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| Manual Title | Chapter | Page |
|---|---|---|
| Community Mental Health Rehabilitative Services Supplement | | |
| Chapter Subject | Page Revision Date | |
| Behavioral Therapy | 8/22/2018 | |

# Behavioral Therapy

**Contents** **Page**








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## BEHAVIORAL THERAPY

Behavioral Therapy is available to individuals under the age of 21 enrolled in either Medicaid or Family Access to Medical Insurance Security (FAMIS) Program who meet the medical necessity criteria for the service. Behavioral Therapy is defined as systematic interventions provided by licensed practitioners within their scope of practice defined under the Virginia Health Professions Regulatory Board and covered as remedial care under 42 CFR 440.130(d) to individuals under 21 years of age. Behavioral Therapy includes, but is not limited to, Applied Behavior Analysis (ABA). Behavioral Therapy may be provided in the individual's home and community settings as deemed by DMAS or its contractor as medically necessary treatment.

Please note that Behavioral Therapy is not an autism specific service.

## THE BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

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

Magellan of Virginia has a centralized contact number **(1-800-424-4046**) for Medicaid/FAMIS members and providers. The Call Center is located in Virginia and is available 24 hours a day, 365 days a year. Staff include bilingual/multi-cultural representatives who speak English and Spanish. Interpreter services, TDD/TTY and relay services are available for individuals with a hearing impairment. The TDD number is 1-800-424-4048.

Magellan of Virginia staff are available to assist callers with questions related to fee-for-service behavioral health services, including Behavioral Therapy, including the following:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,

- claims resolution,
- reconsiderations, and
- grievances and complaints.

**MEDICAID MANAGED CARE ORGANIZATIONS (MCOs)**

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid MCOs. 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 credentialing, contractual coverage, and reimbursement guidelines for services provided through the MCO. Information on Medicaid MCOs can be found on the DMAS website at:

- http://www.dmas.virginia.gov/#/med3 (Medallion 3.0)
- http://www.dmas.virginia.gov/#/cccplus (CCC Plus) and
- http://www.dmas.virginia.gov/#/med4 (Medallion 4.0)

Behavioral Therapy was previously carved out of all managed care contracts and covered through the BHSA. DMAS is transitioning coverage for Behavioral Therapy into the managed care contracts. Please see the chart below for additional details.

| **Managed Care Plan** | **Coverage for Behavioral Therapy** |
|---|---|
| Medallion 3.0 (includes both Medicaid and FAMIS) – ending as of 12/1/2018 | Carved out of the Medallion 3.0 contract. Services authorized and billed through the BHSA. |
| Commonwealth Coordinated Care Plus (CCC Plus) | Effective 1/1/2018, covered by CCC Plus. Services authorized and billed through CCC Plus for their members. |
| Medallion 4.0 (includes both Medicaid and FAMIS) | Effective 8/1/2018, covered by Medallion 4.0 through regional rollout to be statewide by 12/1/2018. Services authorized and billed through Medallion 4.0 for their members |

For additional information on providing Behavioral Therapy to a member transitioning to Medallion 4.0 (effective 8/1/2018), please refer to the Medicaid Memo, dated June 11, 2018, "Transitioning Community Mental Health Rehabilitation Services (CMHRS) and Behavioral Therapy into the Medallion 4.0 program" available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/.

**DEFINITIONS**

"Assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of children with disabilities.

"Applied Behavior Analysis" or "ABA" means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Behavioral Therapy" means systematic interventions provided by licensed practitioners within their scope of practice defined under Virginia Health Professions Regulatory Board and covered as remedial care under 42 CFR 440.130(d) to individuals under 21 years of age. Behavioral Therapy includes, but is not limited to, Applied Behavior Analysis (ABA).

"Counseling" means a professional mental health service that can only be provided by a person holding a license issued by a health regulatory board at the Department of Health Professions, which includes conducting assessments, making diagnoses of mental disorders and conditions, establishing treatment plans, and determining treatment interventions.

"DSM" means the Diagnostic and Statistical Manual of Mental Disorders (DSM) standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems).

Licensed Behavior Analyst" or "LBA" means an individual who is licensed as a Behavior Analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq.

"Licensed Assistant Behavior Analyst" or "LABA" means an individual who is licensed as an Assistant Behavior Analyst by the Virginia Board of Medicine as defined in 18VAC85-150-10 et seq.

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

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An

LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee" or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

“Treatment planning” means development of an individual service plan (ISP) to include a behavior treatment plan that is specific to the individual’s unique treatment needs and acuity levels.

