



*COMMONWEALTH of VIRGINIA*  
*Office of the Governor*

Vanessa Walker Harris  
Secretary of Health and Human Resources

November 30, 2021

Francis McCullough, Associate Regional Administrator  
Centers for Medicare & Medicaid Services  
801 Market Street, Suite 9400  
Philadelphia, PA 19107-3134

Dear Mr. McCullough:

Attached for your review and approval is amendment 21-031, entitled "Removal of Outdated Substance Use Disorder, Behavioral Health, and Intellectual Disability (formerly "Mental Retardation") Case Management Utilization Review Language" to the Plan for Medical Assistance for the Commonwealth. I request that your office approve these changes as quickly as possible.

Sincerely,

A handwritten signature in black ink, appearing to read "Vanessa Walker Harris".

Vanessa Walker Harris, M.D.

Attachment

cc: Karen Kimsey, Director, Department of Medical Assistance Services

## Transmittal Summary

SPA 21-031

### I. IDENTIFICATION INFORMATION

Title of Amendment: Removal of Outdated Substance Use Disorder, Behavioral Health, and Intellectual Disability (formerly, “Mental Retardation”) Case Management Utilization Review Language

### II. SYNOPSIS

Basis and Authority: The Code of Virginia (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The Code of Virginia (1950) as amended, § 32.1-324, authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance according to the Board's requirements.

Purpose: This SPA will allow DMAS to remove outdated substance use disorder (pre-ARTS), behavioral health, and intellectual disability case management utilization review language from the state plan. A portion of the intellectual disability case management utilization review language was deleted from the state plan in 2003, but the language should have been deleted in its entirety. CMS does not want substance use disorder, behavioral health, and intellectual disability case management utilization review language in the state plan anymore, so the obsolete language for these three services does not need to be updated and replaced.

Substance and Analysis: The section of the State Plan that is affected by this amendment is “Standards Established And Methods Used to Assure High Quality Care.”

Impact: There are no costs associated with this SPA.

Tribal Notice: Please see Attachments A-1 and A-2.

Prior Public Notice: N/A

Public Comments and Agency Analysis: N/A

# ATTACHMENT A-1



Lee, Meredith <meredith.lee@dmas.virginia.gov>

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## Tribal Notice - Removal of Outdated Case Management Utilization Review Language

1 message

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Lee, Meredith <meredith.lee@dmas.virginia.gov>

Wed, Oct 27, 2021 at 9:44 AM

To: TribalOffice@monacannation.com, chiefannerich@aol.com, Pamelathompson4@yahoo.com, rappahannocktrib@aol.com, regstew007@gmail.com, obert.gray@pamunkey.org, robert.gray@pamunkey.org, tribaladmin@monacannation.com, samflyingeagle48@yahoo.com, chiefstephenadkins@gmail.com, WFrankAdams@verizon.net, bradbybrown@gmail.com, heather.hendrix@ihs.gov, tabitha.garrett@ihs.gov, Kara.Kearns@ihs.gov, jerry.stewart@cit-ed.org

Dear Tribal Leaders and Indian Health Programs:

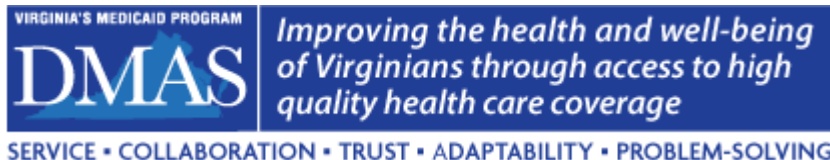
Attached is a Tribal Notice letter from Virginia Medicaid Director Karen Kimsey indicating that the Dept. of Medical Assistance Services (DMAS) plans to submit a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services. This SPA will allow DMAS to remove outdated substance use disorder (pre-ARTS), behavioral health, and intellectual disability case management utilization review language from the state plan.

If you would like a copy of the SPA documents or proposed text changes, or if you have any questions, please let us know.

