under the supervision of at least a QMHP-A.

(3) Limits on amount, duration, and scope.

ACT has been shown to be effective for individuals aged 18 and above. As required by EPSDT, youth may receive ACT if medically necessary.

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Community Stabilization

(1) Service definition: Community Stabilization service is a rehabilitative services benefit provided according to 42 CFR 440.130(d). Community Stabilization services provide intensive, short term behavioral health care to non-hospitalized individuals who recently experienced an acute behavioral health crisis. The goal is to address and stabilize the acute behavioral health needs at the earliest possible time to prevent decompensation while a comprehensive array of services is established. Goals include averting the client from hospitalization or re-hospitalization, providing a high assurance of safety and security in the least restrictive environment, and mobilizing the resources of the community support system, family members,and others for ongoing maintenance, rehabilitation, and recovery.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C and QMHP-E are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1.Provider qualifications for CSAC, CSAC-supervisee and CSAC-A are on page 42 of Attachment 3.1A&B, Supp. 1. PRS are on page 55 of Attachment 3.1A&B, Supp. 1.

Service Component Definitions – Community Stabilization	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's behavioral health status. It includes documented history of the severity, intensity, and duration of behavioral health care problems and issues.	LMHP LMHP-R LMHP-RP LMHP-S

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"Treatment Planning" means development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate. Treatment planning that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S QMHP-A, QMHP-C QMHP-E, CSAC, CSAC-supervisee
"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher levels of acuity.	LMHP, LMHP-R, LMHP-RP, LMHP-S QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, CSAC-A
"Health literacy counseling" means patient counseling on mental health, and, as appropriate, substance use disorder, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC, CSAC-supervisee
"Skills restoration" means facilitating improved communication, problem solving, coping skills, and stress management through modeling, coaching and cueing to increase the individual's continued adjustment to and management of mental illness.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E.

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"Individual, Family, and Group Therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate behavioral health disorders and associated distresses that interfere with behavioral health.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer recovery support services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	PRS
"Care coordination" means locating and coordinating services across multiple providers to include sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans. Care coordination must include locating and coordinating a psychiatric evaluation.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, or CSAC-A

(3) Limits on amount, duration, and scope.

Community Stabilization services are available to individuals who meet the medical necessity criteria for the service.

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Residential Crisis Stabilization

(1) Service definition: Residential Crisis Stabilization is a rehabilitative services benefit provided according to 42 CFR 440.130(d). Residential Crisis Stabilization serves as a diversion from inpatient hospitalization by offering psychiatric stabilization in licensed crisis services provider units of less than 16 beds. Residential Crisis Stabilization may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010.

Residential Crisis Stabilization provides short-term, 24/7, residential crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or amarked increase in personal distress. Residential Crisis Stabilization can also be provided as a 23 hour service if it is expected that the crisis can be resolved in 23 hours or to allow for a complete assessment todetermine the most appropriate level of care.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C and QMHP-E are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1. Provider qualifications for CSAC, CSAC-supervisee and CSAC-A are on page 42 of Attachment 3.1A&B, Supp. 1. PRS are on page 55 of Attachment 3.1A&B, Supp. 1. Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners shall hold an active license issued by theVirginia Board of Nursing. Psychiatrists and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine. Residential Aides shall have a minimum of a high school diploma.

Service Component Definitions – Residential Crisis Stabilization	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, aboutthe individual's behavioral health status. It includes documented history of the severity, intensity, and duration of behavioral health care problems and issues. Assessments that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Treatment Planning" means the development of a person-centered plan of carethat is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate. Treatment planning service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee

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"Psychiatric evaluation" means prescription medication intervention and ongoing care to prevent future crises of a psychiatric nature.	Psychiatrist, Physician Assistant or Nurse Practitioner
"Health literacy counseling" means patient counseling on mental health, and, as appropriate, substance use disorder, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC or CSAC-supervisee. A RN or LPN with at least one year of clinical experience involving medication management
"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: self-management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee or residential aide under the supervision of a minimum of a QMHP-A or QMHP-C.
"Individual, family, or group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate behavioral health disorders and associated distresses that interfere with behavioral health.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher levels of acuity.	LMHP, LMHP-R, LMHP-RP, LMHP-S QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, CSAC-A

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"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer recovery support services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service."	PRS
"Care coordination" means locating and coordinating services across multiple providers to include sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care andalign service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC, CSAC-supervisee, or CSAC-A

(3) Limits on amount, duration, and scope. Residential Crisis Stabilization may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010. Services are available to individuals who meet the medical necessity criteria for the service.

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f. Independent Living and Recovery Services shall be defined as training and supports to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment.

