Chapter: 22-A34

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MENTAL HEALTH REHABILITATION SERVICES PROVIDER CERTIFICATION STANDARDS

Title: 22-A MENTAL HEALTH

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3400 GENERAL PROVISIONS

3400.1 The Department of Mental Health (DMH) entered into a Memorandum of Agreement with the Department of Health, Medical Assistance Administration to implement a Medicaid Rehabilitation Option for the provision of mental health rehabilitative services (MHRS).

3400.2 The purpose of these rules is to set forth the requirements for certification of organizations as DMH-certified MHRS providers by DMH.

3400.2 Each DMH-certified MHRS provider shall meet and adhere to the terms and conditions of its Human Care Agreement with DMH and its Medicaid provider agreement with the Department of Health Care Finance (DHCF).

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3401 MHRS PROVIDER CERTIFICATION PROCESS

3401.1 Each applicant seeking certification as an MHRS provider shall submit a certification application to DMH. A DMH-certified MHRS provider seeking renewal of certification shall submit a certification application at least ninety (90) days prior to the termination of its current certification. The certification of an MHRS provider that has submitted a timely application for renewal certification shall continue until DMH takes action to renew or deny renewal of certification.

3401.2 Upon receipt of a certification application, DMH shall review the certification application to determine if it is complete. If a certification application is incomplete, DMH shall return the incomplete certification application to the applicant. An incomplete certification application shall not be regarded as a certification application, and return of the incomplete certification application and DMH's failure to take further action to issue certification to the applicant shall not constitute denial of an application for certification or renewal of certification.

3401.3 Following DMH's acceptance of the certification application, DMH shall determine whether the applicant's services and activities meet the certification standards described in this Chapter. DMH shall schedule and conduct an on-site survey of the applicant's services to determine whether the applicant satisfies all the certification standards.

3401.4 DMH may conduct an on-site survey at the time of certification application or certification renewal, or at any other time with appropriate notice, and shall have access to all records necessary to verify compliance with certification standards, and may conduct interviews with staff, others in the community, and consumers with consumer permission.

3401.5 DMH shall issue certification to each applicant complying with the certification standards. DMH shall issue certification to each DMH-certified MHRS provider seeking renewal of certification that complies with the certification standards.

3401.6 An applicant or DMH-certified MHRS provider that fails to comply with the certification standards shall receive a corrective measures plan (CMP) from DMH within thirty (30) working days, after the conclusion of the on-site survey. The CMP shall describe the areas of non-compliance, suggest actions needed to bring operations into compliance with the certification standards, and set forth a timeframe for the submission of a written corrective action plan (CAP).

3401.7 An applicant or DMH-certified MHRS provider's CAP shall describe the actions to be taken and specify a timeframe for correcting the areas of non-

compliance with the certification standards. The CAP shall be submitted to DMH within ten (10) working days after receipt of the CMP from DMH.

3401.8 DMH shall notify the applicant or DMH-certified MHRS provider whether the provider's CAP is accepted within five (5) working days after receipt.

3401.9 DMH shall issue certification after DMH verifies that the applicant or DMH-certified MHRS provider has complied with its CAP and meets all the certification standards.

3401.10 If a DMH-certified MHRS provider adds an MHRS service during the term of certification, the MHRS provider shall submit a certification application describing the service. Upon determination by DMH that the service is in compliance with certification standards, DMH shall certify the MHRS provider to provide that service.

3401.11 Certification as an MHRS provider shall be two calendar years from the date of issuance of certification by DMH, subject to the MHRS provider's continuous compliance with these certification standards. Certification shall remain in effect until it expires, is renewed or revoked. Certification shall specify the effective date of the certification, whether the MHRS provider is certified as a CSA, sub-provider or specialty provider, and the types of services the MHRS provider is certified to provide.

3401.12 Certification is not transferable to any other organization.

3401.13 The MHRS provider shall notify DMH immediately of any changes in its operation that affect the MHRS provider's continued compliance with these certification standards, including changes in ownership or control, changes in service and changes in its affiliation and referral arrangements.

3401.14 The Director may deny or revoke certification if the applicant or MHRS provider fails to comply with any certification standard.

3401.15 Certification shall be considered terminated and invalid if the MHRS provider fails to apply for renewal of certification prior to the expiration date of the certification, voluntarily relinquishes certification, or goes out of business.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3402 SERVICE COVERAGE

3402.1 MHRS are those rehabilitative or palliative services administered by DMH and rendered by DMH-certified MHRS providers to eligible consumers who require such services.

3402.2 MHRS are intended for the maximum reduction of mental disability and restoration of a consumer to his or her best possible functional level.

3402.3 MHRS are recommended by a physician or a licensed practitioner of the healing arts (approving qualified practitioners) and rendered by practitioners and clinicians (qualified practitioners) and credentialed staff under the supervision of qualified practitioners, in certified community mental health rehabilitation services agencies (MHRS providers) in accordance with the certification standards established in this chapter.

3402.4 Rehabilitative services covered as MHRS are:

(a) Diagnostic/Assessment;

(b) Medication/Somatic Treatment;

(c) Counseling;

(d) Community Support;

(e) Crisis/Emergency;

(f) Rehabilitation/Day Services;

(g) Intensive Day Treatment;

(h) CBI; and

(i) ACT.

3402.5 Eligible consumers of MHRS shall meet eligibility requirements established in § 3403.

3402.6 Eligible MHRS providers include CSAs, sub-providers and specialty providers that are certified in compliance with the certification standards set forth in this chapter.

3402.7 Qualified practitioners rendering MHRS through DMH-certified MHRS providers shall meet eligibility requirements described in § 3413.

3402.8 MHRS coverage limitations are set forth in § 3424. Coverage for any MHRS is contingent on whether all of the following criteria are met:

(a) The service shall be medically necessary;

(b) The service shall be delivered by a DMH-certified MHRS provider as described in § 3410, § 3411 and § 3412;

(c) The service shall be delivered by qualified practitioners (and credentialed staff under the supervision of qualified practitioners) acting within their scope of practice as identified in § 3413;

(d) The service shall be delivered in accordance with an approved IRP/IPC as described in § 3407, § 3408 and § 3409; and

(e) The service shall be delivered in accordance with the service specific standards set forth in § 3414, § 3415, § 3416, § 3417, § 3418, § 3419, § 3420, § 3421, § 3422 and § 3423.

3402.9 All consumers receiving MHRS shall have free choice of MHRS providers and free choice of qualified practitioners delivering services through a DMH-certified MHRS provider, as described in § 3406.

3402.10 All consumers receiving MHRS shall have the right to file a grievance with DMH and shall receive fair hearing rights and notice of such rights in accordance with the requirements set forth in 22A DCMR Chapter 3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Final Rulemaking published at 58 DCR 8366 (September 30, 2011).

3403 ELIGIBLE CONSUMERS

3403.1 Eligible consumers of MHRS include children and youth with mental health problems and adults with mental illness as described in D.C. Official Code § 7-1131.02(1) and (24) (2001) certified as requiring MHRS by a qualified practitioner.

3403.2 Eligible consumers of MHRS shall have a primary diagnosis on either Axis 1 or 2 of the DSM-IV.

3403.3 Persons with a primary substance abuse diagnosis only are not eligible consumers of MHRS.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3404 AUTHORIZATION AND RE-AUTHORIZATION OF MHRS

3404.1 Most MHRS do not require prior authorization by DMH, although some require re-authorization after specified amounts of services have been delivered. Prior authorization and re-authorization requirements are described in §3424.

3404.2 For services requiring either prior authorization or re-authorization under §3424, the CSA shall submit an authorization plan request to DMH for review and approval.

3404.3 Upon receiving the authorization plan request, DMH shall determine whether MHRS are medically necessary and issue a service authorization decision to the CSA.

3404.4 As part of the service authorization process, DMH may review the consumer's IRP/IPC or other clinical material if additional clinical information is required in order to evaluate consumer needs and make a level of care determination.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3405 CONSUMER PROTECTIONS

3405.1 Each MHRS provider shall establish and adhere to a consumer rights policy authorized by its governing authority (Consumer Rights Policy) that complies with the requirements of 22A DCMR §301.1.

3405.2 Each MHRS provider shall establish and adhere to a system for distributing the Consumer Rights Policy that complies with the requirements of 22A DCMR §301.3.

3405.3 Each MHRS provider shall establish and adhere to a well-publicized complaint and grievance system, which includes written policies and procedures for handling consumer, family, and practitioner complaints and grievances that complies with. 22A DCMR §306 (Complaint and Grievance Policy).

3405.4 Each MHRS provider shall establish and adhere to policies and procedures for obtaining written informed consent to treatment from consumers (Consent to Treatment Policy), which comply with applicable federal and District laws and regulations, including 22A DCMR Chapter 1.

3405.5 Each MHRS provider shall establish and adhere to policies and procedures governing the release of mental health information about consumers (Release of Consumer Information Policy), which comply with applicable federal and District laws and regulations. For consumers with co-occurring psychiatric and addictive disorders, the MHRS provider shall comply with the requirements of 42 CFR Part 2 governing the confidentiality and release of drug and alcohol treatment records.

3405.6 Each MHRS provider shall establish and adhere to policies and procedures governing the use of advance instructions for mental health treatment, durable power of attorney for health care and advance directives that comply with applicable federal and District laws and regulations, including 22A DCMR Chapter 1 and DMH policy (Advance Instructions Policy).

3405.7 Each MHRS provider's Advance Instructions Policy shall require qualified practitioners to incorporate the development of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives into the IRP/IPC planning process.

3405.8 DMH shall review and approve each MHRS provider's Consumer Rights Statement, Complaint and Grievance Policy, Consent to Treatment Policy, Release of Consumer Information Policy and Advance Instructions Policy, during the certification process.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3406 CONSUMER CHOICE

3406.1 Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers, qualified practitioners and other mental health service providers available, including information about peer support and family support services and groups and how to access these services (MH Consumer Choice Policy).

3406.2 DMH shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process.

3406.3 The MH Consumer Choice Policy shall comply with applicable federal and District laws and regulations.

3406.4 Each MHRS provider shall:

(a) Make its MH Consumer Choice Policy available to consumers and their families; and

(b) Establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.

3406.5 Each CSA's MH Consumer Choice Policy shall ensure that each enrolled consumer:

(a) Requesting MHRS directly from the CSA is informed that the consumer may choose to have MHRS provided by any of the other DMH-certified CSAs;

(b) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified sub-providers that have entered into affiliation agreements with that CSA;

(c) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the CSA to provide MHRS, including qualified practitioners providing MHRS through one of the CSA's subcontractors; and

(d) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified specialty providers that have entered into affiliation agreements with that CSA.

3406.6 Each sub-provider's MH Consumer Choice Policy shall ensure that each consumer:

(a) Enrolled in a CSA requesting MHRS directly from the sub-provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;

(b) Not enrolled in a CSA and requesting MHRS directly from the sub-provider is directed to DMH's Consumer Enrollment and Referral System; and

(c) Enrolled in a CSA and referred by that CSA to the sub-provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the sub-provider to provide MHRS, including the sub-provider's subcontractors.

3406.7 Each specialty provider's MH Consumer Choice Policy shall ensure that each consumer:

(a) Enrolled in a CSA requesting MHRS directly from the specialty provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;

(b) Not enrolled in a CSA and requesting MHRS directly from the specialty provider is directed to DMH's Consumer Enrollment and Referral System; and

(c) Enrolled in a CSA and referred by that CSA to the specialty provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the specialty provider to provide MHRS, including the specialty provider's subcontractors.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3407 TREATMENT PLANNING PROCESS

3407.1 Each CSA shall coordinate the treatment planning process for its enrolled consumers, except that the treatment planning process for consumers authorized to receive:

(a) CBI shall be coordinated by the consumer's CBI provider; and

(b) ACT services shall be coordinated by the consumer's ACT provider.

3407.2 The treatment planning process for consumers shall, at a minimum, include:

(a) The completion of a Diagnostic/Assessment service and required components as described in section 3415;

(b) Development of an IRP/IPC as described in section 3408; and

(c) Consideration of the consumer's beliefs, values, and cultural norms in how, what, and by whom MHRS are to be provided.