Thank you! -- Meredith Lee

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Meredith Lee  
Policy, Regulations, and Manuals Supervisor  
Division of Policy, Regulation, and Member Engagement  
Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219  
[meredith.lee@dmas.virginia.gov](mailto:meredith.lee@dmas.virginia.gov)  
(804) 371-0552



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Tribal\_Notice\_letter, signed.pdf  
305K



COMMONWEALTH of VIRGINIA  
*Department of Medical Assistance Services*

KAREN KIMSEY  
DIRECTOR

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RICHMOND, VA 23219  
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October 27, 2021

SUBJECT: Notice of Opportunity for Tribal Comment – State Plan Amendment related to Removal of Outdated Substance Use Disorder, Behavioral Health, and Intellectual Disability (formerly, “Mental Retardation”) Case Management Utilization Review Language

Dear Tribal Leader and Indian Health Programs:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to amend the Virginia State Plan for Medical Assistance with the Centers for Medicare and Medicaid Services (CMS). Specifically, DMAS is providing you notice about a State Plan Amendment (SPA) that the Agency will file with CMS in order to remove outdated substance use disorder (pre-ARTS), behavioral health, and intellectual disability case management utilization review language from the state plan. A portion of the intellectual disability case management utilization review language was deleted from the state plan in 2003, but the language should have been deleted in its entirety. CMS does not want substance use disorder, behavioral health, and intellectual disability case management utilization review language in the state plan anymore, so the obsolete language for these three services does not need to be updated and replaced.

The tribal comment period for this SPA is open through November 26, 2021. You may submit your comments directly to Meredith Lee, DMAS Policy, Regulation, and Member Engagement Division, by phone (804) 371-0552, or via email: [Meredith.Lee@dmas.virginia.gov](mailto:Meredith.Lee@dmas.virginia.gov). Finally, if you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services  
Attn: Meredith Lee  
600 East Broad Street  
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

A handwritten signature in blue ink that reads "Karen Kimsey".

Karen Kimsey

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~~E. Psychiatric Services resulting from an EPSDT screening. Repealed. (12 VAC 30-60-60)~~

~~E. Services related to the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). (12 VAC 30-60-61).~~

~~1. Community mental health services for children.~~

~~a. Intensive in-home services for children and adolescents:~~

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

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

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

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

~~(2) At admission, an appropriate assessment is made by the Licensed Mental Health Professional (LMHP) or an individual who is an LMHP eligible, as that term is defined in Supplement 1 of Attach 3.1 A&B, pp 6a and 30-31.4, or an individual who is LMHP eligible documenting that service needs can best be met through intervention provided typically but not solely in the client's residence. A LMHP eligible individual is someone who is actively working toward licensure and is complying with requirements of the relevant professional board in Virginia. A LMHP or a LMHP eligible individual must make and document the diagnosis. The assessment shall include, but is not limited to: medical, psychiatric, educational, and social history, and recent behavioral history. The assessment shall be utilized to develop the Individual Service Plan (ISP), which must be fully completed within 30 days of initiation of services.~~

~~(3) Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present. The assessment referenced in paragraph (2) above must be done face to face in the residence. In some circumstances, such as a lack of privacy or unsafe conditions, the assessment and provision of services may be provided in the community if the rationale is supported in the clinical record.~~