Subcomponents of Service and Providers

These services shall provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. These services include the following components:

(i) providing opportunities to enhance recovery plans that include but are not limited to: a. Daily health activities and trainings on personal care/hygiene to restore and regain functional skills and appropriate behavior related to health and safety; and b. Skills training and reinforcement on the use of available community resources, such as public transportation to improve daily living and community integration skills and independent use of community resources; etc.	May only be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, C, or E.
(ii) recovery and symptom management activities that include but are not limited to: a. condition specific education and training and reinforcement of symptom identification designed to increase the individual's ability to recognize and respond to symptoms; and b. goal directed and individualized stress management and coping skills training to increase the individual's continued adjustment to and management of mental illness; and c. training and coaching to facilitate improved communication, problem solving, and appropriate coping skills; etc.	May only be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a QMHP-A, QMHP-C, or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, or LMHP-S.
(iii) assistance with medication management that includes but is not limited to: a. Counseling on role of prescription medications and their effects including side effects; and b. Monitoring the use and effects of medications; etc.	May only be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S.
(iv) conducting targeted exercises and coaching to restore an individual's ability to monitor and regulate their health, nutrition, and physical condition that includes but is not limited to: a. Self-assessment exercises and recovery coaching that builds self-awareness of symptoms and how to identify and monitor symptoms; and b. Coaching and training on maintaining adherence to recommended medical care such as scheduling and keeping medical appointments; etc.	May only be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, C, or E.

Limitations on Amount, Duration, and Scope

Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary and are prior authorized by the Department.

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Mental Health Intensive Outpatient

(1) Service Definition: Mental Health Intensive Outpatient (MH-IOP) is a rehabilitative benefit provided according to 42 CFR 440.130(d). IOP includes skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinaryapproach to treatment. The service is non-residential and is not an IMD.

MH-IOP is based on a comprehensive, coordinated and individualized individual service plan that involves the use of multiple, concurrent service components and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. This service is provided to individuals who do not require the intensive level of care of inpatient, residential, or partial hospitalization service, but require more intensive services than outpatient services and would benefit from the structure and safety available in the MH-IOP setting.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, and QMHP-E are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1. Provider qualifications for PRS are on page 55 of Attachment 3.1A&B, Supp. 1. Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP) shall hold an active licenseissued by the Virginia Board of Nursing. Physician Assistants and Occupational Therapists shall hold anactive license issued by the Virginia Board of Medicine.

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Service Component Definitions –Mental Health Intensive Outpatient	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health problems and behavioral and emotional issues.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, or Physician Assistant
"Treatment Planning" means the development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, or Physician Assistant
"Individual, Family, and Group Therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. The individual is present during family therapy except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: self-management, symptom management, interpersonal, communication, community living, and problem solving skills through modeling, coaching, and cueing.	LMHP, LMHP-R, LMHP-RP, LMHP-S, or a QMHP-A, QMHP-C, or QMHP-E

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"Health literacy counseling" means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant Occupational Therapist A RN or LPN with at least one year of clinical experience involving medication management
"Crisis treatment" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and a higher level of acuity.	LMHP, LMHP-R, LMHP-RP, LMHP-S or a QMHP-A, QMHP-C, or QMHP-E
"Peer Recovery Support Services" means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual. Peer recovery support services to the beneficiary's family and significant others is for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.	PRS
"Care coordination" means locating and coordinating services across mental health providers to include sharing of information among health care providers, who are involved with an individual's health care, to improve the restorative care and align service plans.	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E

(3) Limits on amount, duration, and scope.
Mental Health Intensive Outpatient services are available to individuals who meet the medical necessity criteria for the service.

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Multisystemic Therapy

(1) Service Definition: Multi-systemic therapy (MST) is a rehabilitative services benefit provided according to 42 CFR 440.130(d). MST is an intensive, evidence-based treatment provided in home and community settings to youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. This service is available to youth from birth to age 21 based on medical necessity and in accordance with 1905(r) of the Social Security Act.

MST includes an emphasis on engagement with the youth's family, caregivers and natural supports and is delivered in the recovery environment. MST is a short-term and rehabilitative intervention that is used as a step-down and diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and community.

(2) Service Components and Provider Qualifications. Definitions of staff qualifications are provided in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.2. LMHP is defined on page 31. LMHP-R, RP, and S are defined on page 31.1. QMHP-C and QMHP-E are defined on page 31.2. CSAC and CSAC-supervisee are defined on page 42 of Attachment 3.1A&B, Supp. 1. MST Professionals include LMHPs, LMHP-RPs, LMHP-Rs, LMHP-Ss, CSACs, CSAC-supervisees, QMHP-Cs and QMHP-Es who work with a team contracted with MST Services, LLC to provide MST Services. CSACs, CSAC-supervisees, QMHP-Cs and QMHP-Es may only provide services in settings in accordance with state law.

Service Component Definitions – Multisystemic Therapy	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the youth, and parent, guardian, or other family members, as appropriate, about the youth's behavioral health status and behaviors. It includes documented history of the severity, intensity, and duration of behavioral health problems and behavioral and emotional issues.	LMHP, LMHP-R, LMHP-RP or LMHP-S
"Therapeutic Interventions" means evidence based, individualized or family focused interventions designed to decrease symptoms of the behavioral health diagnosis, reduce maladaptive behaviors and increase pro-social behaviors at home and across the multiple interconnected systems (includes family, extended family, peers, neighbors, and other community members relative to the youth). All family interventions are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the plan of care.	MST Professional
"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.	MST Professional

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"Care Coordination" means locating and coordinating services across multiple providers to include collaborating and sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans.	MST Professional

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Functional Family Therapy

(1) Service Definition: Functional Family Therapy (FFT) is a rehabilitative services benefit provided according to 42 CFR 440.130(d). FFT is a short-term, evidence-based treatment program for at-risk youth who have been referred for behavioral or emotional problems including co-occurring substance use disorders by thejuvenile justice, behavioral health, school or child welfare systems. This service is available to youth from birth to age 21 based on medical necessity and in accordance with 1905(r) of the Social Security Act. FFT services will not be provided to inmates residing in public institutions.

