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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

INTRODUCTION

Case Management and Home and Community-Based services under the Children's Mental Health (CMH) Program described in this chapter are covered under the Virginia Medicaid Program. At the time of the screening for CMH Program services, the client or family/caregiver makes an informed choice between receiving services in a Psychiatric Residential Treatment Facility (PRTF) or in the community through the CMH Program. Providers of CMH Program services must meet the qualifications described in Chapter II, "Provider Participation Requirements." Services must be provided in accordance with the service criteria defined in this chapter and in conjunction with the current assessment of the client's support needs and Comprehensive Service Plan (CSP) developed for that client. A provider is reimbursed only for the amount and type of services included in the Individual Service Plan (ISP) and prior authorized by DMAS or its contractor.

The CMH Program was created to allow Medicaid to fund intensive community based services for Medicaid eligible children and youth who have been in a PRTF for ninety or more days and for whom community-based care services under the program are the critical services that enable the individual to remain at home rather than reside in a PRTF. The objectives of the CMH Program are to: shorten stays in PRTFs by offering a community alternative; provide access to an array of community based services designed to promote independence and support for children with serious emotional disturbances (SED); and improve outcomes for children and their families by allowing children to reside at home with their natural support system.

To initiate CMH Program services, a qualified transition coordinator must complete the initial CSP. The CSP is the combination of a current assessment of the client's needs in all life areas and the supporting documentation that describes the services and supports necessary to address these needs. The ISPs developed by individual service providers describe the manner in which their services will meet the client's needs and are incorporated into the CSP. The individual service providers, client and family or guardian must participate in the development of the CSP.

Forms referenced in this chapter may be found in the appendix following this chapter and on the DMAS website at www.dmas.virginia.gov.

TEAM APPROACH FOR COORDINATION OF SERVICES

For clients receiving CMH Program services, it is recommended that the team approach involving self-determination be utilized. A team approach involving the client helps to ensure the client's satisfaction with services, health, and safety, and will increase the likelihood that services are coordinated, organized, unduplicated, and are provided without breaks in services. Ultimately, the team approach may result in optimal service delivery.

The team approach uses a group of people (i.e. team members) who work collaboratively with the client and family/caregiver to develop and implement the CSP. Teams consist of the client, the transition coordinator, the case manager, and any provider or direct service staff. It also may

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include any family member, legal guardian, significant other, authorized representative, or friend whom the client wishes to involve in the planning process. All team members work on behalf of the client.

The team approach is the basis for decision-making. The client or case manager, as well as any other team member, may request a team meeting at any time during the plan year. Modifications should not be made to the client's goals, objectives, activities, or service location without previous communication to the case manager and agreement by the team. This can be done via telephone calls or in a team meeting.

Critical to this team approach is the role the transition coordinator and case manager play in effective team communication, coordination, and monitoring of all of the client's services. The transition coordinator serves as the initial team facilitator and is responsible for the development of the initial CSP. The transition coordinator is responsible for ensuring that all team members have input into the final CSP. During team meetings, the client's needs and preferences are identified and discussed. Through team consensus, the client's goals and objectives are selected. Each provider documents these goals and objectives on their ISP. The CSP and all ISPs must be developed and completed prior to the client's discharge to the community. It is the case manager's responsibility to monitor implementation of the CSP. Service quality and client satisfaction are a shared responsibility and are accomplished through effective and consistent communication between the case manager, service providers, and other team members.

TRANSPORTATION FOR CLIENTS RECEIVING CMH PROGRAM SERVICES

The Department of Medical Assistance Services (DMAS) has contracted with a transportation broker for transportation services to and from Medicaid covered services. Because CMH Program services are covered Medicaid services, this transportation may be used for clients needing to go to and from CMH Program services. The following are guidelines for what types of transportation services are to be provided by the broker. The transportation broker has a copy of these guidelines:

1. Payment will be made for transportation from the client's place of residence or other designated location, such as school, to the enrolled CMH Program provider and back.
2. Payment will be made for transportation to a respite location of an enrolled CMH Program provider and back to the residence or other designated location.
3. The broker will not arrange or pay service providers for transportation for community integration activities such as shopping or social activities.
4. The transportation broker will not request the CSP. The transportation broker may request a Broker Authorization Form or the Individual Service Authorization Request (ISAR) to verify weekly schedules (i.e., which days are authorized for services).
5. The transportation broker will arrange and pay for transportation to and from medical providers for all Medicaid covered services.

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DOCUMENTATION REQUIRED FOR ALL CASE MANAGEMENT AND CMH PROGRAM SERVICE PROVIDERS

The Provider Agreement requires that the records fully disclose the extent of services provided to clients receiving Medicaid services. Records must be made available to authorized state and federal personnel in the form and manner requested. Records must clearly document the clinical medical necessity for the service or supports needed, type, schedule, and amount of services to be provided, and actual services rendered.

Specific documentation required for each CMH Program service is described within this chapter.

In addition, Medicaid policy regarding the documentation requirements for any service provider requires the following:

- The record must identify the client on each page;
- Documentation must be legible and clear;
- Signatures are required for all documentation or entries and must include, at a minimum, the first initial and last name;
- Errors must be corrected by drawing a line through the incorrect information, adding the correct information, and including the date of the revisions as well as the initials of the person making the revisions. Correction fluid or other methods of obliterating the previous documentation may not be used;
- The record must contain all the assessment information used to develop the CSP and ISP as appropriate;
- The CSP/ISP and any revisions to it must be part of the record and reflect the assessment information. All changes in the CSP/ISP require supporting documentation;
- All DMAS and DMHMRSAS correspondence, including any information relevant to approvals or denials of services, must be in the case management file and available at the applicable provider offices;
- The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits of billed services. The documentation must include, at a minimum, the Medicaid ID number or name of the person receiving services, the type of service rendered, the date and time (when applicable) the service was rendered, the setting in which the service was rendered, the amount of time required to deliver the service, and the signature of the person who rendered the service;
- Progress notes or data collection are also part of the minimum documentation requirements for any agency-directed service billed and are to convey the client's status and response to various setting and supports as appropriate as well as progress

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toward goals and objectives in the ISP. If weekly or monthly progress notes are used instead of daily notes, they must clearly reflect the date of entry and the dates of service;

- Any drugs prescribed as a part of the client's treatment, including the quantities, dosage, side effects, and reason for use, must be entered in the DMAS-enrolled provider's record;
- The case management and transition coordination records must contain a copy of the current Children's Mental Health Program Pre-Release Referral form DMAS 800 as issued by the local DSS office;
- Written documentation verifying the qualifications of the provider and staff providing the services must be maintained and available for review; and
- Written evidence that information regarding the client is shared to ensure that services are of high quality, communication flows between service providers and case managers, and the client benefits from the services provided.

ELIGIBILITY FOR CMH PROGRAM SERVICES

To be eligible for CMH Program services, the client must:

1. Be younger than 21 years of age;
2. Have a psychiatric diagnosis;
3. Have been a resident of a PRTF for at least 90 days prior to applying for the CMH program;
4. Continue to meet the PRTF criteria described in 12VAC30-50-130;
5. Have services identified in the community to meet the client's needs;
6. Have a case manager assigned (once the client is in the community); and
7. Continue to meet Medicaid eligibility criteria upon discharge from the PRTF.

In order to meet functional eligibility for CMH Program services, all clients receiving CMH Program services must require the same level of services as individuals residing in a PRTF. CMH Program services must be determined to be the critical service that enables the client to be discharged home rather than remaining in the PRTF.

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In addition to the above criteria, other critical factors that will be used to determine if community-based services are appropriate for the individual requesting admission to the CMH Program include:

1. The client has a family/caregiver with whom to live in the community (not a group home or an Assisted Living Facility); and
2. The client and family/caregiver agree to receive services in the community.

Functional status is measured by the Child and Adolescent Functional Assessment Scale (CAFAS). The CAFAS, which is Virginia's state-designated uniform assessment instrument for individuals with serious emotional disturbances, is used to inform but not dictate a level of care. The CAFAS is one component of the assessment but will be considered the main tool used during the evaluation.

The case management and/or transition coordination record must contain the initial CAFAS that was completed prior to the start date of any CMH Program services, and any subsequent updates.

Financial Eligibility

It is the responsibility of the DSS office to determine a client's financial eligibility. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. To qualify for CMH Program services, the client must remain Medicaid eligible upon discharge from the PRTF. Countable family income for clients receiving CMH Program services can not exceed 133% of the Federal Poverty Level.

For all clients applying for CMH Program services, DSS must receive a Children's Mental Health Program Pre-Release Referral form (DMAS 800) from the transition coordinator in order to make the determination that the client will continue to be Medicaid eligible when discharged to the community.

PRE-SCREENING FOR CMH PROGRAM SERVICES

CMH Program services must be determined by DMAS or a DMAS contracted entity to be an appropriate service alternative to remaining in a PRTF. Children who have resided in a PRTF for at least 90 days will be identified by DMAS. A pre-screening will be conducted to determine if the client's current situation (has a family home) merits discharge into the community. If a client is a Comprehensive Services Act (CSA) client, the client will be pre-screened by the CSA entity or its' qualified designee (such as a FAPT member). If the client is not a CSA client, the client will be pre-screened by DMAS with information submitted as part of the preauthorization process for the PRTF stay.

Once the pre-screening is completed, either the CSA or CSB entity will be contacted with information that the client has been in the PRTF for at least 90 days and may be eligible for the CMH Program. At that point, either the CSA or CSB entity will contact the client and family to explain the CMH Program and offer the choice to receive CMH Program services in the

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community or to remain in the PRTF. The client or family/caregiver's choice must be documented on the Recipient Choice Form (DMAS 801). This form must be updated annually and a copy submitted to DMAS.

Transition Coordination

Once the option of receiving CMH Program community services is chosen, the client and family/caregiver must then choose a transition coordination provider (transition coordinator) to assist with service planning and preparing documentation needed for CMH Program enrollment. As detailed in Chapter II of this manual, the transition coordinator can be a treatment foster care case manager, a mental health case manager, a Comprehensive Services Act (CSA) coordinator or qualified designee. The client and family/caregiver must be given a choice of community transition coordination providers if there is more than one provider available that can meet the client's needs.

The transition coordinator performs the following tasks with the client and family/caregiver:

1. Compiles assessment documentation and conducts a strengths and needs assessment to guide CSP development;
2. Provides assistance with meeting the requirements of program enrollment;
3. Refers for Medicaid eligibility redetermination;
4. Develops the CSP in coordination with the family, CSA (if involved), the appropriate school personnel, and other involved parties that includes non-program services that are needed to meet the client's needs;
5. Identifies community service providers; and
6. Monitors the initial transition to the community.

Provider requirements for community transition services are further detailed in the "Transition Coordination Services" section of this Chapter and in Chapter II of this manual.

Financial Eligibility Determination

After the initial contact with the client and family caregiver to verify interest in the CMH Program, the transition coordinator should complete sections A and B of the Children's Mental Health Program Pre-Release Referral form (DMAS 800) and forward a copy to DSS as soon as possible. The completed form includes the anticipated discharge date from the PRTF. The client's eligibility worker at DSS has thirty days to complete section C, indicating the anticipated Medicaid eligibility of the client upon discharge from the PRTF. DSS will return a copy of the form to the transition coordinator. The transition coordinator should include a copy of the

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completed DMAS 800 in their initial packet to DMAS, along with the other documents needed for entrance to the program.