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TN No. 10-14

Approval Date 05/24/11

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- ~~(4) — These services shall be provided when the clinical needs of the child put the child at risk for out of home placement and:
  - ~~(a) — When services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or~~
  - ~~(b) — When the child's residence as the setting for services is more likely to be successful than a clinic.~~~~
- ~~(5) — Services may not be billed when provided to a family while the child is not residing in the home.~~
- ~~(6) — Services shall also be used to facilitate the transition to home from an out of home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The child and responsible parent/guardian must be available and in agreement to participate in the transition.~~
- ~~(7) — At least one parent or responsible adult with whom the child is living must be willing to participate in the intensive in home services, with the goal of keeping the child with the family.~~
- ~~(8) — The enrolled provider must be licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as a provider of intensive in home services.~~
- ~~(9) — Services must be provided by a LMHP or a QMHP as defined in Supp. 1 of Attach 3.1 A&B, pp 6a and 30-31.4. Reimbursement shall not be provided for such services when they have been rendered by a QPPMH as defined in Supp. 1 of Attach 3.1 A&B, pp 30-31.4.~~
- ~~(10) — The billing unit for intensive in home service is one hour. Although the pattern of service delivery may vary, in home services is an intensive service provided to individuals for whom there is a plan of care in effect which demonstrates the need for a minimum of five hours a week of intensive in home service, and includes a plan for service provision of a minimum of five hours of service delivery per client/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the client and family initially with a lessening or tapering off of intensity toward the latter of weeks of service. Intensive in home services below the five hour a week minimum may be covered. However, variations in this pattern must be consistent with the individual service plan. Service plans must incorporate a discharge plan which identifies transition from intensive in home to less intensive or non home based services. If there is a lapse in service for more than two weeks, the reason for the lapse and the rationale for the continued need for the service must be documented.~~

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~~The ISP must be reviewed, updated to determine if there are changes, and signed by the client or family or both.~~

- ~~(11) — The provider must ensure that the maximum staff to caseload ratio fully meets the needs of the individual. For full time staff, the staff to client ratio shall not exceed five cases per staff. The ratio for half time staff to clients is 1 to 3. Staff that work less than half time must be cleared with the licensing specialist for more than one case. A case load may be 1:6 staff to client ratio if the staff is transitioning one of the clients off of the case load for up to 30 days.~~
- ~~(12) — A full time clinical supervisor may not have more than ten QMHPs to supervise. A half time clinical supervisor may not have more than five QMHPs to supervise.~~
- ~~(13) — Emergency assistance shall be available 24 hours per day, seven days a week.~~
- ~~(14) — Providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements shall be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider's participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in provider appropriate agency guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.~~
- ~~(15) — If an individual receiving intensive in home services is also receiving targeted case management services, the provider must collaborate with the targeted case manager and provide notification of the provision of services. The provider must also inform the primary care provider of the child's receipt of community mental health rehabilitative services. In addition, the provider must send monthly updates to the targeted case manager on the individual's progress. A discharge summary must be sent to the targeted case manager within 30 days of the service discontinuation date.~~

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b. ~~Therapeutic day treatment for children and adolescents.~~

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

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

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

~~(i) this programming during the school day; or~~

~~(ii) this programming to supplement the school day or school year.~~

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

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

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- ~~(e) Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.~~
- ~~(2) Such services must not duplicate those services provided by the school.~~
- ~~(3) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:
  - ~~(a) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out of home placement because of conflicts with family or community.~~
  - ~~(b) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.~~
  - ~~(c) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.~~~~
- ~~(4) The enrolled provider of therapeutic day treatment for child and adolescents services must be licensed by the DBHDS to provide day support services.~~
- ~~(5) Services must be provided by a LMNP or QMHP.~~
- ~~(6) The minimum staff to youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the ISP. The staff to youth ratio shall not exceed one clinical staff to six clients.~~
- ~~(7) The program must operate a minimum of two hours per day and may offer flexible program hours (i.e., before or after school or during the summer). One unit of service is defined as a minimum of two hours but less than three hours in a given day.~~