**PROVIDER ENROLLMENT**

Providers of Behavioral Therapy must contact the BHSA and/or MCOs for information regarding contract and credentialing requirements. Each provider of services must be credentialed with the BHSA to provide Behavioral Therapy to children enrolled in fee for service (FFS) and Medallion 3.0 prior to billing for any Behavioral Therapy service. For children enrolled in CCC Plus and Medallion 4.0, Behavioral Therapy providers must be credentialed with the individual’s MCO prior to billing for any Behavioral Therapy service.

Providers are responsible for adhering to this manual, available on the DMAS website portal, their BHSA and MCO provider contract and policies, and related state and federal regulations.

The following types of providers are eligible to provide Behavioral Therapy:

- **Licensed Providers**:
    - A Licensed Mental Health Practitioner (LMHP) as defined in 12 VAC 35-105-20 acting within the scope of their practice. For instance, if the LMHP has specific training in behavioral therapy sufficient for their professional board to say they are competent to provide behavioral therapy services; or
    - A Licensed Behavior Analyst (LBA) meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.; or
    - A Licensed Assistant Behavior Analyst (LABA) meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.

    Note: An LMHP completing requirements for the certification by the Behavior Analyst Certification Board is still required to act within the scope of their practice as defined by the applicable Virginia Health Regulatory Board.

- **Providers Under Supervision for Licensure**:
    - An LMHP-resident (LMHP-R); or
    - An LMHP-resident in psychology (LMHP-RP); or
    - An LMHP-supervisee in social work (LMHP-S).

- Unlicensed personnel may assist with the provision of Behavioral Therapy in accordance with the applicable Virginia Health Regulatory Board. Unlicensed staff includes, but is not limited to, Registered Behavioral Technicians.
    - Supervision: LBAs and LABAs must follow the supervisory responsibilities as specified in 18VAC85-150-10 et seq). Virginia Board of Medicine regulations (18VAC85-150-120) state that the LBA is ultimately responsible and accountable for client care and outcomes under his or her clinical supervisions. LMHPs must follow the supervisory responsibilities as specified by the licensed professional's Virginia Health Regulatory Board (18VAC140-10 et seq, 18VAC 125-20-10 et seq, 18VAC 115-20-10 et seq).

- Delegation: LBAs may delegate tasks in accordance with 18-VAC85-150-10 et seq. Licensed Psychologists may delegate in accordance with -§54.1-3614. Licensed Clinical Social Workers (LCSWs) and Licensed Professional Counselors (LPCs) do not have regulatory authority for delegation of activities.

Tasks performed by these unlicensed personnel cannot constitute the practice of behavior analysis, counseling, social work or psychology, as defined by the applicable Virginia Health Regulatory Boards.

An LMHP-R, LMHP-RP, or an LMHP-S may not provide clinical supervision in accordance with the applicable Virginia Health Regulatory Board.

**MEDICAL NECESSITY AND ELIGIBILITY CRITERIA**

Behavioral Therapy services shall be covered for individuals under age 21 who are eligible for Medicaid or FAMIS when the service is recommended by the individual's primary care provider or other licensed physician, licensed physician assistant, or licensed nurse practitioner and determined by DMAS or its contractor to be medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from either developmental, behavioral, or mental disabilities. The physician, nurse practitioner, or physician assistant does not need to be enrolled with DMAS, a Medicaid MCO or the BHSA.

DMAS offers a web-based Internet option for DMAS enrolled providers to access information regarding Medicaid or FAMIS member eligibility. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1- 866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800- 772-9996. Both options are available at no cost to the provider.

Providers may also verify member eligibility through the MCOs and/or BHSA.

In addition, the following criteria must be met:

- The individual must be medically stable to benefit from treatment at this level of care;

- The individual must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is relevant to the need for Behavioral Therapy or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made. A LMHP, LMHP-R, LMHP-RP or LMHP-S may provide a behavioral health diagnosis or working diagnosis of autism spectrum disorder. A diagnosis of autism spectrum disorder should be confirmed by a comprehensive medical, developmental and behavioral evaluation. LBAs cannot diagnose but can use an existing diagnosis from an LMHP within the past 12 months or collaborate with the LMHP to develop a diagnosis;

- The individual must meet at least two of the following criteria on a continuing or intermittent basis:

    - Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language;

    - Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness;

    - Frequent intense behavioral outbursts that are self-injurious or aggressive towards others;

    - Disruptive obsessive, repetitive, or ritualized behaviors; or

    - Difficulty with sensory integration;

The individual must have a level of impairment which requires treatment that cannot be provided by another Medicaid covered service and requires behavioral interventions and the expertise of a LMHP or a LBA or LABA. The provider must document that less intensive treatment modalities have been ruled out (and why), or have been tried but have not been successful in effectively modifying the target behavior. The documentation must support how:

- Behavioral Therapy is 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.