(2) Service Components and Provider Qualifications. Definitions of staff qualifications are provided in Attachment 3.1 A&B, Supplement 1, pages 31 through 31.2. LMHP is defined on page 31. LMHP-R, RP, and S are defined on page 31.1. QMHP-C and QMHP-E are defined on page 31.2. CSAC and CSAC-supervisee are defined on page 42 of Attachment 3.1A&B, Supp. 1. FFT Professionals include LMHPs, LMHP-RPs, LMHP-Rs, LMHP-Ss, CSACs, CSAC-supervisees, QMHP-Cs and QMHP-Es who work as part of a team with an active FFT site certification from FFT, LLC. CSACs, CSAC-supervisees, QMHP-Cs and QMHP-Es may only provide services in settings in accordance with state law.

Service Component Definitions – Functional Family Therapy	***Staff That Provide Service Components***
"Assessment" means the face-to-face interaction in which the provider obtains information from the youth, and parent, guardian, or other family members, as appropriate, about the youth's behavioral health status and behaviors. It includes documented history of the severity, intensity, and duration of behavioral health problems and behavioral and emotional issues.	LMHP, LMHP-R, LMHP-RP, LMHP-S
"Therapeutic Interventions" means evidence based, individualized or family focused interventions designed to decrease symptoms of the behavioral health diagnosis, reduce maladaptive behaviors and increase pro-social behaviors at home and across the multiple interconnected systems (includes family, extended family, peers, neighbors, and other community members relative to the youth). All family interventions are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the plan of care.	FFT Professional
"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.	FFT Professional
"Care coordination" means locating and coordinating services across multiple providers to include collaborating and sharing of information among health care providers, and others who are involved with an individual's health care, to improve the restorative care and align service plans.	FFT Professional

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(3) Limits on amount, duration, or scope:

a. The FFT provider must hold a license from the Department of Behavioral Health and Developmental Services and they must maintain any required program certifications with FFT, LLC. Providers of FFT must meet the specific training and supervision requirements of the program as required by FFT, LLC.

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Mental Health Intensive Outpatient

(1) Service Definition: Mental Health Intensive Outpatient (MH-IOP) is a rehabilitative benefit provided according to 42 CFR 440.130(d). IOP includes skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinaryapproach to treatment. The service is non-residential and is not an IMD.

MH-IOP is based on a comprehensive, coordinated and individualized individual service plan that involves the use of multiple, concurrent service components and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. This service is provided to individuals who do not require the intensive level of care of inpatient, residential, or partial hospitalization service, but require more intensive services than outpatient services and would benefit from the structure and safety available in the MH-IOP setting.

(2) Service Components and Provider Qualifications. Provider qualifications for LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, and QMHP-E are on page 31, 31.1, and 31.2 of Attachment 3.1A&B, Supp. 1. Provider qualifications for PRS are on page 55 of Attachment 3.1A&B, Supp. 1. Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP) shall hold an active licenseissued by the Virginia Board of Nursing. Physician Assistants and Occupational Therapists shall hold anactive license issued by the Virginia Board of Medicine.

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2. Mental retardation (MR) services/Related Conditions. Repealed. (12 VAC 30-50-227).

12 VAC 30-50-229. Lead contamination. Coverage shall be provided for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Only costs that are eligible for federal funding participation in accordance with current federal regulations shall be covered. Payments for environmental investigations under this section shall be limited to no more than two visits per residence.

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14. Services for individuals age 65 or older in institutions for mental diseases. (12 VAC 30-50-230)

14a. Inpatient hospital services provided with no limitations.

14b. Skilled nursing facility services provided with no limitations.

15. Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) (12 VAC 30-50-240)

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902 (a)(31)(A) of the Act, to be in need of such care are provided with no limitations.

15b. Including such services in a public institution (or distinct part thereof) for persons with intellectual disabilities or persons with related conditions are provided with no limitations.

16. Inpatient psychiatric facility services for individuals under 21 years of age, other than those provided under Early and Periodic Screening, Diagnosis, and Treatment (12 VAC30-50-130). (12 VAC 30-50-250) are not provided.

17. Nurse-midwife services. (12 VAC 30-50-260)

A. Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations at 42 CFR § 440.165.

18. Hospice care (in accordance with §1905 (o) of the Act). (12 VAC 30-50-270)

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

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B. Categories of Care: As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of 8 hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

C. Covered Services.

1. As required under Medicare and applicable to Medicaid, the hospice itself must provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, physician services, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that must be available but are not considered "core" services are drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services, and any other item or service which is specified under the plan and which is reasonable and necessary for the palliation and management of terminal illness and for which payment may otherwise be made under Title XIX.

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3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill must have been completed by the physician, or physicians as required by 12 VAC 30-60-130 D, and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

   a. Nursing Care: Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

   b. Medical Social Services: Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

   c. Physician Services: Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

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d. Counseling Services: Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term Inpatient Care: Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable Medical Equipment and Supplies: Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and Biologicals: Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

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h. Home Health Aide and Homemaker Services: Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation Services: Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

D. Eligible Groups. To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and, except for individuals under 21 years of age, elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director, or the attending physician and the physician member of the interdisciplinary team, must initially certify the life expectancy. Thereafter, subsequent certifications shall be conducted pursuant to 12 VAC 30-60-130.