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

- ~~(8) Time for academic instruction when no treatment activity is going on cannot be included in the billing unit.~~
- ~~(9) Services shall be provided following a diagnostic assessment that is authorized by a LMHP or individual who is LMHP eligible. A LMHP or LMHP eligible individual must make the diagnosis. Services must be provided in accordance with an ISP based upon the diagnostic assessment and which must be fully completed within 30 days of initiation of the service. The diagnostic assessment must include the elements specified by DMAS in the Community Mental Health Rehabilitation manual. The assessment shall include, but is not limited to: medical, psychiatric, educational, and social history, and recent behavioral history.~~
- ~~(10) If an individual receiving therapeutic day treatment is receiving targeted case management services, the provider must collaborate with the targeted case manager and provide notification of the provision of services. The provider must also inform the primary care provider of the child's receipt of community mental health rehabilitative services. In addition, the provider must send monthly updates to the targeted case manager on the individual's progress. A discharge summary must be sent to the targeted case manager on the individual's progress. A discharge summary must be sent to the targeted case manager within 30 days of the service discontinuation date.~~
- ~~(11) Providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements shall be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider's participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in the provider appropriate agency guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.~~
- ~~(12) If there is a lapse in service for more than two weeks, the reason for the lapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed, updated to determine if there are changes, and signed by the client, when appropriate and family.~~

~~Additional information regarding Therapeutic Day Treatment, including types of providers and qualifications, may be found at Supplement 1, Attachment 3.1 A&B, pp. 3.15 through 3.10 of 79.~~

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TN No. 04-04

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~~2. Community Based Services for Children and Adolescents under 21 (Level A).~~

- ~~a. The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while asleep. The program director supervising the program/group home must be, at minimum, a qualified mental health professional (as defined in Supp 1 of Attach 3.1 A&B, pp 6a and 30-31.4) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must be employed full time.~~
- ~~b. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, defined in Supp 1 of Attach 3.1 A&B, pp 6a and 31.5.~~
- ~~c. Authorization is required for Medicaid reimbursement. DMAS shall monitor the services rendered. All Community Based Services for Children and Adolescents under 21 (Level A) must be authorized by DMAS prior to reimbursement for these services. Services rendered without such authorization shall not be covered. Reimbursement shall not be made for this service when other less intensive services may achieve stabilization.~~

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

- ~~d. Services must be provided in accordance with an Individual Service Plan (ISP) (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.~~
- ~~e. Prior to admission, a diagnostic assessment is done according to DMAs specifications described in the Community Mental Health Rehabilitation manual; this assessment shall be used to develop the ISP. The assessment shall include, but is not limited to: medical, psychiatric, educational, and social history and recent behavioral history.~~
- ~~f. If an individual receiving Community Based Services for Children and Adolescents under 21 (Level A) is also receiving care coordination services the provider must collaborate with the care manager by notifying the care manager of the provision of Level A services and send monthly updates on the individual's progress. The provider must also inform the primary care provider of the child's receipt of community mental health rehabilitative services. A discharge summary must be sent when the service is discontinued.~~

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- ~~3. Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B).~~
- ~~a. The staff ratio must be at least 1 to 4 during the day and at least 1 to 8 while asleep. The clinical director must be a licensed mental health professional. The caseload of the clinical director must not exceed sixteen clients including all sites for which the clinical director is responsible. The program director must be full time and be a qualified mental health professional with a bachelor's degree and at least one year's clinical experience.~~
  - ~~b. At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria, as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4. The program/group home must coordinate services with other providers.~~
  - ~~c. All Therapeutic Behavioral Services (Level B) must be authorized prior to reimbursement for these services. Services rendered without such prior authorization shall not be covered.~~
  - ~~d. Services must be provided in accordance with an ISP (plan of care), which must be fully completed within 30 days of authorization for Medicaid reimbursement.~~
  - ~~e. Prior to admission, a diagnostic assessment is done according to DMAS specifications described in the Community Mental Health Rehabilitation manual; this assessment shall be used to develop the ISP. The assessment shall include, but is not limited to, medical, psychiatric, educational, and social history, and recent behavioral history.~~
  - ~~f. If an individual receiving Day Therapeutic Behavioral services for Children and Adolescents under 21 (Level B) is also receiving care coordination services, the provider must collaborate with the care manager by notifying the care manager of the provision of Level B services and send monthly updates on the individual's progress. A discharge summary must be sent when the service is discontinued. The provider must also inform the primary care provider of the child's receipt community mental health rehabilitation services. A discharge summary must be sent when the services are discontinued.~~
- ~~4. Utilization Review: Utilization reviews for Community Based Services for Children and Adolescents under 21 (Level A) and Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) shall include determinations whether providers meet all DMAS requirements, including compliance with DMAS marketing requirements. Providers that violate the DMAS marketing requirements will be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time will result in the termination of the provider's participation agreement for this service.~~