If the client is admitted to the CMH Program upon discharge from the PRTF, the transition coordinator updates the DMAS 800 with the actual discharge date and forwards a copy to DSS. A copy of this form must be maintained in the transition coordination record and forwarded to the case manager once the client is discharged from the PRTF.

Comprehensive Services Plan (CSP) Development

The CSP is the overall service plan that addresses the total needs of the client in all life areas. The CSP incorporates the Individual Service Plans (ISPs) developed for each individual service and defines and describes the goals, objectives and expected outcomes of services. The client and family/caregiver are involved to the maximum extent possible in the development and revision of the CSP.

The CSP contains, at a minimum, the following elements:

- Identifying information: client's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and quarterly review dates, if applicable;
- A summary or reference to the assessment;
- Goals and measurable objectives for addressing each identified need;
- Identified supports and services to accomplish the goals and objectives including the frequency, amount, anticipated duration and scope of services;
- Provider names and ISPs;
- Target dates for accomplishment of goals and objectives;
- Estimated duration of service;
- The role of other agencies if the plan is a shared responsibility;
- The staff responsible for coordination and integration of services, including the staff of other agencies if the plan is a shared responsibility; and
- The signature of the client, when appropriate, and family/caregiver.

The CSP must include back up plans for services in the event that the provider is not available. Through the monitoring of the CSP and ISPs, the case manager, service providers and DMAS will be kept informed of the effectiveness of the back up plans. Clients and family/caregivers choosing consumer-directed services will be responsible for the effectiveness of the back up

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plans for those services and if necessary will work with the CD services facilitator if additional supports are needed.

The transition coordinator collaborates with the client and family/caregiver, the FAPT or CSB case manager and any other persons identified by the family to write the CSP. Using a team approach, the CSP is developed prior to discharge from the PRTF so that services will be in place on the day of discharge from the facility. The CSP process determines the services to be rendered to clients, the frequency of services, the type of service provider, and a description of the services to be offered. All CSPs developed by the transition coordinator and revised and updated by the case manager are subject to approval by DMAS.

Transition coordinators and case managers may use either the CSP (DMAS 802) provided in the appendix to this chapter, or the Model Individual and Family Service Plan (IFSP) that is available on the CSA web site. If the Model IFSP is used, it must include all of the information included in the DMAS 802.

The transition coordinator works with the client and family/caregiver to assess the client's needs and identify the services that are necessary to allow the client to live in the community. One component of this assessment is the Social Assessment which is described in more detail under the "Case Management" section of this Chapter.

The transition coordinator explains available CMH Program services as well as other services that are available through the Medicaid State Plan, through the EPSDT program and through other community resources. The transition coordinator uses the CAFAS and a review of current and previous records along with input from the client, family/caregiver, school, FAPT or CSB team and service providers to complete the assessment process.

During the assessment process, the transition coordinator also communicates with school representatives from the school that the client will attend upon discharge from the PRTF. This communication should begin as soon as it is determined that the child qualifies for the CMH Program in an effort to allow school representatives input into the assessment process and identification of the client's needs after discharge.

The transition coordinator provides the client and family/caregiver with a list of available service providers in the client's community. The client and family/caregiver must be given a choice of providers if there is more than one provider available that can meet the client's needs. If the client's CSP includes either companion or respite services, the client and family/caregiver must also be given a choice of consumer-directed or agency-directed delivery models. The client or family/caregiver choices are documented on the Recipient Choice Form (DMAS 801), a copy of which is maintained in the transition coordination record. Once a case manager is designated for the client, a copy of this form is forwarded to them and maintained in the case management record.

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The transition coordinator submits the CSP, social assessment, choice forms and copy of the most recent CAFAS to DMAS for approval and enrollment into the CMH Program. All CSPs are subject to DMAS approval. Documentation for enrollment into the CMH Program must be submitted by mail or fax to:

CMH Program Project Manager
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
FAX: 1-804-786-5799

ENROLLMENT INTO THE CMH PROGRAM

Upon receipt of the documentation submitted by the transition coordinator, DMAS will review the requested services for appropriateness and make a decision regarding the client's eligibility for CMH Program Services. DMAS will not approve any CSP for which there are health and welfare concerns, or for which the CSP does not seem to adequately meet the client's needs.

All requests for program services will be reviewed under the health, welfare, and safety standard. This standard assures that a client's right to receive a program service is dependent on a finding that the client needs the service, based on appropriate assessment criteria and a written CSP and that services can safely be provided in the community. If the determination is made that these services cannot be safely provided to a client, then the client can not be approved for the program.

Services will be reviewed using the following criteria:

1. Clients qualifying for CMH Program services must have a demonstrated need for the service resulting in limitations as documented on the CAFAS. The need for the service must arise from the client having a serious emotional disturbance (SED) and meeting the level of care for admission to a PRTF; and
2. The services described in the ISP, and services as delivered, must be consistent with the Medicaid definition of each service.

DMAS will notify the transition coordinator, client and family/caregiver of the decision to approve or deny the request for admission into the CMH Program. If the client is denied entrance into the CMH Program, DMAS will include appeal rights in the written notification.

Clients and family/caregivers requesting CMH Program services will receive services on a first-come, first-served basis based on the availability of services in the community to support the client.

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Upon determination by DMAS that the client is appropriate for admission to the program, the transition coordinator will work with the client and family/caregiver, the PRTF where the client currently resides, and the selected service providers to determine an appropriate discharge date.

PREAUTHORIZATION OF CMH PROGRAM SERVICES

After the client's CSP is approved by DMAS and the anticipated discharge date from the PRTF has been determined, the transition coordinator or case manager must submit the Individual Service Authorization Request (ISAR) to DMAS for preauthorization of each service the client will receive. Authorization of services cannot take place prior to the date of receipt by DMAS or its contractor of a correct, complete ISAR.

DMAS or its' contractor will review the ISAR or information submitted electronically to determine the appropriateness of services, and will approve, deny, reject, or pend the request until additional information is received.

When services are approved, a Notification of Approval, which includes the authorized start date of services, will be sent to the client and family/caregiver, the service provider and the transition coordinator. This notification letter is generated by the Virginia Medicaid Management Information System (VAMMIS) and must be maintained in the client's transition coordination file and CMH Program service provider's files.

Transition coordinators and case managers must notify DMAS when services are provided by multiple providers, when services (including case management services) are transferred to a new provider and when a program service or services end.

ISARs can be submitted to DMAS by mail or fax to:

CMH Program Project Manager
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
FAX: 1-804-786-5799

DMAS will have 10 business days to review ISARs and render a decision.

Authorization must be received prior to the start of services. Reimbursement will not be made for any CMH Program Services delivered prior to the authorization date approved by DMAS. Providers who choose to start services prior to receiving authorization do so with the knowledge that if authorization is not received, reimbursement may not be available for any services that have already been provided.

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TRANSITIONING TO CASE MANAGEMENT

When transition coordination is complete, the final CSP must be discussed and forwarded to the ongoing case manager before the end of transition coordination. This transfer may begin as soon as the case manager is designated but must occur within 30 days of the client's discharge from the PRTF. The transition coordination provider must include:

1. All documentation pertaining to the client's admission to the CMH Program including the approved CSP and progress made on objectives;
2. Unresolved issues; and
3. Consultant recommendations.

A client's case manager can be the same person as the transition coordinator but can not be the direct staff person or immediate supervisor of a staff person who provides CMH program services for the client. Transition Coordination and case management cannot be billed concurrently.

CASE MANAGEMENT SERVICES

Case management is a State Plan service covered under the Medicaid Program for clients participating in the CMH Program. The case manager may be a mental health case manager, a treatment foster care case manager or a provider of intensive in-home services. Details regarding case management services case be found at 12VAC30-50-420 through 12VAC3050-430, 12VAC30-50-480, and 12VAC30-50-130(B)(5)(a) of the Code of Virginia. Only one type of case management may be reimbursed during the same month.

The case management requirements in this chapter mirror the Mental Health Case Management requirements (Community Mental Health Rehabilitative Services Manual). Providers of Treatment Foster Care Case Management and Intensive In-Home Services may also provide case management for the CMH Program and must adhere to the specific documentation requirements outlined in the CMH Program Manual.

Case managers assist the client and family/caregiver in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services provided include:

1. Assessment and planning services, to include developing any new ISPs and revisions to the CSP (does not include performing medical and psychiatric assessment but does include referral for such assessment);
2. Request pre-authorization for service initiation or modifications to current requests;
3. Linking the client to services and supports specified in the CSP;
4. Assisting the client directly for the purpose of locating, developing or obtaining needed services and resources;

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5. Coordinating services and service planning with other agencies and providers involved with the client.
6. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;
7. Making collateral contacts with the clients' significant others to promote implementation of the service plan and community adjustment;
8. Conducting quarterly and annual reviews with the client and family/caregiver to ensure that the PRTF level of care continues to be needed and to consistently monitor the health and welfare of the client;
9. Follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and
10. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

It is the responsibility of the case manager to notify DMAS, in writing, when any of the following circumstances or events occurs:

1. Home and community-based program services are implemented;
2. A client dies;
3. A client is discharged from all program services;
4. Any other circumstances (including hospitalization) that cause home and community-based program services to cease or be interrupted; or
5. A selection by the client of a different provider of case management services.

Social Assessment

A comprehensive assessment process must be completed initially by the transition coordinator to determine the client's need for services and supports and the outcomes desired from the services. This involves the gathering by the transition coordinator of relevant social, psychological, medical, and level of care information and serves as the basis for the development of the CSP. The Social Assessment summarizes the assessment information and includes the client's strengths, personal preferences and desires, and previous services or supports that may or may not have been successful. The Social Assessment completed by the transition coordinator is forwarded to the case manager who updates the assessment at least annually with any changes that have occurred during the CSP year. Many of these items are already included in the CSP

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and IFSP so additional forms are not needed. The social assessment summarizes the current status of the client in the following areas:

1. Physical or Mental Health, Personal Safety, and Behavior Issues;
2. Financial, Insurance, Transportation, and other Resources;
3. Home and Daily Living;
4. Education and Vocation;
5. Leisure and Recreation;
6. Relationships and Social Supports;
7. Legal Issues and Guardianship; and
8. Client Empowerment, Advocacy, and Volunteerism.

Monitoring of Service Need

Planning meetings are scheduled at the convenience of the family/caregiver and client who participates as appropriate. After the transition coordinator transfers coordination activities to the case manager, the case manager assumes responsibility for monitoring the CSP implementation, monitoring the health and welfare of the client, and providing follow up on any issues. At a minimum, the case manager will maintain contact with the client and family/caregiver on a monthly basis and will visit the client and family/caregiver on at least a quarterly basis. The purpose of the face-to-face contact is for the case manager to observe the client's status, to verify that services are being provided as described in the CSP, to assess the client's satisfaction with services, and to determine any unmet needs or changes needed to the CSP.

The face to face visit will be conducted more often if the client's and family/caregiver's situation warrants. It is expected that contacts will be more frequent in the first months of admission to the CMH program. The case manager must be available to the client and family/caregiver to discuss any issues that arise and work with the client and family/caregiver to resolve these issues.