19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A, in accordance with Section 1915(g)(1) of the Act. (12 VAC 30-50-280)

A. Provided, with limitations. See Supplement 2 for detail.

20. Extended services to pregnant women. (12 VAC 30-50-290)

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

A. The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

A. The same limitations on all covered services apply to this group as to all other recipient groups.

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21. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of Health and Human Services. (12 VAC 30-50-300)

21a. Transportation.

A. Emergency transportation services shall be provided to Virginia Medicaid recipients to ensure that they have necessary access to and from providers of all emergency medical services. Emergency transport services shall be covered; non-emergency transport services shall be covered as medical services. The Single State Agency may enter into contracts with friends of recipients, public agencies, non-profit private agencies, for-profit private agencies, and public carriers to provide transportation to Medicaid recipients.

21b. Services of Christian Science nurses are not provided.

21c. Care and services provided in Christian Science sanitoria are provided with no limitations.

21d. Skilled nursing facility services for patients under 21 years of age are provided with no limitations.

21e. Emergency hospital services are provided with no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse are not provided.

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22. Emergency Services for Aliens (12 VAC 30-50-310)

A. No payment shall be made for medical assistance furnished to qualified aliens who entered the U.S. on or after August 22, 1996, who are not eligible for Medicaid for 5 years after their entry, and non-qualified aliens, including illegal aliens and legal non-immigrants who are otherwise eligible, unless such services are necessary for the treatment of an emergency medical condition of the alien.

B. Emergency services are defined as: Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. placing the patient's health in serious jeopardy;

2. serious impairment of bodily functions; or

3. serious dysfunction of any bodily organ or part.

For purposes of this definition, emergency treatment of a medical condition does not include care and services related to either an organ transplant procedure or routine perinatal or postpartum care.

C. Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

D. Claims for conditions which do not meet emergency criteria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

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Provider Qualifications:

"Care Coordination Provider" means one of the following: 1.) At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and have one of the following qualifications (i) substance use related direct experience providing services to individuals with a diagnosis substance abuse use disorder or (ii) clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; 2.) Licensure by the Commonwealth as a registered nurse with (i) substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or 3.) Certification as a Board of Counseling Certified Substance Abuse Counselor CSAC, CSAC-supervisee or CSAC-Assistant under supervision as defined in state law.

"Credentialed addiction treatment professional" means (i) an addiction-credentialed physician or physician or physician extender with experience or training in addiction medicine; (ii) a licensed psychiatrist; (iii) a licensed clinical psychologist; (iv) a licensed clinical social worker; (v) a licensed professional counselor; (vi) a certified psychiatric clinical nurse specialist; (vii) a licensed psychiatric nurse practitioner; (viii) a licensed marriage and family therapist; (ix) a licensed substance abuse treatment practitioner; (x) a licensed behavior analyst; (xi) residents under supervision of a licensed professional counselor, licensed marriage and family therapist, or licensed substance abuse treatment practitioner who is registered with the Virginia Board of Counseling; (xii) a resident in psychology under supervision of a licensed clinical psychologist who is registered with the Virginia Board of Psychology; (xiii) a supervisee in social work under the supervision of a licensed clinical social worker who is registered with the Virginia Board of Social Work;

"CSAC" means (as certified by the Virginia Department of Health Professions) a certified substance abuse counselor shall be qualified to perform, under clinical supervision or direction, substance abuse treatment functions described in subsequent pages of this document. Certified substance abuse counselors shall not engage in independent or autonomous practice.

"CSAC-A" means (as certified by Virginia's Department of Health Professions) a certified substance abuse counseling assistant shall be qualified to perform, under appropriate clinical supervision or direction, the substance abuse treatment functions described in subsequent pages of this document. Certified substance abuse counseling assistants may participate in recovery group discussions, but shall not engage in counseling with either individuals or groups or engage in independent or autonomous practice.

"CSAC-supervisee" means a certified substance abuse counseling supervisee, which is an individual who has completed the educational requirements, but not the practice hours, to become a CSAC.

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"Clinical Supervision" for CSACs means the ongoing process performed by a clinical supervisor who is credentialed as defined in regulations of the Virginia Board of Counseling.

"Physician extenders" means licensed nurse practitioners and licensed physician assistants as defined in state law.

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1. Screening, Brief Intervention, and Referral to Treatment

Service Definition: Service components match those forth in ASAM and are provided by ASAM approved staff plus pharmacists.

Service Component Definitions - Screening, Brief Intervention, and Referral to Treatment	***Staff That Provide Service Components***
Assessment: means the individualized, person-centered assessment performed face-to-face, in which the provider obtains comprehensive information from the individual.	Physician Credentialed addiction treatment professional
Screening and brief intervention and referral to treatment (SBIRT) by a licensed or certified treatment professional shall be provided to counsel individuals about substance use, alert these individuals to possible consequences and, if needed, begin to motivate individuals to take steps to change their behaviors.	Credentialed addiction treatment professional CSAC, CSAC-supervisee, RN, LPN

Limits on amount, duration, and scope: SBIRT services do not require service authorization. There are no annual service limits.