3407.3 Court-appointed guardians for adults, children and youth and the parents or family members of children and youth shall be involved in the treatment planning process. The families and significant others of adult consumers may participate in the treatment planning process to the extent that the adult consumer consents to the involvement of family and significant others.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476 (April 22, 2011).

3408 IRP/IPC DEVELOPMENT AND IMPLEMENTATION

3408.1 The IRP/IPC shall serve as authorization for the provision of MHRS. Certain services require pre-authorization or authorization by DMH, prior to commencement of the treatment planning process. All services, including those that require pre-authorization or authorization by DMH shall be addressed in the IRP/IPC.

3408.2 The IRP/IPC shall serve as certification that the MHRS are medically necessary as indicated by the approving qualified practitioner's signature on the initial and subsequent IRP/IPC. The approving qualified practitioner's approval of an IRP/IPC shall occur by the fourth visit or within thirty (30) calendar days after the consumer enrolls with the CSA, whichever occurs first.

3408.3 Each CSA shall develop and maintain a complete and current IRP/IPC for each enrolled consumer. The CSA is responsible for coordinating the development of the IRP/IPC with any sub-provider or specialty provider involved in the provision of services.

3408.4 Development of the IRP/IPC shall commence after the first clinical contact with the consumer, so that payment may be made for MHRS delivered consistent with the initial IRP/IPC. Consumers in a crisis situation who are eligible for ACT, CBI or Crisis/Emergency shall receive such services while the IRP/IPC is being developed.

3408.5 The IRP/IPC shall include the following elements:

(a) A description of the consumer's strengths or assets and challenges and how the consumer's strengths and assets will be utilized in achieving treatment goals.

(b) A statement of the mutually desired overall long-term results of each intervention, intermediate steps to be taken to achieve those long-term results and the overall treatment being provided for the consumer (Treatment Goals). Treatment Goals shall be based on the consumer's expressed needs and needs identified through Diagnostic/Assessment services, and referral information.

(c) A statement of the specific consumer or family skills that need to be developed or improved. This statement shall identify services and resources that need to be changed or modified to achieve each Treatment Goal (Objectives). Objectives shall be stated in terms of attainable and measurable results.

(d) A description of the interventions to be used to achieve each Objective and Treatment Goal including, but not limited to:

(1) A staff position or service component responsible for the intervention;

(2) The names of other agencies (and other human services systems if applicable) providing services for the consumer, a description of the service being provided, identification by name and title of the staff persons of those agencies or systems of care responsible for providing such services, and evidence of interagency service coordination;

(3) The intervention by service type, with the IRP/IPC identifying all services related to the provision of mental health services, regardless of the payment source for the service;

(4) The frequency and duration of the interventions;

(5) For each service, the MHRS provider chosen by the consumer; and

(6) A plan for addressing any medical problems that significantly impact or could be expected to affect the consumer's functioning which is to be carried out by either the CSA or another health-providing organization or practitioner.

(e) Development of psychiatric advance instructions, advance directives, crisis prevention plan, and relapse prevention plan.

3408.6 The clinical manager shall discuss the IRP/IPC with the consumer on an ongoing basis.

3408.7 Specific information describing the consumer's response to, participation in and agreement to the IRP/IPC shall be recorded in the consumer's clinical record.

3408.8 The clinical manager shall document the consumer's participation in the development of the IRP/IPC by obtaining the consumer's signature on the IRP/IPC, and documenting the consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may sign the IRP/IPC, if required by District laws and regulations.

3408.9 In situations where the consumer does not demonstrate the capacity to sign or does not sign the IRP/IPC, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted.

3408.10 The approving qualified practitioner and the clinical manager shall sign the IRP/IPC.

3408.11 The clinical manager has an affirmative obligation to ask the consumer to document participation and agreement with the IRP/IPC at each subsequent encounter if the consumer did not sign the IRP/IPC.

3408.12 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

3408.13 Each MHRS provider shall develop policies and procedures for IRP/IPC review (IRP/IPC Review Policy). The IRP/IPC Review Policy shall be part of the MHRS provider's Treatment Planning Policy as required by § 3410.12.

3408.14 The IRP/IPC Review Policy shall require that the IRP/IPC be reviewed and updated every one hundred eighty (180) days and at any time there is a significant change in the consumer's condition or situation to reflect progress toward or the lack of progress toward the Treatment Goals. The IRP/IPC may be reviewed more frequently, as necessary, based on the consumer's progress or circumstances.

3408.15 Each IRP/IPC review shall include a review of each of the items stated in § 3408.5 including progress on Treatment Goals, re-identification of strengths and progress on Objectives.

3408.16 The consumer, the consumer's clinical manager, approving qualified practitioner and other qualified practitioners as necessary or appropriate shall establish new Objectives and modify, add/or delete Treatment Goals based on the results of the IRP/IPC review, the consumer's assessment of progress toward meeting Treatment Goals and any new needs, and any other assessments provided by significant others, family or other professionals.

3408.17 At a minimum the approving qualified practitioner and the consumer shall participate in the IRP/IPC review.

3408.18 At the IRP/IPC review, the approving qualified practitioner shall identify all required MHRS re-authorizations and establish a target date for requesting the re-authorizations well in advance of their expiration dates.

3408.19 The approving qualified practitioner shall document the consumer's participation in the IRP/IPC review by obtaining the consumer's signature on the revised IRP/IPC. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may be required to sign the revised IRP/IPC, if required by District laws and regulations.

3408.20 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the review of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476 (April 22, 2011); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8367 (September 30, 2011).

3409 IRP/IPC GUIDING PRINCIPLES AND ADDITIONAL REQUIREMENTS

3409.1 Each IRP/IPC shall:

(a) Be person-centered;

(b) Include the consumer's self-identified recovery goals; and

(c) Provide for the delivery of services in the most normative, least restrictive environment that is appropriate for the consumer.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3477 (April 22, 2011).

3410 MHRS PROVIDER QUALIFICATIONS--GENERAL

3410.1 Each MHRS provider shall be established as a legally recognized entity in the United States and qualified to conduct business in the District. A certificate of good standing issued by the District of Columbia Department of Consumer and Regulatory Affairs shall be evidence of qualification to conduct business.

3410.2 Each MHRS provider shall maintain the clinical operations policies and procedures described in this section which shall be reviewed and approved by DMH, during the certification survey process.

3410.3 Each MHRS provider shall:

(a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;

(b) Comply with all applicable federal and District laws and regulations;

(c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;

(d) Ensure that qualified practitioners, listed in § 3413, are available to provide appropriate and adequate supervision of all clinical activities; and

(e) Employ qualified practitioners that meet all professional requirements as defined by the District's licensing laws and regulations relating to the profession of the qualified practitioner.

3410.4 Each MHRS provider shall establish and adhere to policies and procedures for selecting and hiring staff (Staff Selection Policy), including, but not limited to requiring:

(a) Evidence of licensure, certification or registration as applicable and as required by the job being performed;

(b) For unlicensed staff, evidence of completion of an appropriate degree, training program, or credentials, such as academic transcripts or a copy of degree;

(c) Appropriate reference and background checks as required by federal and District of Columbia law, including ensuring on an on-going basis that no individual is excluded from participation in a federal health care program as found on the Department of Health

and Human Services *List of Excluded Individuals/Entities* (http://oig.hhs.gov/fraud/exclusion.asp) or the General Services Administration *Excluded Parties List System* (http://www.wpls.gov);

(d) Evidence of completion of all communicable disease testing required by District laws and regulations, including a Tuberculin skin test or a chest x-ray;

(e) A process by which all staff, as a condition of hiring, shall:

(1) Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations;

(2) Indicate whether they are presently using illegal drugs; and

(3) Attest that they are capable of performing the essential functions of their jobs, with or without accommodation; and

(f) A mechanism for ongoing monitoring of staff licensure, certification, or registration, such as an annual confirmation process concurrent with staff performance evaluations that includes repeats of screening checks outlined above as appropriate.

3410.5 Each MHRS provider shall establish and adhere to written job descriptions for all positions, including, at a minimum, the role, responsibilities, reporting relationships, and minimum qualifications for each position. The minimum qualifications for each position shall be appropriate for the scope of responsibility and clinical practice described for each position.

3410.6 Each MHRS provider shall establish and adhere to policies and procedures requiring a periodic evaluation of clinical and administrative staff performance (Performance Review Policy) that require an assessment of clinical competence, as well as general organizational work requirements, and an assessment of key functions as described in the job description.

3410.7 Each MHRS provider shall establish and adhere to policies and procedures to ensure that clinical staff are licensed and to the extent required by applicable District laws and regulations, work under the supervision of a qualified practitioner (Supervision and Peer Review Policy). The Supervision and Peer Review Policy shall:

(a) Include procedures for clinical supervision, which require sufficient clinical supervision conducted by qualified practitioners;

(b) Require personnel files of non-licensed clinical staff and consumer clinical records to contain evidence that the Supervision and Peer Review Policy is observed; and

(c) Include an active peer review process to monitor quality of care delivered by qualified practitioners and credentialed staff.

3410.8 Each MHRS provider shall establish and adhere to policies and procedures governing the credentialing or privileging of staff (Credentialing Policy) consistent with DMH rules on privileging and competency-based credentialing systems. The Credentialing Policy shall:

(a) Allow staff who do not possess college degrees to be credentialed for direct service work, based on educational equivalent qualifications which include experience that provides an individual with an understanding of mental illness and which was acquired as an adult through personal experience with the mental health treatment system and recovery or through the provision of significant supports to adults with mental illness or children and youth with mental health problems and with serious emotional disturbance;

(b) Facilitate the employment of persons in recovery as peer counselors and members of community support teams; and

(c) Include an assessment of qualified practitioners' cultural competence.

3410.9 Each MHRS provider shall provide training to all staff, including all qualified practitioners (both those employed and those under contract to the MHRS provider), as orientation to MHRS (Staff Orientation Training) during the first three (3) months of employment and on an ongoing basis. The Staff Orientation Training curriculum shall address the following:

(a) Mental illnesses and evidence-based clinical interventions;

(b) Consumer rights;

(c) Declaration of advance instructions for mental health treatment, durable power of attorney for health care, and advance directives;

(d) Definitions and types of abuse and neglect and the MHRS provider's policies on investigating allegations of abuse and neglect;

(e) Recovery model, psychiatric rehabilitation, consumer and family empowerment, and self-help or peer support;

(f) Knowledge of medication, its benefits, and side effects;

(g) Child-centered, family-focused, and multi-system service delivery;

(h) Communication skills;

(i) Integrated treatment for co-occurring psychiatric and addictive disorders;

(j) Behavior management;

(k) Handling emergency situations;

(l) Recordkeeping and clinical documentation standards;

(m) Confidentiality;

(n) DMH Consumer Enrollment and Referral System;

(o) MHRS provider's policies and procedures;

(p) Medicaid MHRS requirements, especially those relating to recordkeeping, billing, documentation, and consumer choice; and

(q) Cultural competence and its relationship to treatment outcomes.

3410.10 Each MHRS provider shall establish and adhere to an annual training plan for staff to ensure that all staff receive at a minimum, annual training on the following topics (Annual Training Plan):

(a) The subjects covered during Staff Orientation Training;

(b) Infection control guidelines, including compliance with the bloodborne pathogens standard, communicable diseases and universal precautions;

(c) Safety and risk management; and

(d) The MHRS provider's Disaster Evacuation Plan.

3410.11 Each MHRS provider shall establish and adhere to policies and procedures defining preadmission, intake, screening, referral, transfer, and discharge procedures (Admission, Transfer, and Discharge Policy) that comply with applicable federal and District laws and regulations.

3410.12 Each MHRS provider shall establish and adhere to policies and procedures governing the coordination of the treatment planning process (Treatment Planning Policy), including procedures for designing, implementing, reviewing, and revising each consumer's IRP/IPC that comply with the requirements of sections 3407, 3408, and 3409.