- The individual and family/caregiver must be willing to participate in services. Family and caregivers who lack the skills needed to effectively manage the individual's behaviors in the home environment shall participate in training necessary to help educate the family and caregivers and teach effective behavioral management techniques. At least one family member or caregiver must be able to participate in services to effectively support the child being served, to receive behavioral management training, and implement behavioral strategies to maintain the child's progress during and after treatment.

Behavioral Therapy is not appropriate for children who have attained behavioral control and who only require services such as social skills enhancement. Children who meet the eligibility requirements to receive Community Mental Health Rehabilitation Services (CMHRS) (described in 12VAC30-50-130(B) or 12VAC30-50-226) are not eligible for Behavioral Therapy.

**SERVICE DESCRIPTION**

Behavioral Therapy services must be 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 intensive level of care. Family training related to the implementation of the behavioral therapy shall be included as part of the Behavioral Therapy service. The service goal shall be to: 1) ameliorate the medically necessary conditions that qualified the child for the service; 2) support and teach the individual using effective strategies and techniques; 3) ensure the individual's family or caregiver is trained to effectively manage the individual's behavior in the home and community using modification strategies. The services shall be provided as documented in the individual service plan (ISP) and clinical assessment summary.

Behavioral Therapy is available to individuals who reside in their family home. Home is considered to be the individual's residence and includes living with natural or adoptive parents, relatives, or a guardian, or the family residence of the child's permanent or temporary foster care or pre-adoption placement. Behavioral Therapy shall be provided in settings that are natural or typical for a child or adolescent without a disability, such as his home, unless there is justification in the Individual Service Plan (ISP), which has been service authorized by the BHSA or MCO. Other service settings include locations where the targeted behaviors are likely to occur, or where the individual can practice new skills to be acquired that can be replicated at home and in the individual's community.

Behavioral Therapy services must require the services of an LMHP, LBA or LABA to effectively treat the child's behaviors. It must be medically necessary to have a clinician involved with the family caregivers to provide the necessary clinical training and supervision to help effectively manage the behaviors in the home environment using a less intensive level of services. Family involvement in therapy is meant to increase the child's adaptive functioning by training the family

in effective methods, intervention and support. Family members do not have to be present during all hours of therapy. Direct family involvement in the treatment program is required at a minimum of weekly but the amount of direct interaction with the treatment provider will vary according to the clinical necessity, progress as documented, and the individual and family goals in the ISP.

Treatment results are expected to indicate a generalization of adaptive behaviors across different settings. Treatment benefits should be able to be maintained and demonstrated outside of the treatment setting in the child's residence and the larger community within which the individual resides, such as child care or school. Measurable variables include but are not limited to: increased social- communicative behavior; increased ability to make requests; increased verbal or nonverbal initiations and interactions; decreased disruptive behavior; increased functional play; and decreased aggressive behavior. Services should be discontinued if the benefit is not seen consistently outside of the treatment environment.

Behavioral Therapy must be coordinated with other medical services to effectively increase adaptive functioning. Services such as speech-language pathology services, occupational therapy or psychiatric care must be coordinated with and integrated with the ISP. All services are planned following a comprehensive assessment and documented in an ISP as defined later in this Supplement.

Behavioral Therapy may be used to facilitate the transition 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 or guardian must be available and must agree to participate in the therapy.

Behavioral Therapy may also be provided at a less intensive, time limited level to facilitate discharge from Behavioral Therapy services. This would allow for clinical supervision when medically necessary to assist the individual transition to a lower level of care.

## COVERED SERVICES AND LIMITATIONS

### Covered Services:

- Initial and periodic provider assessments including time spent scoring assessment and creating the report;
- Development of initial and updated ISPs;
- Clinical supervision activities to include delegation activities as allowed by the appropriate licensing board.
- Behavioral training to increase the individual's adaptive functioning and communication skills;

- Training of family members in behavioral modification methods and ABA strategies as appropriate. ;
- Documentation and analysis of quantifiable behavioral data related to treatment objectives;
- Care coordination;
- Behavioral modification services and/or ABA services;
- Direct consultation by the LMHP, 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;
- 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;
- In limited circumstances, providers may bill for two staff members. Examples include supervision hours as described above, the use of additional staff to observe during assessments and short-term use to ensure safety of the member and/or staff in the home or treatment location.