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2. Opioid Treatment Programs (OTP)

Service Component Definitions – Opioid Treatment Programs	***Staff That Provide Service Components***
Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.	Physicians and physician extenders; Credentialed addiction professional trained in the treatment of opioid use disorder
Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.	Physicians and physician extenders; Credentialed addiction professional trained in the treatment of opioid use disorder
Provide cognitive, behavioral psychotherapy and other substance use disorder-focused counseling provided to the member on an individual, group, or family basis.	Credentialed addiction treatment professional, CSAC, CSAC-supervisee
Provision of onsite screening or ability to refer for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors. Ability to provide or refer for treatment for infectious diseases as necessary.	Physicians and physician extenders, credentialed addiction professional, Registered Nurse, or Licensed Practical Nurse
Medication administration on site during the induction phase must be provided by a Registered Nurse. Medication administration during the maintenance phase may be provided either by a RN or Licensed Practical Nurse.	Physician, Pharmacist, Nurse Practitioner, Physician Assistant, Registered Nurse, or Licensed Practical Nurse
OTP risk management shall include the following activities which must be clearly and adequately documented in each member's record: • Random urine drug screening for all members, conducted at least eight times during a 12 month period. Urine drug testing (UDT) is used as part of a comprehensive treatment program to assist with recovery and to restore an individual to health. UDT is used in SUD treatment to determine if the patient is taking medication as prescribed and to assess if the patient is taking other medications which may have a higher risk of overdose when taken with medications for opioid use disorder. • Opioid overdose prevention counseling including the prescribing of naloxone.	Physician, Physician Extender, Pharmacist, Registered Nurse or Licensed Practical Nurse

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Provide optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress and tracking member outcomes; linking members with community resources to facilitate referrals and respond to peer supports; and tracking and supporting members when they obtain medical or behavioral health outside the practice. Substance use care coordination cannot be provided simultaneously with substance use case management.	Care Coordination Provider
Provide optional peer recovery support services that includes non-medical, peer-to-peer activities that engage and support an individual's, and as applicable the caregiver's, self-help efforts to improve health recovery, resiliency, and wellness.	Peer Recovery Support Specialist

Limits on amount, duration, and scope: OTP services do not require service authorization.

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2. Preferred Office-Based Addiction Treatment (OBAT)

Service Definition: a service provided under 42 CFR 440.130(d) Rehabilitative Services Benefit for individuals with a primary diagnosis from the most current Diagnostic and Statistical Manual of Mental Disorders for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related addictive disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems. Services are provided by physicians or physician extenders working in collaboration with credentialed addiction treatment practitioners providing psychosocial counseling in public and private practice settings that encompasses pharmacological and nonpharmacological treatment modalities.

From October 1, 2020, through September 30, 2025, the state assures that Medication Assisted Treatment (MAT) to treat Opioid Use Disorder (OUD) as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

Service Component Definitions—Preferred Office-Based Addiction Treatment	***Staff That Provide Service Components***
Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual who is withdrawing from alcohol; supervising withdrawal management from alcohol and other non-opioid substances; and overseeing and facilitating access to appropriate treatment for alcohol use disorder and other substance use disorders (SUD) other than OUD. The medications approved by the U.S. Food and Drug Administration to treat alcohol use disorder: acamprosate, disulfiram, and naltrexone.	Physicians and physician extenders; and Credentialed addiction treatment professional
Provide cognitive, behavioral psychotherapies, and other substance use disorder-focused counseling shall be provided to the individual on an individual, group, or family basis and shall be provided in collaboration with the physician or physician extender. This does not apply to opioid counseling as part of the MAT benefit. Family counseling service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.	Credentialed Addiction Treatment Professional, CSAC, CSAC-supervisee.

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Provision of onsite screening or the ability to refer for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors for individuals with SUD other than OUD. Ability to provide or refer for treatment for infectious diseases as necessary.	Physicians and physician extenders, credentialed addiction treatment professional, Pharmacist, Registered Nurse, or Licensed Practical Nurse.
OBAT risk management shall be documented in each individual's record and shall include: • Random presumptive urine drug testing for non-opioid SUD treatment for all individuals, conducted at a minimum of eight times per 12 month period. Urine drug testing (UDT) is used as part of a comprehensive treatment program to assist with recovery and to restore an individual to health. UDT is used in SUD treatment to determine if the patient is taking medication as prescribed and to assess if the patient is taking other medications which may have a higher risk of overdose. • Overdose prevention counseling including the prescribing of naloxone.	Physician, Physician Extender, Pharmacist, Registered Nurse, or Licensed Practical Nurse licensed by the state

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Provide optional substance use care coordination that includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress and tracking member outcomes; linking members with community resources to facilitate referrals and respond to peer supports; and supporting members in meeting their goals identified in the treatment plan. . Substance use care coordination cannot be providedsimultaneously with substance use case management. From October 1, 2020, through September 30, 2025, the state assures that substance use care coordination for OUD is as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.	Care Coordination Provider
Provider optional peer recovery support services in accordance with SMDL 07-011, that includes activities that engage and support an individual's, and as applicable the caregiver's, self-help efforts toimprove health recovery, resiliency, and wellness.	Peer Recovery Support Specialist

All provider qualifications are described in Attachment 3.1 A and B Supplement 1 page 42, 43 and 55. Pharmacists, Nurse Practitioners, Registered Nurses and Licensed Practical Nurses must be licensed by the appropriate Board and permitted to practice in Virginia.