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~~§10.0 Community mental health services. (12 VAC 30-60-140)~~

~~A. Utilization review general requirements.~~

- ~~1. Utilization reviews shall be conducted, at a minimum annually at each enrolled provider, by the state Department of Medical Assistance Services (DMAS) or its contractors. During each review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified.~~

~~B. The DMAS or its contractor review shall include the following items:~~

- ~~1. medical or clinical necessity of the delivered service;~~
- ~~2. the admission to service and level of care was appropriate;~~
- ~~3. the services were provided by appropriately qualified individuals as defined in the Amount, Duration, and Scope of Services found in Attachment 3.1 A and B, Supplement 1 §13d Rehabilitative services;~~
- ~~4. delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.~~

~~C. Mental health services utilization criteria. (12 VAC 30-60-143) Utilization reviews shall include determinations that providers meet the following requirements.~~

- ~~a. The provider shall meet the federal and state requirements for administrative and financial management capacity.~~
- ~~b. The provider shall document and maintain individual case records in accordance with state and federal requirements.~~
- ~~c. The provider shall ensure eligible recipients have free choice of providers of mental health services and other medical care under the Individual Service Plan.~~
- ~~d. The providers shall comply with DMAS marketing requirements. Providers that violate the DMAS marketing requirements will be assessed financial penalties for the first two violations. A provider that violates the marketing requirements for a third time shall have his provider's participation agreement for this service terminated. The DMAS marketing requirements and sanctions are published in the provider appropriate guidance documents, including but not limited to, the Community Mental Health Rehabilitation manual.~~

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~~e. If an individual receiving services is also receiving targeted case management services, the provider must collaborate with the targeted case manager by notifying the case manager of the provisions of Community Mental Health Rehabilitative services and send monthly updates on the individual's progress. The provider must inform the primary care provider of the child's receipt of community mental health rehabilitative services. A discharge summary must be sent when the services are discontinued.~~

~~2. Therapeutic day treatment/partial hospitalization services shall be provided following an initial diagnostic assessment completed and authorized by the physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or licensed clinical nurse specialist psychiatric. The assessment shall be utilized to develop the Individual Service Plan (ISP). The ISP shall be fully completed by either the LMHP or the QMHP as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4 within 30 days of service initiation.~~

~~a. The enrolled provider of therapeutic day treatment/partial hospitalization shall be licensed by DBHDS as providers of therapeutic day treatment services.~~

~~b. Services shall be provided by an LMHP, a QMHP, or a qualified paraprofessional under the supervision of a QMHP or an LMHP as defined at Supp 1 of Attach 3.1 A&B, pp 30-31.4.~~

~~c. The program shall operate a minimum of two continuous hours in a 24-hour period.~~

~~d. Individuals shall be discharged from this service when other less intensive services may achieve or maintain psychiatric stabilization.~~

~~3. Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.~~

~~a. Psychosocial rehabilitation services shall be provided following an assessment which clearly documents the need for services. The assessment shall be completed by an LMHP, or a QMHP, and approved by an LMHP within 30 days of admission to services. The assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history. An ISP shall be completed by the LMHP or the QMHP within 30 days of service initiation. Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP.~~