**Service Limitations and Non Covered Services:**

The following shall not be covered under Behavioral Therapy:

- Screening to identify physical, mental, or developmental conditions that may require evaluation or treatment. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as a Behavioral Therapy service under this section.
- Services other than the initial assessment that are provided but are not based upon the individual's ISP or linked to a service in the ISP. Time not actively involved in providing services directed by the ISP shall not be reimbursed.
- Services that are based upon an incomplete, missing, or outdated assessment or ISP.
- Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.
- Services rendered primarily by a relative or guardian who is legally responsible for the individual's care.
- Services that are provided in a clinic or provider's office without documented justification for the location in the ISP (since targeted location is individual's residence).
- Services that are provided in the absence of the individual or a parent or other authorized caregiver identified in the ISP with the exception of the review of the behavior treatment plan, care coordination and clinical supervision.

- Services provided by a local education agency. Behavioral Therapy may only be provided in the school setting when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.
- Provider travel time.

Behavioral Therapy services shall not be reimbursed concurrently with Community Mental Health Rehabilitation (CMHRS) services as defined in 12VAC30-50-130(B) and 12VAC30-50-226 or behavioral, psychological or psychiatric therapeutic consultation described in 12VAC30-120-756, 12VAC30-120-1000, or 12VAC30-135-320.

Targeted case management services as defined in 12VAC30-50-410 through 12VAC30-50-499 may be reimbursed by DMAS while an individual is authorized for Behavioral Therapy. The provider must notify the case manager of the provision of Behavioral Therapy services unless the parent or guardian requests that the information not be released. The provider must send monthly updates to the case manager and a discharge summary within 30 days of the service discontinuation. A refusal of the parent or guardian to release information shall be documented in the medical record for the date the request was discussed.

The services below are covered by either DMAS contracted Managed Care Organizations or DMAS under the Medicaid FFS program and are not billed as part of Behavioral Therapy:

- Assistive technology devices;
- Pharmacy items;
- Health services;
- Nutrition services;
- Nursing services;
- Targeted Case Management;
- Psychological services including outpatient counseling;
- Medical services (including neurological and psychiatric);
- Speech-language pathology services;
- Occupational therapy;
- Physical therapy;
- Audiology services; and

- Vision services.

**Assessment Requirements**

Behavioral Therapy services are based on a comprehensive assessment by a licensed practitioner. Assessments are allowed for up to 5 hours per child, per provider, without service authorization. Assessments that exceed 5 hours require service authorization. Assessments must be done face-to-face with both the child and family prior to starting services. Assessments must be updated at least annually.

The initial assessment must:

- be completed by the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA acting within the scope of practice;
- be conducted face to face with the child and the child's family/caregivers;
- include a DSM diagnosis relevant to the need for Behavioral Therapy;
- include a comprehensive health and developmental history;
- include the reasons the individual needs Behavioral Therapy including how the child meets medical necessity and eligibility criteria for the service;
- include the reasons the individual's treatment cannot be managed effectively using traditional outpatient treatments;
- include information about the targeted behaviors including frequency, duration, and intensity;
- include the treatment history within the last year including: pediatrics, medication management, neurology, psychiatry, outpatient speech-language pathology services, physical therapy or occupational therapy, outpatient counseling/family therapy/consultation, Behavioral Therapy, family training in behavior management practices, and residential or inpatient care;
- include educational/vocational status including: school, grade, exceptional education /IEP status, services received in the school setting including psychological, presence of an instructional direct care aide, speech-language pathology services, occupational and physical therapies provided in the school setting, academic performance, behaviors, suspensions/expulsions, and any changes in academic functioning related to behavioral concerns; and
- include current living situation, family history, and relationships including: daily routine & structure, housing arrangements, financial resources and benefits, significant family

history including family conflicts, relationships and interactions affecting client, family's functioning and list of significant family members.

- include the dated signature of the licensed professional completing the assessment. If the assessment is completed by a LMHP-R, LMHP-RP or LMHP-S, the supervising provider must co-sign within one business day from the date the service was rendered indicating that he or she has reviewed the assessment.

**The Individual Service Plan (ISP)**

The ISP means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the assessment. A comprehensive ISP is person-centered, includes all planned interventions, aligns with the individual's identified needs, care coordination needs, is regularly updated as the individual's needs and progress change, and shows progress throughout the course of treatment.

