CHAPTER IV
COVERED SERVICES AND LIMITATIONS

CHAPTER IV

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CHAPTER IV

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

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

GENERAL INFORMATION

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

All psychiatric residential treatment facility and therapeutic group home providers are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the MCOs, MMPs and the BHSA and state and federal regulations.

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

COMMONWEALTH COORDINATED CARE PLUS (CCC Plus) PROGRAM

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

Target Population –

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

2. Individuals who receive Medicaid LTSS in a facility or through CCC Plus Waiver except Alzheimer's Assisted Living waiver. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, will enroll for their non-waiver services only. At this time, DD waiver services will continue to be covered through Medicaid fee-for-service.

3. Individuals who are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including ABD individuals currently enrolled in the Medallion 3.0 program. Medallion ABD members who are not enrolled in the CCC Plus Waiver (per 2 above) will transition as of January 1, 2018.

This section relates only to individuals enrolled in CCC Plus Managed Care Program:

CCC Plus Managed Care Program enrollment status does not change the assessment and certification process for individuals seeking residential treatment services. All Independent Assessment, Certification and Coordination Teams (IACCT) teams will complete the independent certification process as described in this chapter.

Therapeutic Group Home (TGH) Services – If an individual enrolled in CCC Plus Managed Care Program is eligible for and chooses TGH services, the individual will remain enrolled in CCC Plus Managed Care Program after admission. If the individual transfers to a TGH after a PRTF stay, the CCC Plus eligible individual will be enrolled into the CCC Plus Managed Care Program.

Psychiatric Residential Treatment Facility (PRTF) Services - If the individual enrolled in CCC Plus Managed Care Program is admitted to a PRTF, they will be removed from the CCC Plus Managed Care Program effective on the day of admission to the PRTF.

MEDALLION 3.0

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

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

For MCO members, assessment and evaluation, and outpatient psychiatric therapy services (individual, family, and group) are handled through the member's MCO. MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

Certain services, however, are carved out of managed care and will continue to be obtained through fee-for-service (e.g., dental and community mental health rehabilitation services). A complete list of carved out services are located online at:
http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc- guide_p4.pdf.

Residential Treatment Coverage for MEDALLION 3.0 MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

The following residential treatment services are carved-out of the MCO Contract and are covered through fee-for-service, including for MCO members, in accordance with DMAS fee-for-service established coverage criteria and guidelines.

Medicaid managed care organizations receive data on the community mental health rehabilitative services utilized by their members. Providers of residential treatment services may be contacted by the managed care organizations to discuss the care of these individuals.

MEDALLION 3.0 MCO Carve Out Services:

Residential Treatment Services

- Community-Based Residential Services for Individuals under age 21-Group Home Level A (this service will end in 2018)
- Therapeutic Group Home (professional services are covered by the MCO)

MEDALLION 3.0 MCO Exclusion Services

In addition, the following individuals will be excluded from participating in the MEDALLION MCO program if receiving mental health services as follows:

- Individuals who are inpatients in State mental hospitals
- Individuals who are under age 21, who are approved for Psychiatric Residential Treatment Facility (PRTF) as defined in 12VAC30-50-130.
- Individuals who are under age 21, who are approved for EPSDT Psychiatric Residential Treatment Facility (EPSDT-PRTF).
- Individuals who are under age 21, who are approved for EPSDT Therapeutic Group Home

Coverage for FAMIS MCO Enrollees*

- Intensive In-Home Services for Children and Adolescents
- Therapeutic Day Treatment for Children and Adolescents

- Mental Health Crisis Intervention
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance

***Note: No CMHRS other than those listed above are covered by DMAS for FAMIS MCO Enrollees.**

MEDALLION 3.0 Managed Care Coverage, Eligibility and PRTF Admissions

Medicaid members who are placed in a DMAS authorized PRTF and EPSDT Therapeutic Group Home (TGH) settings are not eligible to participate in the Department's MCO program. *(In the event that an MCO member requires placement in a PRTF or EPSDT TGH, the member will be dis-enrolled from the Medallion 3.0 MCO to fee-for-service (FFS) coverage as part of the PRTF service authorization process through Magellan).* Additionally, Medicaid members who are admitted to a freestanding psychiatric hospital under FFS coverage will remain in fee-for-service until discharged. For more information see "Hospitalized at the time of MCO enrollment" on the DMAS website at: http://www.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_hsptlzd.pdf.

Coverage for services rendered to Medicaid MCO enrolled members in a freestanding psychiatric hospital is available through the MCO contract. In order to be reimbursed for services provided to MCO enrolled members, freestanding psychiatric hospital providers must follow their respective contract(s) with the MCO. The MCO may utilize different service authorization, billing, and reimbursement guidelines than those described for Medicaid FFS members. For more information, please contact the MCO directly. Additional information about the Medallion 3.0 MCO program, including MCO contacts, can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Behavioral Health Services Administrator (BHSA)

Magellan Health serves as the DMAS contracted Behavioral Health Services Administrator or "BHSA". The BHSA is responsible for the management of the behavioral health benefits program and ARTS benefit for fee-for-service members in Medicaid, FAMIS and the Governor's Access Plan (GAP).

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

All Residential Treatment Service providers are responsible for adhering to the residential treatment regulations defined in 12 VAC 30-50-130 (B)(6)(c) (as amended) this manual, their provider contract with the BHSA, and state and federal regulations.

QUALIFIED MEDICARE BENEFICIARIES (QMBs) - COVERAGE LIMITATIONS

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

QUALIFIED MEDICARE BENEFICIARIES (QMBs) - EXTENDED COVERAGE LIMITATIONS

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These members are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

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

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

TRANSPORTATION

Non-Emergency Medical Transportation (NEMT) is transportation of a Medicaid member to a non-emergency Medicaid-covered service. NEMT is not transportation where emergency

services are required. Members should dial 9-1-1 if immediate response is needed for emergencies or worsening conditions that threaten life or limb.

Transportation is covered as both a Fee for Service and as a managed care covered service in Medallion 3.0 and in the CCC Plus programs.

To arrange NEMT for FFS, or Medallion 3.0 MCO enrolled members please contact the contracted transportation broker to arrange for transportation. You may use the DMAS website to find resources on Medallion 3.0 Managed Care Organizations. Please go to http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Please click on Transportation Contacts for a complete list of all transportation telephone numbers for FFS and MCO plans.

To arrange NEMT for CCC Plus enrolled members please contact the members assigned CCC Plus Care Coordinator for the member to arrange for transportation. CCC Plus contacts are listed on the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Additional FFS NEMT information can be found at: http://transportation.dmas.virginia.gov

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

Non-emergency transportation for the individual receiving services to medical appointments, including psychiatric appointments, must be pre authorized by and billed to the Medicaid transportation broker or the member's assigned MCO or MCO transportation contractor and is not included as part of the Psychiatric service. Individual providers and agencies, with the exception of state psychiatric hospitals, may seek mileage reimbursement through the transportation broker for services under which transportation is not covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

In order to make reservations for the FFS NEMT program please call 1-866-386-8331 to arrange transportation services. Please call the same number for gas reimbursement preauthorization and to receive forms. Reservations for transportation must be made five days in advance unless the trip is urgent in nature.

Telemedicine Services

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a

means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014: "Updates to Telemedicine Coverage". Medicaid Memos are posted at: https://www.virginiamedicaid.dmas.virginia.gov under Provider Services.

RESIDENTIAL TREATMENT SERVICES

Service Criteria and Requirements for all PRTF and TGH Services

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

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

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

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

All services must be described with sufficient detail in a Plan of Care based on assessed needs of the individual defined in the assessment, the plan of care, most recent treatment team review and clinical review of the individuals treatment needs. These services are person-centered with emphasis on the delivery of youth guided and family driven principles. The individuals who are receiving these services shall be included in all service planning activities.