Limits on amount, duration, and scope:

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

Group counseling by credentialed addiction treatment professionals, CSACs and CSAC-supervisees shall have a maximum limit of 12 individuals in the group or less depending on the clinical model. Such counseling shall focus on the needs of the members served.

OBAT services do not require service authorization.

Individuals under 21 years of age qualifying under EPSDT may receive the services described in excess of any service limit, if services are determined to be medically necessary.

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5. Intensive Outpatient Services

Service Component Definitions – Intensive Outpatient Services	***Staff That Provide Service Components***
Multidimensional Assessment: means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the individual (including family members and significant others as needed) including history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations.	Credentialed addiction treatment professional, CSAC, CSAC-supervisee
Diagnosis of substance use disorder means the assessment to determine the individual meets the diagnostic criteria for substance-related and/or addictive disorder of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.	Credentialed addiction treatment professional
Development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.	Credentialed addiction treatment professional
Individual, Family, and Group Psychotherapy: application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.	Credentialed addiction treatment professional

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Psychoeducational substance use disorder counseling means: (i) a specific form of counseling aimed at helping individuals who have a substance use disorder or mental illness and their family members or caregivers to access clear and concise information about substance use disorders or co-occurring substance use disorder and mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or co-occurring substance use and mental illness and its effects in order to design effective treatment plans and strategies.	Credentialed addiction treatment professional, CSAC, CSAC-supervisee
Medication Management means counseling on the role of prescription medications and their effects including side effects; the importance of compliance and adherence; and monitoring the use and effects of medications. Assistance with medication management is only available to parents and guardians when it is for the direct benefit of the child and if the child is present.	Credentialed addiction treatment professional A registered nurse or a practical nurse who is licensed by the Commonwealth with experience involving medication management.
24-hour crisis services means immediate behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to prevent harm and higher levels of acuity.	Credentialed addiction treatment professional
Withdrawal Management services as necessary; the extent to which withdrawal management is needed for specific classes of drugs is determined. Additionally, medical decision-making by the addiction specialist physician includes determining whether, for a patient in acute withdrawal, the indicated intervention is acute management of the withdrawal syndrome or induction into agonist, partial agonist, or antagonist maintenance therapy. Thus, if the patient is to be placed on ongoing treatment with an agonist or partial agonist, then he or she should not be placed on a withdrawal regimen for that class of drugs, though other withdrawal management interventions may be indicated for other classes of drugs.	Physicians and Physician extenders
Medication for Opioid Use Disorder (MOUD) and Alcohol Use Disorder shall be provided onsite or through referral.	Physicians and physician extenders

Limits on amount, duration, and scope: Intensive outpatient services require service authorization.

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6. Partial Hospitalization

Service Component Definitions – Partial Hospitalization	***Staff That Provide Service Components***
Multidimensional Assessment: means the individualized, person-centered biopsychosocial assessment performed face-to-face, in which the provider obtains comprehensive information from the individual (including family members and significant others as needed) including history of the present illness; family history; developmental history; alcohol, tobacco, and other drug use or addictive behavior history; personal/social history; legal history; psychiatric history; medical history; spiritual history as appropriate; review of systems; mental status exam; physical examination; formulation and diagnoses; survey of assets, vulnerabilities and supports; and treatment recommendations.	Physician, Nurse practitioners or Physician Assistants licensed by the state Credentialed addiction treatment professional, CSAC, CSAC-supervisee
Diagnosis of substance use disorder means the assessment to determine the individual meets the diagnostic criteria for substance-related and/or addictive disorder of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.	Credentialed addiction treatment professional
Treatment Planning: development of a person-centered plan of care that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.	Physician, Nurse practitioners or Physician Assistants licensed by the state Credentialed addiction treatment professional
Individual, Family, and Group Psychotherapy: application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health.	Physician, Credentialed addiction treatment professional
Psychoeducational substance use disorder counseling: means (i) a specific form of counseling aimed at helping individuals who have a substance use disorder or co-occurring substance use and mental illness and their family members or caregivers to access clear and concise information about substance use disorders or co-occurring substance use disorder and mental illness and (ii) a way of accessing and learning strategies to deal with substance use disorders or mental illness and its effects in order to design effective treatment plans and strategies.	Credentialed addiction treatment professional, CSAC, CSAC-supervisee

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Medication Management means counseling on the role of prescription medications and their effects including side effects; the importance of compliance and adherence; and monitoring the use and effects of medications. Assistance with medication management is only available to parents and guardians when it is for the direct benefit of the child and if the child is present.	Physicians and physician extenders Credentialed addiction treatment professional
Withdrawal management services as necessary; the extent to which withdrawal management is needed for specific classes of drugs is determined. Additionally, medical decision-making by the addiction specialist physician includes determining whether, for a patient in acute withdrawal, the indicated intervention is acute management of the withdrawal syndrome or induction into agonist, partial agonist, or antagonist maintenance therapy. Thus, if the patient is to be placed on ongoing treatment with an agonist or partial agonist, then he or she should not be placed on a withdrawal regimen for that class of drugs, though other withdrawal management interventions may be indicated for other classes of drugs.	Physicians and Physician extenders
Medication for Opioid Use Disorder (MOUD) and Alcohol Use Disorder shall be provided onsite or through referral.	Physicians and physician extenders
24-hour crisis services means immediate behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to prevent harm and higher levels of acuity.	Physician and physician extenders Credentialed addiction treatment professional

Limits on amount, duration, and scope: Service authorization is required. There are no maximum annual limits.