The case manager must continuously monitor the appropriateness of the client's CSP, including ISPs from service providers to ensure that all providers are working toward the identified goals of the client. The case manager works with the client, family/caregiver and service providers as well as other identified team members to make revisions to the CSP as indicated by the changing needs of the client. At a minimum, the case manager must review the CSP, including updated provider ISPs, every three months to determine if service goals and objectives are being met, assess the client's satisfaction with the services, confirm the status of the client's health and welfare, and determine if any modifications are needed to the CSP.

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If there is evidence of serious problems revealed upon case management review including: the client or family/caregiver is dissatisfied with services; services are not delivered as described in the CSP; or the client's health and safety are at risk, the case manager must take necessary actions and document in the client's appropriate record(s). Actions may include: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency; reporting the information to DMAS or DMHMRSAS; informing the client and family/caregiver of other providers of the service in question; and as a last resort, after all other options have been exhausted, informing the client and family/caregiver that eligibility may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure health and safety or other requirements. Any time abuse or neglect is suspected, the case manager is required to inform DSS, DMAS, and DMHMRSAS, as appropriate.

A minimum of one contact or communication by the case manager per month with the client or with the family, service providers, or other organizations on behalf of the client must be provided in order for case management services to be billed for that month. This contact or communication must be meaningful, such as monitoring service delivery, as specified in the CSP. Examples may include but are not limited to team meetings, face-to-face meetings with providers, investigating a complaint, etc., and must consist of more than a telephone call to check on the status of the client. The contact may occur anytime during the month.

Prior to the end of the 12-month CSP period, the case manager meets with the client and family/caregiver, service providers, consultants, and others involved in the care of the client to reassess service needs and develop a new CSP based on relevant, current assessment data. This annual CSP must be completed in time for reauthorization to occur; however, the effective date of the new CSP does not need to begin until the previous one expires. DMAS staff will review the CSP every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the CSP must be approved by the client or family/caregiver, as appropriate, and be authorized by DMAS.

Documentation Requirements

The case management agency must maintain the following documentation for review by the DMAS staff for each CMH Program client:

1. All CSPs, case management ISPs, assessment summaries, and any other documentation completed for the client;
2. All individual providers' ISPs and ISARs from any provider rendering CMH Program services to the client and all supporting documentation related to any change in the ISPs;
3. All documentation related to any change in the CSP;
4. All related communication with the providers, client, consultants, DMHMRSAS, CSA, DMAS, DSS, DRS; and others involved in the care of the client;

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5. An ongoing log which documents all contacts made by the case manager related to the client including the date of the contact and with whom contact was made;
6. Case notes which may take the form of contact-by-contact entries or a monthly summary corresponding with a contact log, which briefly notes the date, type, and nature of each contact. All entries must be signed (first initial and last name minimum) and dated;
7. Appropriate progress notes reflecting client's status and, as appropriate, progress toward the goals on the CSP.
8. Documentation of a face-to-face contact every 90 days (with a 10-day grace period permitted if contact cannot be made within 90 days because the client is unavailable). This documentation must clearly state that the case manager was in the presence of the client, assessed his/her satisfaction with services, determined any unmet needs, evaluated the client's status, and assisted with adjustments in the services and supports as appropriate;
9. Documentation of a quarterly review of the client's CSP. Quarterly review documentation must include any revisions to the CSP as well as the general status (including health and safety) of the client, significant events, progress or lack of progress in meeting the CSP, and client or family satisfaction with case management services and other services received under the CSP;
10. Documentation that the client and family/caregiver is presented with all feasible alternatives of available agency and consumer-directed services for which he/she is eligible under the CMH Program;
11. The Recipient Choice Form (DMAS 801), indicating the desire of the client or family/caregiver, as appropriate, for CMH Program services over institutional placement;
12. Documentation that the choice of provider(s) from among those appropriate and available has been offered when program services are initiated, when there is a request for a change in provider(s), when additional services are initiated, or when the client or family/caregiver is dissatisfied with the current provider. Choice must be documented in writing by having the client or family/caregiver, as appropriate, sign a list of available providers and designate the selected provider(s); and
13. Documentation that the client and family/caregiver were given the option of choosing consumer-directed services when respite or companion services were included in the CSP.

All supporting documentation developed for the client must be retained for a period of not less than six years from each client's last date of service or as provided by applicable state or federal laws, whichever period is longer. Records of minors must be kept for at least six years after such minor has reached the age of 18 years.

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Reassessments and Level of Care Review

The case manager must complete (or refer for completion) an annual comprehensive reassessment, in coordination with the client, family/caregivers and service providers. The reassessment must include an update of the CSP, the CAFAS, and any other appropriate assessment data.

The CAFAS will be used as the primary reevaluation tool to ensure that the client continues to meet PRTF level of care. If the client participates in the CSA program, reevaluations will be conducted by the CSA entity or its' qualified designee. Reevaluations for clients who are not participating in the CSA program will be completed by the client's case manager. At a minimum, reevaluations are performed on an annual basis. Reevaluations may occur as often as necessary based on the client's condition.

Reevaluations are completed in coordination with the client, family/caregiver, service providers, consultants, and others involved in the care of the client, to ensure that the client continues to meet the PRTF criteria. While the CAFAS is the primary reevaluations tool, any other appropriate assessment data should be included in the reassessment of the client's condition. The case manager must notify DMAS when a client no longer meets PRTF criteria. Other assessment criteria that must be considered when determining if the client continues to meet the PRTF level of care are:

1. The client continues to require a high level of supervision based on the client's psychiatric or behavioral condition;
2. The client continues to need intensive therapeutic intervention; or
3. The client continues to need a high level of medication management.

If warranted, the case manager must also coordinate a medical examination and a mental health assessment for the client. Medical examinations must be completed according to the recommended frequency and periodicity of the EPSDT program. The mental health assessment for clients must reflect the current psychological status, including diagnoses, and adaptive level of functioning. A new mental health assessment is required whenever the current mental health assessment is no longer reflective of the client's current condition.

The case manager gathers relevant social, psychological, medical and level of care information in order to coordinate a new CSP for each client receiving CMH Program services every year. Based on the results of the reevaluation and comprehensive reassessment, the CSP must be revised as appropriate using a team approach to identify the service revisions that best meet the client's needs. The CSP must include all the current CMH Program ISPs and information on the non-program services to be maintained in the case management record.

Every 365 days (or 366 in a leap year), a new CSP is required, even if the hours or units remain the same. The CSP must be approved by DMAS.

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CHANGES OR TERMINATION OF CARE

The case manager authorizes changes to a client's CSP based on the recommendations of the service provider and approval by the client and family/caregiver. Providers of direct services must submit a revised ISP and an appropriate ISAR to the case manager any time there is a change in the client's condition or circumstances which may warrant a change in the amount or type of service rendered. Providers must modify their ISP with the involvement and agreement of the client and family/caregiver. The case manager will review the need for a change and submit the revised CSP to DMAS to receive approval for that change. DMAS staff has the final authority to approve or deny the requested changes in the CSP.

A case manager can add or amend a service on an existing CSP at any time during the CSP year; however, the end date and quarterly review dates shall coincide with the CSP year.

To change a provider for an approved service, the case manager must submit the DMAS 98-A form to DMAS requesting a transfer. Revised CSPs or ISPs are not needed by DMAS for changes in providers during the CSP year, but must be updated and maintained in the case management file. DMAS can request information as needed if a new or revised preauthorization is requested.

In the case of reduction, termination, suspension or denial of CMH Program services by DMAS staff, clients must be notified in writing of their appeal rights by the transition coordinator or case manager pursuant to 12VAC30-110-10 et seq.

Termination of All CMH Program Services

When a client stops receiving all CMH Program services, the case manager must notify DMAS that services have stopped and provide reasons for the termination.

Client Enters an Institutional Setting:

When a client enters an institutional setting (i.e. acute or residential), DMAS must be notified with an explanation of the reason for the change in setting. DMAS will end the dates of service in the CMH Program to allow billing for the institutional setting. Once the child is discharged from the institutional setting, the case manager must notify DMAS to resume CMH services and must confirm to DMAS that the child continues to meet the CMH Program criteria. This does not apply to clients entering an institution to receive respite services.

A new ISAR must be submitted to DMAS or its contractor for approval and prior authorization to resume services. If the client's service needs have changed, a revised CSP and/or ISP will also be required.

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Non-emergency Termination of CMH Program Services by the Participating Provider

The participating provider must give the client and case manager 10 business days' written notification of the intent to terminate services. The letter must provide the reasons for and the effective date of the termination. The effective date of services termination must be at least 10 days from the date of the termination notification letter. The client is not eligible for appeal rights in this situation and may pursue services from another provider.

Emergency Termination of CMH Program Services by the Participating Provider.

In an emergency situation when the health and safety of the client or provider agency personnel is endangered, the case manager, DMAS and the DMHMRSAS Offices of Licensing and Human Rights must be notified prior to termination of services. The 10 business day written notification period is not required. If appropriate, the local DSS protective services unit must be notified immediately. The client must be given the right to appeal an emergency termination from a provider.

DMAS Termination of Eligibility to Receive CMH Program Services.

DMAS has the ultimate responsibility for assuring appropriate placement of the client in home and community-based care services and the authority to terminate such services to the client for the following reasons:

1. The client no longer meets the institutional level of care criteria;
2. The client's environment does not provide for his health, safety, and welfare;
3. The client is no longer Medicaid eligible; or
4. An appropriate and cost-effective CSP cannot be developed.

The case manager has the responsibility to identify those clients who no longer meet the level of care criteria or for whom CMH Program services are no longer an appropriate alternative to residential placement. For clients who no longer meet the level of care criteria, the case manager will work with the client and family/caregiver to provide available resources to allow the client to remain in the community. If the client must return to the PRTF, the case manager will maintain contact with the family in the event the client returns to the community at a later date.

Transition for Clients Reaching the Age of 21

On the client's 20th birthday, the case manager will receive a notice from DMAS alerting the case manager that the client will age out of the program at age 21. The case manager will be

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responsible for planning transition services for clients as they approach the age of 21. Planning will include identifying needed Medicaid and non-Medicaid covered services after age defined eligibility for the CMH Program ends. The case manager will also determine the likelihood of continued Medicaid eligibility and whether or not the client may qualify for other Medicaid services or programs. The case manager will assist the client and family/caregiver to access needed services. The case manager will coordinate with schools, vocational programs, housing services, and health care providers as indicated for each client and the family/caregiver.

CMH PROGRAM SERVICES

DMAS will pay for a range of Home and Community-Based services under the authority of Section 1915(c) Programs for clients under the age of 21 who have resided in a PRTF for at least 90 days and have been determined to continue to meet PRTF level of care, but with additional supports could reside in the community.

Services available through the CMH Program include: transition coordination services; companion services (agency and consumer-directed); respite services (agency and consumer-directed); services facilitation for consumer-directed services; environmental modifications; family/caregiver training; in-home residential support services; and therapeutic consultation.

Services must be medically appropriate and necessary to maintain the client in the community. Federal program requirements provide that the overall costs of community care can not be more than the overall costs that would have been incurred at the same level of service in the PRTF.

Program services may not be furnished to clients who are inpatients of a hospital, nursing facility, intermediate care facility for persons with mental retardation, inpatient rehabilitation facility, or a PRTF consistent with federal program limitations. Clients who are admitted to one of the facilities mentioned above may be re-enrolled in the CMH Program upon re-entry to the community. However, a new preauthorization must be obtained.

