Therapeutic Consultation Information for Behavior Analysts

ID therapeutic consultation is a service available to all individuals served under one of the ID waivers. It is also an available service under the DD waiver, though this information is not listed on their website it is the listed in the code of Virginia and if you contact DMAS they will help you through the application for this service.

1. ID Therapeutic consultation-
   a. Licensure as a Behavior Analyst or Assistant Behavior Analyst (Licensure with DBHDS is NOT required for this service)
   b. Provider agreement with DMAS (Department of Medicaid Services) is required
      
   
   c. Pre-Authorization by Support coordinator is required
   d. Need to be set up to use the Delta Portal and to make Submissions to IDOLS, as these are the systems that are used for authorization and billing in the ID waivers
   e. Rates are NOVA $62.77 per hour ROS 54.58 per hour
   f. Can be provided by Licensed Assistant Behavior Analyst
   g. Can Bill treatment trials as part of the assessment but billed as assessment and not as direct service to the individual

The modules at the following website provide good general information about the ID waivers, services and processes..

http://www.dbhds.virginia.gov/ODS-Training.htm#Modules

Selected Medicaid Regulations Regarding Therapeutic Consultation

Therapeutic consultation. In addition to meeting the service coverage requirements in 12VAC30-120-1020 and the general conditions and requirements for home and community-based participating providers as specified in 12VAC30-120-1040, professionals rendering therapeutic consultation services shall meet all applicable state or national licensure, endorsement or certification requirements. The following documentation shall be required for therapeutic consultation:

1. A Plan for Supports, that contains at a minimum, the following elements:
   a. Identifying information;
   b. Desired outcomes, support activities, and time frames; and
   c. Specific consultation activities.

2. A written support plan detailing the recommended interventions or support strategies for providers and family/caregivers to better support the individual enrolled in the waiver in the service.

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3. Ongoing documentation of rendered consultative services which may be in the form of contact-by-contact or monthly notes, which must be signed and dated, that identify each contact, what was accomplished, the professional who made the contact and rendered the service.

4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the Plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate, and the case manager and shall be submitted to the case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.

5. A final disposition summary must be forwarded to the case manager within 30 days following the end of this service.

12VAC30-120-1020

O. Therapeutic consultation. Service description. This service shall provide expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual enrolled in the waiver. The specialty areas shall be (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering. The need for any of these services shall be based on the individuals' Individual Support Plans, and shall be provided to those individuals for whom specialized consultation is clinically necessary and who have additional challenges restricting their abilities to function in the community. Therapeutic consultation services may be provided in individuals' homes, and in appropriate community settings (such as licensed or approved homes or day support programs) as long as they are intended to facilitate implementation of individuals' desired outcomes as identified in their Individual Support Plans.

1. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the Individual Support Plan cannot be implemented effectively and efficiently without such consultation as provided by this covered service.

a. The individual's therapeutic consultation Plan for Supports shall clearly reflect the individual’s needs, as documented in the assessment information, for specialized consultation provided to family/caregivers and providers in order to effectively implement the Plan for Supports.

b. Therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.
2. The **unit of service shall be one hour**. The services must be explicitly detailed in the Plan for Supports. Travel time, written preparation, and telephone communication shall be considered as in-kind expenses within this service and shall not be reimbursed as separate items. Therapeutic consultation shall not be billed solely for purposes of monitoring the individual.

3. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service when the consultation is determined to be necessary.

**12VAC30-120-1040**

12VAC30-120-1040. General requirements for participating providers.

A. Requests for participation as Medicaid providers of waiver services shall be screened by DMAS or its designated contractor to determine whether the provider applicant meets the basic requirements for provider participation. All providers must be currently enrolled with DMAS in order to be reimbursed for services rendered. Providers who are not enrolled shall not be reimbursed. Consumer-directed assistants shall not be considered Medicaid providers for the purpose of enrollment procedures.

B. For DMAS to approve provider agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, the standards of any state licensure or certification requirements, or both as applicable pursuant to 42 CFR 441.302; and

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 42 CFR 455.105; and

3. The ability to document and maintain individual records in accordance with state and federal requirements.

C. Providers approved for participation shall, at a minimum, perform the following activities:

1. Screen all new and existing employees and contractors to determine whether any are excluded from eligibility for payment from federal health care programs, including Medicaid (i.e., via the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals or Entities (LEIE) website). Immediately report in writing to DMAS any exclusion information discovered to: DMAS, ATTN: Program Integrity/Exclusions, 600 E. Broad St., Suite 1300, Richmond, VA 23219 or emailed to providerexclusion@dmas.virginia.gov;

2. Immediately notify DMAS and DBHDS, in writing, of any change in the information that the provider previously submitted, for the purpose of the provider agreement, to DMAS and DBHDS;
3. Assure freedom of choice to individuals in seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid program at the time the service or services were performed;

4. Assure the individual's freedom to refuse medical care, treatment, and services;

5. Accept referrals for services only when staff is available to initiate services and perform, as may be required, such services on an ongoing basis;

6. Provide services and supplies to individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; the Fair Housing Amendments Act of 1988 (42 USC § 3601 et seq.); and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications;

7. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

8. Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by the DMAS payment methodology from the individual's authorization date for the waiver services;

9. Use program-designated billing forms for submission of charges;

10. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the services provided;

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

   b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of 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.

11. Agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the state Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and
records shall survive any termination of the provider agreement. No business or professional
records shall be created or modified by providers once an audit has been initiated;

12. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other
interests in any and all firms, corporations, partnerships, associations, business enterprises, joint
ventures, agencies, institutions, or other legal entities providing any form of health care services
to individuals receiving Medicaid;

13. Hold confidential and use for authorized DMAS or DBHDS purposes only, all medical
assistance information regarding individuals served pursuant to Subpart F of 42 CFR Part 431,
12VAC30-20-90, and any other applicable state or federal law. A provider shall disclose
information in his possession only when the information is used in conjunction with a claim for
health benefits or the data is necessary for the functioning of DMAS in conjunction with the
cited laws;

14. Notify DMAS of change of ownership. When ownership of the provider changes, DMAS
shall be notified at least 15 calendar days before the date of change;

15. Comply with applicable standards that meet the requirements for board and care facilities for
all facilities covered by § 1616(e) of the Social Security Act in which home and community-
based waiver services will be provided. Health and safety standards shall be monitored through
the DBHDS' licensure standards or through VDSS-approved standards for adult foster care
providers;

16. Immediately report, pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, such
knowledge if a participating provider knows or suspects that an individual enrolled in a home
and community-based waiver service is being abused, neglected, or exploited. The party having
knowledge or suspicion of the abuse, neglect, or exploitation shall from first knowledge report
the same to the local department of social services' adult or child protective services worker and
to DBHDS Offices of Licensing and Human Rights as applicable;

17. Perform criminal history record checks for barrier crimes, as defined in 12VAC30-120-1000,
within 15 days from the date of employment. If the individual enrolled in the waiver to be served
is a minor child, perform a search of the VDSS Child Protective Services Central Registry. The
personal care/respite assistant or companion for either agency-directed or consumer-directed
services shall not be compensated for services provided to the individual enrolled in the waiver if
any of these records checks verifies that the assistant or companion has been convicted of crimes
described in § 37.2-416 of the Code of Virginia or if the assistant or companion has a finding in
the VDSS Child Protective Services Central Registry; or if the assistant or companion is
determined by a local department of social services as having abused, neglected, or exploited an
adult 60 years of age or older or an adult who is 18 years of age if incapacitated. The personal
assistant or companion shall not be reimbursed by DMAS for services provided to the
individual enrolled in the waiver effective on the date and thereafter that the criminal record
check verifies that the assistant or companion has been convicted of crimes described in § 37.2-
416 of the Code of Virginia. The personal assistant (for either agency-directed or consumer-
directed services) and companion shall notify either their employer or the services facilitator, the
individual enrolled in the waiver and EOR, as appropriate, of all convictions occurring subsequent to this record check. Failure to report any subsequent convictions may result in termination of employment. Assistants or companions who refuse to consent to child protective services registry checks shall not be eligible for Medicaid reimbursement of services that they may provide;

18. Refrain from performing any type of direct marketing activities, as defined in 12VAC30-120-1000, to Medicaid individuals;

19. Adhere to the provider participation agreement and the Virginia Medicaid Provider Manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the Virginia Medicaid Provider Manual; and

20. Participate, as may be requested, in the completion of the DBHDS-approved assessment instrument when the provider possesses specific, relevant information about the individual enrolled in the waiver.

D. DMAS or its contractor shall be responsible for assuring continued adherence to provider participation standards. DMAS or its contractor shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically recertify each provider for participation agreement renewal to provide home and community-based waiver services. A provider's noncompliance with DMAS' policies and procedures, as required in the provider's participation agreement, may result in a written request from DMAS for a corrective action plan that details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited. Failure to comply may result in termination of the provider enrollment agreement as well as other sanctions.

E. Felony convictions. DMAS shall immediately terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia as may be required for federal financial participation. A provider who has been convicted of a felony, or who has otherwise pled guilty to a felony, in Virginia or in any other of the 50 states, the District of Columbia, or the U.S. Territories shall, within 30 days of such conviction, notify DMAS of this conviction and relinquish its provider agreement. Such provider agreement terminations shall be effective immediately and conform to 12VAC30-10-690 and 12VAC30-20-491.