Level A Group Home Level of Care

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

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

Revised regulations establish two levels of residential care, i.e., Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH). Both levels of care require licensure by DBHDS.

In order to better align service delivery with federal mandates and licensing requirements, Level A group home service providers who wish to provide continued Medicaid covered services and be reimbursed by Medicaid must obtain a TGH license from DBHDS. As instructed in the DMAS Program Manual update issued on December 9, 2016, Level A service providers were to contact DBHDS and indicate their interest in applying for licensure by February 1, 2017. On January 20, 2017, DBHDS conducted an information session to Level A providers, outlining the transition process to become licensed as a Therapeutic Group Home. As of February 1, 2017, Magellan stopped enrolling new Level A providers with licenses issued by DSS.
As of May 1, 2018, DMAS and Magellan will no longer reimburse for therapeutic group home services provided by a DSS licensed facility.

Level A Transition Summary:

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

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

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

Current providers of Community-Based Residential Services for Children and Adolescents under 21 (Level A) will no longer be eligible for continued Medicaid reimbursement as of May 1, 2018

For providers that applied to DBHDS after June 30, 2017 and have not obtained a Therapeutic Group Home license by April 30, 2018, Magellan will terminate the Level A service provider agreement and contract effective on May 1, 2018. By terminating the Level A provider contract, Magellan will prevent future submissions and reimbursement for CPT code H2022, for those providers.

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

1. Continue to accept new Level A admissions via the IACCT process using TGH medical necessity criteria (MNC); and
2. Continue receiving reimbursement for authorized services through April 30, 2018.

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

1. Accept new Level A admissions via the IACCT process through September 30, 2017 using TGH medical necessity criteria;
2. Receive reimbursement for previously authorized admissions through April 30, 2018; and
3. May begin the DBHDS licensure process after June 30, 2017 but will not be able to receive reimbursement after April 30, 2018 until a DBHDS license is issued.

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

DEFINITIONS

"Active treatment" means implementation of an initial plan of care (IPOC) and comprehensive individual plan of care (CIPOC) that shall be developed, supervised, and approved by the family or legally authorized representative, treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC. Each plan of care shall be designed to improve the

individual's condition and to achieve the individual's safe discharge from residential care at the earliest possible time.

"Assessment" means a service conducted within seven calendar days of admission by an LMHP, LMHP-R, LMHP-RP, or LMHP-S utilizing a tool or series of tools to provide a comprehensive evaluation and review of an individual's current mental health status in order to make recommendations; provide diagnosis; identify strengths, needs, and risk level; and describe the severity of symptoms.

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

"Combined treatment services" means a structured, therapeutic milieu and planned interventions that promote the development or restoration of adaptive functioning, self-care, social skills and community integrated activities and community living skills that each individual requires to live in less restrictive environments, behavioral consultation, individual and group therapy, recreation therapy, family education and family therapy, and individualized treatment planning.

“Comprehensive Individual Plan of Care” or “CIPOC” means a person-centered plan of care that meets all of the requirements of this subsection, is specific to the individual's unique treatment needs and acuity levels as identified in the clinical assessment and information gathered during the referral process.

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

"Crisis management" means immediately provided activities and interventions designed to rapidly manage a crisis.

"Daily supervision" means the supervision provided in a residential treatment facility through a resident-to-staff ratio as approved by the department of behavioral health and developmental services office of licensure, with documented supervision checks every 15 minutes throughout the 24-hour period.

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

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” EPSDT is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is

geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the member.
Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary.

"Emergency admissions" means those admissions that are made when, pending a review for the certificate of need, it appears that the individual is in need of an immediate admission to group home or residential treatment and likely does not meet the medical necessity criteria to receive crisis intervention, crisis stabilization or acute psychiatric inpatient services.

"Emergency services" means unscheduled or scheduled crisis intervention, stabilization, acute psychiatric inpatient services, and referral assistance provided over the telephone or face to face if indicated, and available 24 hours a day, seven days per week.

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

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

"Foster Care Emergency Placements" means those placements made when the individual is in need of immediate group home or residential treatment and does not meet the criteria to receive crisis intervention, crisis stabilization or acute psychiatric inpatient services. The rules for coordinating an emergency placement of children in foster care are defined by the Virginia department of social services.

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

"Individual" or "individuals" means the child or adolescent younger than 21 years of age who is receiving therapeutic group home or residential treatment facility services.

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

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

"Intervention" means scheduled therapeutic treatment such as individual or group psychoeducation; psychoeducational activities with specific topics focused to address individualized needs; structured behavior support and training activities; recreation, art, and music therapies; community integration activities that promote or assist in the youth's ability to acquire coping and functional or self-regulating behavior skills; day and overnight passes and family engagement activities. Interventions shall not include individual, group, and family therapy, medical or dental appointments, physician services, medication evaluation or management provided by a licensed clinician or physician, and shall not include school attendance. Interventions shall be provided in the therapeutic group home or residential treatment facility and, when clinically necessary, in a community setting, or as part of a therapeutic leave activity. All interventions and settings of the intervention shall be established in the CIPOC.

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

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

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

"Residential case management" means care coordination, maintaining records, making calls, sending emails, compiling monthly reports, scheduling meetings, and other administrative tasks related to the individual. Residential case management is a component of the combined treatment services provided in a group home setting or residential treatment facility.

"Residential medical supervision" means around-the-clock nursing and medical care through on-site nurses and on-site or on-call physicians, as well as nurse and physician attendance at each

treatment planning meeting. Residential medical supervision is a component of the combined treatment services provided in a congregate residential care facility and is included in the reimbursement for residential services.

"Residential supplemental therapies" means a specified minimum of daily interventions and other professional therapies. Residential supplemental therapies are a component of the combined treatment services provided in a congregate residential care facility and are included in the reimbursement for residential services. Residential providers shall not bill other payment sources in addition to DMAS for these covered services as part of a residential stay.

"Residential treatment facility," means the same as defined in 42 CFR 483.352, and is a 24-hour, supervised, clinically and medically-necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual under 21 years of age in order to prevent or minimize the need for more intensive inpatient treatment.

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

"Therapeutic group home" means a congregate residential service providing 24-hour awake supervision in a community-based home having eight or fewer residents.

"Therapeutic leave" and "therapeutic passes" mean time at home or time with family consisting of partial or entire days of time away from the group home or treatment facility with identified goals as approved by the treating physician, psychiatrist, or LMHP responsible for the overall supervision of the CIPOC and documented in the CIPOC that facilitate or measure treatment progress, facilitate aftercare designed to promote family/community engagement, connection and permanency, and provide for goal-directed family engagement.

RESIDENTIAL TREATMENT SERVICES

Residential Treatment and Therapeutic Group Home Program Requirement Changes

The 2017 revision to the regulations governing residential treatment services establish practices promoting the creation of strong and closely coordinated partnerships and collaborations between families, youth, and community- and residential-based treatment service providers. These partnerships help to ensure that comprehensive services and supports are family-driven, youth-guided, strengths-based, culturally and linguistically competent, individualized, evidence and practice-informed, and consistent with the research on sustained positive outcomes. Highlights of the program requirement changes include:

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

Family Engagement Coordination Process and Activity

For each service authorization period when family engagement is not possible, the residential treatment services provider shall identify and document the specific barriers to the individual's engagement with his family or legally authorized representatives. The residential treatment services provider shall document on a weekly basis, the reasons why family engagement is not occurring as required. The residential treatment services provider shall document alternative family engagement strategies to be used as part of the interventions in the IPOC or CIPOC and include documentation of the revised IPOC or CIPOC for review at the next service authorization submitted to Magellan. When family engagement is not possible, the residential treatment services provider shall notify Magellan on a weekly basis using the Family Notification form. The residential treatment services provider shall develop individualized family engagement strategies and document the revised strategies in the IPOC or CIPOC.