A client must receive a minimum of one CMH Program service, with the exceptions of environmental modifications and therapeutic consultation services. Environmental modifications and therapeutic consultation services may only be provided to clients who are receiving at least one other CMH Program service. Behavior consultation is an exception to this requirement and may be offered in the absence of any other program service when the consultation is determined necessary to prevent institutionalization.

The case manager must present the client with a choice of consumer-directed (CD) services or agency-directed (AD) services (or a combination of the two service delivery models). When the client chooses CD services, the case manager offers the client a choice of CD services facilitators. The CD services facilitator assists the client with employing and maintaining companions and assistants.

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TRANSITION COORDINATION SERVICES

Service Description

Transition Coordination Services are provided to clients who are leaving the PRTF and have chosen to receive services in the community. Transition Coordination Services include assessment of the child and family; assistance with meeting the requirements of program enrollment; referral for Medicaid eligibility; developing a community plan of care in coordination with the family, CSA (if involved), and other involved parties; identifying community service providers; and monitoring the initial transition to the community. Transition Coordination Services do not include monthly rental or mortgage expenses, food, regular utility charges, household appliances or items that are intended for purely diversional or recreational purposes.

Transition Coordination Services ensure the development, coordination, implementation, monitoring, and modification of the CSP; link recipients with appropriate community resources and supports; and coordinate service providers.

Transition Coordination Services may be provided up to three months prior to discharge from the PRTF and one month after discharge. The cost of transition coordination services is considered to be incurred and billable when the client leaves the PRTF and enters the Children's Mental Health Program. Transition Coordination Services may be provided in the PRTF, in the home, school or other community locations.

Criteria

In order to qualify for these services, the client must be a resident of the PRTF, must be under the age of 21, and be identified as a possible participant in the Children's Mental Health Program.

Service Units and Service Limitations

The unit of service is 15 minutes with a maximum of 80 units for each admission to the CMH Program. Services may be provided up to 3 months while the client is in the PRTF and for one month post discharge. Reimbursement may not be made for these services unless the client is enrolled in the CMH Program. Transition Coordination Services cannot be provided concurrently with case management services.

Documentation Requirements

The client record must include, at a minimum, the following:

1. A CSP that contains at a minimum, the following elements:

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- Identifying information: client's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and quarterly and semi-annual review dates, if applicable;
 - Identified services, provider names and ISPs; and
 - Targeted objectives, time frames, and expected outcomes.
2. Ongoing documentation of all contacts. All notes must include:
- Specific details of the activities conducted;
 - Dates, locations, and times of service delivery;
 - CSP objectives addressed;
 - Services delivered as planned or modified;
 - Effectiveness of the strategies and satisfaction of the client and family/caregiver with the service;
 - Client status; and
 - Outcomes and effectiveness of the CSP.

AGENCY-DIRECTED COMPANION SERVICES

Service Definition

Companion services provide assistance with skill development and with understanding family interaction, behavioral interventions for support and safety, non-medical care, non-medical transportation, community integration and rewarding appropriate behaviors.

Services include, but are not limited to, non-medical care, socialization, mentoring, or support to a client. Companions may assist or support the client with such tasks as meal preparation, community access and activities, laundry and shopping, but companions do not perform these activities as discrete services. This service is provided in accordance with a therapeutic goal in the ISP and is not purely diversional in nature.

Criteria

In order to qualify for companion services, the client must have demonstrated a need for assistance with IADLs, light housekeeping, community access, reminders for medication self-administration or support to assure safety.

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The inclusion of companion services in the ISP is appropriate only when the client cannot be left alone at any time due to the SED. There must be a clear and present danger to the client as a result of being left unsupervised.

Companion services may be authorized when no one else is in the home who is competent to monitor the client for safety.

Companion care may be authorized for family/caregivers to sleep either during the day or during the night when the client cannot be left alone at any time due to his or her condition. Companion services must be necessary to ensure the client's safety if he or she cannot be left unsupervised due to health and safety concerns.

Service Units and Limitations

A unit of service is one hour. The amount of companion services time included in the ISP must be no more than is necessary to prevent the deterioration or injury to the client. In no event may the amount of time relegated solely to companion care on the ISP exceed eight hours per day, either separately or in any combination of consumer-directed and agency-directed companion services.

The hours authorized are based on individual need. No more than three unrelated clients who are receiving program services and live in the same home are permitted to share the authorized work hours of the same companion. For households in which there are two or more clients receiving CMH Program services from the same provider, the provider will assess the needs of all authorized clients independently and determine the amount of time required for each client for those tasks which must be provided independently, such as assistance with self medication. The amount of time for tasks which can be provided for both clients simultaneously (such as meal preparation, light housekeeping, laundry, shopping and community access) must be combined and the hours split between the clients' ISPs.

The following exclusions apply to this service:

1. The provision of companion services does not entail hands-on care;
2. Companion services cannot be authorized for clients whose only need for such services is for assistance exiting the home in the event of an emergency; and
3. Companion services can not be covered if required only because the client does not have a telephone in the home or because the client does not speak English.

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Provider Requirements

Companions must be employees of providers that have provider participation agreements with DMAS to provide companion services. Providers are required to have a companion services supervisor to monitor companion services. The supervisor must be at least a QMHP.

The supervisor must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish an ISP for the client. The supervisor must provide follow-up home visits to monitor the provision of services at a minimum of every three months or as often as needed. The client must be reassessed for services annually.

The provider must maintain a record of each client receiving companion services. At a minimum these records must contain:

1. An initial assessment completed by the supervisor prior to the date services are initiated and subsequent reassessments and changes to the ISP;
2. An ISP containing the following elements:
 - The client's strengths, desired outcomes, required or desired supports, or both; and
 - The services to be rendered and the schedule of services to accomplish the desired outcomes;
3. The appropriate ISAR completed and submitted to the case manager with the ISP. The ISAR is necessary for authorization by DMAS or its contractor to occur. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date.
4. Documentation that the ISP goals, objectives, and activities have been reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate and the results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the client and family/caregiver.
5. All correspondence to the client, family/caregiver, case manager, DMAS and DMHMRSAS;
6. Contacts made with family/caregiver, physicians, formal and informal service providers and others involved in the care of the child;

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7. Summary notes completed by the companion services supervisor following significant contacts with the companion and home visits with the client that occur at least quarterly. Summary notes include:

- Whether companion services continue to be appropriate;
- Whether the plan is adequate to meet the client's needs or if changes are indicated in the plan;
- The satisfaction of the client and family/caregiver with the service;
- The presence or absence of the companion during the supervisor's visit;
- Any suspected abuse, neglect or exploitation and to whom it was reported; and
- Any hospitalization or change in medical condition, functioning or cognitive status.

8. Companion records containing the following:

- The specific services delivered to the client by the companion, dated the day of service delivery, and the client's responses;
- The companion's arrival and departure times;
- The companion's weekly comments or observations about the client to include observations of the client's physical and emotional condition, daily activities, and responses to services rendered; and
- The weekly signature of the companion and the client or family/caregiver, as appropriate, recorded and dated on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

AGENCY-DIRECTED (AD) RESPITE SERVICES

Service Definition

Respite services means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid caregiver living in the home with a client who is in need of specialized supervision due to a SED. Respite services include assistance with or monitoring of personal hygiene, nutritional support, safety, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

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Respite services do not include either practical or professional nursing services or those practices regulated in Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to 18VAC90-20-420 through 18VAC90-20-460.

Respite care services may be provided in the client's home or place of residence or a licensed respite facility (such as a group home or foster care home).

Activities

The allowable activities include but are not limited to:

1. Assistance with or monitoring or prompting of ADLs, routine personal hygiene skills, dressing, etc;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;
4. Cueing and prompting for preparation and eating of meals (;
5. Prompting or cueing to perform housekeeping activities, such as bed making, dusting and vacuuming, laundry, grocery shopping, etc., when specified in the client's ISP and essential to the client's health and welfare;
6. Support to assure the safety of the client;
7. Accompanying the client to appointments or meetings when supervision is required; and
8. Assistance or supervision (or both) needed by the client to participate in social, recreational, or community activities.

Criteria

Respite services may only be offered to clients who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the client. Respite services are designed to focus on the need of the caregiver for temporary relief.

Respite services are supports for the family or other unpaid primary caregiver of a client. These services are furnished on a short-term basis because of the absence or need for relief of those unpaid caregivers normally providing the care for the clients.

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Service Units and Service Limitations

The unit of service is one hour. Respite services are limited to a maximum of 720 hours per calendar year. Clients who are receiving services through both the agency and consumer-directed models cannot exceed 720 hours per calendar year combined.

Clients can have respite services, companion services and in-home residential support services listed in the CSP but cannot receive these services at the same time.

The client must have an emergency back-up plan in case the respite assistant does not show up for work as expected.

Training of the client is not expected with respite services.

Respite services may not be provided by a group home, an Assisted Living Facility or a DSS-approved Adult Foster Care/Family Care provider to a client residing in that home.

Supervision of Direct Care Staff

The provider must employ and directly supervise respite assistants who provide direct care to clients. Each assistant hired by the provider must be evaluated by the provider agency to ensure compliance with minimum qualifications.

The respite provider must employ or subcontract with a QMHP or LMHP to supervise all assistants. The QMHP/LMHP supervisor must make a home visit to conduct an initial assessment prior to the start of services for all clients requesting respite services. The supervisor must also perform any subsequent reassessments or changes to the ISP.

The QMHP/LMHP supervisor must make supervisory home visits as often as needed to ensure both quality and appropriateness of services:

- When respite services are received on a routine basis, the minimum acceptable frequency of these supervisory visits is every 30 to 90 days, depending on the needs of the client.
- When respite services are not received on a routine basis, but are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30 to 90 days. Instead, the QMHP/LMHP supervisor must conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite services period.

Based on continuing evaluations of the assistant's performance and client's needs, the QMHP/LMHP supervisor identifies any gaps in the assistant's ability to function competently and provides training as indicated.

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Inability of a Provider to Provide Services and Substitution of Assistants

When a respite assistant is absent and the provider has no other assistant available to provide services, the provider is responsible for ensuring that services continue to the client within a reasonable amount of time.

1. If a provider cannot supply an assistant to render authorized services, the agency may either obtain a substitute assistant from another provider if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the client's services to another provider. The respite care provider that has the authorization to provide services to the client must contact the case manager to determine if additional preauthorization is necessary.
2. If no other provider is available who can supply an assistant, the provider shall notify the client or family and case manager so that they may find another available provider of the client's choice.
3. During temporary, short-term lapses in coverage not to exceed two weeks in duration, a substitute assistant may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements apply:
 - a. The preauthorized respite care provider is responsible for providing the supervision for the substitute assistant.
 - b. The preauthorized respite care provider must obtain a copy of the assistant's daily records signed by the client and/or family/caregiver, as appropriate, and the substitute assistant from the respite care agency providing the substitute assistant. All documentation of services rendered by the substitute assistant must be in the client's record. The documentation of the substitute assistant's qualifications must also be obtained and recorded in the personnel files of the preauthorized care provider. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.
 - c. Only the preauthorized provider may bill DMAS for services rendered by the substitute assistant.
4. Substitute assistants obtained from other providers may be used only in cases where no other arrangements can be made for client respite care services coverage and may be used only on a temporary basis. If a substitute assistant is needed for more than two weeks, the case must be transferred to another respite care provider that has the assistant capability to serve the client or clients.