1. Providers shall not be reimbursed for services that may be rendered between the conviction of a felony and the provider's notification to DMAS of the conviction.

2. Except as otherwise provided by applicable state or federal law, the Medicaid provider agreement may be terminated by DMAS at will on 30 days written notice. The agreement may be terminated if DMAS determines that the provider poses a threat to the health, safety, or welfare of any individual enrolled in a DMAS administered program.
3. A participating provider may voluntarily terminate his participation with DMAS by providing 30 days written notification.

F. Providers shall be required to use IDOLS to document services, for purposes of reimbursement, to individuals enrolled in the waiver. The DBHDS approved assessment shall be the Supports Intensity Scale (SIS), as published by the American Association on Intellectual and Developmental Disabilities and as may be amended from time to time.

G. Fiscal employer/agent requirements. Pursuant to a duly negotiated contract or interagency agreement, the contractor or entity shall be reimbursed by DMAS to perform certain employer functions including, but not limited to, payroll and bookkeeping functions on the part of the individual/employer who is receiving consumer-directed services.

1. The fiscal employer/agent shall be responsible for administering payroll services on behalf of the individual enrolled in the waiver including, but not limited to:

   a. Collecting and maintaining citizenship and alien status employment eligibility information required by the Department of Homeland Security;

   b. Securing all necessary authorizations and approvals in accordance with state and federal tax requirements;

   c. Deducting and filing state and federal income and employment taxes and other withholdings;

   d. Verifying that assistants’ or companions' submitted timesheets do not exceed the maximum hours prior authorized for individuals enrolled in the waiver;

   e. Processing timesheets for payment;

   f. Making all deposits of income taxes, FICA, and other withholdings according to state and federal requirements; and

   g. Distributing bi-weekly payroll checks to individuals' assistants.

2. All timesheet discrepancies shall be reported promptly upon their identification to DMAS for investigation and resolution.

3. The fiscal employer/agent shall maintain records and information as required by DMAS and state and federal laws and regulations and make such records available upon DMAS’ request in the needed format.

4. The fiscal employer/agent shall establish and operate a customer service center to respond to individuals' and assistants’ payroll and related inquiries.
5. The fiscal employer/agent shall maintain confidentiality of all Medicaid information pursuant to HIPAA and DMAS requirements. Should any breaches of confidential information occur, the fiscal/employer agent shall assume all liabilities under both state and federal law.

H. Changes to or termination of services. DBHDS shall have the authority, subject to final approval by DMAS, to approve changes to an individual's Individual Support Plan, based on the recommendations of the case management provider.

1. Providers of direct services shall be responsible for modifying their plans for supports, with the involvement of the individual enrolled in the waiver and the individual's family/caregiver, as appropriate, and submitting such revised plans for supports to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered.

   a. The case manager shall review the need for a change and may recommend a change to the plan for supports to the DBHDS staff.

   b. DBHDS shall review and approve, deny, or suspend for additional information, the requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its determination to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three business days of receipt of the request for change.

2. The individual enrolled in the waiver and the individual's family/caregiver, as appropriate, shall be notified in writing by the case manager of his right to appeal pursuant to DMAS client appeals regulations, Part I of 12VAC30-110, about the decision or decisions to reduce, terminate, suspend, or deny services. The case manager shall submit this written notification to the individual enrolled in the waiver within 10 business days of the decision.

3. In a nonemergency situation, when a participating provider determines that services to an individual enrolled in the waiver must be terminated, the participating provider shall give the individual and the individual's family/caregiver, as appropriate, and case manager 10 business days written notification of the provider's intent to discontinue services. The notification letter shall provide the reasons for the planned termination and the effective date the provider will be discontinuing services. The effective date shall be at least 10 business days from the date of the notification letter. The individual enrolled in the waiver shall be eligible for appeal rights in this situation and may pursue services from another provider.

4. In an emergency situation when the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the case manager and DBHDS shall be notified prior to discontinuing services. The 10-business-day prior written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and DBHDS Offices of Licensing and Human Rights shall be notified immediately by the case manager and the provider when the individual's health, safety, or welfare may be in danger.
5. The case manager shall have the responsibility to identify those individuals who no longer meet the level of care criteria or for whom home and community-based waiver services are no longer an appropriate alternative. In such situations, such individuals shall be discharged from the waiver.

a. The case manager shall notify the individual of this determination and afford the individual and family/caregiver, as appropriate, with his right to appeal such discharge.

b. The individual shall be entitled to the continuation of his waiver services pending the final outcome of his appeal action. Should the appeal action confirm the case manager's determination that the individual shall be discharged from the waiver, the individual shall be responsible for the costs of his waiver services incurred by DMAS during his appeal action.