3410.13 Each MHRS provider shall establish and adhere to policies and procedures requiring that treatment be provided in accordance with the service specific standards in § 3414, § 3415, § 3416, § 3417, § 3418, § 3419, § 3420, § 3421 and § 3422 (Service Specific Policy). The Service Specific Policy shall:

(a) Address supervision requirements and required caseload ratios that are appropriate to the population served and treatment modalities employed; and

(b) Include a written description of the services offered by the MHRS provider (Service Description) describing the purpose of the service, the hours of operation, the intended population to be served, treatment modalities provided by the service, treatment objectives, and expected outcomes.

3410.14 Each MHRS provider shall establish and adhere to policies and procedures governing communication with the consumer's primary care providers (Primary Care Provider Communication Policy). The Primary Care Provider Communication Policy shall:

(a) Require the MHRS provider to obtain and document authorization from the consumer in the consumer's clinical records before contacting the consumer's primary care providers;

(b) Outline the MHRS provider's interface with primary health care providers, managed health care plans, and other providers of mental health services; and

(c) Describe the MHRS provider's activities which will enhance consumer access to primary health care and the coordination of mental health and primary health care services.

3410.15 Each MHRS provider shall establish and adhere to policies and procedures for handling routine, urgent, and emergency situations (Unscheduled Service Access Policy). The Unscheduled Service Access Policy shall:

(a) Include referral procedures to local emergency departments;

(b) Include staff assignment to cover emergency walk-in hours;

(c) Include on-call arrangements for clinical staff and physicians that provide for both:

(1) Direct telephone access to a qualified practitioner, for the consumer, including an employee of an emergency services provider selected by the consumer or other person acting on behalf of the consumer making contact with the MHRS provider; and

(2) Timely access to face-to-face crisis support services;

(d) Specify how the MHRS provider will interact and coordinate services with the DMH-designated crisis and emergency service; and

(e) Include procedures for triaging consumers who require Crisis/Emergency services or psychiatric hospitalization.

3410.16 Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and District laws and regulations (Clinical Records Policy). The Clinical Records Policy shall:

(a) Require the MHRS provider to maintain all clinical records in a secured and locked storage area;

(b) Require the MHRS provider to maintain and secure a current, clear, organized, and comprehensive clinical record for every individual assessed, treated, or served which includes information deemed necessary to provide treatment, protect the MHRS provider, or comply with applicable federal and District laws and regulations; and

(c) Require that the clinical record contain information to identify the consumer, support the diagnosis, justify the treatment, document

the course and results of treatment, and facilitate continuity of care. The clinical record shall include, at a minimum:

(1) Consumer identification information, including enrollment information;

(2) Identification of a person to be contacted in the event of emergency;

(3) Basic screening and intake information;

(4) Documentation of internal or external referrals;

(5) Comprehensive diagnostic and psychosocial assessments;

(6) Pertinent medical information including the name, address, and telephone number of the consumer's primary care physician and the name and address of the consumer's preferred hospital;

(7) Advance instructions and advance directives;

(8) The IRP/IPC;

(9) For children and youth, documentation of family involvement in treatment planning and services or statement of reasons why it is not clinically indicated;

(10) Methods for addressing consumers' and families' special needs, especially those which relate to communication, cultural, and social factors;

(11) Detailed description of services provided;

(12) Progress notes;

(13) Discharge planning information;

(14) Appropriate consents for service;

(15) Appropriate release of information forms; and

(16) Signed Consumer Rights Statement.

3410.17 Progress notes shall:

(a) Be written at least once per month and as needed;

(b) Reflect IRP/IPC implementation, including documentation of the choices and perceptions of the consumer regarding the service(s) provided;

(c) Describe the progress the consumer has made towards his or her IRP/IPC goals;

(d) Be signed and dated by the credentialed staff or qualified practitioner making the entry. A qualified practitioner shall countersign progress notes made by credentialed staff; and

(e) Clinical documentation to support billing for a service as described in subsection 3410.18 does not suffice as a Progress Note.

3410.18 Each MHRS provider shall develop and maintain sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of:

(a) The specific service type rendered;

(b) The date, duration, and actual time, a.m. or p.m. (beginning and ending), during which the services were rendered;

(c) Name, title, and credentials of the person providing the services;

(d) The setting in which the services were rendered;

(e) Confirmation that the services delivered are contained in the consumer's IRP/IPC;

(f) A description of each encounter or service by a qualified practitioner or credentialed staff with the consumer which is sufficient to document that the service was provided in accordance with this Chapter; and

(g) Dated and authenticated entries, with their authors identified, which are legible and concise, including the printed name and the signature of the person rendering the service, diagnosis and clinical impression recorded in the terminology of the ICD-9 CM, and the service provided.

3410.19 Each MHRS provider shall ensure that all clinical records of consumers are completed promptly, filed, and retained in accordance with the MHRS provider's Clinical Records Policy.

3410.20 MHRS providers shall make MHRS available as follows:

MHRS	HOURS OF OPERATION	OTHER AVAILABILITY REQUIREMENTS
Diagnostic/Assessment	Six (6) days per week 9:00 am - 6:00 p.m., 3 days per week 9:00 am - 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on- call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Medication/Somatic Treatment	Six (6) days per week 9:00 am - 6:00 p.m., 3 days per week 9:00 am - 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on- call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Counseling	Six (6) days per week 9:00 am - 6:00 p.m., 3 days per week 9:00 am - 9:00 p.m., 2 days per week 4 hours on Saturday	CSA shall operate an on- call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week.
Community Support	Twenty-four (24) hours per day, Seven (7) days per week	CSA shall operate an on- call system for enrolled consumers, twenty-four (24) hours per day, seven (7) days per week. Seventy-five percent (75%) or more of services shall be performed face-to-face. At least fifty percent (50%) of staff time shall be spent working outside the service site(s) with or on behalf of consumers.
Crisis/Emergency	Twenty-four (24) hours per day, Seven (7) days per week	Psychiatric consultation shall be available twenty- four (24) hours per day, seven (7) days per week
Rehabilitation/Day Services	Thirty (30) hours per week, no less than six (6) hours per day	Consumers authorized and referred for service shall be admitted within seven (7) business days of the referral from the CSA.

Intensive Day Treatment	Seven (7) days per week, no less than five (5) hours per day	Programs serving adults shall offer a minimum of forty (40) hours of active programming per week. Programs serving children shall offer a minimum of thirty (30) hours of active programming per week. Consumers authorized and referred for Intensive Day Treatment shall be admitted within forty-eight (48) hours of referral by a CSA.
Community-Based Intervention (CBI)	Levels I , II, III and IV - Twenty-four (24) hours per day, seven (7) days per week	Consumers authorized and referred for all levels of CBI shall be admitted within forty-eight (48) hours of referral by a CSA. A CBI Team member shall respond to a call from a family member or a significant other, either by telephone or face- to-face contact, within sixty (60) minutes of receiving the call. All CBI providers shall develop a crisis intervention plan for each consumer receiving CBI. Level IV providers shall develop a crisis intervention plan for afterhours response which shall include Mobile Crisis Response Team.
Assertive Community Treatment	Twenty-four (24) hours per day, Seven (7) days per week, with emergency response coverage, to include psychiatric availability	Consumers authorized and referred for ACT shall be admitted within forty-eight (48) hours of referral by a CSA. At least sixty percent (60%) of ACT Services shall be provided in locations other than the office, according to consumer need, preference and clinical appropriateness. An ACT team member shall respond to a call from family or a significant other, either by telephone or face-to-face contact within sixty (60) minutes of receiving the call.

3410.21 Each MHRS provider shall establish and adhere to policies and procedures requiring the MHRS provider to make language interpreters available as

needed for persons who do not use English as a first language or use a non-primary language for communication (Interpreter Policy). The Interpreter Policy shall:

(a) Prohibit a person acting as a language interpreter from simultaneously functioning as a qualified practitioner, in either individual treatment or treatment planning sessions;

(b) Address the employment of qualified sign language interpreters.

3410.22 The Interpreter Policy shall allow staff and contractors who do not possess valid certification from the National Registry of Interpreters for the Deaf to be credentialed based on skills in mental health interpreting gained through supervised experience. For purposes of this rule, supervised experience shall include supervision by an interpreter certified by the National Registry of Interpreters for the Deaf and ongoing training in sign language interpreting, preferably related to mental health, and may include on-the-job learning prior to employment by the MHRS provider.

3410.23 Each MHRS provider shall utilize a TTY communications line (or an equivalent) to enhance the MHRS provider's ability to respond to service requests and needs of consumers and potential consumers. MHRS provider staff shall be trained in the use of such communication devices.

3410.24 Each MHRS provider shall establish and adhere to policies and procedures which govern the provision of services in natural settings (Natural Settings Policy). The Natural Settings Policy shall require the MHRS provider to document how it respects consumers' and families' right to privacy and confidentiality when services are provided in natural settings.

3410.25 Each MHRS provider shall establish and adhere to policies and procedures and an in-service training program for all staff regarding sensitivity to cultural issues, increasing cultural competence of all staff, and treating consumers with dignity and respect, addressing the following areas: beliefs, values, tradition, lifestyle practices, laws and regulations, formal and informal rules of behavior, spirituality, poverty, powerlessness, patienthood and disability (Cultural Competence Policy). Personnel files of all staff shall contain documentation that, at a minimum, eight (8) hours of training is completed annually, and that the training follows DMH's recommended curriculum for cultural sensitivity. Each MHRS provider shall ensure that services are delivered in a culturally sensitive manner.

3410.26 Each MHRS provider shall establish and adhere to anti-discrimination policies and procedures relative to hiring, promotion, and provision of services to consumers that comply with applicable federal and District laws and regulations (Anti-Discrimination Policy).

3410.27 Each MHRS provider shall establish and adhere to policies and procedures governing quality improvement (Quality Improvement Policy). The Quality Improvement Policy shall require the MHRS provider to adopt a written Quality Improvement (QI) plan describing the objectives and scope of its QI program and requiring MHRS provider staff, consumer, and family involvement in the QI program. DMH shall review and approve each MHRS provider's QI program. The QI program shall be operational and shall measure and ensure at least the following:

(a) Access and availability of services;

(b) Treatment and prevention of acute and chronic conditions;

(c) High volume services, high risk conditions and services, especially children and youth services;

(d) Coordination of care across behavioral health treatment and primary care treatment settings;

(e) Compliance with all MHRS certification standards;

(f) Adequacy, appropriateness and quality of care;

(g) Efficient utilization of resources; and

(h) Consumer and family satisfaction with services.

3410.28 Each MHRS provider shall comply with the following requirements for facilities management:

(a) Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group counseling sessions in consumer interview rooms.

(b) Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.

(c) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.

(d) In-office waiting time shall be less than one (1) hour from the scheduled appointment time. Each MHRS provider shall

demonstrate that it can document the time period for in-office waiting.

(e) Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.

(f) Each MHRS provider's main service site shall be located within reasonable walking distance of public transportation.

(g) Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the work place, or other disaster for all service sites (Disaster Evacuation Plan).

(h) The Disaster Evacuation Plan shall require the MHRS provider:

(1) To conduct periodic disaster evacuation drills;

(2) Ensure that all evacuation routes are clearly marked by lighted exit signs; and

(3) Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.

(i) Each MHRS provider shall obtain a written certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services indicating that all applicable fire and safety code requirements have been satisfied.

(j) Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and District laws and regulations for adequacy of construction, safety, sanitation and health.

(k) Each MHRS provider shall establish and adhere to policies and procedures governing infection control (Infection Control Policy). The Infection Control Policy shall comply with applicable federal and District laws and regulations, including, but not limited to the bloodborne pathogens standard set forth in 29 CFR § 1910.1030.

(l) Each MHRS provider shall establish and adhere to policies and procedures governing the purchasing, receipt, storage, distribution, return, and destruction of medication that include accountability for and security of medications located at any of its service site(s) (Medication Policy). The Medication Policy shall comply with

applicable federal and District laws and regulations regarding the purchasing, receipt, storage, distribution, dispensing, return, and destruction of medications and require the MHRS provider to maintain all medications and prescription blanks in a secured and locked area.