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- ~~b. Psychosocial rehabilitation services of any individual that continues more than six months must be reviewed by an LMHP who must document the continued need for the service. The ISP shall be rewritten at least annually.~~
  - ~~c. The enrolled provider of psychosocial rehabilitation services shall be licensed by DBHDS as a provider of psychosocial rehabilitation or clubhouse services.~~
  - ~~d. Psychosocial rehabilitation services may be provided by an LMHP, a QMHP, or a qualified paraprofessional under the supervision of a QMHP or an LMHP.~~
  - ~~e. The program shall operate a minimum of two continuous hours in a 24-hour period.~~
  - ~~f. Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the client's understanding or ability to access community resources.~~
- ~~4. Admisison to crisis intervention services is indicated following a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.~~
- ~~a. The crisis intervention services provider shall be licensed as a provider of outpatient services by DBHDS.~~
  - ~~b. Client related activities provided in association with a face to face contact are reimbursable.~~
  - ~~c. An Individual Service Plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.~~

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- ~~d. For individuals receiving scheduled, short term counseling as part of the crisis intervention service, an ISP must be developed or revised to reflect the short term counseling goals by the fourth face to face contact.~~
- ~~e. Reimbursement shall be provided for short term crisis counseling contacts occurring within a 30 day period from the time of the first face to face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.~~
- ~~f. Crisis intervention services may be provided to eligible individuals outside of the clinic and billed, provided the provision of out of clinic services is clinically/programmatically appropriate. Travel by staff to provide out of clinic services is not reimbursable. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.~~
- ~~g. An LMHP, a QMHP, or certified prescriber must conduct a face to face assessment. If the QMHP performs the assessment, it must be reviewed and approved by a LMHP or certified prescriber within 72 hours of the face to face assessment. The assessment shall document the need for and the anticipated duration of the crisis service. Crisis intervention will be provided by an LMHP, certified prescriber, or QMHP.~~
- ~~h. Crisis intervention shall not require an ISP.~~
- ~~i. For an admission to a freestanding psychiatric facility for individuals younger than age 21, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. Preadmission screenings cannot be billed unless the requirement for an independent team, with a physician's signature, is met.~~
- ~~j. Services must be documented through daily notes and a daily log of time spent in the delivery of services.~~

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

~~E. Case management services. (pursuant to Supp 1 of Attachment 3.1 A&B, pp 30-31.4)~~

**NOTE: Subsection E (Case Management Services) has been moved to Supplement 2 of Attachment 3.1, page 3.1-A, page 6.1 of 25, Subsection I.**

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- ~~i. Mental health support services, which continue for six consecutive months, must be reviewed and renewed at the end of the six month period of authorization by an LMHP or LMHP eligible who must document the continued need for the services. The LMHP or LMHP eligible must see the client face to face to conduct the six month review.~~
- ~~j. Mental health support services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.~~

~~D. Mental retardation utilization criteria. Repealed.~~

~~B. Substance abuse treatment services utilization review criteria (12 VAC 30-60-147)~~

~~1. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The services referenced below must be rendered to program participants and documented in their case file in order for this residential service to be reimbursed by Medicaid. The residential facilities in which these services are provided shall have 16 beds or less. Covered services are found at Supp 3 to Attach 3.1 A&B, pp 2 through 4 of 8.~~

~~a. Services must be authorized following face to face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in Supp.3 to Attach 3.1 A&B, pp 6 through 8 of 8. The assessment shall include, but not be limited to, medical, psychiatric, educational, and social history, and recent behavioral history.~~

~~(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of~~

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~~the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.~~

~~(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.~~

~~(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.~~

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~~(c) — Services for the individual must be preauthorized annually by DMHMRSAS.~~

~~(d) — Each individual must have a written plan of care developed by the provider which must be fully complete within 30 days of initiation of the service, with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.~~

~~(e) — The provider must update the plan of care at least annually.~~

~~(f) — The individual's record must contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.~~

~~(g) — The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be at least four but less than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of a reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.~~

~~(h) The provider must be licensed by DMHMRSAS.~~

~~2. — Appropriate use of case management services for persons with mental retardation requires the following conditions to be met:~~

~~a. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services must be obtained from DMHMRSAS Care Coordination Unit annually.~~