The Family Notification form is used to communicate to Magellan when weekly family engagement did not occur for a member who is in a Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Group Home (TGH). Providers shall complete this form within 3 business days of a missed family engagement activity or within 3 business days of the end of the week in which family engagement did not occur. The residential treatment services provider should also notify and document the notification to the local DSS worker and/or family members (as appropriate) for all instances when a scheduled appointment or family engagement activity is missed to ensure communications are clear and expectations for family engagement and the involvement of the family member are clearly communicated.

If a family engagement activity was missed but was rescheduled and did occur within that week providers do NOT need to fill out the form.

The facility should document the communication and care coordination with the Local Department of Social Services (LDSS) Worker when there is no weekly family engagement:
For instances when there is a lack of family engagement with the identified family the facility should document the following:

- What days were family engagement scheduled;
- What were the barriers;
- Steps taken to overcome barriers;
- Plan to engage the family moving forward; and
- Adjustments to the treatment plan based on plan.

Transportation benefits may be used to support family engagement, the residential treatment services provider is encouraged to contact the DMAS designated transportation contractor for assistance in coordinating services. Refer to the Transportation section in this chapter for more coverage information. Please go to http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Please click on Transportation Contacts for a complete list of all transportation telephone numbers for FFS and MCO plans. Additional FFS NEMT information can be found at: http://transportation.dmas.virginia.gov. To arrange NEMT for FFS, or Medallion 3.0 MCO enrolled members please contact the contracted transportation broker to arrange for transportation.

You may use the DMAS website to find resources on Medallion 3.0 Managed Care Organizations. Please go to http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Please click on Transportation Contacts for a complete list of all transportation telephone numbers for FFS and MCO plans.

To arrange NEMT for CCC Plus enrolled members please contact the members assigned CCC Plus Care Coordinator for the member to arrange for transportation. CCC Plus contacts are listed on the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

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

The residential services provider must notify and coordinate care with a local DSS office when family engagement is not occurring as a part of the required residential interventions. At each treatment team meeting the facility team should be actively discussing the family involvement and planning for family engagement strategies.

The facility will coordinate efforts with Magellan to achieve effective family engagement strategies. The facility's weekly notices to Magellan will be assessed by Magellan residential care managers to coordinate strategies and care management at least every 30 days.

Therapeutic Passes

Therapeutic leave passes should consist of collaboration with the family and involve consideration for what is clinically appropriate for the youth and family within the family's structure, culture and goals for engagement with the youth as they receive the residential intervention.
The facility shall:

- Have a discussion with the family and include a preliminary plan for how to incorporate therapeutic leave passes in the initial plan of care.
- Update the plan when changes arise that impact therapeutic leave passes and document in the comprehensive plan of care.
- Ensure that therapeutic leave passes should be individualized and take into account he youth and family's needs; and,
- Develop and review a safety plan for therapeutic leave passes with all involved parties that include an assessment of safety risks.

Therapeutic Interventions

- Therapeutic interventions are part of the IPOC and CIPOC to help the youth achieve his or her treatment goals and objectives.
- Therapeutic interventions should be focused on helping the youth build a skill or resiliency factor.
- Therapeutic interventions should be meaningful and planned. However, there may be times when an unplanned intervention occurs. If this occurs, the facility must document the need for the unplanned intervention.

Documentation of an intervention shall include:

- Specific interventions used;

- How the intervention relates to the youth's stated goals and objectives as contained in the treatment plan;
- Duration of the intervention (is it a reasonable amount of time that can be used to help build a skill); and
-
- The youth's response to the intervention.

Documentation for a missed intervention shall include:

- When was the intervention scheduled;
- What was the barrier to providing the intervention;
- How was this barrier addressed or what is the plan to address this barrier; and
- If there continues to be a barrier, how will the treatment plan be adjusted to address this barrier?

Included Services and Supports-What's in the Per Diem?

See chart below for services provided under arrangement that may be billed separately for each provider type, provided that the requirements discussed above are met. (Certain services are included in the per-diem rates for each provider type, which results in the differences shown in the list below.) No other services may be billed for members under age 21 residing in a residential treatment setting.

Therapeutic Group Home services are a "carve out" service, the individual will remain covered by their Medallion or CCC Plus Managed Care Organization (MCO). The per diem charges for the TGH will be reimbursed by Magellan while the individual is enrolled in a Medallion or CCC Plus MCO.** ***Note that all *optional services provided by the Therapeutic Group Home must be billed to the individuals MCO.

Optional Services* Provided in Addition to the Per Diem	Psychiatric Residential Treatment Facilities	Therapeutic Group Home
Physician Services	Yes	Yes
Other medical and psychological "professional" services including those furnished by licensed mental health professionals and other licensed or certified health professionals (i.e. oral surgeons, nutritionists, podiatrists, respiratory therapists, substance abuse treatment practitioners)	Yes	Yes
Outpatient Hospital Services	Yes	Yes
Pharmacy services	Yes	Yes

Physical therapy, occupational therapy and therapy for individuals with speech, hearing or language disorders	Yes	Yes
Laboratory and radiology services	Yes	Yes
Durable medical equipment (including prostheses/orthopedic services and supplies and supplemental nutritional supplies)	Yes	Yes
Vision services	Yes	Yes
Dental and orthodontic services	Yes	Yes
Non-Emergency Transportation services	Yes	Yes
Emergency services (including outpatient hospital, physician and transportation services)	Yes	Yes

The following services are included in the facility per diem reimbursement for the residential service and shall not be collected from a third party payer.

Per Diem Component-Cannot be reimbursed Separately from or in Addition to the Per Diem unless approved by the Children's Services Act Community Policy and Management Team	Psychiatric Residential Treatment Facilities	Therapeutic Group Home
Intervention	Yes	Yes
Family Engagement	Yes	Yes
Room and Board	Yes	No
Daily Supervision	Yes	Yes
Direct Behavior Modification Services/Interventions	Yes	Yes
Discharge Coordination	Yes	Yes
Transportation to Appointments and Family Engagement	No	No
Combined Treatment Services	Yes	Yes
Psychoeducation Activities	Yes	Yes
Non-Emergency Transportation	No	No
Crisis Response	Yes	Yes
Clinical and Professional Services	No	No

Services Provided under Arrangement (Applies to PRTF Level)

The U.S. Court of Appeals issued a decision on May 8, 2012 in a lawsuit brought by the Department of Medical Assistance Services (DMAS) challenging a federal audit finding related to DMAS reimbursements for services provided to members under the age of 21 in psychiatric residential treatment facilities (PRTF) (both state and private). This also applies to EPSDT specialized contracts for psychiatric residential treatment facilities. when referencing services provided under arrangement, these facilities will be referred to as Inpatient Psychiatric Facilities or IPFs.

In order to comply with the court decision and federal law, DMAS modified the reimbursement process for certain services furnished to Medicaid members who are under the age of 21 and who are residing in an IPF.

The services that are affected are "services provided under arrangement" with the IPF, including physician and other health care services that are furnished to children in an IPF and billed separately from the IPF per diem. Services that can be provided under arrangement with an IPF are listed below for each provider type.

In order for DMAS to continue to reimburse these services separately from the per-diem rate paid to IPFs, the Centers for Medicare and Medicaid Services (CMS) requires that the IPF:

1) Arrange for and oversee the provision of all services;
2) maintain all medical records of services provided under arrangement furnished to the member residing in the IPF;
3) ensure that each member residing in an IPF has a comprehensive plan of care that includes services provided under arrangement; and
4) ensure that all services, including services provided under arrangement, are furnished under the direction of a physician.

If these requirements are not met, DMAS will not reimburse for these services and providers may not charge members directly. These requirements will apply to both in-state providers and out-of-state providers. These requirements also apply across all contractors (Magellan, DentaQuest, and LogistiCare) who administer claims on behalf of DMAS and reimburse for services furnished members residing in IPFs. **Detailed requirements for reimbursement of services provided under arrangement can be found in Chapter II of this manual.**

Seclusion and Restraint

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

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

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

Each use of a seclusion or restraint, as defined in 42 CFR § 483.350 through 42 CFR § 483.376, shall be reported by the service provider to Magellan within one calendar day of the incident.