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Peer Support Services and Family Support Partners are Peer Recovery Support Services and are non-clinical, peer to peer activities that engage, counsel, and support an individual's, and as applicable, the caregiver's self-help efforts to improve health, recovery, resiliency and wellness. These services are provided under 42 CFR 440.130(d) in accordance with the rehabilitative services benefit. These services shall be available to:

1. Individuals 21 years or older with mental health or substance use disorders or co-occurring mental health and substance use disorders; or

2. The caregiver of individuals under the age of 17 years old who have a mental health or substance use disorder or co-occurring mental health and substance use disorder when the services is directed exclusively toward the benefit of a Medicaid-eligible child; or

3. Individuals 18-20 years old who meet the medical necessity criteria, who would benefit from receiving Peer Support Services directly, and who choose to receive Peer Support Services directly instead of through their family, shall be permitted to receive Peer Support Services by an appropriate Peer Recovery Specialist.

Definitions:

"CSAC" means the same as defined in Attachment 3.1 A&B Supplement 1, page 42. CSACs shall be supervised by an LMHP, LMHP-R, LMHP-RP, or LMHP S, as defined in 3.1 A&B, Supplement 1, page 31 and 31.1.

"CSAC-A" means the same as defined in Attachment 3.1 A&B Supplement 1, page 42. CSAC-A's shall be supervised by a CSAC or by an LMHP, LMHP-R, LMHP-RP, or LMHP S, as defined in 3.1 A&B, Supplement 1, page 31 and 31.1.

"Credentialed addiction treatment professional" means the same as defined in Attachment 3.1 A&B Supplement 1 Page 42.

"Direct Supervisor" means the person who provides direct supervision to the Peer Recovery Specialist ("PRS"). The direct supervisor:

1) shall be a Licensed Mental Health Professional (LMHP), including a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist or a Licensed Mental Health Professional – Resident, Licensed Mental Health Professional – Resident in Psychology, Licensed Mental Health Professional – Supervisee, who has documented completion of the DBHDS PRS supervisor training who is acting within their scope of practice under state law; or

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2) shall have two consecutive years of documented practical experience rendering Peer Support Services or Family Support Services, have certification training as a PRS under a certifying body approved by the Department of Behavioral Health and Developmental Services (DBHDS), and have documented completion of the DBHDS PRS supervisor training; or,

3) shall be a qualified mental health professional (QMHP) as defined in Supplement 1 to Attachment 3.1A&B, page 31.2 with at least two consecutive years of documented experience as a QMHP, and who has documented completion of the DBHDS PRS supervisor training; or

4) shall be a CSAC, CSAC Supervisee, or CSAC-A, as defined on the next page, if they are acting under the supervision
or direction of a licensed substance use treatment practitioner or licensed mental health professional or a nurse practitioner, and who has documented completion of the DBHDS PRS supervisor training.

LMHP means the same as defined in 3.1 A&B, Supplement 1, page 31.

LMHP-Resident or LMHP-R means the same as defined in 3.1 A&B, Supplement 1, page 31.1.

LMHP-Resident in Psychology or LMHP-RP means the same as defined in 3.1 A&B, Supplement 1, page
31.1.

LMHP-Supervisee or LMHP-S means the same as defined in 3.1 A&B, Supplement 1, page 31.1.

"Peer Recovery Specialist" or "PRS" means a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services (DBHDS). A PRS is professionally qualified and trained (i) to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental health disorders, substance use disorders, or both ii) to provide peer supports as a self-identified individual successful in the recovery process with lived experience with mental health disorders or substance use disorders, or co-occurring mental health and substance use disorders, and (iii) to offer support and assistance in helping others in the recovery and community-integration process. A PRS may be a parent of a minor or adult child with similar mental health or substance use disorders or co-occurring mental health and substance use disorders, or an adult with personal experience with a family member with similar mental health or substance use disorders or co-occurring mental health and substance use disorders with experience navigating substance use or behavioral health care services. A PRS shall have the qualifications, education,

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and experience, and certification required by DBHDS in order to be eligible to register with the Board of Counseling at the Department of Health Professions on or after July 1, 2018. Upon the promulgation of regulations by the Board of Counseling at the Department of Health Professions, registration of Peer Recovery Specialists by the Board of Counseling shall be required.

1) The PRS shall perform Family Support Partners services for individuals with a primary mental health diagnosis under the oversight of the LMHP making the recommendation for services and providing the clinical oversight of the Recovery, Resiliency, and Wellness Plan.

2) The PRS shall perform Family Support Partners services for individuals with a primary substance use diagnosis, or individuals with co-occurring substance use and mental health diagnoses, under the oversight of the Credentialed Addiction Treatment Professional (excluding the Certified Substance Abuse Counselor-Assistant) making the recommendation for services and providing the clinical oversight of the Recovery, Resiliency, and Wellness Plan.