3410.29 Each MHRS provider shall have established by-laws or other legal documentation regulating the conduct of its internal financial affairs. This documentation shall clearly identify the individual(s) that are legally responsible for making financial decisions for the MHRS provider and the scope of such decision-making authority. Each MHRS provider shall:

(a) Maintain an accounting system that conforms to generally acceptable accounting principles, provides for adequate internal controls, permits, the development of an annual budget, an audit of all income received and an audit of all expenditures disbursed by the MHRS provider in the provision of services;

(b) Have an internal process that allows for the development of interim and annual financial statements that compares actual income and expenditures with budgeted amounts, accounts receivable, and accounts payable information; and

(c) Operate in accordance with an annual budget established by its governing authority.

3410.30 Each MHRS provider shall establish and adhere to policies and procedures governing the retention, maintenance, purging and destruction of its business records (Records Retention Policy). The Records Retention Policy shall:

(a) Comply with applicable federal and District laws and regulations;

(b) Require the MHRS provider to maintain all business records pertaining to costs, payments received and made, and services provided to consumers for a period of six (6) years or until all audits are completed, whichever is longer; and

(c) Require the MHRS provider to allow DMH, DHCF, the District's Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their authorized representatives to review the MHRS provider's business records, including clinical and financial records.

3410.31 Each MHRS provider shall comply with the following requirements for maintaining certification, provider status, and contracts:

(a) Maintain proof of DMH certification;

(b) Maintain an active Medicaid provider status at all times;

(c) Document referral arrangements in writing, using the DMH-approved affiliation agreement;

(d) Maintain copies of contracts with DMH, vendors, suppliers, and independent contractors; and

(e) Require that its subcontractors continuously comply with the provisions of the MHRS provider's Human Care Agreement with DMH.

3410.32 Each MHRS provider, at its expense, shall:

(a) Obtain the minimum insurance coverage required by its Human Care Agreement; and

(b) Make evidence of its insurance coverage available to DMH upon request.

3410.33 Each MHRS provider shall establish and adhere to policies and procedures governing billing and payment for MHRS (Billing and Payment Policy). The Billing and Payment Policy shall require the MHRS provider to have the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity shall include the ability to:

(a) Verify eligibility for Medicaid and other third party payers;

(b) Document MHRS provided (by MHRS provider staff and subcontractors);

(c) Submit claims and documentation of MHRS to DMH on a timely basis; and

(d) Track payments for all MHRS provided to enrolled or referred consumers.

3410.34 Each MHRS provider shall submit claims for MHRS provided to enrolled consumers to DMH within ninety (90) days of the date of service, or thirty (30) days after a secondary or third party payer has adjudicated a claim for this service. DMH shall not pay for a claim that is submitted more than

one (1) year from the date of service, except when federal law or regulations would require such payment to be made.

3410.35 Each MHRS provider shall have an established sliding fee schedule covering each of the MHRS it provides. For services provided to Medicaid-eligible consumers, no additional charge shall be imposed for services beyond that paid by Medicaid.

3410.36 Each MHRS provider shall utilize and require its subcontractors to utilize payments from other public or private sources, including Medicare. Payment of DMH and federal funds to the MHRS provider shall be conditional upon the utilization of all benefits from other payment sources.

3410.37 Each MHRS provider shall operate according to all applicable federal and District laws and regulations relating to fraud and abuse in health care, the provision of mental health services, and the Medicaid program. An MHRS provider's failure to report potential or suspected fraud or abuse may result in sanctions, cancellation of contract, or exclusion from participation as an MHRS provider. Each MHRS provider shall:

(a) Cooperate and assist the District and any federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud and abuse;

(b) Be responsible for promptly reporting suspected fraud and abuse to DMH, taking prompt corrective actions consistent with the terms of any contract or subcontract with DMH, and cooperating with DHCF or other governmental investigations; and

(c) Ensure that none of its practitioners have been excluded from participation as a Medicaid or Medicare provider and, if a practitioner is determined to be excluded by the Center for Medicare and Medicaid Services (CMS), notify DMH immediately.

3410.38 Each MHRS provider shall establish and adhere to a plan for ensuring compliance with applicable federal and District laws and regulations (Corporate Compliance Plan), approved by DMH. Each MHRS provider shall submit any updates or modifications to its Corporate Compliance Plan to DMH for prior review and approval. Each MHRS provider's Corporate Compliance Plan shall:

(a) Designate an officer or director with responsibility and authority to implement and oversee the operation of the Corporate Compliance Plan;

(b) Require that all officers, directors, managers, and employees know and understand its provisions;

(c) Include procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of MHRS;

(d) Include procedures for the confidential reporting of violations of the Corporate Compliance Plan to DMH, including procedures for the investigation and follow-up of any reported violations;

(e) Ensure that the identities of individuals reporting suspected violations of the Corporate Compliance Plan are protected and that individuals reporting suspected violations, fraud, or abuse are not retaliated against;

(f) Require that confirmed violations of the Corporate Compliance Plan be reported to DMH within twenty-four (24) hours of confirmation; and

(g) Require any confirmed or suspected fraud and abuse under state or federal law or regulation be reported to DMH.

3410.39 Each MHRS provider shall ensure that sufficient resources (e.g. personnel, hardware, software) are available to support the operations of computerized systems for collection, analysis, and reporting of information, along with claims submission.

3410.40 Each MHRS provider shall have the capability to interact with the DMH contract management system as required by DMH.

3410.41 Claims for MHRS shall be submitted using the format required by DMH.

3410.42 Each MHRS provider shall manage information in compliance with the confidentiality requirements contained in applicable federal and District laws and regulations.

3410.43 Each MHRS provider shall establish and adhere to a plan that contains policies and procedures for maintaining the security of data and information (Disaster Recovery Plan). Each MHRS provider's Disaster Recovery Plan shall also stipulate back-up and redundant systems and measures that are designed to prevent the loss of data and information and to enable the recovery of data and information lost due to disastrous events.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking

published at 57 DCR 10392, 10393 (November 5, 2010); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3477 (April 22, 2011); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8367 (September 30, 2011).

3411 CORE SERVICES AGENCY REQUIREMENTS

3411.1 Each CSA shall comply with the general certification standards described in § 3410, the service specific certification standards applicable to core services and the certification standards set forth in this section, as well as the other certification standards in this Chapter.

3411.2 Each CSA shall:

(a) Serve as the clinical home for the consumers it enrolls;

(b) Employ clinical managers, except that a psychiatrist serving as a clinical manager may be- under contract to the CSA;

(c) Be responsible for ensuring that IRPs/IPCs are developed and approved for its enrolled consumers; and

(d) Provide clinical management for its enrolled consumers.

3411.3 Each CSA shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer with professional qualifications and experience who meets the requirements established by the MHRS provider's governing authority. The Chief Executive Officer shall be charged with responsibility for day-to-day management of the CSA, and shall be a full-time employee devoting at least twenty (20) hours a week to administrative and management functions for the CSA;

(b) A Medical Director who is a board-eligible psychiatrist, responsible for the quality of medical and psychiatric care provided by the MHRS provider. A child and youth-serving CSA may have a staff or consulting board-eligible child psychiatrist or a staff board-eligible psychiatrist with substantial child and adolescent experience as its Medical Director;

(c) A Clinical Director who is a qualified practitioner with an appropriate, relevant behavioral health advanced degree, with overall responsibility for oversight of the clinical program of the MHRS provider. The Clinical Director may also serve as the Medical Director if the Clinical Director is a board-eligible psychiatrist;

(d) A full-time Controller, Chief Financial Officer, or designated individual responsible for executing or overseeing the financial operations of the MHRS provider. The designated financial officer

shall have a Bachelors Degree plus two (2) years of fiscal experience and may also oversee administrative operations and information services;

(e) A Quality Improvement Director responsible for developing and implementing the CSA's QI program; and

(f) A Medical Records Administrator, responsible for:

(1) Ongoing quality control of clinical documentation;

(2) Assuring that clinical records are maintained, completed, and preserved in accordance with the MHRS provider's Clinical Records Policy;

(3) Assuring that information on enrolled consumers is immediately retrievable; and

(4) Establishing a central records index for the MHRS provider.

3411.4 Each CSA shall comply with the following requirements regarding clinical operations:

(a) All consumers receiving treatment from or through a CSA shall choose a clinical manager from the CSA's staff.

(b) The clinical manager, along with the consumer and the approving practitioner, shall be responsible for the development of the consumer's IRP/IPC and coordinating the delivery of all MHRS received by the consumer.

(c) The clinical manager shall participate in the development of the IRP/IPC and shall periodically review its effectiveness with the consumer.

(d) The clinical manager shall be primarily responsible for assuring that the IRP assists the adult consumer in developing self-care skills and achieving recovery, and that the IPC assists the child or youth consumer and family to achieve age-appropriate growth and development.

(e) Each CSA shall establish and adhere to policies and procedures governing its relationship with sub-providers and specialty providers (Affiliated Provider Policy). The Affiliated Provider Policy shall address, at a minimum, access to records, clinical

responsibility, treatment planning responsibility, and dispute resolution.

(f) Each CSA shall establish and adhere to policies and procedures governing its relationship with subcontractors (Subcontractor Policy). The Subcontractor Policy shall address, at a minimum, access to records, clinical responsibility and supervision, legal liability, insurance and dispute resolution.

(g) Each CSA shall establish and adhere to policies and procedures governing the means by which family education and support will be offered and provided (Consumer and Family Education Policy). The Consumer and Family Education Policy shall require, at a minimum, the following:

(1) The CSA shall make family education and support available for all consumer families;

(2) Family education and support shall include general information about mental health and psychiatric illness;

(3) Specific information about a consumer's situation shall be provided with the permission of the consumer, or in the case of child, with the permission of the parent or guardian in accordance with the CSA's Release of Consumer Information Policy;

(4) The availability of appointments for family members to meet with staff and availability of family support and education groups to be scheduled at times convenient for the family; and

(5) In written materials and face-to-face contacts provide information about available and needed services, as well as how the consumer may access Crisis/Emergency services. The materials shall be written at the 4th grade reading level and shall be printed in English and either Spanish or the secondary language conducive to facilitating communication with the majority of the CSA's target population.

(h) All materials regarding the availability of certified MHRS providers shall be reviewed and approved by DMH.

3411.5 Each CSA shall comply with the following requirements regarding service accessibility:

(a) Each CSA shall operate an on-call system for its enrolled consumers twenty-four (24) hours per day, seven (7) days per week, which is staffed by qualified practitioners to respond to urgent, emergency and routine situations (CSA On-Call System).

(b) Each CSA shall establish and adhere to policies and procedures governing the operation of its On-Call System (On-Call System Policy). The On-Call System Policy shall require the CSA to provide:

(1) Direct telephone access to a qualified practitioner for consumers and their significant others to resolve problems telephonically, where possible;

(2) Timely access to a qualified practitioner in order to provide any needed face-to-face crisis support services; and

(3) Linkage to Crisis/Emergency services, including crisis stabilization services and "next day" appointments to assist the consumer to address urgent problems during the next business day; and

(4) Face-to-face response by a qualified practitioner within two (2) hours to the consumer's request for service.

(c) Each CSA shall, at a minimum, offer the core services as required by § 3414, § 3415, § 3416, § 3417 and § 3418 of these certification standards.

(d) Each CSA shall ensure that its business hours comply with the requirements of § 3410.20 and facilitate each enrolled consumer's ability to choose an MHRS provider.

(e) Each potential consumer presenting with an urgent need shall be provided an appointment by a CSA with a qualified practitioner for a face-to-face intervention within the same day that the consumer presents for service.

(f) Each potential consumer presenting with a routine need shall be provided an intake appointment by a CSA for an intake appointment within seven (7) business days of presentation for service.

(g) Each CSA shall have policies and procedures for the provision of outreach services, including means by which these services and

individuals will be targeted for such efforts (Outreach Policy). The Outreach Policy shall include procedures for protecting the safety of staff who engage in outreach activities.