A preliminary ISP is used to obtain a service authorization from the BHSA or MCO and to provide the necessary information to staff when beginning treatment. A preliminary ISP may be developed using information gathered during the provider's assessment. Once services begin, the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA must review and update as necessary the ISP within 30 days of the initiation of services to ensure that all treatment goals are reflective of the individual's clinical needs. The ISP must demonstrate the need for Behavioral Therapy and document the methods to be used in the coordination of other professional services and medical evaluations as necessary to implement the behavior modification plan. The ISP must specifically describe each treatment goal, targeted behavior, one or more measurable objectives for each targeted behavior, the behavioral modification strategy to be used to manage each targeted behavior, the plan for parent or caregiver training, care coordination, and the measurement and data collection methods to be used for each targeted behavior in the ISP. The ISP must be signed by the individual and/or parent/guardian participating in treatment and the licensed professional completing the ISP (to include any applicable supervisor co-signature). Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

The LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S must review the ISP every three months, or more often as needed, and update the ISP at least annually. Review of ISP means that the service provider reviews the ISP, evaluates and updates the individual's progress toward meeting the individualized service plan objectives, and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall:

- Update the goals, objectives, and strategies of the ISP, as clinically appropriate, to reflect any change in the individual's progress and treatment needs as well as any newly identified problems;

- Be conducted in a manner that enables the individual to participate in the process; and
- The review shall be documented and placed in the individual's medical record no later than 15 calendar days from the date of the review.

The ISP must include:

- Child Focused Behavior Modification Goals and Objectives
    - All preliminary goals and objectives presented in a way that summarizes and defines the overall approach to the child's treatment based on the clinical needs and target behaviors as defined in the assessment summary;
    - Prioritization of the treatment focus defined according to the severity of need;
    - Goals and objectives which define how the provider will measure progress;
    - Baseline status (as identified during the assessment and parent interviews) describing the intensity, frequency and duration of each behavior that is targeted for therapy; and
    - For all requests exceeding 20 hours or more per week, the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan. Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested.

- Parent and Caregiver Goals and Objectives
    - Describe the goals for parent/caregiver education related to the child's behaviors to be achieved within the authorized time period;
    - Describe the specific objectives and the methods used to measure progress within each goal area; and
    - Describe the goals for other care provider's education related to the child's behaviors. Other care providers may include Medicaid Home and Community Based Waiver funded attendants and relatives who routinely come in contact with the child.

- Care Coordination Goals
    - Specific description of the care coordination and/or referral activities that will be implemented by the provider within the authorized time period to facilitate ISP outcomes based on the assessed needs of the child and family including the families desired outcomes from receiving services;

- Specific care coordination treatment goals and the desired outcome based on the services provided by the ancillary service provider;
- Referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) and case management services to facilitate access to desired medical services including the desired outcome from the collaborative efforts with each therapeutic discipline including the target dates for achievement; and
- All goals and objectives presented in a way that summarizes and defines the overall approach including the prioritization of the treatment goals based on the clinical needs and target behaviors as defined in the assessment summary.

Providers must communicate the results of the assessment and treatment planning to the child's primary care provider. Care coordination with the child's primary care provider is an essential component of the provision of Behavioral Therapy services and must be documented in the individual's record.

**Supervision Requirements**

Clinical supervision shall be required for Medicaid reimbursement of Behavioral Therapy services rendered by a LABA, LMHP-R, LMHP-RP, or LMHP-S. Clinical supervision must be consistent with the scope of practice as described by the applicable Virginia Department of Health Professions (DHP) regulatory board. Supervision of unlicensed staff shall occur at least weekly by the licensed supervisor. As documented in the individual's medical record, supervision shall include a review of progress notes and data and dialogue with supervised staff about the individual's progress and effectiveness of the ISP. Supervision shall be documented by, at a minimum, the contemporaneously dated signature of the licensed supervisor.

Supervision time is permitted to be billed simultaneously with direct care staff billing.

**Family Training**

Family training involving the individual's family and significant others to advance the treatment goals of the individual shall be provided when:

- The training with the family member or significant others is for the direct benefit of the individual;
- The training is not aimed at addressing the treatment needs of the individual's family or significant others;
- The individual is present except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals; and,
- The training is aligned with the goals of the individual's ISP.

## SERVICE AUTHORIZATION REQUIREMENTS

All treatment service hours require service authorization prior to beginning services. The Behavioral Therapy provider must submit the following information to the BHSA or MCO for the initial service authorization:

- An order or letter recommending services signed by a physician, nurse practitioner or physician assistant who is the child's primary care provider or another provider familiar with the developmental history and current status of the child. The letter recommending services may be in the form of a behavior treatment plan summary signed by a medical provider listed above;

- The provider assessment completed by the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA;

- The preliminary ISP; and,

- A description of the preliminary discharge plan to include referrals as service goals are met.