Direct supervision of the PRS shall be performed as needed based on the level of urgency and intensity of service being provided.

1. If the PRS has less than 12 months experience delivering Peer Support Services or Family Support Partners, they shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty.

2. If the PRS has been delivering Peer Recovery Services for over 12 months and fewer than 24 months they must receive monthly face-to-face, one-to-one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. The direct supervisor must be available by phone for consult within 24 hours of service delivery if needed for challenging situations.

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Family Support Partners:

Service Definition: Family Support Partners is a Peer Recovery Support Service and is a strength-based, individualized, service provided to the caregiver of Medicaid-eligible individual under age 21, with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver and individual must be directed exclusively toward the benefit of the Medicaid-eligible individual. Services are expected to improve outcomes for individuals under age 21 with complex needs who are involved with multiple systems and increase the individual's and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar substance use disorder or co-occurring mental health and substance use disorder, or (ii) an adult with personal experience with a family member with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of their knowledge, lived experience, and education.

Peer Support Services:

Service Definition: Peer Support Services for Adults is a Peer Recovery Support Service and is a person centered, strength-based, and recovery oriented rehabilitative service for individuals 21 years or older provided by a Peer Recovery Specialist (PRS) successful in the recovery process with lived experience with a mental health or substance use disorder, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. Services assist the individual with developing and maintaining a path to recovery, resiliency, and wellness. Specific Peer Support Service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

Service components, staff that may provide those service components, and service limitations for Family Support Partners and Peer Support Services may be found in Attachment 3.1A&B, Supplement 1, pages 58 - 59.

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Subcomponents of Peer Support Service and Family Support Partners and Providers:
These services shall provide recovery oriented services and activities, defined in the person centered Recovery Resiliency and Wellness Plan that guides the individual and the healthcare team to move the individual toward the maximum achievable independence and autonomy in the community. The Recovery, Resiliency, and Wellness Plan is a component of the individual's overall plan of care.
These services include the following components:

Service Component Definitions –Peer Support Services and Family Support Partners	***Staff That Provide Service Components***
A licensed practitioner acting within the scope of practice makes the determination an individual meets the medical necessity criteria for Peer Support Services or Family Support Partner. Under the clinical oversight of the licensed practitioner the Peer Support Services or Family Support Partners the Peer Recovery Specialist (PRS) in consultation with their direct supervisor shall develop a Recovery, Resiliency, and Wellness Plan based on the recommendation for service, the individual's and the caregiver's perceived recovery needs, and any clinical assessments or service specific provider intakes within 30 calendar days of the initiation of service. Development of the Recovery, Resiliency, and Wellness Plan shall include collaboration with the individual and the individual's caregiver, as applicable. Individualized goals and strategies shall be focused on the individual's identified needs for self-advocacy and recovery.	PRS, Direct Supervisor, LMHP or Credentialed Addiction Treatment Professional, excluding the CSAC-A
The PRS and individual, and caregiver as applicable, shall perform a review of the Recovery, Resiliency, and Wellness Plan every 90 calendar days in consultation with the Direct Supervisor. Review of the Recovery Resiliency and Wellness Plan means the PRS evaluates and updates the individual's progress every 90 days toward meeting the Plan's goals and documents the outcome of this review in the individual's medical record.	PRS
Strategies and activities shall include at a minimum: 1) person centered, strength based planning to promote the development of self-advocacy skills; 2) empowering the individual to take a proactive role in the development and updating of their Recovery, Resiliency, and Wellness Plan; 3) crisis support; and 4) assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the Recovery, Resiliency and Wellness Plan so that the individual: i) remains in the least restrictive setting; ii) achieves their goals and objectives identified in the Recovery, Resiliency and Wellness Plan; iii) self-advocates for quality physical and behavioral health services; and iv) has access to strength-based behavioral health services, social services, educational services and other supports and resources.	PRS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY
and MEDICALLY NEEDY

Limits on amount, duration, and scope in Peer Support Services and Family Support Partners:

Service authorization shall be required. A unit of service shall be defined as 15 minutes. Peer Support Services and Family Support Partners shall be limited to four hours per day (up to 16 units per calendar day) and nine hundred (900) hours per calendar year. The four units of services per day may be exceeded based on medical necessity and that for individuals under age 21 limitations are not applicable because children must receive all medically necessary services in accordance with 1905(r) of the Social Security Act.

If a service recommendation for Peer Support Services or Family Support Partners made in a Mental Health setting in addition to a service recommendation for Peer Support Services or Family Support Partners in an addiction and recovery treatment setting, the individual may receive services in both settings however the enrolled provider shall coordinate services to ensure the four hour daily service limit is not exceeded. No more than a total of four hours of services in each of the settings, or a total of four hours of services in a combination of settings, up to 16 units of total service, shall be provided per calendar day. Peer Support Services or Family Support Partners shall not be rendered in these two settings at the same time. A separate annual service limit of up to 900 hours shall apply to each of these settings..

Service delivery limits may be exceeded based upon documented medical necessity and service authorization approval. Individuals 18-20 years old who meet the medical necessity criteria who would benefit from receiving peer supports directly, and who choose to receive Peer Support Services directly instead of through their caregiver shall be permitted to receive Peer Support Services by an appropriate Peer Recover Specialist (PRS).