Facilities must report any serious incident involving a resident to Magellan within **1 business day** of the occurrence.

Facilities must report each instance of restraint or seclusion as defined in 42 CFR §483.352 involving a resident to Magellan within **1 business day** of the occurrence.

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

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

Service Limitations

Psychiatric residential treatment services may not be billed concurrently with any Community Mental Health Rehabilitative Services, with one exception: Intensive In-Home Services for Children and Adolescents (H2012). This service may be billed for up to seven days, immediately upon admission to a psychiatric residential treatment facility or immediately prior to discharge from a psychiatric residential treatment facility, to transition the individual from home to the psychiatric residential treatment facility or from the psychiatric residential treatment facility to home, as applicable.

Providers may not bill another payer source for any supervisory services; daily supervision, including one-on-one support when provided as PRTF services, as all covered services must be in included in the CIPOC and subject to approval for Medicaid reimbursement.

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

FAMIS Fee for Service does not cover psychiatric residential treatment services.

Out of State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers of PRTF, TGH and EPSDT services in those levels of care. These specific procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period. Additional information may be found in Chapter II of this manual.

SERVICE AUTHORIZATION

Service Authorization

For more service detail please refer to the Service Limit Chart in Appendix C.

All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Service Authorization is required for the following services:

- Community Residential Treatment, Level A (H2022 HW (CSA) H2022 HK (non CSA)
- Therapeutic Group Home Services – H2020 HW (CSA) H2020 HK (non-CSA)
- Psychiatric Residential Treatment Facility – Revenue Code 1001 (CSA) Revenue Code 1001 (non-CSA)
- EPSDT Therapeutic Group Home Services – H0019
- EPSDT Psychiatric Residential Treatment Facility – T2048 Revenue Code 0961
- EPSDT 1:1 Services H2027

Requirements applicable to both therapeutic group homes and residential treatment facilities:

A. Authorization shall be required and shall be conducted by Magellan using medical necessity criteria specified in this subsection.

B. An individual shall have a valid psychiatric diagnosis and meet the medical necessity criteria as defined in this subsection to satisfy the criteria for admission. The diagnosis shall be current, as documented within the past 12 months. If a current diagnosis is not available, the individual will require a mental health evaluation by an LMHP employed or contracted with the independent certification team to establish a diagnosis, recommend and coordinate referral to the available treatment options.

C. At authorization, an initial length of stay shall be agreed upon by the individual and parent or legally authorized representative with the treating provider and the treating provider shall be responsible for evaluating and documenting evidence of treatment progress, assessing the need for ongoing out-of-home placement and obtaining authorization for continued stay.

D. Information that is required to obtain authorization for these services shall include:

(1) A completed state-designated uniform assessment instrument approved by DMAS;

(2) A certificate of need completed by an independent certification team specifying all of the following:

(a) the ambulatory care and Medicaid or FAPT-funded services available in the community do not meet the specific treatment needs of the individual;

(b) alternative community-based care was not successful;

(c) proper treatment of the individual's psychiatric condition requires services in a 24-hour supervised setting under the direction of a physician; and

(d) the services can reasonably be expected to improve the individual's condition or prevent further regression so that a more intensive level of care will not be needed;

(3) Diagnosis, as defined in the DSM 5th edition, and based on an evaluation by a psychiatrist, LMHP completed within 30 days of admission or if the diagnosis is confirmed, in writing, by an LMHP after reviewing a previous evaluation completed within one year of admission;

(4) A description of the individual's behavior during the seven days immediately prior to admission;

(5) A description of alternate placements and CMHRS and traditional behavioral health services pursued and attempted and the outcomes of each service;

(6) The individual's level of functioning and clinical stability;

(7) The level of family involvement and supports available; and

(8) The initial plan of care (IPOC).

6. Requirements applicable to both therapeutic group homes and residential treatment facilities: continued stay criteria. For a continued stay authorization or a reauthorization to occur, the individual shall meet the medical necessity criteria as defined in this subsection to satisfy the criteria for continuing care. The length of the authorized stay shall be determined by DMAS, the behavioral health services administrator, or the utilization management contractor. A current CIPOC and a current (within 30 days) summary of progress related to the goals and objectives of the CIPOC shall be submitted to DMAS, the behavioral health services administrator, or the utilization management contractor for continuation of the service. The service provider shall also submit:

a. A state uniform assessment instrument, completed no more than 30 business days prior to the date of submission;

b. Documentation that the required services have been provided as defined in the CIPOC;

c. Current (within the last 14 days) information on progress related to the achievement of all treatment and discharge-related goals; and

d. A description of the individual's continued impairment and treatment needs, problem behaviors, family engagement activities, community-based discharge planning and care coordination, and need for a residential level of care.

7. Requirements applicable to therapeutic group homes and residential treatment facilities: EPSDT services. EPSDT services may involve service modalities not available to other individuals, such as applied behavioral analysis and neuro-rehabilitative services. Individualized services to address specific clinical needs identified in an EPSDT screening shall require authorization by DMAS, a DMAS contractor, or the BHSA. In unique EPSDT cases, DMAS, the DMAS contractor, or the BHSA may authorize specialized services beyond the standard therapeutic group home or residential treatment medical necessity criteria and program requirements, as medically and clinically indicated to ensure the most appropriate treatment is available to each individual. Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes and residential treatment facilities on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS, the DMAS contractor, or the BHSA. All documentation, independent certification team, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT inpatient, residential treatment, or therapeutic group home service.

Magellan Care Management, Provider Service Coordination and Coordination with CSA Coordinators/CSA Case Managers, DSS Social Workers, CSB and TFC Case Managers

Care management is provided by Magellan employed clinical staff who are licensed behavioral health clinicians. The central purpose of care management is to help individuals receive quality services in the most cost-effective manner. The primary activities of care management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care transition, quality management, and independent review.

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

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

outcomes.

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

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

Care Coordination

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

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

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

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

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

Service Provider Care Coordination includes:

- Assisting the individual to access and appropriately utilize needed services and supports;
- Assisting them to overcome barriers to being able to maximize the use of these resources;

- Actively collaborating with all internal and external service providers;
- Coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer's life);
- Assessing the effectiveness of these services/supports;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the service plan as clinically indicated to ensure that service planning is consistent with other services being provided to the individual.

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

Residential Services for Substance Use and Behavioral Health

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

Residential: Addiction and Recovery Treatment Services (ARTS)

ARTS residential services for adolescents include: American Society of Addiction Medicine (ASAM) Levels 3.1, 3.5, 3.7, and 4.0. The ASAM levels of residential services vary in intensity from low, medium, to high. If the adolescent's primary diagnosis is a substance use disorder, please submit an ARTS residential service request to the MCO or Magellan. For assistance or a list of ARTS residential providers, contact the adolescent's MCO or Magellan. Providers can also be contacted directly for services.

Residential Services for Behavioral Health

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

INTERACTION BETWEEN ARTS AND IACCT

If the youth is in a PRTF or TGH and it is determined that ARTS Residential services are needed, please notify the Magellan Residential Care Manager (RCM) who will assist with identifying appropriate ARTS resources for the youth.
If the youth is in an ARTS Residential facility and needs to transition to a PRTF or a TGH, please submit an IACCT Inquiry form as soon as the need is identified.