Provider Documentation Requirements

The provider must maintain all records of each client receiving services. These records must be separated from those of other non-program services. These records will be reviewed periodically by DMAS staff. At a minimum these records must contain:

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1. An initial assessment and ISP completed by the QMHP/LMHP supervisor prior to or on the date services are initiated;
2. The appropriate ISAR completed and submitted to the case manager with the ISP. The ISAR is necessary for authorization by DMAS or its contractor to occur. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date.
3. Reassessments and any changes to the ISP made during the provision of services by the supervisor;
4. The most recent ISP and assessment that contains, at a minimum, the following elements:
 - The client's strengths, desired outcomes and required or desired supports;
 - The client's and family/caregiver's goals and objectives to meet the identified outcomes;
 - Services to be rendered and the frequency of services to accomplish the goals and objectives; and
 - The provider staff responsible for the overall coordination and integration of the services specified in the ISP;
5. Documentation that the ISP goals, objectives and activities have been reviewed by the supervisor quarterly, annually, and more often as needed and modified as appropriate. The results of these reviews must be submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with the client and family/caregiver;
6. The QMHP/LMHP supervisor's notes recorded and dated during significant contacts with the respite assistant and during supervisory visits to the client's home. The written summary of the supervision visits must include:
 - Whether services continue to be appropriate and whether the ISP is adequate to meet the needs or if changes are indicated in the ISP;
 - Any suspected abuse, neglect, or exploitation and to whom it was reported;
 - Any special tasks performed by the assistant and the assistant's qualifications to perform these tasks;
 - The satisfaction of the client and family/caregiver with the service;
 - Any hospitalization or change in medical condition or functioning status;
 - Other services received and their amount; and

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- The presence or absence of the assistant in the home during the supervisor's visit.
7. All correspondence to the client, family/caregiver, case manager, DMAS, DMHMRSAS and CSA;
 8. Significant contacts made with the client, family/caregivers, physicians, DMAS and others involved in the care of the client;
 9. Assistant records which must contain:
 - The specific services delivered to the client by the assistant, dated the day of service delivery, and the client's responses;
 - The assistant's arrival and departure times;
 - The assistant's weekly comments or observations about the client to include observations of the client's physical and emotional condition, daily activities and responses to services rendered; and
 - The weekly signatures of the assistant, client and/or family/caregiver with dates recorded on the last day of service delivery for any given week to verify that services during that week have been rendered. Signatures, times, and dates shall not be placed on the assistant record prior to the last date of the week that the services are delivered.
 10. All DMAS quality management review forms.

Quarterly reviews are not required when this service is delivered on an intermittent basis. However, respite care providers should regularly communicate with the client's case manager about service provision and related issues.

CONSUMER-DIRECTED COMPANION AND RESPITE SERVICES

In consumer-directed (CD) services, the client or family/caregiver is responsible for the hiring, training, supervising and firing of staff. If a client is unable to direct his own care or is under 18 years of age, a family/caregiver may serve as the employer on behalf of the client.

Consumer-directed companions and respite assistants are considered personal assistants. In Virginia, personal assistants are classified as domestic servants and are not subject to worker's compensation claims.

Clients or family/caregivers, as appropriate, choosing the CD model of service delivery must receive support from a Fiscal Management Services Agent contracted by DMAS and CD services facilitator.

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Companion Services: Service Description

Companion services provide assistance with skill development and with understanding family interaction, behavioral interventions for support and safety, non-medical care, non-medical transportation, community integration, and rewarding appropriate behaviors. These services include, but are not limited to, non-medical care, socialization, or support to a client as well as supervision or monitoring to those clients who require the physical presence of a companion to ensure their safety during times when no other supportive individuals are available. This service is provided in accordance with a therapeutic goal in the ISP and is not purely diversional in nature.

Companion Services: Criteria

The inclusion of companion services in the ISP is appropriate only when the client cannot be left alone at any time due to the SED. There must be a clear and present danger to the client as a result of being left unsupervised.

Companion services may be authorized for family/caregivers to sleep either during the day or during the night when the client cannot be left alone at any time due to the client's condition. Companion services must be necessary to ensure the client's safety if the client cannot be left unsupervised due to health and safety concerns.

Companion services can be authorized when no one else in the home is competent to monitor the client for safety.

Companion Services: Service Units and Service Limitations

A unit of service is one hour; however, timesheets completed by the attendant must have time entered in quarter-hour increments. The amount of companion service time included in the ISP must be no more than eight hours per day, either separately or in any combination of consumer-directed or agency-directed companion services.

The hours authorized are based on individual need. No more than three unrelated individuals who are receiving program services and live in the same home are permitted to share the authorized work hours of the same companion.

The following exclusions apply to this service:

1. The provision of companion services does not entail hands-on care;
2. Companion services cannot be authorized for clients whose only need for such services is for assistance exiting the home in the event of an emergency; and
3. Companion services can not be covered if required only because the client does not have a telephone in the home or because the client does not speak English.

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Respite Services: Service Description

Respite services include assistance with or monitoring of personal hygiene, nutritional support, safety, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver. For the purposes of this section, an assistant refers to the individual providing CD respite.

Respite Services: Criteria

CD respite services may only be offered to clients who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the client. Respite is designed to focus on the need of the caregiver for temporary relief.

The inclusion of respite services in the ISP is appropriate only when the client cannot be left unsupervised at any time due to his or her mental health condition.

Respite Services: Service Units and Service Limitations

CD respite services are limited to a maximum of 720 hours per calendar year. Clients who are receiving services through both the agency-directed and consumer-directed models cannot exceed 720 hours per calendar year combined.

Clients can have respite services, companion services and in-home residential support services listed in the CSP but cannot receive these services at the same time.

Services requiring professional skills or invasive therapies, such as tube feedings, foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by CD respite assistants.

Respite Services: Covered Services

The allowable activities include but are not limited to:

1. Assistance with or monitoring of ADLs, such as bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;

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4. Assistance with preparation and eating of meals (preparation only of the client's meal is allowed);
5. Assistance with housekeeping activities, such as bed making, dusting and vacuuming, laundry, grocery shopping, etc., when specified in the client's ISP and essential to the client's health and welfare;
6. Support to assure the safety of the client;
7. Accompanying the client to appointments or meetings when supervision is required; and
8. Assistance or supervision (or both) needed by the client to participate in social, recreational, or community activities.

Employer Responsibilities

The client or family/caregiver, as appropriate, serves as the employer in this service and is responsible for hiring, training, supervising, and firing assistants and companions. Specific duties include checking references of assistants/companions, determining that assistants/companions meet basic qualifications, training assistants/companions, supervising the performance of assistants/companions, and submitting timesheets to the FMS agent on a consistent and timely basis. The client must have an emergency back-up plan in case the assistant/companion does not show up for work as expected or terminates employment without prior notice.

Retention, Hiring and Substitution of CD Companions and Assistants

If a client or family/caregiver is consistently unable to hire and retain the employment of an assistant/companion or has a lapse in services for more than 90 consecutive days, the services facilitator must contact the case manager and DMAS to transfer the client, at the client's choice, to a provider that provides Medicaid funded agency-directed companion and/or respite services. The CD services facilitator will make arrangements with the case manager to have the client transferred. Any time there is a transfer, the facilitator is responsible for coordinating the transfer of documents to the appropriate facilitator or agency to ensure that the client does not lose services.

Fiscal Management Services (FMS) Agent Responsibilities

DMAS currently contracts for the services of a FMS agent for CD companion and respite services. DMAS currently contracts with Public Partnerships Limited (PPL) to perform the FMS services. PPL is reimbursed by DMAS to perform certain tasks as an agent for clients receiving CD services. PPL will provide a packet of employment information and necessary forms to the client or family/caregiver who is serving as the CD employer. The forms must be completed, returned and processed by PPL before the companion or assistant can be employed. PPL will

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handle responsibilities for the client by paying the companion and/or assistant and the related employment taxes (not to include client state and federal income tax). PPL will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services (IRS) in order to fulfill all of these duties.

PPL can be reached at the following contact information:

Public Partnerships, LLC
 PO Box 662
 Richmond, Va.
 23218-0662
 (866)259-3009 (phone)
 (888)564-1532 (fax)
www.publicpartnerships.com

Criminal History Record Check

All CD companions and respite assistants must complete the paperwork provided by PPL for a criminal history record check before beginning services for the client. These requests must be sent to PPL for processing. . Attendants convicted of any of the crimes listed in Section 32.1-162.9:1 of the Code of Virginia and the state Medicaid regulations (12 VAC 30-120-770) will not be permitted to work for clients in this program and will not be compensated for services after the record check is complete.

Section 32.1-162.9:1 of the Code of Virginia and 12 VAC 30-120-770 prohibit home care organizations from hiring, for compensated employment, persons who have been convicted of:

1. Murder or abduction for immoral purposes as set out in § 18.2-48;
2. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2;
3. Robbery as set out in § 18.2-58;
4. Sexual assault as set out in Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2;
5. Arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2;
6. Pandering as set out in §18.2-355;
7. Crimes against nature involving children as set out in § 18.2-361;
8. Taking indecent liberties with children as set out in § 18.2-370 or § 18.2-370.1;

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9. Abuse and neglect of children as set out in § 18.2-371.1;
10. Failure to secure medical attention for an injured child as set out in § 18.2-314;
11. Obscenity offenses as set out in § 18.2-374.1 or § 18.2-379; or
12. Abuse or neglect of an incapacitated adult as set out in § 18.2-369.

Section 32.1-162.9:1 of the Code of Virginia also specifies an applicant may be hired if the applicant is convicted of one misdemeanor specified in the convictions described in this section that involves abuse or neglect or moral turpitude, provided five years have elapsed since the conviction.

If the CD companion/assistant is providing services to a client less than 18 years of age, the companion/assistant must also complete the paperwork provided by PPL to be screened through the DSS Child Protective Services Registry. If the registry confirms a complaint on the companion/assistant, the companion/assistant will no longer be reimbursed under this program for services provided to the client after the registry check is complete.

Clients have the right to choose, hire, and employ a companion/assistant whom they know has been convicted of a crime that is not specified above. When doing so, clients and CD employers must understand this decision and the consequences thereof are their sole responsibility. The client or CD employer must complete the Individual/Employer Acceptance of Responsibility for Employment form in which the client agrees, by employing the assistant/companion, to hold harmless from any claims and responsibility DMAS, the CD services facilitator and the FMS agent. This form must be kept in the client's file.

Transportation

The CD companion or assistant may be allowed to transport the client in the client's vehicle or accompany the client to assist the client with his/her ADLs or IADLs as stated and documented in the client's supporting documentation. The CD companion or assistant may drive the client in the client's or companion/assistant's vehicle if all of the following criteria are met:

- The total time required by the CD companion or assistant for the day, including the time required to drive the client, does not exceed the client's weekly authorized hours. If the total time required exceeds the daily hours, the additional time may be deducted from another day in that week as long as this does not jeopardize the client's health and safety. DMAS will not reimburse the gas and mileage expenses;
- The client's or companion/assistant's vehicle is registered in the Commonwealth of Virginia;
- The owner of the vehicle has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance will insure the client and cover the companion/assistant as a driver of the client's vehicle;
- The CD companion or assistant has a valid Virginia driver's license; and
- It is necessary to assist the client with ADLs or IADLs as documented in the client's ISP.