3411.6 In addition to complying with the requirements set forth in § 3410.27, each CSA shall have a QI program directed by a committee comprised of qualified practitioners and staff directly involved in the provision of services (QI Committee). The QI Committee shall:

(a) Be chaired by a qualified practitioner with direct access to the Chief Executive Officer;

(b) Include consumers and family members;

(c) Review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances; and

(d) Conduct an annual evaluation of the QI program, periodically revise the QI program description, and develop the annual QI plan.

3411.7 Each CSA shall make a play area available for children in the waiting room area.

3411.8 Each CSA shall have a full-time Controller, Chief Financial Officer, or a designated individual who is responsible for executing or overseeing the financial operations of the CSA, as described in § 3410.29, § 3410.33, § 3410.34, § 3410.35, § 3410.36, § 3410.37, § 3410.40, § 3410.41 and § 3411.9.

3411.9 Each CSA shall have an annual audit by a certified public accounting firm, and the resulting audit report shall be consistent with formats recommended by the American Institute of Public Accountants. A copy of the most recently certified annual audit report shall be submitted to DMH within one hundred-twenty (120) days after the close of the CSA's fiscal year.

3411.10 Each CSA shall enter into an affiliation agreement with its sub-providers and all specialty providers that specifies the responsibilities of the parties, except for sub-providers and specialty providers providing ACT or CBI services. No affiliation agreement is needed for the provision of ACT or CBI services.

3411.11 Each CSA shall be responsible for submitting IRP/IPC information to the DMH contract management system in order to register all medically necessary MHRS for its enrolled consumers and for updating and re-

submitting the IRP/IPC for each of its enrolled consumers to the DMH contract management system at least once every one hundred eighty (180) days and more frequently as necessary.

3411.12 Each CSA shall have the capability to submit timely and accurate claims, encounter data and other submissions as necessary directly to the DMH contract management system.

3411.13 DMH shall review and approve each CSA's Affiliated Provider Policy, Subcontractor Policy, Consumer and Family Education Policy, On-Call System Policy and Outreach Policy.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 57 DCR 10392, 10393 (November 5, 2010); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3478 (April 22, 2011); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8369 (September 30, 2011).

3412 SUBPROVIDER AND SPECIALTY PROVIDER REQUIREMENTS

3412.1 Each sub-provider and specialty provider shall comply with the certification standards described in § 3410, the service specific standards applicable to the MHRS offered by the sub-provider or specialty provider and the certification standards described in this section, as well as the other certification standards in this Chapter.

3412.2 Sub-providers shall provide one (1) or more of the core services only through an affiliation agreement with a CSA.

3412.3 Each sub-provider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibility, legal liability, dispute resolution, and all other MHRS certification standards (CSA Affiliation Policy).

3412.4 Except for the provision of ACT or CBI services, specialty providers shall provide one (1) or more of the specialty services only through a referral arrangement with a CSA which is documented in an affiliation agreement. An affiliation agreement is not necessary for the provision of ACT or CBI services.

3412.5 Each specialty provider shall establish and adhere to policies and procedures governing its relationship with a CSA which address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards (CSA Referral Policy).

3412.6 Each sub-provider and specialty provider shall satisfy the following minimum staffing requirements:

(a) A Chief Executive Officer or Program Director with professional qualifications and experience who shall meet requirements as established by the MHRS provider's governing authority and is responsible for day-to-day management of the MHRS provider;

(b) A sub-provider or specialty provider who provides rehabilitation/day services must also have a Consulting Psychiatrist who is a board-eligible psychiatrist and advises the sub-provider or specialty provider on the quality of medical and psychiatric care provided;

(c) A Clinical Director who is a qualified practitioner with overall responsibility for oversight of the clinical program of the sub-provider or specialty provider;

(d) Each sub-provider who provides either Diagnostic/Assessment or Medication/Somatic Treatment shall demonstrate adequate oversight of quality of medical and psychiatric care by employing or contracting with a Medical Director or arranging for the Medical Director for the consumer's CSA to provide such oversight; and

(e) The required staff listed in this subsection shall be either employees of the sub-provider or specialty provider or under contract to the sub-provider or specialty provider for an amount of time sufficient to carry out the duties assigned.

3412.7 Each sub-provider and specialty provider shall establish and adhere to policies and procedures governing its collaboration with a referring CSA in the development, implementation, evaluation, and revision of each consumer's IRP/IPC, that comply with DMH rules (Collaboration Policy). The Collaboration Policy shall:

(a) Be a part of each sub-provider and specialty provider's Treatment Planning Policy;

(b) Require sub-providers and specialty providers to incorporate CSA-developed Diagnostic/Assessment material into the sub-provider and specialty provider's treatment planning process; and

(c) Require sub-providers and specialty providers to coordinate the consumer's treatment with the consumer's clinical manager.

3412.8 Each subprovider shall offer core services as required by § 3410.20. At a minimum, the subprovider shall offer services during these hours at its primary location.

3412.9 At a minimum, each specialty provider shall offer access to specialty services as required by § 3410.20.

3412.10 Each subprovider and specialty provider QI program shall be directed by a coordinator who is a qualified practitioner and who has direct access to the Chief Executive Officer (QI Coordinator). The QI Coordinator shall review unusual incidents, deaths, and other sentinel events, monitor and review utilization patterns, and track consumer complaints and grievances.

3412.11 Each subprovider and specialty provider with total annual revenues at or exceeding three hundred thousand dollars ($ 300,000) shall have an annual audit by a certified public accounting firm in accordance with generally accepted auditing standards. The resulting financial audit report shall be consistent with formats recommended by the American Institute of Public Accountants. Each subprovider and specialty provider shall submit a copy

of the financial audit report to DMH ninety (90) days after the end of its fiscal year.

3412.12 Each subprovider and specialty provider with total annual revenues less than three hundred thousand dollars ($ 300,000) shall submit financial statements reviewed by an independent certified public accounting firm one hundred twenty (120) days after the end of its fiscal year.

3412.13 Each sub-provider shall enter into an affiliation agreement with one (1) or more CSAs that specifies the terms of the arrangement between the parties.

3412.14 Each specialty provider shall enter into an affiliation agreement with all CSAs that specifies the terms of the arrangement between the parties.

3412.15 Each sub-provider and specialty provider shall have the capability to submit timely and accurate claims, encounter data, and other submissions as necessary directly to the DMH contract management system.

3412.16 Each sub-provider and specialty provider shall only provide those MHRS to consumers that are specified in the consumers' IRP/IPC as designated by the consumers' CSA.

3412.17 DMH shall review and approve the CSA Affiliation Policy, the CSA Referral Policy and the Collaboration Policy.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 57 DCR 10392, 10393 (November 5, 2010); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3478 (April 22, 2011).

3413 QUALIFIED PRACTITIONERS AND CREDENTIALED STAFF

3413.1 MHRS shall be provided by qualified practitioners either directly or under the supervision of another qualified practitioner as set forth in this chapter. Qualified practitioners are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs;

(e) RNs;

(f) LPC;

(g) LISWs; and

(h) Addiction counselors.

3413.2 Only four (4) categories of qualified practitioners shall be authorized to diagnose mental illness for purposes of determining eligibility for MHRS. Those qualified practitioners are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs; and

(d) APRNs.

3413.3 Qualified practitioners and credentialed staff shall provide MHRS to the extent permitted by and in accordance with District law. Credentialed staff shall be authorized to provide MHRS or components of MHRS under the supervision of an appropriate qualified practitioner in accordance with applicable federal and District law.

3413.4 A psychiatrist shall include a:

(a) Physician licensed by the District who is, at a minimum a board-eligible psychiatrist;

(b) Psychiatric resident providing care in an approved clinical rotation; or

(c) Moonlighting psychiatric resident.

3413.5 A psychiatric resident is a medical school graduate from a program that meets the standards for medical education found in 17 DCMR §4602.3, who:

(a) Has completed at least one year of a psychiatric residency program that satisfies the requirements of 17 DCMR §4611.4;

(b) Is currently in a psychiatric residency program that satisfies the requirements of 17 DCMR §4611.5 and is approved by DMH's chief clinical officer as a training program in community psychiatry;

(c) Is supervised by a licensed psychiatrist who satisfies the requirements of 17 DCMR §4611.6;

(d) Complies with the requirements of 17 DCMR §§4611.7 and 8; and

(d) Complies with the standards of conduct for licensed physicians found in 17 DCMR §4612

3413.6 A moonlighting psychiatric resident is a medical school graduate who:

(a) Satisfies all of the requirements of §3413.4; and

(b) Is working under the supervision of the medical director or consulting psychiatrist of a certified MHRS provider in accordance with protocols approved by DMH's chief clinical officer.

3413.7 Qualified practitioners are authorized to provide MHRS as described below:

(a) Psychiatrists are authorized to provide:

(1) Diagnostic/Assessment;

(2) Medication/Somatic Treatment;

(3) Counseling;

(4) Community Support

(5) Crisis/Emergency;

(6) Rehabilitation/Day Services;

(7) Intensive Day Treatment;

(8) CBI; and

(9) ACT;

(b) Psychologists are authorized to provide:

(1) Diagnostic/Assessment;

(2) Counseling;

(3) Community Support

(4) Crisis/Emergency;

(5) Rehabilitation/Day Services;

(6) Intensive Day Treatment;

(7) CBI; and

(8) ACT;

(c) LICSWs are authorized to provide:

(1) Diagnostic/Assessment;

(2) Counseling;

(3) Community Support;

(4) Crisis/Emergency;

(5) Rehabilitation/Day Services;

(6) Intensive Day Treatment; and

(7) CBI;

(d) LISWs are authorized to provide:

(1) Diagnostic/Assessment (assessment only);

(2) Counseling;

(3) Community Support;

(4) Crisis/Emergency;

(5) Rehabilitation/Day Services;

(6) Intensive Day Treatment; and

(7) CBI;

(e) APRNs are authorized to provide:

(1) Diagnostic/Assessment;

(2) Medication/Somatic Treatment;

(3) Counseling;

(4) Community Support;

(5) Crisis/Emergency;

(6) Rehabilitation/Day Services;

(7) Intensive Day Treatment;

(8) CBI; and

(9) ACT;

(f) RNs are authorized to provide:

(1) Diagnostic/Assessment (assessment only)

(2) Medication/Somatic Treatment;

(3) Counseling;

(4) Community Support;

(5) Rehabilitation/Day Services;

(6) Intensive Day Treatment;

(7) CBI; and

(8) ACT;

(g) LPCs are authorized to provide:

(1) Diagnostic/Assessment (assessment only);

(2) Counseling;

(3) Community Support;

(4) Rehabilitation/Day Services;

(5) Intensive Day Treatment; and

(6) CBI;

(h) Addiction Counselors are authorized to provide:

(1) Diagnostic/Assessement (assessment only)

(2) Counseling;

(3) Community Support;

(4) Rehabilitation/Day Services;

(5) Intensive Day Treatment;

(6) CBI; and

(7) ACT

3413.8 The staffing requirements for MHRS are described below.

MHRS	QUALIFIED PRACTITIONERS	QUALIFIED PRACTITIONERS AND CREDENTIALED STAFI WITH SUPERVISION

Diagnostic/ Assessment	• Psychiatrist • Psychologist • LICSW • APRN May diagnose and assess May serve as the approving qualified practitioner for the development of the IRP/IPC	• Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff May provide assessment services only An LPC may serve as the approving qualified practitioner for the development of the IRP/IPC
Medication/ Somatic Treatment	• Psychiatrist • APRN • Registered Nurse	None
Counseling	• Psychiatrist • Psychologist • LICSW • APRN • RN • LPC • LISW • Addiction Counselor	• Licensed Graduate Social Worker may provide Counseling under the supervision of an LICSW or an LISW. • Credentialed Staff
Community Support	• Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
Crisis/ Emergency	• Psychiatrist • Psychologist • LICSW • APRN	• Registered Nurse • LPC • LISW • Addiction Counselor • Credentialed Staff

Rehabilitation/Day Services	• Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
Intensive Day Treatment	• Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
CBI	• Psychiatrist • Psychologist • LICSW • APRN • Registered Nurse • LPC • LISW • Addiction Counselor	Credentialed Staff
ACT	• Psychiatrist • APRN • RN • Addiction Counselor	Credentialed Staff

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8369 (September 30, 2011).