Co-Occurring Disorders

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

For persons with co-occurring psychiatric and substance abuse conditions, providers are expected to integrate the treatment needs. There may be concurrent authorizations for psychiatric services and substance abuse services if medical necessity criteria are met for the requested service. Collaboration and coordination of care among all treating practitioners shall be documented. Providers should obtain a release of information from the member so they can collaborate to coordinate effective treatment

INDEPENDENT CERTIFICATION PROCESS

Medical Necessity Review Process Changes

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

Authorizations will be issued using a maximum duration of 30 days per admission based on medical necessity requirements and to allow for complex care coordination in order to transition to an appropriate level of care. EPSDT cases will be authorized for a maximum duration of 60 days per admission based on medical necessity requirements.

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

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

Independent Certification of Need (CON) and Care Coordination Process Administered by Magellan

Independent Assessment, Certification and Coordination Teams (IACCT)

CMS requires, per §441.153, that an independent certification team assess the needs of a youth to determine the appropriate level of care and, if appropriate, to certify medical necessity for residential treatment services. Membership and qualifications of the team are also stipulated in §441.153. Historically, DMAS has not required the certification teams to be enrolled providers and did not reimburse the certification teams for their services. Effective January 1, 2017 DMAS will require that all certification teams are credentialed and contracted with Magellan in order to administer the independent certification process on behalf of DMAS. DMAS will also allow localities to enter into a partnership agreement with DMAS to administer the IACCT process in collaboration with Magellan. The new certification teams will be called the Independent Assessment, Certification and Coordination Team (IACCT) and the team will enhance the current certification process by:

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

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

IACCT Oversight and Support

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

Magellan will support the IACCT process through activities including:

- Ensure that all appropriate community services are explored in lieu of residential placement;
- Make the final medical necessity determination for residential placement;
- Handle all grievances and appeals per the established DMAS appeals process; and
- Provide freedom of choice of providers to youth and families.

Magellan's Role

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

Magellan Residential Care Manager (RCM) The RCM will notify the IACCT serving a locality of any youth from that locality referred to Magellan for consideration of residential treatment.

In all circumstances, the RCM will:

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

Magellan Family Support Coordinator (FSC) The FSC will perform outreach to the family or guardian to coordinate any face-to-face assessments, encourage and facilitate family engagement in any treatment option decisions, provide education for informed decision making regarding treatment, and offer any other support or assistance to the family throughout the course of

treatment. The FSC's primary role is to provide support to the family, helping them to stay involved while their child is in care and preparing for a successful reunification upon the youth's discharge.

IACCT Requirements: Members and Roles

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

IACCT Requirements: Required Activities

- Receive and respond to Residential Inquiry requests and IACCT Referrals from Magellan of youth[2] to be considered for residential treatment services.
- Determine each youth's appropriate level of care and certify, as appropriate, the need for residential treatment services. Assessment must include psychosocial history, CANS, approved ACEs tool (Center for Youth Wellness-Adverse Childhood Experiences Questionnaire as completed by an MD, PA, of CNP or the Whole Child Assessment –

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

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

Adverse Childhood Experiences- Only completed by a LMHP or LMHP Supervisee/Resident), medical history and current status.

- If the youth has had a CANS (including the Magellan 2016 CANS or the Virginia Comprehensive CANS) completed within the last 30 days, the LMHP/LMHP Supervisee/Resident can utilize this CANS for the assessment.

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

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

- Adhere to IACCT procedures established by DMAS regulations, provider manuals, and Magellan contractual agreements including:
  - Meet all specified timeframes;
  - Assess the youth and family's needs;
  - Apply medical necessity criteria in accordance with DMAS regulations;
  - Ensure the youth is served in the least restrictive environment in accordance with the Department of Justice Settlement Agreement; and
  - Ensure family engagement throughout the assessment process;
- Assume responsibility for assessment of youth in inpatient facilities who are referred for consideration of transfer to a residential treatment facility.[3]
  - The LMHP OR LMHP Resident/Supervisee will assess the youth (expedited, if possible) through either a face-to-face or telemedicine contact. For youth who are currently in an inpatient setting where telemedicine is not available and distance is a barrier for the IACCT LMHP or LMHP Resident/Supervisee, a telephonic interview with the youth may be conducted while the IACCT LMHP or LMHP Resident/Supervisee conducts a face to face with the legal guardian.
  - The LMHP OR LMHP Resident/Supervisee will coordinate with the inpatient facility to gather diagnostic and clinical assessments completed during the youth's inpatient treatment.
  - The LMHP OR LMHP Resident/Supervisee will partner with the inpatient facility to complete the CON with the facility physician[4] and to make sure all viable options, including community based options, have been explored.

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

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

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

IACCT Requirements: LMHP OR LMHP RESIDENT IACCT Timeframes

1. When a residential inquiry is received by Magellan, a Magellan Residential Care Manager (RCM) will conduct the education session[5] to the youth and the parent/legally authorized representative.

2. After all education sessions, the parent(s)/legally authorized representatives' wishes for community based services or for engaging in the IACCT process shall be documented. The parent(s)/legally authorized representatives' verbal response for community based services or engaging in the IACCT process shall be documented. Magellan will initiate a referral to the identified locality partner or the contracted IACCT provider to begin the IACCT process.

3. The IACCT shall assess the treatment needs of the individual and recommend a level of care ***within 10 business days from the referral*** from Magellan.
    a. The LMHP or LMHP Resident/Supervisee will conduct the face to face assessment within two business days of the referral from Magellan
    b. If the youth and parent/legally authorized representative are unable to attend the face to face appointment ***within two business days***, the LMHP OR LMHP Resident/Supervisee must notify the Magellan Residential Care Manager (RCM) of this missed appointment and request a ***3 business day extension***.
    c. ***Up to two 3 day extensions*** can be offered due to the youth and parent/legally authorized representative being unable to attend a scheduled appointment.
    d. ***Up to two 3 day extensions*** can be offered for challenges engaging a physician in completing a review of a known client or face to face meeting with an unknown client and making Certificate of Need (CON) recommendations.

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

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

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

    a. For **contracted IACCT providers**, the Magellan RCM will assist with a referral list for community providers and the RCM and FSC are available to the youth and legal guardian for up to 90 days after the IACCT process is completed so that they can provide ongoing support and care coordination.

    b. For **identified IACCT locality partners (MOU with DMAS)**, the Magellan RCM will assist with a referral list for community providers. The locality partner will be responsible for providing ongoing support and care coordination for the youth and legal guardian.

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

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

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

5. If the youth has been authorized for residential treatment service options via the IACCT process and medical necessity determination, the RCM will provide a listing of credentialed residential facilities to the youth's legal guardian so that the legal guardian and youth can begin to make their selection of facility based care. The RCM will engage in care coordination at 14 days after admission. The RCM will continue to engage in care coordination at a minimum of every 30 days.

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

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

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

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

IACCT Process: Medicaid Enrolled at the time of Admission

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

IACCT Process: Emergency Placements for Foster Care Youth

DMAS and the Department of Social Services (DSS) have completed final edits on the Residential Treatment Regulations to defer to DSS for guidance on defining emergency placements for foster care youth. The emergency placements for both Medicaid eligible and non-Medicaid eligible foster care youth will be allowed to be admitted to a residential treatment facility or a therapeutic group home immediately according to DSS protocol that will ensure all potential community placement options are not viable prior to placing a child into services. The IACCT will receive notice of all emergency placements from the residential treatment facility or

the therapeutic group home within five days of admission to care or five days from the date that Medicaid eligibility and coverage begins. For emergency admissions, the certification must be made by the team responsible for the comprehensive individual plan of care (CIPOC) within 14 days after admission. These certifications of need for these "emergency admissions" shall be made by the team responsible for the CIPOC and the certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid. After processing an emergency admission the residential treatment facility or IMD shall notify Magellan of the individual's status as being under the care of the facility within 5 days.