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~~b. — An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of on face to face contact within a 90 day period.~~

~~e. — The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.~~

~~(1) The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.~~

~~(2) The need for case management services shall be assessed and justified through the development of an annual consumer service plan.~~

~~d. — The individual's record must contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.~~

~~E. Substance abuse treatment services utilization review criteria. (12 VAC 30-60-147)~~

~~1. — Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.~~

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

~~(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.~~

~~(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.~~

~~(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.~~

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- ~~(4) The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.~~
- ~~(5) The ISP shall be reviewed and updated every two weeks.~~
- ~~(6) Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.~~
- ~~(7) Face to face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.~~
- ~~(8) While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently rendered to her.~~
- ~~(9) Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug free environment and treatment supports for the woman.~~
- ~~b. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:~~
- ~~(1) The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.~~

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~~2. The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.~~

~~3. In addition, the provider must provide access to the following services either through staff at the residential program or through contract:~~

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

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

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

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

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

~~2. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:~~

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

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

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

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

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

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

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

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

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

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

~~b. To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II. I (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II. I (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.~~

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

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

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

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

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

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

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

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

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

~~a. — The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~1. — Services must be authorized following face to face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC 30-50-510.~~

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- ~~a. — To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically Managed Medium Intensity Residential Treatment) or Level III.5 (Clinically Managed Medium High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.~~
- ~~b. — Utilization reviews shall verify, but not be limited to, the presence of these 90 day reauthorizations as well as the appropriate re-authorizations after absences.~~
- ~~c. — Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.~~
- ~~d. — The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.~~
- ~~e. — The ISP shall be reviewed and updated every two weeks.~~
- ~~f. — Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.~~

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

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

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

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

~~a. The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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~~b. — To assess whether the woman will benefit from the treatment provided by this service, the licensed health professional shall utilize the Adult Patient Placement Criteria for Level II.I (Intensive Outpatient Treatment) or Level II.5 (Partial Hospitalization) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services shall be reauthorized every 90 days by one of these appropriately authorized professionals, based on documented assessment using Level II. I (Adult Continued Service Criteria for Intensive Outpatient Treatment) or Level II.5 (Adult Continued Service Criteria for Partial Hospitalization Treatment) as described in Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services shall be reauthorized by one of the appropriately authorized professionals if the patient is absent for five consecutively scheduled days of services without staff permission. All of the authorized professionals shall demonstrate competency in the use of these criteria. This individual shall not be the same individual providing nonmedical clinical supervision in the program.~~

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

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

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

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

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

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

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

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

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

~~a. The program must have a contractual relationship with an obstetrician/gynecologist. The obstetrician/gynecologist must be licensed by the Virginia Board of Medicine as a medical doctor.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER  
2 1 — 0 3 1

2. STATE  
Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
10/1/2021

5. TYPE OF PLAN MATERIAL (Check One)

- NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR 456

7. FEDERAL BUDGET IMPACT

a. FFY 2021 \$ 0  
b. FFY 2022 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1C, revised pages 11, 12, 12.1, 12.2, 12.3, 12.4, 12.5, 12.6, 29, 30, 31, 32, 33, 37, 37.1, 38, 38.1, 38.2, 38.3, 38.4, 38.5, 38.6, 38.7, 38.8, 38.9, 38.10, 38.11, 38.12, 38.13, 38.14, 38.15, 38.16, 38.17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Same as box #8.

10. SUBJECT OF AMENDMENT

Removal of Outdated SUD, BH, and ID (formerly "MR") Case Management UR Language

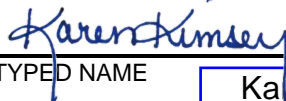
11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED

Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL



13. TYPED NAME

Karen Kimsey

14. TITLE

Director

15. DATE SUBMITTED

10/27/2021

16. RETURN TO

Dept. of Medical Assistance Services 600 East Broad Street, #1300 Richmond VA 23219  
  
Attn: Policy, Regulations, & Manuals Supervisor

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

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