3414 COVERED MHRS

3414.1 The service specific standards described in this section apply to the individual MHRS offered by each MHRS provider and reimbursed by DMH in accordance with this chapter.

3414.2 Covered core services shall include Diagnostic/Assessment, Medication/Somatic Treatment, Counseling, and Community Support.

3414.3 Covered specialty services shall include Crisis/Emergency, Rehabilitation/Day Services, Intensive Day Treatment, CBI, and ACT.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3415 DIAGNOSTIC/ASSESSMENT

3415.1 A Diagnostic/Assessment is an intensive clinical and functional evaluation of a consumer's mental health condition by the Diagnostic/Assessment team that results in the issuance of a Diagnostic Assessment report with recommendations for service delivery that provides the basis for the development of an IRP/IPC. A psychiatrist shall supervise and coordinate all psychiatric and medical functions required by a consumer's Diagnostic/Assessment.

3415.2 A Diagnostic/Assessment shall:

(a) Determine whether the consumer is appropriate for and can benefit from MHRS based upon the consumer's diagnosis, presenting problems, and recovery goals; and

(b) Evaluate the consumer's level of readiness and motivation to engage in treatment.

3415.3 The Diagnostic/Assessment team shall consist of at least two (2) qualified practitioners, and shall include the following persons:

(a) A psychiatrist, psychologist, LICSW, or APRN to establish the diagnosis;

(b) An approving qualified practitioner; and

(c) A qualified practitioner who is knowledgeable about community resources, if one of the required Diagnostic/Assessment team members does not possess this knowledge.

3415.4 An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each consumer being considered for enrollment with a CSA.

3415.5 The Diagnostic/Assessment shall include the following elements:

(a) A chronological behavioral health history of the consumer's symptoms, treatment, treatment response, and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;

(b) For youth and adults, the chronological behavioral health history includes both psychiatric history and substance abuse history, treatment history for either or both diagnoses and the consumer's perception of the outcome;

(c) Biological, psychological, familial, social, and environmental dimensions and identified strengths and weaknesses in each area;

(d) A description of the presenting problem(s), including source of distress, precipitating events, associated problems or symptoms, and recent progression;

(e) Both a strengths summary and a problem summary, which address the following:

(1) Risk of harm;

(2) Functional status, including relevant emotional and behavioral conditions or complications and addressing self-control, self-care, interpersonal abilities, coping, and independent living skills;

(3) Co-morbidity, including biomedical conditions and complications;

(4) Recovery environment, including supports and stressors; and

(5) Treatment and recovery history, including relapse potential;

(f) Diagnoses on all five (5) Axes of the DSM-IV;

(g) A review of the consumer's alcohol and substance abuse history and presenting problem(s), including an assessment of substances used and intensity of use, the likelihood and severity of withdrawal, and the medical and behavioral risk secondary to intoxication. This review either identifies or excludes substance abuse or dependence as a co-occurring treatment need;

(h) Assessment of the need for psychiatric hospitalization for consumers being referred to psychiatric inpatient services to assure that less restrictive alternatives are considered and used when appropriate;

(i) Evidence of an interdisciplinary team process; and

(j) Evidence of consumer participation including, families or guardians where required.

3415.6 The Diagnostic/Assessment may include psychological testing.

3415.7 Following the completion of the Diagnostic/Assessment, a summary of findings and recommendations for treatment shall be listed in a Diagnostic/Assessment report. A Diagnostic/Assessment report shall identify barriers to be addressed during treatment in order to reduce or eliminate identified deficits.

3415.8 A qualified practitioner shall complete the Diagnostic/Assessment report no later than ten (10) business days after the completion of the Diagnostic/Assessment by the Diagnostic/Assessment team. The qualified practitioner shall provide the Diagnostic/Assessment report to the approving qualified practitioner, and the approving qualified practitioner shall incorporate results of the Diagnostic/Assessment into the IRP/IPC.

3415.9 The approving qualified practitioner shall convene the consumer, the consumer's family and significant others, if appropriate, and the consumer's clinical manager to review the Diagnostic/Assessment report and develop the IRP/IPC.

3415.10 One Diagnostic/Assessment shall be allowable every six (6) months. Additional units of Diagnostic/Assessment shall be allowable when pre-authorized by DMH for:

(a) Periodic assessment;

(b) Pre-Hospitalization screening;

(c) Neuro-psychological assessment; or

(d) Re-Admission to Rehabilitation/Day Services.

3415.11 Diagnostic/Assessment shall not be billed on the same day as ACT.

3415.12 Diagnostic/Assessment services shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or other community setting; or

(c) In a residential facility of sixteen (16) beds or less.

3415.13 Qualified practitioners of Diagnostic/Assessment authorized to both diagnose and assess are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs; and

(d) APRNs.

3415.14 Qualified practitioners of Diagnostic/Assessment authorized to provide assessment services under the supervision of a qualified practitioner identified in §3415.13 are:

(a) RNs;

(b) LISWs;

(c) LPCs; and

(d) Addiction counselors.

3415.15 Credential staff shall be authorized to provide assessment services under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8369 (September 30, 2011).

3416 MEDICATION/SOMATIC TREATMENT

3416.1 Medication/Somatic Treatment services are medical interventions including physical examinations; prescription, supervision or administration of mental- health related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

3416.2 Medication/Somatic Treatment services include monitoring the side effects and interactions of medication and the adverse reactions which a consumer may experience, and providing education and direction for symptom and medication self-management.

3416.3 Group Medication/Somatic Treatment services shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support as specified in the IRP/IPC.

3416.4 Each Medication/Somatic Treatment provider shall offer a comprehensive psycho-educational program for consumers and families, as appropriate, regarding the consumer's mental illness, emotional disturbance or behavior disorder, treatment goals, potential benefits and risk of treatment, self-monitoring aids, and consumer/family groups for education, support, and enhancement of the therapeutic alliance between the consumer and the MHRS provider.

3416.5 Consumers receiving Medication/Somatic Treatment shall participate in a psychoeducational session to discuss medication side effects, adverse reactions to medications, and medication self-monitoring and management at the following times:

(a) During development of the IRP/IPC;

(b) In conjunction with the one hundred eighty day (180) day IRP/IPC review; and

(c) At any time the consumer's medications are changed.

3416.6 All consumers receiving Medication/Somatic Treatment services shall be evaluated on the Abnormal Involuntary Movement Scale (AIMS) annually, and the results of the AIMS testing shall be incorporated into the medication assessment and treatment planning process for each consumer receiving Medication/Somatic Treatment.

3416.7 Medication/Somatic Treatment shall be provided with no annual limits on service.

3416.8 Medication/Somatic Treatment shall not be billed on the same day as ACT.

3416.9 Medication/Somatic Treatment shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or other community setting; or

(c) A residential facility of sixteen (16) beds or less.

3416.10 Qualified practitioners of Medication/Somatic Treatment are:

(a) Psychiatrists;

(b) APRNs; and

(c) RNs.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3478 (April 22, 2011).

3417 COUNSELING AND PSYCHOTHERAPY

3417.1 Counseling services are individual, group or family face-to-face services for symptom and behavior management, development, restoration or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills.

3417.2 Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills, and restoration or enhancement of the family unit and/or support of the family. Mental health supports and consultation services provided to consumers' families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer.

3417.3 Counseling services provided in excess of one hundred sixty (160) units require pre-authorization from DMH in accordance with §3404.

3417.4 Counseling shall not be billed on the same day as:

(a) Rehabilitation/Day Services;

(b) Intensive Day Treatment;

(c) CBI; or

(d) ACT.

3417.5 Counseling services shall be provided:

(a) At the MHRS provider's service site;

(b) In natural settings, including the consumer's home or other community setting; or

(c) A residential facility of sixteen (16) beds or less.

3417.6 Qualified practitioners of Counseling are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs;

(e) RNs;

(f) LPCs;

(g) LISWs; and

(h) Addiction counselors.

3417.7 Credentialed staff shall be authorized to provide Counseling services under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3418 COMMUNITY SUPPORT

3418.1 Community Support services are rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer.

3418.2 Community Support services include a variety of interventions, such as:

(a) Participation in the development and implementation of a consumer's IRP/IPC;

(b) Assistance and support for the consumer in stressor situations;

(c) Mental health education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer;

(d) Individual mental health intervention for the development of interpersonal and community coping skills, including adapting to home, school, and work environments;

(e) Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance;

(f) Assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the consumer's mental illness or emotional disturbance and are necessary to enable and maintain the consumer's independent living;

(g) Developing strategies and supportive mental health intervention for avoiding out-of-home placement for adults, children, and youth and building stronger family support skills and knowledge of the adult, child, or youth's strengths and limitations; and

(h) Developing mental health relapse prevention strategies and plans.

3418.3 Community Support services may be provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers.

3418.4 Community Support services provided to children and youth shall include coordination with family and significant others and with other systems of

care, such as education managed health plans (including Medicaid managed care plans), juvenile justice, and children's protective services when appropriate to treatment and educational needs.

3418.5 Community Support services shall be provided:

(a) At the MHRS provider service site;

(b) In natural settings, including the consumer's home or other community settings; or

(c) In a residential facility of sixteen (16) beds or less.

3418.6 Each Community Support provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Community Support (Community Support Organizational Plan) which addresses the following:

(a) Description of the particular rehabilitation, recovery, and case management models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) Description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(a) The use of level of functioning assessments to determine the number of consumers each staff can serve based on DMH guidelines.

3418.7 The Community Support provider shall maintain a staffing ratio of no less than one (1) staff person for every twenty (20) consumers for children and youth, and one (1) staff person for every forty (40) consumers for adults.

3418.8 Community Support services shall be delivered in accordance with the service accessibility requirements in § 3410.20.

3418.9 Community Support shall be provided with no annual limits on service.

3418.10 Community Support shall not be billed on the same day as ACT.

3418.11 Qualified practitioners of Community Support are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs;

(e) RNs;

(f) LPCs;

(g) LISWs; and

(h) Addiction counselors.

3418.12 Credentialed staff shall be authorized to provide Community Support services under the supervision of a qualified practitioner as set forth in §3413.3.

3418.13 Community Support services provided through a Mental Health Clubhouse established under Chapter 39 of this Title must meet all of the requirements of Chapter 39.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Emergency and Proposed Rulemaking published at 57 DCR 4010 (May 7, 2010)[EXPIRED]; as amended by Emergency and Proposed Rulemaking published at 57 DCR 7734 (August 20, 2010)[EXPIRED]; as amended by Final Rulemaking published at 57 DCR 8698 (September 24, 2010); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3479 (April 22, 2011).

3419 CRISIS/EMERGENCY

3419.1 Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week.

3419.2 Crisis/Emergency services are provided to consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the consumer's access to care at the appropriate level.

3419.3 Crisis/Emergency services may be delivered in natural settings, and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response.

3419.4 Each Crisis/Emergency provider shall:

(a) Obtain consultation, locate other MHRS and resources, and provide written and oral information to assist the consumer in obtaining follow-up MHRS;

(b) Be a DMH-certified MHRS provider of Diagnostic/Assessment or have an agreement with a CSA or a CSA's affiliated sub-provider to assure the provision of necessary hospital pre-admission screenings;

(c) Demonstrate the capacity to assure continuity of care for consumers by facilitating follow-up mental health appointments and providing telephonic support until outpatient services occur; and

(d) Have an agreement with the DMH Consumer Enrollment and Referral System.

3419.5 Each Crisis/Emergency provider shall have waiting, assessment, and treatment areas for children, youth, and families that are separate from the areas for adults.