Accurate and complete authorization requests help reduce delays in authorization and service initiation. To ensure timely authorization for services, all requests for service authorization must be submitted to the BHSA or MCO prior to the initiation of Behavioral Therapy services. Providers should not start services before receiving an authorization from the BHSA or MCO. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided. The provider must have a Medicaid member identification number for any authorized individual prior to requesting services.

Service authorizations are valid for up to 6 months per authorization. The BHSA or MCO may choose to authorize services for less than 6 months per authorization. Authorized time periods may be adjusted by the BHSA or MCO to resolve clinical concerns and questions or to allow time for the provider to fully define the treatment needs and identify the most appropriate therapy program for the individual.

If the service request is denied, a letter will be sent to the provider and individual/family indicating the reason for the denial. This letter will include appeal rights.

### Continuation of Service Requests

When a continuation of services is being requested, service authorization requests must be submitted to the BHSA or MCO by the last day of the currently authorized end date. The provider must summarize the results of Behavioral Therapy including outcomes from the care coordination activity and submit an update to the individual's primary care provider. Documentation that the update was sent to the individual's primary care provider must be included in the individual's record. The BHSA/MCO may request an updated order or letter of recommendation from the child's primary care provider or a physician, nurse practitioner or physician assistant familiar with the child's current status if necessary to complete a continuation of service request.

Continuation of service requests must include:

- A summary of the child's treatment progress that contains the following information:
    - Any changes in the child's diagnosis;
    - A summary of recommended service goals;
    - A description of how the current therapy protocol is impacting the child's clinical progress;
    - Objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values and specific references to each goal and objective in the ISP;
    - Overview of family involvement during service period with regards to the individual's ISP to include: who has been involved; progress made: and continuing needs of family goals/training to include reasons the individual and parent/caregiver need continued clinically directed Behavioral Therapy.
    - Progress toward achieving educational goals with other care providers (Medicaid Home and Community Based Waiver funded attendants, relatives, etc.) who routinely come in contact with the child;
    - A summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments;
    - A description of any service gaps (no greater than 30 days) and how the lapse in service affected treatment planning and progress, care coordination and family

learning and family/caregiver involvement in the application of behavior modification practices;

- Progress toward the anticipated date of discharge from services including any plan to gradually reduce services and consultative actions as planned to include identifying lower levels of care, natural supports care coordination needs;

- The reasons the individual and parent/caregiver need continued clinically directed Behavioral Therapy; and

- The reasons the individual's continued therapy cannot be managed in a lower level of care.

- A summary of the care coordination activities that contains the following information:

  - A description of all care coordination and/or referral activities that were scheduled to be implemented by the caregivers and provider within the previously authorized time period;

  - A discussion of how the care coordination served to facilitate ISP outcomes based on the assessed needs of the child and the desired service outcomes of the caregivers; and

  - A description of how the referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) have impacted the overall progress and generalization of skills gained from Behavioral Therapy services.

Based on the needs of the child and family/caregiver, it may be appropriate to request a service authorization extension at a reduced number of hours to assist the child and family to successfully transition from a higher intensity of Behavioral Therapy services to a lower level of service. Individuals must have a current, valid psychiatric diagnosis as defined in the DSM and be clinically stable to benefit from treatment at this level of care.

**Discharges, Transfers and Provider Notification Requirements**

Providers must notify the parent/caregiver in writing five business days prior to service termination or suspension when the discharge is not due to the health, safety and welfare of the provider. The provider must notify the BHSA or MCO of all service discharges or transfers within three business days of the last date of service.

The service provider must transfer an individual's care to another agency whenever the agency is no longer able to sufficiently staff the individual's care or the individual requests services from another agency. For service transfers for services authorized by the BHSA, providers must submit either the previous provider's discharge summary or a written notice of provider choice from the family to the BHSA along with any appropriate BHSA service transfer request form. If the individual has a current valid service authorization, the new provider may start services using the previous provider's ISP to provide assessment services and develop the ISP.

For more details about processing transfer requests for individuals enrolled in CCC Plus and Medallion 4.0 (effective 8/1/2018), refer to the MCO.

**DISCHARGE CRITERIA**

The provider must terminate Behavioral Therapy if the service is no longer medically necessary. The service is no longer deemed medically necessary if one of the following criteria is met within a thirty day time period:

1. No meaningful or measurable improvement has been documented in the individual's behavior(s) despite receiving services according to the ISP; there is reasonable expectation that the family and /or caregiver are adequately trained and able to manage the child's behavior; and termination of the current level of services would not result in further deterioration or the recurrence of the signs and symptoms that necessitated treatment.
2. Treatment is making the symptoms persistently worse or child is not medically stable for Behavioral Therapy to be effective;
3. The child has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate;
4. The child demonstrates an inability to maintain long-term gains from the proposed ISP; or
5. The family and/or caregiver refuses or is unable to participate meaningfully in the behavior treatment plan.