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Provision of Services for Other Members of the Client's Household

DMAS will reimburse the CD companion or assistant only for services rendered to the client and will not reimburse the companion or assistant while they are sleeping.

DMAS will not reimburse the CD companion or assistant for services rendered to or for the convenience of other members of the client's household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.) DMAS also will not reimburse for the provision of unauthorized services.

Provision of Services to More Than One Client in the Same Household

For services provided in the home when more than one client lives in the same household, the provider will assess the needs of all authorized clients independently and develop the amount of time required for each client for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. For households in which there are two or more clients receiving CMH Program services from the same provider, the amount of time for tasks which can be provided for both clients simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined.

When two clients who live in the same home request services, the following rules will apply:

- ISPs are to be developed separately, and each client will receive the number of hours required for his/her ISP;
- Time for IADLs such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split between the ISPs. For example, if it requires one hour to completed IADLs for both clients, then 30 minutes will be added to each ISP;
- Respite or companion hours are to be split between the ISPs unless there is justification for one-on-one supervision; and
- The clients have the right to choose separate agencies to provide care. In this event, follow rules in the first two bullets.

CD Services Facilitation

The CD services facilitator is responsible for assessing the client's particular needs for a requested CD service, assisting in the development of the ISP for either companion or respite services, providing training to the family/caregiver on his responsibilities as an employer, and providing ongoing support of the CD model of services. The CD services facilitator cannot be the client, the client's case manager, direct service provider, spouse, parent or legally responsible party of the client who is a minor child, or a family/caregiver employing the assistant/companion. CD services facilitation is not a separate program service and does not require an ISP, ISAR, or prior authorization by DMAS.

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Activities of the CD services facilitator include:

1. An initial comprehensive home visit. During the initial comprehensive visit, the CD services facilitator collaborates with the client and family/caregiver to identify needs and develop the ISP for the CD service. The initial comprehensive visit must occur prior to the start of services for any client choosing to receive CD services. The information gathered during the comprehensive visit should result in the development of the ISP for the appropriate CD service(s) for the client. A copy of the ISP and the required ISAR must be forwarded to the case manager by the CD services facilitator to initiate the authorization process. The initial comprehensive visit is done only once upon the client's entry into the CD model of service regardless of the number or type of CD services that a client chooses to receive. If a client changes CD services facilitators, the new CD services facilitator must complete and bill for a reassessment visit in lieu of an initial comprehensive visit.
2. Employee management training. The CD services facilitator must provide the client or CD employer with training on his/her responsibilities and duties as an employer within seven days of receipt of the authorization of CD services. The CD services facilitator can complete the comprehensive visit and management training the same day if appropriate. To assure that the training content for employee management training meets the acceptable requirements, the CD services facilitator must use the Consumer-Directed Services in the Community-Based Waivers' Employer Manual as a guide to meet these requirements. Regardless of the method of training received, documentation must be present indicating the training has been received prior to the hiring of CD companions/assistants. Service Facilitators are required to print this manual and give a copy to the client.
3. Periodic reviews. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months or, for respite services, either every six months or upon the use of 300 respite service hours, whichever comes first.
4. Reassessments. The CD services facilitator will complete a reassessment of the client's level of care six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the client's home, the CD services facilitator must observe, evaluate, and consult with the client and family/caregiver and document the adequacy and appropriateness of CD services with regard to the client's current functioning and cognitive status, medical, and social needs. The CD services facilitator's summary must include, but not necessarily be limited to:
 - Whether CD respite services continue to be appropriate and medically necessary to prevent institutionalization. The CD services facilitator must notify the case manager if the client does not meet the criteria for CD services or if the CD services facilitator has an indication that the client may no longer meet PRTF criteria;
 - Whether the service is adequate to meet the client's needs;

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- Any special tasks performed by the assistant/companion and the assistant's/companion's qualifications to perform these tasks;
 - The satisfaction of the client and family/caregiver with the service;
 - Hospitalization or change in behavior, medical condition, functioning, or cognitive status;
 - Dates of and reasons for any service lapses;
 - Any change in CD employees;
 - Other services received and their amount; and
 - The presence or absence of the companion/assistant in the home during the CD services facilitator's visit.
5. Face-to-face meetings. A face-to-face meeting with the client and family/caregiver must be conducted at least every six months to reassess the client's needs and to ensure appropriateness of any CD services received by the client.
 6. Availability by phone. The CD services facilitator must be available to the client and family/caregiver by telephone.
 7. Monitoring. The CD services facilitator is responsible for taking appropriate action to assure continued appropriate and adequate service to the client. Appropriate actions may include: counseling an assistant/companion about the services to be provided to the client (at the request of the client and/or family caregiver); counseling or training a client or family/caregiver regarding his/her responsibilities as an employer; or requesting from the case manager an increase or decrease to the client's ISP as needed after discussing with the client and family/caregiver the need for additional services. Any time the CD services facilitator is unsure of the action that needs to be taken, the CD services facilitator should contact the case manager.
 8. Timesheet review. The CD services facilitator may review and verify bi-weekly timesheets signed by the client or family/caregiver, as appropriate, and the assistant/companion during the face-to-face visits or more often as needed to ensure that the number of ISP-approved hours is not exceeded. If discrepancies are identified, the CD services facilitator must discuss these with the client to resolve discrepancies and must notify PPL. If the client is consistently identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation. The CD services facilitator cannot verify timesheets for assistants/companions who have been convicted of a barrier crime or who have a founded complaint on record in the DSS Child Protective Services Registry and must notify PPL.
 9. Maintain Companion/Assistant Registry. The CD services facilitator maintains a companion/assistant registry. The registry is a list that contains the names of persons who have experience with providing CD respite or CD companion services or who are

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interested in providing CD respite or CD companion services. The registry is maintained as a supportive source for the client who may use the registry to obtain the names of potential companions/assistants. DMAS does not require CD services facilitators to verify qualifications of companions/assistants prior to enrollment in a registry. CD companions and assistants may choose not to be listed in the registry.

10. Management Training. This training is provided by the CD services facilitator upon the request of the client or CD employer. PPL may also contact the Service Facilitator to request that training be provided to the client if the client appears to be having repeated difficulties with the CD process. This may be additional management training for the client or CD employer or special training for the CD companion/assistant at the request of the client or CD employer. CD services facilitators can provide up to four hours of management training on behalf of a client or CD employer within any six-month period. Each hour of management training is billed as one unit. Management training can also be used to reimburse the CD services facilitator for the costs of TB tests required of CD companions/assistants. CD services facilitators can bill DMAS for the costs of these requirements on behalf of the client by billing for these costs in units and maintaining documentation of these costs in the client's file.
11. Transfers to agency-directed services. If a client or family/caregiver is consistently unable to hire and retain the employment of an assistant/companion to provide CD respite or companion services, the CD services facilitator will make arrangements with the case manager to have the services transferred to an agency-directed services provider or to discuss with the client and family/caregiver other service options.

The CD services facilitator must maintain records for each client. At a minimum these records must contain:

- All copies of the ISPs. This includes the documentation that reflects the results of the CD services facilitator's initial comprehensive visit (and subsequent reassessment visits, as needed), including the types of assistance (allowable activities) that will be provided and the approximate hours. At the annual CSP review, the services facilitator must ensure that the case manager receives a copy of the updated ISP prior to its due date;
- The appropriate ISAR completed and submitted to the case manager with the ISP. The ISAR is necessary for authorization by DMAS or its contractor to occur. The start date on the ISAR will be the start date of CD services facilitation services for the client. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date.
- All DMAS quality management review forms;
- CD services facilitator's notes contemporaneously recorded and dated during any contacts with the client and family/caregiver and during visits to the client's home;
- All correspondence to the client, family/caregiver, case manager and DMAS;

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- Reassessments made during the provision of services;
- Records of contacts made with family/caregivers, physicians, DMAS, formal and informal service providers, and others involved in the care of the client;
- All training provided to assistants/companions on behalf of the client;
- All management training provided to the client or CD employer including the client's or CD employer's responsibility for the accuracy of the timesheets; and
- All documents signed by the client or family/caregiver that acknowledge the responsibilities of the services.

ENVIRONMENTAL MODIFICATIONS

Service Definition

Environmental modifications are physical adaptations to a client's home or vehicle, included in the client's CSP, that are necessary to ensure the health, welfare, and safety of the client, or which enable the client to function with greater independence in the home and without which the client would require continued institutionalization. Environmental modifications may not be used to purchase a vehicle. Such adaptations include items to ensure the safety of the client, family/caregiver and the community. Modifications can be made to an automotive vehicle only if it is the primary vehicle being used by the client.

All services must be provided in accordance with applicable state or local building codes.

Activities

The modifications and activities are:

1. Physical adaptations to a house or primary place of residence necessary to ensure a client's health or safety;
2. Physical adaptations to a house or place of residence that enable a client to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the place of residence;
3. Environmental modifications to the work site (which exceed reasonable accommodation requirements of the Americans with Disabilities Act); and
4. Modifications to the primary vehicle being used by the client. This service does not include the purchase of vehicles.

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Criteria

Environmental modifications are available to clients who are receiving at least one other program service.

In order to qualify for these services, the client must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in a client's primary home, primary vehicle used by the client or for the client by the family/caregiver, to specifically improve the client's personal functioning. This service does not include items otherwise covered in the Medicaid State Plan or through another program.

The case manager could possibly deal with four different providers in order to complete one modification, for example:

1. A rehabilitation engineer or rehabilitation specialist may be used to evaluate the client's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the rehabilitation engineer may actually design and personally complete the modification. A physical therapist, speech therapist, or occupational therapist, available through the Medicaid State Plan or CMH Program therapeutic consultation, may also be utilized to evaluate the needs for environmental modifications;
2. A building contractor may design and complete the structural modification;
3. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or rehabilitation engineer; and/or
4. A Durable Medical Equipment (DME) provider enrolled with DMAS must perform and bill for modifications.

A rehabilitation engineer might be required if (for example):

- The environmental modification involves combinations of systems which are not designed to go together; or
- The structural modification requires a project manager to assure that design and functionality meet ADA accessibility guidelines.

Service Units and Service Limitations

A maximum limit of \$5,000 may be reimbursed per CSP year. Costs for environmental modifications can not be carried over from one CSP year to the next CSP year. Environmental modifications must be preauthorized by DMAS or the contracted preauthorization entity for each CSP year.

Exclusions from this service include:

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- Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the client, such as carpeting, roof repairs, central air conditioning, etc.
- Adaptations that add to the total square footage of the home;
- Modifications used to bring a substandard dwelling up to minimum habitation standards; and
- Modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

Environmental modifications will be covered in the least expensive, most cost-effective manner.

Provider Documentation Requirements

The provider must submit information regarding environmental modifications to the case manager. The following are provider documentation requirements that must be included in the client's record:

1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials. The ISP/ISAR must include documentation of the reason that a rehabilitation engineer is needed, if one is to be involved. The ISAR must be submitted to DMAS or its contractor for authorization to occur;
2. Documentation of the date services are rendered and the amount of services and supplies;
3. Any other relevant information regarding the modification;
4. Documentation of notification by the client and family/caregiver of satisfactory completion of the service; and
5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.

Case managers must, upon completion of each modification, meet face-to-face with each client and assure that the client can use the modification safely and appropriately.