3419.6 Each Crisis/Emergency provider shall establish and adhere to policies and procedures and staffing sufficient to ensure that all individuals seeking and in need of Crisis/Emergency services receive face-to-face services within one (1) hour of request or referral (Crisis/Emergency Staffing Policy). The Crisis/Emergency Staffing Policy shall:

(a) Require qualified practitioners to be available twenty-four (24) hours per day, seven (7) days per week for telephone, face-to-face and mobile interventions for individuals needing crisis services;

(b) Delineate the criteria upon which appropriate venue for service delivery is determined;

(c) Require that backup support for staff who need assistance during an intervention is always available;

(d) Require that all staff receive current training in persuasion, engagement, and de-escalation techniques for disruptive or aggressive acts, consumers, and situations; and

(e) Require all staff to hold current certification in cardiopulmonary resuscitation technique and first aid.

3419.7 Crisis/Emergency shall be provided with no annual limits on services.

3419.8 Retrospective authorization from DMH is required for Crisis/Emergency services provided on the same day as ACT.

3419.9 Crisis/Emergency services shall be provided:

(a) At the MHRS provider service site; or

(b) In natural settings, including the consumer's home or other community settings.

3419.10 Qualified practitioners of Crisis/Emergency are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) and APRNs.

3419.11 Qualified practitioners authorized to provide Crisis/Emergency under the supervision of a qualified practitioner identified in §3419.10 are:

(a) LISWs;

(b) LPCs;

(c) RNs; and

(d) Addiction counselors.

3419.12 Credentialed staff shall be authorized to provide Crisis/Emergency services under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3420 REHABILITATION/DAY SERVICES

3420.1 Rehabilitation/Day Services is a structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. Rehabilitation/Day Services:

(a) Are curriculum-driven and psycho-educational and assist the consumer in the retention, or restoration of independent and community living, socialization, and adaptive skills;

(b) Include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment; and

(c) Are offered most often in group settings, and may be provided individually.

3420.2 Rehabilitation/Day Services shall:

(a) Be founded on the principles of consumer choice and the active involvement of each consumer in the consumer's mental health recovery;

(b) Provide both formal and informal structures through which consumers can influence and shape service development;

(c) Facilitate the development of a consumer's independent living and social skills, including the ability to make decisions regarding self care, management of illness, life work, and community participation;

(d) Promote the use of resources to integrate the consumer into the community; and

(e) Include education on self-management of symptoms, medications and side effects, the identification of rehabilitation preferences, the setting of rehabilitation goals, and skills teaching and development.

3420.3 Each consumer shall choose a full-time staff member to assist the consumer in assessing the consumer's needs and progress toward achievement of Rehabilitation/Day Services Treatment Goals.

3420.4 Each Rehabilitation/Day Services provider shall provide adequate space, equipment, and supplies to ensure that services can be provided effectively. Rehabilitation/Day Services program space and furnishings shall be

separate and distinct from other services offered within the same service site(s).

3420.5 Each Rehabilitation/Day Services provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Rehabilitation/Day Services (Rehabilitation/Day Services Organizational Plan) which includes:

(a) A description of the particular rehabilitation models utilized, types of intervention practiced, and typical daily curriculum and schedule; and

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated.

3420.6 Each Rehabilitation/Day Services provider shall have a minimum of one (1) full-time equivalent staff for every ten (10) consumers, based on average daily attendance.

3420.7 At least one (1) qualified practitioner shall be present on site at all times.

3420.8 Each Rehabilitation/Day Services provider shall have a clinical supervisor or director who is a qualified practitioner on site at least thirty (30) hours per week.

3420.9 Each consumer shall participate in at least three (3) hours of Rehabilitation/Day Services per day, in order for the services to be reimbursable.

3420.10 Rehabilitation/Day Services in excess of ninety (90) days within a twelve (12) month period shall require pre-authorization from DMH in accordance with §3404.

3420.11 Rehabilitation/Day Services shall not be billed on the same day as ACT.

3420.12 Rehabilitation/Day Services shall only be provided at an MHRS provider's service site.

3420.13 Qualified practitioners of Rehabilitation/Day Services are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs;

(e) RNs;

(f) LPCs;

(g) LISWs; and

(h) Addiction counselors.

3420.14 Credentialed staff shall be authorized to provide Rehabilitation/Day Services under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3479 (April 22, 2011).

3421 INTENSIVE DAY TREATMENT

3421.1 Intensive Day Treatment is a facility-based, structured, intensive, and coordinated acute treatment program which serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an interdisciplinary team to provide stabilization of psychiatric impairments.

3421.2 Daily physician and nursing services are essential components of Intensive Day Treatment services.

3421.3 Intensive Day Treatment shall:

(a) Be time-limited and provided in an ambulatory setting to consumers who are not in danger but have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities;

(b) Be provided within a structured program of care which offers individualized, strengths-based, active, and timely treatment directed toward the alleviation of the impairment which caused the admission to Intensive Day Treatment;

(c) Be an active treatment program that consists of documented mental health interventions that address the individualized needs of the consumer as identified in the IRP/IPC;

(d) Consist of structured individual and group activities and therapies that are planned and goal-oriented and provided under active psychiatric supervision;

(e) Offer short-term day-programming consisting of therapeutically intensive, acute, and active treatment;

(f) Be services that closely resemble the intensity and comprehensiveness of inpatient services; and

(g) Include psychiatric, medical, nursing, social work, occupational therapy, Medication/Somatic Treatment, and psychology services focusing on timely crisis intervention and psychiatric stabilization so that consumers can return to their normal daily lives.

3421.4 Each consumer shall participate in at least five (5) hours of Intensive Day Treatment per day, in order for the services to be reimbursable.

3421.5 Each consumer shall be directly evaluated by a qualified practitioner as part of the admissions process.

3421.6 Each consumer's care shall be supervised by a qualified practitioner who assumes primary responsibility for the consumer's assessment, treatment planning, and treatment services.

3421.7 Each consumer shall be assigned to a full-time staff member who assists the consumer and the consumer's family to assess the consumer's needs and progress toward achievement of Treatment Goals.

3421.8 An interdisciplinary treatment team shall meet within one (1) working day of the consumer's admission to develop an initial Intensive Day Treatment IRP.

3421.9 Each Intensive Day Treatment IRP shall be updated every three (3) days and shall be reviewed by the interdisciplinary treatment team on a weekly basis and upon termination of treatment.

3421.10 All Intensive Day Treatment services shall occur under the supervision of a psychiatrist. A psychiatrist shall assess each consumer on a daily basis.

3421.11 Each Intensive Day Treatment provider shall have policies and procedures included in its Service Specific Policies addressing the provision of Intensive Day Treatment (Intensive Day Treatment Organizational Plan) which includes the following:

(a) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(b) A description of the staffing pattern and how staff is deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated; and

(c) A description of how the Intensive Day Treatment IRP is modified or adjusted to meet the needs specified in each consumer's IRP/IPC.

3421.12 The Intensive Day Treatment provider shall maintain a minimum staffing ratio of one (1) staff for every eight (8) consumers. The Intensive Day Treatment provider shall maintain a minimum staffing pattern sufficient to address consumer needs, including adequate physician, nursing, social work, therapy, and psychology services to assure the availability of intensive services.

3421.13 Intensive Day Treatment units in excess of seven (7) units within a twelve (12) month period shall require pre-authorization from DMH.

3421.14 Intensive Day Treatment shall not be billed on the same day as any other MHRS except for Community Support, Crisis/Emergency or CBI.

3421.15 Intensive Day Treatment shall only be provided in an MHRS provider service site.

3421.16 Qualified practitioners of Intensive Day Treatment are:

(a) Psychiatrists;

(b) Psychologists;

(c) LICSWs;

(d) APRNs;

(e) RNs;

(f) LPCs;

(g) LISWs; and

(h) Addiction counselors.

3421.17 Credentialed staff shall be authorized to provide Intensive Day Treatment under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3479 (April 22, 2011).

3422 COMMUNITY-BASED INTERVENTION

3422.1 CBI services are time-limited, intensive, mental health services delivered to children and youth ages six (6) through twenty-one (21). CBI services are intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. CBI services may be provided at the time a child or youth is identified for a service, particularly to meet an urgent or emergent need during his or her course of treatment.

3422.2 In order to be eligible for CBI services, a consumer shall have:

(a) Insufficient or severely limited individual or family resources or skills to cope with an immediate crisis; and

(b) Either individual or family issues, or a combination of individual and family issues, that are unmanageable and require intensive coordinated clinical and positive behavioral interventions.

3422.3 There shall be four (4) levels of CBI services available to children and youth. A provider may be certified to offer one (1) or more level(s) of CBI services. The four (4) levels of CBI services are:

(a) CBI Level I, delivered using the Multisystemic Therapy (MST) treatment model adopted by DMH;

(b) CBI Level II, delivered using the Intensive Home and Community-Based Services (IHCBS) model adopted by DMH;

(c) CBI Level III, delivered using the IHCBS model adopted by DMH; and

(d) CBI Level IV, delivered using the Functional Family Therapy (FFT) model adopted by DMH.

3422.4 All levels of CBI services shall include the services described in subsection 3422.7, as medically necessary and clinically appropriate for the consumer.

3422.5 The CBI provider shall be responsible for coordinating the treatment planning process for all consumers authorized to receive CBI for the duration of CBI services. CBI services shall be delivered primarily in natural settings and shall include in-home services.

3422.6 The basic goals of all levels of CBI services are to:

(a) Defuse the consumer's current situation to reduce the likelihood of a recurrence, which if not addressed, could result in the use of more intensive therapeutic interventions;

(b) Coordinate access to covered mental health services and other covered Medicaid services;

(c) Provide mental health services and support interventions for consumers that develop and improve consumer and family interaction and improve the ability of parents, legal guardians, or caregivers to care for the consumer; and

(d) Transition the consumer to an appropriate level of care following the end of CBI treatment services.

3422.7 All levels of CBI services shall include the following services, as medically necessary and clinically appropriate for the consumer:

(a) Immediate crisis response for enrolled consumers;

(b) Stabilization services to:

(1) Reduce family conflict;

(2) Stabilize the family unit;

(3) Maintain the consumer in the home environment;

(4) Increase family support; and

(5) Monitor the consumer's medication compliance with prescribed psychiatric medications;

(c) Environmental assessment to:

(1) Identify risk factors that may endanger either the consumer or the consumer's family; and

(2) Assess the strengths of the consumer and the consumer's family;

(d) Individual and family support interventions that develop and improve the ability of parents, legal guardians, or significant others to care for the consumer's behavioral and emotional disturbance(s);

(e) Skills training related to:

(1) Consumer self-help;

(2) Parenting techniques to help the consumer's family develop skills for managing the consumer's emotional disturbance;

(3) Problem solving;

(4) Behavior management;

(5) Communication techniques, including the facilitation of communication and consistency of communication for both the consumer and the consumer's family; and

(6) Medication management, monitoring, and follow-up for family members and other caregivers; and

(f) Coordination and linkage with other covered MHRS and supports and other covered Medicaid services in order to prevent the utilization of more restrictive residential treatment, including one (1) or more of the following activities:

(1) Referral of consumers to other MHRS providers;

(2) Assisting consumers in transition to less intensive or more intensive MHRS;

(3) Referral of consumers to providers of other Medicaid covered services (for example, physicians); or

(4) Supporting and consulting with the consumer's family or support system, which is directed exclusively to the well-being and benefit of the consumer.

3422.8 CBI Level I services are intended for children and youth who are experiencing serious emotional disturbance with either of the following:

(a) A documented behavioral concern with externalizing (aggressive or violent) behaviors; or

(b) A history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system.

3422.9 CBI Level I services shall not be authorized for:

(a) Children or youth who require the safety of a hospital or other secure setting;

(b) Children or youth in independent living programs; or

(c) Children or youth without a long-term placement option.

3422.10 Eligible consumers of CBI Level I services shall have a permanent caregiver who is willing to participate with service providers for the duration of CBI Level I treatment services and be:

(a) At imminent risk for out-of-home placement within thirty (30) days; or

(b) Currently in out-of-home placement due to the consumer's disruptive behavior, with permanent placement expected to occur within thirty (30) days.

3422.11 CBI Level I Service providers shall obtain prior authorization of CBI Level I services from DMH for a period not to exceed six (6) months.