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

IACCT Process: Individuals who are admitted to Residential Treatment and apply for Medicaid coverage while in the Facility

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

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

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

1. A Board-eligible or Board-certified psychiatrist; or
2. A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist; and

3. The team shall also include one of the following: LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP. Upon the individual's enrollment into the Medicaid program, the residential treatment facility or IMD shall notify Magellan of the individual's status as being under the care of the facility within five days of the individual becoming eligible for Medicaid benefits to begin the coordination and assessment process by the IACCT.

IACCT Process: Inpatient Transfer to Residential Services: Referral to IACCT

1. Upon a member's admission to an inpatient facility, the facility will assess for viable discharge treatment options and develop an initial discharge plan.
2. If residential services are recommended as an option for the discharge plan, the inpatient facility will submit an online residential referral form to Magellan within one business day. Alternatively, this form can be completed telephonically with Magellan during a concurrent review.
3. When the residential referral form is received by Magellan, Magellan will contact the IACCT LMHP to begin the IACCT assessment process. The IACCT LMHP will schedule a face-to-face or telemedicine assessment (expedited, if possible), and will coordinate with the inpatient facility to gather any diagnostic and clinical assessments that were completed during the member's inpatient treatment.
4. If the member is clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will arrange community-based services to maintain member's stability during IACCT process.
5. If the member is not clinically stable enough to return to the community during the IACCT assessment process, the inpatient facility will continue will engage in an acute discharge planning process.

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

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

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES

ELIGIBILTY FOR PSYCHIATRIC RESIDENTIAL TREATMENT SERVICES

Psychiatric Residential Treatment Services are available to Medicaid/FAMIS Plus members who are admitted to treatment when under 21 years of age.

COVERED SERVICES

Residential treatment facility services~~,~~ are a 24-hour, supervised, clinically and medically necessary out-of-home program designed to provide necessary support and address mental health, behavioral, substance use, cognitive, or other treatment needs of an individual under the age of 21 in order to prevent or minimize the need for more intensive inpatient treatment. Active treatment and comprehensive discharge planning shall begin prior to admission. In order to be covered for individuals younger than age 21 these services shall meet DMAS-approved psychiatric medical necessity criteria or be approved as an EPSDT service, based upon a diagnosis made by an LMHP, LMHP-R, LMHP-RP, or LMHP-S who is practicing within the scope of their license; and 2) be reflected in provider records and on the provider's claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. Failure to perform any of the covered services as described below up until the discharge of the individual shall result in a retraction of the per diem and all other contracted and coordinated service payments for each day of non-compliance.

Psychiatric Residential Treatment Facility Covered Services

Psychiatric residential treatment facility services shall include assessment and re-assessment; room and board; daily supervision; combined treatment services; treatment planning, family engagement, planned time at home/therapeutic leave, crisis management, individual, family, and group therapy; residential care coordination; interventions; general or special education (not covered by the Medicaid program); medical treatment (including medication, coordination of necessary medical services, specialty services; and discharge planning that meets the medical and clinical needs of the individual.

SERVICE REQUIREMENTS:

The following clinical activities shall be required for each residential treatment facility resident:

1. A face-to-face assessment shall be performed by an LMHP, LMHP-R, LMHP-RS, or LMHP-S upon admission, and shall document a DSM5/ICD-10 diagnosis.

2. A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130(D) (4). Recertification by the team responsible for the CIPOC shall occur at least every 30 days and be approved by a physician acting within their scope of practice.

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

a) 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) any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the individual;
f) plans for continuing care, including review and modification to the plan of care;
g) Plans for discharge; and
h) Signature and date by the individual, parent, or legally authorized representative, a physician and treatment team members.

4. The CIPOC shall be completed no later than 14 calendar days after admission by the treatment team. The residential treatment facility shall request authorizations from families to release confidential information to collect information from medical and behavioral health treatment providers, schools, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the CIPOC. The CIPOC shall meet all of the following criteria:

a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for residential treatment facility care;

b) Be developed by an interdisciplinary team of physicians and other personnel specified in section 12VAC30-50-130(D)(3)(d) who are employed by, or provide services to the individual in the facility in consultation with the individual, family member, or legally authorized representative, or appropriate others into whose care the individual will be released after discharge;

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

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

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

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

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

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

b) The team shall include either: (i) a board-eligible or board-certified psychiatrist; (ii) a licensed clinical psychologist and a physician licensed to practice medicine or osteopathy; or (iii) a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a licensed clinical psychologist.

c) The team shall also include one of the following: (i) an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP

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

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

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

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

10. Three interventions shall be provided per 24-hour period including nights and weekends. Family engagement activities are considered to be an intervention and shall occur based on the treatment and visitation goals and scheduling needs of the family or legally authorized representative. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be documented along with a clinical or medical justification for the deviation based on the needs of the individual.

11. Therapeutic passes shall be provided as clinically indicated, and as paired with community and facility-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating physician and documented in the CIPOC. Additional therapeutic leave passes shall require service authorization. Any unauthorized therapeutic leave passes shall result in retraction for those days of service.

a) Unscheduled passes requested by the family but not approved by the facility shall be communicated to Magellan to “authorize” situations that may be allowed to accommodate family desires. All such passes shall be documented by the provider and the outcomes of the pass and a summary of the pass and the interaction between the facility and family member shall be submitted to Magellan as part of the service review process.

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

12. Discharge planning. Beginning at admission and continuing throughout the individual's placement at the residential treatment facility, the parent or legally authorized representative, the Community Services Board (CSB), the Family Assessment and Planning Team (FAPT) case manager if applicable, and either the MCO or Magellan care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and identify the available services in the community. Prior to discharge, the residential treatment facility shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to Magellan for review with its service authorization request. Once

Magellan approves the discharge plan, the provider shall begin collaborating with the parent or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The residential treatment facility shall request written permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a valid release. The residential treatment facility shall request information from post-discharge providers to establish that the planning of services and activities has begun, shall establish that the individual has been enrolled in school, and shall provide IEP recommendations to the school if necessary. The residential treatment facility shall inform Magellan of all scheduled appointments within 30 calendar days of discharge, and shall notify Magellan within one business day of the individual's discharge date from the residential treatment facility.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

MEDICAL NECESSITY CRITERIA

Admission Criteria

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

(1) Admission - severity of need. The following criteria shall be met to satisfy the criteria for severity of need.

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

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

(c) Either

(i) there is clinical evidence that the patient would be at risk to self or others if he or she were not in a residential treatment program, or

(ii) as a result of the patient's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

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

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

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

Admission - Intensity and Quality of Service

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

(a) The evaluation and assignment of a DSM-5 diagnosis must result from a face-to-face psychiatric evaluation.
(b) The program provides supervision seven days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the patient to live outside of a residential setting.
(c) An individualized plan of active psychiatric treatment and residential living support is provided in a timely manner. This treatment must be medically monitored, with 24-hour medical availability and 24-hour nursing services availability. This plan includes:

(i) at least once-a-week psychiatric reassessments;
(ii) intensive family and/or support system involvement occurring at least once per week, or identifies valid reasons why such a plan is not clinically appropriate or feasible;
(iii) psychotropic medications, when used, are to be used with specific target symptoms identified;
(iv) evaluation for current medical problems;
(v) evaluation for concomitant substance use issues;
(vi) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

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

Criteria for Continued Stay

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

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

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

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

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

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

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

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

(f) A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

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

THERAPEUTIC GROUP HOME SERVICES

Therapeutic group home services for children and adolescents under the age of 21 are combined treatment services. The combination of therapeutic services rendered in a residential setting provides a therapeutic structure of daily psycho-education activities, therapeutic supervision, behavioral modification, and mental health care to ensure the attainment of therapeutic goals. The therapeutic group home shall provide therapeutic services to restore, develop, or maintain appropriate skills necessary to promote prosocial behavior and healthy living to include the development of coping skills, family living and health awareness, interpersonal skills, communication skills, and stress management skills. Treatment for substance use disorders shall be addressed as clinically indicated. The program shall include individualized activities provided in accordance with the IPOC and CIPOC including a minimum of one intervention per 24-hour period in addition to individual, group, and family therapies. Interventions shall be documented on a progress note and shall be outlined in and aligned with the treatment goals and objectives in the IPOC and CIPOC. Any deviation from the IPOC or CIPOC shall be

documented along with a clinical or medical justification for the deviation. Failure to perform any of the items described in the covered services section shall result in a retraction of the per diem for each day of non-compliance.