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FAMILY/CAREGIVER TRAINING

Service Definition

Family/caregiver training is the provision of identified training and education related to SED, community integration, family dynamics, stress management, behavioral interventions and mental health to the family/caregiver. For purposes of this service, “family” is defined as the persons who live with, provide care to or support a program client, and may include a spouse, children, relatives, a legal guardian, foster family, or in-laws. “Family” does not include individuals who are employed to care for the client. All family/caregiver training must be included in the client’s ISP.

Criteria

The need for the training and the content of the training in order to assist the family or caregivers with maintaining the client at home must be documented in the client’s ISP. The training must be necessary in order to improve the family or caregiver’s ability to provide care and support.

Service Units and Service Limitations

Services are billed hourly and must be preauthorized. Family members or primary caregivers may receive up to 80 hours of family/caregiver training per ISP treatment year.

Family/caregiver training must be provided on an individual basis, in small groups or through seminars and conferences provided by Medicaid approved or enrolled family and caregiver training providers;

Training may only be billed as it is rendered, for example, billed as client training when rendered to a client (including two or more caregivers for the same client), or billed as a group when rendered to a group of clients. DMAS will not reimburse for training provided through educational classes.

Provider Documentation Requirements

The family/caregiver training provider must submit documentation of all training to the case manager quarterly. This documentation must include:

1. All assessments and reassessments;
2. All supporting documentation, including the ISP and any revisions, developed for the client, which must include:
 - targeted objectives
 - time frames

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- expected outcomes, and
 - documentation to support that services provided are appropriate and necessary to maintain the client in the home and in the community;
3. The appropriate ISAR form, completed and submitted to the case manager with the ISP. The ISAR is necessary for authorization by DMAS or its contractor to occur.
 4. Contact notes which document the date services were rendered, amount and type of services rendered and persons to whom activities were directed. Documentation can be in the form of monthly summaries and must include:
 - Summary of training activities;
 - Dates, locations, and times of service delivery;
 - ISP objective(s) addressed;
 - Specific details of the activities conducted;
 - Whether services were delivered as planned or modified;
 - Effectiveness of the strategies; and
 - Client and family/caregiver satisfaction with the service.
 5. Quarterly reviews are required by the service provider if training extends three months or longer and are to be forwarded to the case manager. Reviews include:
 - Activities related to the supporting documentation;
 - Client status and satisfaction with services; and
 - Training outcomes and effectiveness of the ISP.
 6. If training services extend less than three months, the provider must forward to the case manager contact notes, monthly notes, or a summary of such to the case manager for the quarterly review.

IN-HOME RESIDENTIAL SUPPORT SERVICES

Service Definition

In-home residential support services provide assistance, training or specialized supervision provided primarily in a client's home or foster home to enable a client to acquire, retain, or improve the self-help, socialization, behaviors and adaptive skills necessary to reside

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successfully in home and community-based settings. In-home residential support services are designed to enable clients qualifying for the CMH Program to live in their homes and include:

- training and assistance in or reinforcement of functional skills and appropriate behavior related to a client's health and safety, personal care, ADLs, and use of community resources;
- assistance with medication management and monitoring the client's health, nutrition, and physical condition;
- life skills training; and
- cognitive rehabilitation.

Services must be provided on a client-specific basis according to the ISP, supporting documentation, and service setting requirements.

In-home residential supports are supplemental to the care provided by a parent or similar caregiver. This service may also support a client whose level of independence does not require a primary caregiver. An in-home residential support staff person provides training in the home or in the community. Supports are delivered on a client basis according to the ISP and are delivered with a 1:1 staff-to-client ratio.

Activities

These activities are:

1. Training in functional skills related to personal care activities (grooming; dressing; eating; ; communication; household chores; food preparation; money management; shopping, etc.);
2. Training in functional skills related to the use of community resources (transportation, shopping, restaurants, social and recreational activities, etc.);
3. Monitoring health and physical condition and assistance with medication or other medical needs (or both);
4. Assistance with personal care, ADLs, and use of community resources, such as (not all inclusive):
 - Completing personal care tasks when unable to learn to do so;
 - Ensuring hygiene and eating needs are met, such as hand-over-hand shaving or brushing teeth; or
 - Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the client's health and welfare.

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5. Assistance with arranging transportation to and from training sites and community resources;
6. Nighttime specialized supervision to ensure client's health and safety; and
7. Training in adapting behavior for home and community environments, such as (not all inclusive):
 - Redirecting anger toward others;
 - Handling social encounters with others; and
 - Developing a circle of supports.

Criteria

All clients must meet the CMH Program criteria in order for Medicaid to reimburse for in-home residential support services. A functional assessment must be conducted to evaluate each client in his home environment and community settings. The client must have a demonstrated need for supports to be provided by staff paid by the in-home residential support provider. The supporting documentation must indicate the necessary amount and type of activities required by the client, the schedule of residential support services, and the total number of projected hours per week of program reimbursed residential support.

The amount and type of in-home residential support services that can be authorized are determined by the client's assessed training and support needs reflected in the ISP and any supporting documentation. In-home residential support services should be provided at a frequency that allows for systematic training and maintenance or improvement of functional supports.

In-home residential support services do not need to be provided on a daily basis. In-home residential support services may be offered on a periodic basis, as long as the ISP documents the client's needs and reflects appropriate and allowable activities to be provided on a periodic basis.

Medicaid reimbursement is available only for in-home residential support services provided when the client is present and when a qualified provider is providing the services.

General Supervision

Federal and state regulations prohibit costs for room, board, and general supervision from being billed to Medicaid under the CMH Program.

In-home residential supports may not supplant primary care (i.e., room, board, and general supervision) available to the client through non-medical sources (e.g., family, foster care provider, etc.). They may provide only the supplemental assistance and training required to maintain the capacity of the primary care provider to offer care. Support services cannot be

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authorized unless the client requires training and support services, which exceed the room, board, and general supervision.

General supervision consists of the need for staff presence without evidence of the client's need for staff intervention. General supervision may help assure that appropriate action is taken in an emergency or if an unanticipated incident occurs. However, routine staff activities, such as the examples described below, are not evidence of a client's need for staff intervention and are therefore considered to be general supervision. Examples (not all-inclusive) of general supervision that may not be billed to Medicaid are:

- Awake staff coverage during nighttime hours if a client generally sleeps through the night and has no documented medical or behavioral problems that indicate a need for staff intervention to ensure health and safety;
- Routine bed checks;
- Oversight of leisure activities;
- Asleep staff at night on the premises for security or safety reasons (or both); or
- Staff "on call" during the day while clients are at a day program.

Nighttime Specialized Supervision

Nighttime specialized supervision provides staff presence for ongoing or intermittent intervention to ensure a client's health and safety. For Medicaid to reimburse for nighttime specialized supervision, the ISP must clearly document the client's ongoing need for specialized supervision. DMAS may request assessment information, recent documentation of specialized supervision related staff intervention (in the form of charts and/or progress notes), and/or staffing patterns in order to corroborate the client's need for and the provider's ability to actually deliver specialized supervision. The ISP must indicate in the form of a specialized supervision objective what specialized supervision activities the staff will perform and when. Documentation should reflect specialized activities on the part of the staff that relate to the client's health and safety needs and indicate occurrences of the provision of those needed supports. The intervention provided may be ongoing or intermittent, and the amount of time included in the ISP must be based on the client's assessed needs.

As specialized supervision is typically provided in a 1:1 fashion, the provider must have sufficient staff to implement the specialized supervision activities for the client.

In the case of awake overnight staff coverage in an in-home residential support plan, specialized supervision may include hours throughout the entire night, but only if assessment information documents ongoing night needs. In some cases, a client may need staff intervention on a regular but unpredictable basis. For example, a client who has a documented history of elopement attempts during the night may need overnight specialized supervision in the form of staff assistance due to the unpredictable nature of the behavior, as well as active intervention when the behavior occurs. In such a case, specialized supervision may be included throughout the night.

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The ongoing need for and utilization of this component of in-home residential support should be included in providers' quarterly reviews similar to training and assistance. If, over a 60-day period, the hours of specialized supervision actually provided are consistently less than the approved amount, the provider is expected to revise the ISP form, the weekly schedule, and amount to reflect this reduction. This revision is reviewed and approved by the case manager and approved by DMAS, as appropriate.

Restrictions with Other Services

Clients can be authorized for respite care, companion care, and in-home residential support services in their CSP but cannot receive these services at the same time.

In-home residential support services will not be authorized for the primary purpose of supervision.

Service Units and Service Limitations

In-home residential support services are reimbursed on an hourly basis for time the in-home residential support staff is working directly with the client. Total monthly billing cannot exceed the total hours authorized by the ISAR. The provider must maintain documentation of the date and times that services are provided, the specific services provided, and specific circumstances that prevented provision of all of the scheduled services, if applicable.

Service providers are reimbursed only for the amount and type of in-home residential support services included in the client's approved ISP. Services will not be reimbursed for a continuous 24-hour period.

This service does not include room and board and general supervision. This service may not be used solely to provide routine or emergency respite care for the family or caregivers with whom the client lives.

In-home residential support services will not be authorized when the activities to be performed are not allowable activities as described for in-home residential support services (i.e., services such as companion care services where the care provider provides general supervision).

If fewer hours than scheduled in the ISP are delivered on a regular basis over a 60-day period, the service provider should determine the reasons, and a revised ISP with fewer hours or a change in schedule may need to be developed.

In-home residential services cannot be authorized retroactively.

Provider Requirements

The ISP and ongoing documentation must be consistent with licensing regulations. Documentation must confirm attendance and the amount of time services were provided and provide specific information regarding the client's response to various settings and supports as agreed to in the ISP objectives. Assessment results must be available in at least a daily note or a

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weekly summary. Data must be collected as described in the ISP, analyzed, summarized, and then clearly addressed in the CSP. The ISP must be reviewed by the provider with the client or family/caregiver, as appropriate, and this review submitted to the case manager, at least quarterly, with goals, objectives, and activities modified as appropriate.

The appropriate ISAR must be completed and submitted to the case manager with the ISP for authorization by DMAS or its contractor to occur. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date.

In addition to licensing requirements, persons providing residential support services are required to participate in training specified by DMAS in the characteristics of SED. The training must include appropriate interventions, training strategies, and support methods for individuals with SED. To provide additional assurance for the protection or preservation of a client's health and safety, there are specific requirements for the supervision and oversight of direct care staff providing in-home residential support as outlined below. All in-home residential support services must be provided under a DMHMRSAS license and include the following requirements:

- An employee of the agency, typically by position, must be formally designated as the supervisor of each direct care staff person who is providing in-home residential support services;
- The supervisor must have and document at least one supervisory contact per month with each staff person regarding service delivery and staff performance;
- The supervisor must observe each staff person delivering services at least semi-annually. Staff performance and service delivery according to the ISP should be documented, along with evaluation and evidence of the satisfaction of the client and family/caregiver with service delivery by staff; and
- Providers of in-home residential supports must also have and document at least one monthly contact with the client and family/caregiver regarding satisfaction with services delivered by each staff person.

Documentation must be maintained for supervision and oversight of all in-home residential support staff. All significant contacts must be documented.