If there is a lapse in service for more than 30 consecutive calendar days, the provider must discharge the child from services and notify the BHSA or MCO. If services resume after a break of more than 30 consecutive calendar days, a new service authorization request including a new assessment and ISP must be submitted to the BHSA or MCO.

## DOCUMENTATION REQUIREMENTS

The Provider Agreement requires that records fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical necessity and support the need for the service. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered.

The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits and review of billed services. The documentation must include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units / hours required to deliver the service.

The following elements must be included in the member's record:

- The member must be referenced on each page of the record by full name or Medicaid ID number;
- Progress notes must be entered for each service that is billed. Progress notes must include a dated signature and credentials of the provider as well as any co-signatures by supervisors as required by the appropriate DHP regulatory board. Individual-specific progress notes shall be created contemporaneously with the service activities and shall document the name and Medicaid number of each individual; the provider's name, signature, and date; and time of service. Documentation shall include activities provided, length of services provided, the individual's reaction to that day's activity, and documentation of the individual's and the parent or caregiver's progress toward achieving each behavioral objective through analysis and reporting of quantifiable behavioral data.

- Any medications prescribed to the individual;
- A member-signed document verifying that freedom of choice of provider was offered and this provider was chosen;
- A psychiatric diagnosis and an assessment upon which the Preliminary ISP is based;
- The results of the most recent EPSDT screening or physician referral for treatment;
- An assessment of adaptive functioning required to support medical necessity criteria;
- All orders or letters of recommendation for the service from the child's primary care provider or a physician, nurse practitioner or physician assistant familiar with the child's developmental history and current status;
- Ongoing treatment documentation data as defined by the most current ISP for those dates of service;
- Description of any assessment tools used;
- Documentation that indicates the coordination of treatment with the child's primary care provider and other health disciplines and coordination of the relevant documentation necessary for ongoing behavioral treatment;
- All ISPs;
- The initial assessment completed by the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA including: the assessment instruments used; dates of services and face to face

contacts; documentation of other interviews conducted as part of the assessment process; staff and participant names; and staff credentials and signatures;

- Documentation of any requests for clinical information from the individual's previous health care providers;
- Documentation of all treatment team meetings and ISP development meetings with family;
- Documentation of the family's agreement for participation in therapy as defined in the ISP;
- Documentation that services are provided in accordance with the ISP;
- Documentation that the ISP is reviewed at least once every three months and updated annually;
- Documentation of supervision activities established by the appropriate DHP regulatory board;
- Documentation of the activities provided, length of services provided, the reaction to that day's activity, and documentation of performance in each treatment objective. At a minimum, the description of treatment progress should be documented through daily data collection as well as a weekly summary note;
- Documentation of family education and their application of effective behavioral modification strategies as designed in the ISP;
- For instances of services when the child is not present, documentation of the reasons that the content of the session is inappropriate for the child to be present;
- Documentation of the review of the ISP and supervision with the family conducted face to face at a minimum of once every three months to observe the child and family interaction, review clinical data and adjust the ISP as necessary;
- If the individual is receiving case management, documentation regarding the types of coordination with the case management provider on a monthly basis or documentation that the family requests that information not be released to the case manager;
- Documentation of referral activity and direct contacts to coordinate various medical assessments and progress reports; and
- Contacts with the individual's assigned Managed Care Organization.
- Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress. Documentation shall include demonstration of generalization for the child and progress for family members toward the therapy goals as defined in the service plan.
- Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service and include any applicable supervisor co-signature.
- Billable time is permitted for the LBA, LABA, LMHP, LMHP-R, LMHP-RP, or LMHP-S to review the behavior treatment plan. The review includes defining targeted behaviors and developing documentation strategies to measure treatment performance and the efficacy of the ISP objectives, provided that these activities are documented in a progress note.

## CLAIMS AND BILLING

Payment is available only for allowable activities that are provided by a qualified provider in accordance with an approved ISP. Services other than the assessment must be service authorized by the BHSA or MCO. Behavioral Therapy Services are limited to the hours of therapy as specified in the ISP and limited to the number of hours authorized by the BHSA or MCO.