THERAPEUTIC GROUP HOME ELIGIBILITY CRITERIA

Individuals who are eligible for Medicaid/ FAMIS Plus (ages 0 to 20), or FAMIS (ages 0 to 19) may receive therapeutic group home services.

THERAPEUTIC GROUP HOME SERVICES

SERVICE REQUIREMENTS:

The following clinical interventions shall be required for each therapeutic group home resident:

1) A Service Specific Provider Intake (SSPI) shall be performed by an LMHP, LMHP-R,LMHP-RP, or LMHP-S upon admission. The SSPI shall be required prior to developing an Individual Service Plan (ISP). A diagnosis confirmation and initial assessment will be provided by the IACCT prior to admission.

2) A certificate of need shall be completed by an independent certification team according to the requirements of 12VAC30-50-130(D)

3) Recertification shall occur at least every 60 days by a LMHP, LMHP-R, LMHP-RP, or LMHP-S acting within their scope of practice.

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

5) The CIPOC shall be completed no later than 14 calendar days after admission and shall meet all of the following criteria: (i) be based on a diagnostic evaluation that includes examination

of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and shall reflect the need for therapeutic group home care; (ii) be based on input from school, home, other healthcare providers, the individual, and the family or legal guardian; (iii) shall state treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement; (iv) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis; and (v) include a comprehensive discharge plan with necessary, clinically appropriate community services to ensure continuity of care upon discharge with the child's family, school, and community.

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

7) Crisis management, clinical assessment, and individualized therapy shall be provided as indicated in the IPOC and CIPOC to address intermittent crises and challenges within the group home setting or community settings as defined in the plan of care and to avoid a higher level of care.

8) Care coordination shall be provided with medical, educational, and other behavioral health providers and other entities involved in the care and discharge planning for the individual as included in the IPOC and CIPOC;

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

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

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

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

10) Weekly individual therapy shall be provided in the therapeutic group home by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61. A week is defined as Sunday through Saturday.

11) Weekly (or more frequently if clinically indicated) group therapy shall be provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the IPOC or CIPOC.

12) Family treatment shall be provided as clinically indicated, provided by an LMHP, LMHP-R, LMHP-RP, or LMHP-S, which shall be documented in progress notes in accordance with the requirements in 12VAC30-60-61 and as planned and documented in the IPOC or CIPOC.

13) Family engagement activities shall be provided in addition to family therapy/counseling. Family engagement activities shall be provided at least weekly as outlined in the IPOC and CIPOC and daily communication with the family or legally authorized representative shall be part of the family engagement strategies in the IPOC or CIPOC.

14) Therapeutic passes shall be provided as clinically indicated, and as paired with facility- and community-based interventions and combined treatment services to promote discharge planning, community integration, and family engagement activities. Twenty-four therapeutic passes shall be permitted per individual, per admission, without authorization as approved by the treating LMHP and documented in the CIPOC. Additional therapeutic leave passes shall require service authorization. Any unauthorized therapeutic leave passes shall result in retraction for those days of service.

    a) Unscheduled passes requested by the family but not approved by the facility shall be communicated to Magellan to "authorize" situations that may be allowed to accommodate family desires. All such passes shall be documented by the provider and the outcomes of the pass and a summary of the pass and the interaction between the facility and family member shall be submitted to Magellan as part of the service review process.

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

15) Discharge planning. Beginning at admission and continuing throughout the individual's stay at the therapeutic group home, the family or guardian, the CSB, the FAPT case manager, and either the MCO or Magellan care manager shall be involved in treatment planning and shall identify the anticipated needs of the individual and family upon discharge and available services in the community. Prior to discharge, the therapeutic group home shall complete a comprehensive discharge plan in the CIPOC and submit the updated plan to Magellan for review with its service authorization request. Once Magellan reviews the discharge plan, the provider shall begin actively collaborating with the family or legally authorized representative and the treatment team to identify behavioral health and medical providers and schedule appointments for service-specific provider intakes as needed. The therapeutic group home shall request permission from the parent or legally authorized representative to share treatment information with these providers and shall share information pursuant to a

valid release. The therapeutic group home shall request information from post-discharge providers to establish that the planning of pending services and transition planning activities have begun, shall establish that active transition planning has begun, the individual has been enrolled in school, and shall provide IEP recommendations to the school if necessary. The therapeutic group home shall inform Magellan of all scheduled appointments within 30 days of discharge, and shall notify Magellan within one business day of the individual's discharge date from the therapeutic group home.

The facility/group home shall coordinate necessary services and discharge planning with other providers as medically and clinically necessary. Documentation of this care coordination shall be maintained by the facility/group home in the individual's record. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted and recommended next steps.

Service Limitations

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

2. Individuals shall be discharged from this service when treatment goals are met or other less intensive services may achieve stabilization.

3. Services that are based upon incomplete, missing, or outdated service-specific provider intakes or CIPOCs shall be denied reimbursement

THERAPEUTIC GROUP HOME

MEDICAL NECESSITY CRITERIA:

Admission Criteria

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

Admission –Severity of Need

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

(a) The individual’s behavioral health condition can only be safely and effectively treated in a 24 hour therapeutic milieu with onsite behavioral health therapy due to significant

impairments in home, school and community functioning caused by current mental health symptoms consistent with a DSM-5 diagnosis.

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

(i) ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the member;

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

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

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

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

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

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

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

(v) limited ability to consider the effect of one's inappropriate conduct on others and interactions consistently involving conflict, which may include impulsive or abusive behaviors.

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

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

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

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

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

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

Admission – Intensity and Quality of Service.

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

(a) Therapeutic group home service has been prescribed by a psychiatrist, psychologist, or other LMHP who has documented that a residential setting is the least restrictive clinically appropriate service that can meet the specifically identified treatment needs of the individual.
(b) Therapeutic group home is not being used for clinically inappropriate reasons, including:
(i) an alternative to incarceration, and/or preventative detention;
(ii) an alternative to parents', guardian's or agency's capacity to provide a place of residence for the individual; or,
(iii) a treatment intervention, when other less restrictive alternatives are available.
(c) The individual's treatment goals are included in the service specific provider intake and include behaviorally defined objectives that require, and can reasonably be achieved within, a therapeutic group home setting.
(d) The therapeutic group home is required to coordinate with the individual's community resources, including schools, with the goal of transitioning the individual out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.
(e) Therapeutic group home program must incorporate nationally established, evidence based, trauma informed services and supports that promote recovery and resiliency.
(f) Discharge planning begins upon admission, with concrete plans for the individual to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan.

Continued Stay Criteria

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

(a) All of the admission guidelines continue to be met and this is supported by the written clinical documentation.
(b) The individual shall meet one of the following:
(i) the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the member's CIPOC or the member continues to be at risk for relapse based on history; or
(ii) the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization.
(c) The individual shall meet one of the following:
(i) the member has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care;
(ii) the member is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care;
(iii) the member is not making progress, and the CIPOC has been modified to identify more effective interventions;

(iv) there are current indications that the member requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

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

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

(ii) identifies the school the individual will attend at discharge;

(iii) includes IEP recommendations, if necessary;

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

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

(e) The active treatment plan includes structure for daily activities, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services care coordination, transition/discharge locality/family based activities. Intensive family interventions, with a recommended frequency of one family therapy session per week, although twice per month are minimally acceptable. Family involvement begins immediately upon admission to therapeutic group home. If the minimum requirement cannot be met, the reasons must be reported, and continued efforts to involve family members must also be documented. Under certain circumstances an alternate plan, aimed at enhancing the individual's connections with other family members and/or supportive adults may be an appropriate substitute

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

Discharge Criteria:

(a) Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

(b) Reimbursement shall not be made for this level of care if any of the following applies:

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

(ii) the member no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 days.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) RESIDENTIAL TREATMENT FACILITY AND THERAPEUTIC GROUP HOME SERVICES

BACKGROUND/DISCUSSION

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT fosters the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly and has more of an impact on the individual and the family. Examination and treatment services are provided at no cost to the Medicaid member.