The provider agency must maintain records of each client receiving in-home residential support services. Documentation must be completed and signed by the staff person designated to perform the supervision and oversight. At a minimum, these records must contain the following:

1. Date of contact or observation and the amount of time spent;
2. Person or persons contacted or observed;
3. A note regarding staff performance and ISP service delivery for monthly contact and semi-annual home visits;

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4. Semi-annual observation documentation which includes the satisfaction of the client and family/caregiver with service provision;
5. Any action planned or taken to correct problems identified during supervision and oversight;
6. A functional assessment conducted by the provider to evaluate each client in the residential environment and community settings;
7. An ISP which must contain the following elements:
 - The client's strengths, desired outcomes, required or desired supports, or both, and training needs;
 - The client's or family/caregiver's goals and measurable objectives to meet the identified outcomes;
 - The services to be rendered and the schedule of services to accomplish the goals, objectives, and desired outcomes;
 - A timetable for the accomplishment of the client's goals and objectives;
 - The estimated duration of the client's needs for services; and
 - The provider staff responsible for the overall coordination and integration of the services specified in the ISP.
8. Appropriate ISARs completed and submitted to the case manager; and
9. The ISP goals, objectives, and activities must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and results of these reviews submitted to the case manager. For the annual review and in cases where the ISP is modified, the ISP must be reviewed with and approved by the client and family/caregiver.

THERAPEUTIC CONSULTATION

Service Definition

Therapeutic consultation provides expertise, training and technical assistance to assist family members, caregivers, and other service providers in supporting the client. The specialty areas are psychology, behavioral consultation, therapeutic recreation, speech and language pathology, occupational therapy and rehabilitation engineering. The need for any of these services is based on the client's ISP.

Therapeutic consultation is provided to those clients for whom specialized consultation is clinically necessary and who have additional challenges restricting their ability to function in the

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community. Therapeutic consultation services may be provided in the client's home and in appropriate community settings. Services are intended to facilitate implementation of the desired outcomes of the client and family/caregiver as identified in the ISP.

Therapeutic consultation services may be provided in in-home residential or treatment support settings or in office settings in conjunction with another service. Behavioral consultation may be offered in the absence of any other program service when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the ISP based on an hourly fee-for-service rate.

Activities

The allowable activities are:

1. Interviewing the client, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;
2. Observing the client in daily activities and natural environments;
3. Assessing the client's need for an assistive device or modification and/or adjustment in the environment or services;
4. Developing data collection mechanisms and collecting baseline data;
5. Observing and assessing current interventions, support strategies, or assistive devices being used with the client;
6. Developing written supporting documentation detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes; this may include recommendations related to specific devices, technology, or adaptation of other training programs or activities;
7. Demonstrating specialized, therapeutic interventions, client supports, or assistive devices;
8. Training a family/caregiver and other relevant persons to assist the client in using an assistive device, to implement specialized, therapeutic interventions, or adjust currently utilized support techniques;
9. Training relevant persons to better support the client simply by observing the client's environment, daily routines, and personal interactions;
10. Reviewing documentation and evaluating the efficacy of assistive devices or the activities and interventions identified in the supporting documentation; and

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11. Training and technical assistance to family members, caregivers, and other clients primarily responsible for carrying out the client's ISP.

Criteria

In order to qualify for these services, the client must have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service. The client's therapeutic consultation ISP must clearly reflect the client's needs, as documented in the assessment, for specialized consultation provided to family/caregivers and providers in order to implement the CSP effectively.

Service Units and Service Limitations

The unit of service equals one hour. The services must be explicitly detailed in the ISP.

Therapeutic consultation services may not include direct therapy provided to program clients or monitoring activities, and may not duplicate the activities of other services that are available to the client through the Medicaid State Plan.

Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

Any services started prior to the receipt of approval by DMAS and authorization of services will not be reimbursed. To request additional hours, the service provider must contact the case manager and request the need for the additional hours. The need for additional hours must be documented in the client's record, and a revised CSP must be submitted by the case manager to DMAS for approval. Additional hours must be preauthorized. Case managers must receive copies of all correspondence between the provider and DMAS. These documents are subject to review during a quality management review visit. Services for therapeutic consultation cannot be authorized retroactively.

Provider Documentation Requirements

The following documentation is required for therapeutic consultation:

1. An ISP that contains, at a minimum, the following elements:
 - Identifying information: client's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and semi-annual review dates, if applicable;
 - Targeted objectives, time frames, and expected outcomes;
 - Specific consultation activities; and

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- The expected outcomes.
2. The appropriate ISAR completed and submitted to the case manager with the ISP. The ISAR is necessary for authorization by DMAS or its contractor to occur. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date.
 3. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to use to better support the client in the service;
 4. Ongoing documentation of consultative services rendered in the form of contact-by-contact or monthly notes that identify each contact. All monthly, quarterly and annual notes must include:
 - Specific details of the activities conducted;
 - Dates, locations, and times of service delivery;
 - Supporting documentation objectives addressed;
 - Services delivered as planned or modified;
 - Effectiveness of the strategies and satisfaction of the client and family/caregiver with service.
 - Client status; and
 - Consultation outcomes and effectiveness of support plan.
 5. If consultation services extend less than three months, the provider must forward monthly contact notes or a summary of them to the case manager;
 6. If the consultation services extend three months or longer, written quarterly reviews must be completed by the service provider and are to be forwarded to the case manager. Any changes to the ISP must be reviewed with the client and family/caregiver;
 7. Quarterly are required by the service provider if consultation extends three months or longer and are to be forwarded to the case manager;
 8. If the consultation service extends beyond one year, the ISP must be reviewed by the provider with the client and family/caregiver and the case manager. The written review must be submitted to the case manager, at least annually, or more often as needed;
 9. A written support plan, detailing the interventions and strategies for staff, family, or caregivers to use to better support the client in the service; and
 10. A final disposition summary must be forwarded to the case manager within 30 days following the end of this service and must include:

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- Strategies utilized;
- Objectives met;
- Unresolved issues; and
- Consultant recommendations.

CLIENT'S RIGHT TO APPEAL AND FAIR HEARING

State [12 VAC (Virginia Administrative Code) § 30-110-70 through 30-110-90] and federal regulations [42 CFR (Code of Federal Regulations) § 431] require a notice of appeal rights to clients who have had a Medicaid-covered service denied, reduced, suspended, terminated or not acted upon within required time frames.

The client must be notified in writing of the right to a hearing and the procedure for requesting a hearing at the time of the application and at the time of any adverse action by DMAS, the screening team, the case manager, client service providers, or the DSS. For applicants and clients not familiar with English, a translation of the appeal rights understood by the applicant or client must be included. Appeal rights at the time of any action by DMAS, the screening team, the case manager, client service providers, or DSS must be issued at least ten (10) days prior to the date of action, except for specified exceptions. The client then has (30) days from the date of denial to request an appeal.

When a client's request for a Medicaid-covered service is denied, reduced, suspended, terminated, or not acted upon within required time frames, the case manager must send the written notification of the action and the right to appeal the action to the client.

The contents of the notification letter must include:

1. What action the agency intends to take;
2. The reason(s) for the intended action;
3. An explanation of the client's right to request a hearing;
4. An explanation of the circumstances under which Medicaid-covered services are continued if a hearing is requested;
5. An explanation of the client's requirement to reimburse DMAS if the agency's action is upheld, if the client continues to receive a Medicaid-covered service; and
6. The effective date of the action.

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Advance Notification

Unless otherwise specified, written notification must be mailed by the case manager to the client or legal guardian at least 10 days prior to the date of action when an agency reduces, suspends, or terminates one or all Medicaid-covered service(s).

Exceptions to the 10-Day Advance Notice Requirements

The 10-day advance written notice is required to be sent to the client or legal guardian except in the following instances: (Note that the written notice is required, even though advance notice is not.)

1. When the agency has factual information confirming the death of a client;
2. When a client or guardian provides a written request indicating that:
 - a) He/she no longer wishes services to continue; OR
 - b) He/she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
3. The client has been admitted to an institution and is ineligible for further services, including a regular admission to a PRTF, or has been incarcerated;
4. The client's whereabouts are unknown, as evidenced by returned mail;
5. The agency establishes the fact that the client has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
6. The client's physician prescribes a change in the level of care;
7. When the client's request for admission into a Medicaid-covered service or when the client's request for an increase in a Medicaid-covered service is denied or not acted upon promptly for any reason (i.e., diagnostic or functional eligibility, funding, no provider, etc.).

All notification letters must be filed in the case management record.

Appeals must be requested in writing to DMAS within 30 days of the notification of action. If the client is currently receiving the services and requests a DMAS appeal hearing, before the effective date of termination, suspension, or reduction, the CMH Program provider may not terminate, suspend, or reduce services until the hearing officer renders a decision. After receiving confirmation from the client or family/caregiver that an appeal has been filed and prior to the date for the proposed change, the case manager must notify (verbally or in writing) the provider agency that an appeal is in progress to enable the agency to continue services at the same level if the client chooses. Similarly, the slot of a client who has been terminated from the program may not be allocated to another client until the 45th day following notification of action.

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Should the client file an appeal during that time frame, the slot must remain assigned to its current client until that client's appeal rights have been exhausted.

Money paid for services provided to the client as a result of the required continuation of services during the appeal process is subject to recovery by DMAS if the agency's action is upheld.

Provider Appeals

If, upon reconsideration, the denial is upheld in whole or part, the provider has the right to a first-level informal appeal of the reconsideration decision, pursuant to Va. Code §2.2-4019. A provider may appeal an adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 calendar days of the receipt of the adverse decision. 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, 11th Floor
Richmond, VA 23219

If the denial is upheld, in whole or in part, as a result of the first-level informal appeal, the provider has the right to file for a second-level formal appeal, pursuant to Va. Code § 2.2-4020. The provider must file a request for a formal appeal within 30 calendar days of receipt of the first-level informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to a client, the provider shall give the client and family/caregiver and case manager 10 calendar days advance written notification. The letter shall provide the reasons the provider is discontinuing services and the effective date. The effective date shall be at least 10 calendar days from the date of the notification letter. The client is not eligible for appeal rights in this situation and may pursue obtaining services from another provider.

In an emergency situation in which the health and safety of the client or provider agency personnel is endangered, the 10-day advance written notification period shall not be required, however the case manager must be notified prior to discontinuing services. DMHMRSAS Offices of Licensing and Human Rights must also be notified as required under the provider's license.

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MAINTAINING RECORDS

Business and Professional Records

Providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the business. An example of documents in this area is Human Resources (HR) documentation. These policies apply even if the agency discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia; and

1. Such records must be retained for at least six years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved; and
2. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years.

Client Records

1. The case manager must maintain for each CMH Program client the following documentation for review by DMAS staff for a period not less than six years from the client's last date of services.
 - a) The comprehensive assessment and all CSPs;
 - b) All ISPs and any other supporting documentation from any provider;
 - c) The Children's Mental Health Program Pre-Release Referral form (DMAS 800);
 - d) All supporting documentation related to any change in the CSP; and
 - e) All related communication with the providers, client, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.
2. The client service providers must maintain the following documentation for review by DMAS staff for a period not less than six years from the client's last date of service:
 - a) All assessments, reassessments and ISPs;
 - b) An attendance log which documents the date services were rendered and the amount and type of services;
 - c) Appropriate progress notes reflecting the client's status and, as appropriate, progress or lack of progress toward the goals on the ISP; and

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- d) Any documentation to support that services provided are appropriate and necessary to maintain the client in the home and in the community.