Providers bill for the initial assessment in one hour increments under service code H0032 with a UA modifier. Initial assessments do not require service authorization with the exception of assessments that exceed 5 hours. If the initial assessment exceeds five hours, the provider must submit a service authorization request to the BHSA or MCO for the additional hours. Only initial assessments and assessments performed after an interruption in services greater than 30 consecutive calendar days are billed under service code H0032 UA. Subsequent reassessments during service provision are billed as part of service code H2033 which requires service authorization.

Behavioral Therapy must be service authorized prior to the provision of services. For procedure codes and descriptions, refer to the fee chart listed below.

**Behavioral Therapy Services Reimbursement Table**

| **Service** | **Code** | **Units** |
|---|---|---|
| Behavioral Therapy Initial Assessment | H0032 UA | 1 hour = 1 unit<br>Limit of 5 units per assessment. Assessments that exceed 5 hours require service authorization. |
| Behavioral Therapy | H2033 | 15 minutes = 1 unit<br>Requires service authorization |

Providers shall not "round up" for Behavioral Therapy Services. One service unit equals 15 minutes for this level of care. Providers shall not round up for partial units of service. Providers may accumulate partial units throughout the week for allowable span billing, however, shall bill only whole units. Time billed shall match the documented time rendering the service in the member's clinical record and in accordance with DMAS requirements.

## TERMINATION OF PROVIDER PARTICIPATION

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

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

## TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

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

## APPEALS OF ADVERSE ACTIONS

Please refer to Chapter 2 of the Community Mental Health Rehabilitative Services Manual for information on provider and client appeals.

## UTILIZATION REVIEW AND CONTROL

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for

services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, the BHSA, or the MCO, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS.

**Financial Review and Verification**

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

**Compliance Reviews**

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS or its contractor if they are found to have billed DMAS or its contractor contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS or its contractor may restrict or terminate the provider's participation in the program.

Effective July 1, 2009, DMAS has contracted with Health Management Systems, Inc. (HMS) to perform audits of Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS

at HMSaudits@dmas.virginia.gov. MCOs will conduct audits of behavioral therapy services provided to their members.

## Fraudulent Claims

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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

### Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, their provider agreement with DMAS, their contract with the BHSA and MCO, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General

900 East Main Street, 5th Floor
Richmond, Virginia 23219

**Member Fraud**

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Member Audit Unit at (804) 786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Program Manager, Recipient Monitoring Unit
Program Integrity Division Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

**Referrals to the Client Medical Management (CMM) Program**

DMAS providers may refer Medicaid enrolled individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Member Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services. Referrals may be made by telephone, FAX, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Program Manager, Recipient Monitoring Unit

Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his/her name and telephone number in case DMAS has questions regarding the referral.

**Utilization Review (UR) - General Requirements for Behavioral Therapy**

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

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

The reviewer determines whether:

- the provider has met all of the documentation requirements outlined earlier in this chapter;
- the provider has the appropriate enrollment agreement;
- the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009);
- the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.);
- the admission to the service and this level of care is appropriate, based upon the service definition, the assessment, and eligibility criteria;
- the medical or clinical necessity of the delivered service is met;

- copies of staff licenses for LMHPs, LMHP-Rs, LMHP-RPs, LMHP-S, LBA and LABA are available to ensure that the services were provided by appropriately qualified individuals as defined earlier in this manual;

- documentation supports supervision as defined by the applicable DHP Regulatory board;

- there is a current, signed Individualized Service Plan (ISP) detailing the need for the specific services;

- documentation supports that the family/caregiver is involved, to the extent of his/her ability, in the development of the ISP;

- the delivered services as documented are consistent with the individual's Individualized Service Plan (ISP), invoices submitted, and specified service limitations;

- the delivered services are provided by qualified staff that meet the requirement for the service being delivered;

- the medical record content corroborates information provided DMAS or its contractor;

- appropriate activities are billed under the assessment code, that all required data elements are met, and that the assessment code is otherwise being used appropriately;

- all documentation is specific to the individual. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for this service;

- all required aspects of treatment (as set forth in the service definition) are being provided, and also determines whether there is any inappropriate overlap or duplication of services;

- all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed;

- only appropriate items have been billed;

- the amount billed matches the documentation of services;

- the provider has documentation that the individual's primary care provider has been informed of the results of the assessment and treatment planning; and,

- the provider has documentation that supports communication with the individual's case manager if appropriate;

Upon completion of on-site activities for a routine UR, DMAS staff or its designated contractor(s) may be available to meet with provider staff. The purpose of the Exit Conference is to provide a general overview of the UR procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The request notice is considered filed when it is date stamped by DMAS. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS staff will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

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

If the provider disagrees with the final audit findings report they may appeal the findings by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of this letter. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be Sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be considered untimely.