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

Service Definition

EPSDT residential treatment services includes, but is not limited to clinically directed programming including applied behavior analysis and other evidence based/evidence informed behavior modification models. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual and family becomes able to more effectively manage the individual's behavior using behavioral modification strategies.

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

EPSDT residential treatment services are intended to be a temporary rehabilitative, structured environment that fosters the use of evidence based behavioral strategies such as applied behavioral analysis and other evidence informed behavior modification strategies. EPSDT residential treatment services are expected to increase appropriate social - communicative interactions and pivotal responses within a social framework, increase adaptive functioning and produce beneficial changes in pivotal responses that result in more widespread behavioral change across a number of other non-targeted behaviors.

Treating service providers authorized to deliver medically necessary EPSDT services in therapeutic group homes, and residential treatment facilities on behalf of a Medicaid-enrolled individual shall adhere to the individualized interventions and evidence based progress measurement criteria described in the CIPOC and approved for reimbursement by DMAS, the DMAS contractor, or Magellan.

All service requirements including but not limited to independent certification team, interventions, family engagement activity, therapeutic pass, and discharge planning requirements shall apply to cases approved as EPSDT residential treatment, or therapeutic group home services.

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

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

ELIGIBILITY CRITERIA

EPSDT Residential Treatment Services may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services.

- EPSDT Residential Treatment services are available to individuals who: are under 21 years of age and enrolled in Medicaid.
- EPSDT Residential Treatment services for Medicaid eligible children with developmental disabilities are service authorized and billed through Magellan.

Covered Services:

- Behavioral modification services to increase the individual's adaptive functioning and communication skills;
- Training of family members to improve the child's adaptive skills in the home and community;
- Care coordination;
- Assessment and behavior analysis encounters are permitted to be billed as an ancillary service in addition to the per diem reimbursement;

- Behavioral modification services and direct consultation by the LBA or LABA with direct services staff, and other professionals and paraprofessionals involved in the child's overall treatment and/or implementation of the behavior modification plan;
- Documentation and analysis of quantifiable behavioral data related to treatment objectives;
- Assistive technology related services (such as instruction or training on use of assistive technology or development of communication methods and materials related to the functional use of assistive communication and assistive technology devices);

Service Requirements for EPSDT Psychiatric Residential Treatment Facility and EPSDT Therapeutic Group Home Services

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

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

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

Limitations:

- All services require authorization for reimbursement.
- Certain EPSDT DD Waiver Services are not allowed simultaneously with EPSDT

EPSDT MEDICAL NECESSITY CRITERIA:
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

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

I. Admission - Severity of Need

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

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

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

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

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

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

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

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

II. Admission - Intensity and Quality of Service

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

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

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

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

This plan includes:

1) at least once-a-week psychiatric reassessments;
2) intensive family and/or support system involvement occurring at least once per week; or identifies valid reasons why such a plan is not clinically appropriate or feasible;
3) psychotropic medications, when used, are to be used with specific target symptoms identified;
4) evaluation for current medical problems;
5) evaluation for concomitant substance use issues, and
6) linkage and/or coordination with the individual's community resources with the goal of returning the individual to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

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

Criteria for Continued Stay (Meet All)

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

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

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

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

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

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

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

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate post-residential treatment resources.

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

DISCHARGE CRITERIA

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

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

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

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

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

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

EPSDT MEDICAL NECESSITY CRITERIA:
THERAPEUTIC GROUP HOME

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

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

Severity of Need Criteria:

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

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

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

B. There is a high degree of potential of the condition leading to acute psychiatric hospitalization or a higher level of care in the absence of therapeutic group home services.
C. There is clinical evidence that the patient would be at risk to self or others if he or she were not in a therapeutic group home,
D. The patient requires supervision seven days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him or her to live outside of a therapeutic group home setting.
E. The patient's current living environment does not provide the behavioral support and access to therapeutic services needed.
F. The patient is medically stable but requires consistent clinical management by multidisciplinary team and needs this level of care to comply with behavioral health and / or healthcare treatment.

ADMISSION CRITERIA (Must meet A-F):

A. The individual must demonstrate behaviors or symptoms which are expected to cause harm to self or others without immediate intervention.
B. The individual is medically stable, but needs systematic treatment interventions to increase adaptive behavioral functioning and increase communication abilities;
C. The individual's needs cannot be met in the home setting or a lower level of care because the behavioral modification strategies that were attempted in the home setting were not successful or the family members or caregivers are not able to or not willing to participate in the behavioral treatment process *and* it can be determined that the individual would be at risk for hospitalization or a higher level of care without such placement.
D. It has been documented that the individual would not achieve a demonstrable clinical or adaptive behavioral improvement if using similar treatment modalities in the home setting or within a less structured environment; The individual cannot be safely maintained or effectively treated at a less-intensive level of care.
E. These symptoms and behaviors present in increasing frequency, duration and intensity that require continual close monitoring and intervention by staff who are trained to treat individuals with DD/ASD in order to ensure member and milieu safety.
F. Therapeutic Group Home services must be reasonably be expected to increase the individual's functional autonomy or prevent regression so that the individual can engage with a lower level of care.

II. Admission - Intensity and Quality of Service

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

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

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

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

1) at least once-a-week psychiatric reassessments;

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

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

4) evaluation for current medical problems;

5) evaluation for concomitant substance use issues;

6) linkage and/or coordination with the patient's community resources with the goal of returning the patient to his/her regular social environment as soon as possible, unless contraindicated. School contact should address Individualized Educational Plan/s as appropriate.

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

Continued Stay Criteria-Must Meet All

A. One of the following:

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

B. One of the following:

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

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

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

DISCHARGE CRITERIA-Must Meet One

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

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

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

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

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

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

1. The level of functioning has improved with respect to the goals outlined in the CIPOC and the member can reasonably expected to maintain these gains at a lower level of treatment; or

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

EPSDT 1:1 SERVICES CRITERIA

- 1:1 Support is an intervention involving a specific level of monitoring for individuals who require one dedicated staff person to personally monitor one member in order to help ensure their health and safety.
- The treatment team must document the need for 1:1 support in the individualized assessment of the member. One to one supports must be included in the plan of care and be ordered by a physician.
- 1:1 supports may be appropriate in the following situations; when a member demonstrates:
    - Serious suicidal intent.
    - The member verbalizes, gestures, or otherwise expresses an intent to inflict, or attempts to inflict, self-injury that would pose a threat to life
    - High risk for imminent attempts at elopement, evidenced by elopement attempt, or clear plan to elope
    - Severe physical aggression towards staff and/or other individual; active or recent homicidal threat to staff and/or other individuals; unpredictable physical aggression; or
    - A severe health risk; the individual's behaviors are a severe health and safety risk to self or others. Accommodations (consisting of support for activities of daily living) for physical disabilities are not an appropriate use of 1:1 supports.
- The need for 1:1 supports must be reviewed at least weekly by the treatment team and the physician to determine if the member continues to meet criteria for this level of monitoring. Daily progress notes shall include the member's response to the intensive treatment supervision.

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

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

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

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

- 1:1 supports will be authorized in increments up to 7 days. *Authorizations are based on the individual needs of the member at the time of the authorization request.

CRITERIA FOR DISCONTINUING 1:1 SUPPORTS (Discharge)

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

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

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

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