3422.12 Readmission to CBI Level I services, after the six (6)-month period may be considered for prior authorization by DMH in accordance with medical necessity requirements specified by DMH.

3422.13 CBI Level I services shall be delivered in accordance with the Multisystemic Treatment (MST) Model.

3422.14 Eligible consumers of CBI Level II services shall have any one (1) or combination of the following:

(a) A history of involvement with the Child and Family Services Agency (CFSA) or the Department of Youth Rehabilitation Services (DYRS);

(b) A history of negative involvement with schools for behavioral-related issues; or

(c) A history of either chronic or recurrent episodes of negative behavior that have or may result in out-of-home placement.

3422.15 CBI Level II services shall not be authorized for children or youth who require the safety of a hospital or other secure setting.

3422.16 CBI Level II service providers shall obtain prior authorization of CBI Level II services from DMH for a period not to exceed six (6) months.

3422.17 Readmission to CBI Level II services, after the six (6)-month period may be considered for prior authorization by DMH in accordance with medical necessity requirements specified by DMH.

3422.18 CBI Level II services shall be delivered in accordance with the Intensive Home and Community-Based Services (IHCBS) model as adopted by DMH.

3422.19 A consumer shall be eligible for CBI Level III services if the consumer:

(a) Has situational behavioral problems that require short-term, intensive treatment;

(b) Is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills;

(c) Recently experienced out-of-home placement and requires development of communication and coping skills to manage the placement change;

(d) Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition;

(e) Was recently discharged from an inpatient setting such as acute hospitalization or psychiatric residential treatment facility; or

(f) Is an adult parent or caregiver with a clinically significant mental health concern and the parent or caregiver will be parenting a child or youth returning from a residential treatment center within the next ninety (90) days.

3422.20 CBI Level III services shall not be authorized for children or youth who require the safety of a hospital or other secure setting.

3422.21 CBI Level III service providers shall obtain prior authorization for CBI Level III services from DMH for a period not to exceed ninety (90) days.

3422.22 Readmission to CBI Level III services, after the ninety (90)-day period may be considered for prior authorization by DMH in accordance with medical necessity requirements specified by DMH.

3422.23 CBI Level III services shall be delivered in accordance with the IHCBS model as adopted by DMH.

3422.24 Eligible consumers of CBI Level IV services shall:

(a) Be between the ages of ten (10) and eighteen (18); and

(b) Have a documented history of moderate to serious behavioral problems which impair functioning in at least one (1) area (for example school or home), or

(c) Exhibit significant externalizing behavior which impairs functioning in at least one (1) area (for example school or home); or

(d) Be at risk of a disruption in placement; and

(e) Be:

(1) Willing to participate with service providers for the duration of CBI Level IV treatment services; or

(2) Involved with a caregiver who is willing to participate with service providers for the duration of CBI Level IV treatment services.

3422.25 CBI Level IV services shall not be authorized for:

(a) Children or youth who require the safety of a hospital or other secure setting;

(b) Children or youth in congregate living programs; or

(c) Children or youth in an emergency or respite placement.

3422.26 CBI Level IV Service providers shall obtain prior authorization of CBI Level IV services from DMH for a period not to exceed six (6) months.

3422.27 Readmission to CBI Level IV services after the six (6)-month period may be considered for prior authorization by DMH in accordance with medical necessity requirements specified by DMH.

3422.28 A maximum of twenty-four (24) additional units of CBI Level IV services may be delivered at the discretion of the provider, in consultation with the consumer and the consumer's caregiver without an additional

authorization, within twelve (12) months of the close of the initial six (6) month authorization period.

3422.29 CBI Level IV services shall be delivered in accordance with the FFT model adopted by DMH.

3422.30 Discharge from all levels of CBI services shall occur when the consumer has achieved the goals for CBI as outlined in the IPC or the consumer no longer benefits from CBI services. Discharge decisions shall be based on one (1) or a combination of the following:

(a) The consumer is performing reasonably well in relation to goals contained in the IPC and discharge to a lower level of care is indicated (for example, the consumer is not exhibiting risky behaviors or family functioning has improved);

(b) The consumer or the consumer's family or caregiver has developed the skills and resources needed to step down to a less intensive service;

(c) The consumer is not making progress or is regressing and all realistic CBI treatment options have been exhausted;

(d) A family member or caregiver requests discharge and the consumer is not imminently dangerous to self or others;

(e) The consumer requires a higher level of care (for example, inpatient hospitalization or psychiatric residential treatment facility); or

(f) The consumer does not reside in the District and:

(1) Is not eligible to participate in the District's Medicaid program;

(2) Is not within the physical or legal custody of the Child and Family Services Agency (CFSA); or

(3) Is not within the physical or legal custody of the Department of Youth Rehabilitation Services (DYRS).

3422.31 Eligible providers of CBI Level I services shall:

(a) Meet the specialty service provider requirements in § 3412;

(b) Be licensed MST providers in good standing and utilize the MST treatment model;

(c) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(1) Have the capacity to deliver CBI Level I services to four (4) to six (6) consumers for each full-time team member; and

(2) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3422.32 Eligible providers of CBI Level II services shall:

(a) Meet the specialty service provider requirements in § 3412;

(b) Utilize the IHCBS treatment model adopted by DMH to deliver CBI Level II services;

(c) Meet CBI Level II training requirements specified by DMH;

(1) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(2) Have the capacity to deliver CBI Level II services to at least four (4) to six (6) consumers for each full-time team member; and

(3) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3422.33 Eligible providers of CBI Level III services shall:

(a) Meet the specialty service provider requirements in § 3412;

(b) Utilize the IHCBS treatment model adopted by DMH to deliver CBI Level III services;

(c) Meet CBI Level III training requirements specified by DMH;

(d) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(e) Have the capacity to deliver CBI Level III services to at least four (4) to six (6) consumers for each full-time team member; and

(f) Be available to consumers twenty-four (24) hours per day, seven (7) days per week.

3422.34 Eligible providers of CBI Level IV services shall:

(a) Meet the specialty service provider requirements in § 3412;

(b) Have current site certification as an FFT provider and utilize the FFT treatment model to deliver CBI Level IV services;

(c) Comply with the FFT site certification and staff training requirements;

(d) Comply with the CBI Level IV training and site certification requirements specified by DMH;

(e) Have the capacity to provide or arrange for the non-Medicaid reimbursed wraparound services required by eligible consumers;

(f) Have the capacity to deliver CBI Level IV services to at least ten (10) to twelve (12) consumers for each full-time therapist; and

(g) Be available to work a flexible schedule based on the needs of the consumer and the family or caregiver.

3422.35 Providers of CBI services shall meet the staffing requirements applicable to the level of services offered in order to render CBI Level I, Level II, Level III or Level IV services.

3422.36 Providers of all levels of CBI services shall:

(a) Individually design CBI services for each consumer and family to minimize intrusion and maximize independence;

(b) Provide more intensive services at the beginning of treatment and decrease the intensity of treatment over time as the strengths and coping skills of the consumer and family develop;

(c) Provide services utilizing a team approach;

(d) Maintain appropriate back-up coverage for team member absences and facilitate substitution of team members as necessary;

(e) Conduct face-to-face transition planning with consumers and families no later than thirty (30) days prior to the anticipated discharge date, including meetings with providers of more intensive or less intensive services;

(f) Conduct continuity of care planning with consumers and families prior to discharge from any level of CBI services, including facilitating follow-up mental health appointments and providing telephonic support until follow-up mental health services occur;

(g) Provide all of the components of treatment specified in §3422.7, as appropriate, based on each consumer's needs;

(h) Provide CBI services with a family-focus;

(i) Assist the consumer and his or her family with the development of mental health relapse prevention strategies and plans, if none exist;

(j) Assist the consumer and his or her family with the development of a safety plan to address risk factors identified during the environmental assessment;

(k) Have policies and procedures included in its Service Specific Policies that address the provision of CBI (CBI Organizational Plan) which include the following:

(1) A description of the particular treatment models utilized, types of intervention practiced, and typical daily curriculum and schedule;

(2) A description of the staffing pattern and how staff is deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated;

(3) A requirement to directly conduct or arrange for the provisions of Diagnostic/Assessment services within thirty (30) days before or after the initiation of CBI services through either an agreement with a CSA or a CSA's affiliated sub-provider. DMH may approve alternative sources to serve as the diagnostic assessment instrument if similar assessments have been conducted within the past twelve (12) months of an individual's referral to CBI services; and

(4) A requirement to collect and submit clinical outcome data using the process, timeline and tools specified or approved by DMH.

3422.37 Each CBI Level I team shall include:

(a) A full-time clinical supervisor;

(b) A full-time team leader; and

(c) Four (4) to six (6) CBI clinicians.

3422.38 The CBI Level I team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3422.39 The CBI Level I team leader shall be a Master's level clinician with a minimum of one (1) year of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3422.40 The CBI Level I team clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings.

3422.41 Each CBI Level II team shall include:

(a) A full-time clinical supervisor; and

(b) Four (4) to six (6) clinicians.

3422.42 The CBI Level II team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3422.43 The CBI Level II team clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings.

3422.44 Each CBI Level III team shall include:

(a) A full-time clinical supervisor; and

(b) Four (4) to six (6) clinicians.

3422.45 The CBI Level III team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years post-graduate experience working with behaviorally challenged youth and their families in community-based settings.

3422. 46 The CBI Level III team clinicians shall be either Master's level qualified practitioners or Bachelor's level clinicians with a minimum of two (2) years of experience working with behaviorally challenged youth and their families in community-based settings.

3422.47 Each CBI Level IV team shall include:

(a) A full-time clinical supervisor who has satisfied the FFT requirements for a clinical supervisor; and

(b) Three (3) to eight (8) full-time equivalent clinicians who have satisfied the FFT requirements for a therapist.

3422.48 The CBI Level IV team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings who has satisfied the FFT requirements for a clinical supervisor.

3422.49 The CBI Level IV clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings, and shall have satisfied the FFT requirements for FFT therapists.

3422.50 Providers of all levels of CBI services shall ensure the availability and provision of alcohol and other drug addiction treatment services as well as

services to facilitate consumers' transition from adolescence to adulthood, as medically necessary for consumers.

3422.51 Prior authorization from DMH is required for enrollment in all levels of CBI services.

3422.52 CBI shall not be billed on the same day as Rehabilitation/Day Services, Intensive Day Treatment or ACT.

3422.53 CBI shall not be billed on the same day as Counseling.

3422.54 CBI shall not be billed on the same day as Community Support unless the Community Support services are provided within thirty (30) days prior to the consumer's discharge from CBI.

3422.55 CBI shall be provided in:

(a) MHRS provider service sites; or

(b) Natural settings, including the consumer's home or other community setting.

3422.56 Qualified practitioners of CBI are:

(a) Psychiatrists;

(b) Psychologists;

(c) Licensed Independent Clinical Social Workers (LICSWs);

(d) Advance Practice Registered Nurses (APRNs);

(e) Registered Nurses (RNs);

(f) Licensed Professional Counselors (LPCs);

(g) Licensed Independent Social Workers (LISWs); and

(h) Addiction counselors.

3422.57 All credentialed staff, including recovery specialists, shall be authorized to provide CBI under the supervision of a qualified practitioner as set forth in §3413.3.

3422.58 CBI services shall not exceed thirty-two (32) units in a twenty-four (24) hour period, without prior authorization from DMH. DMH may conduct

clinical record reviews to verify the medical necessity of services provided.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 53 DCR 9197 (November 10, 2006); as amended by Final Rulemaking published at 57 DCR 10392, 10394 (November 5, 2010); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3480 (April 22, 2011); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 2857 (April 1, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 4159 (May 13, 2011).

3423 ASSERTIVE COMMUNITY TREATMENT

3423.1 ACT is an intensive, integrated, rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness with dedicated staff time and specific staff to consumer ratios.

3423.2 Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week.

3423.3 The consumer's ACT team shall complete a comprehensive or supplemental assessment and develop a self care-oriented IRP (if a current and effective one does not already exist).

3423.4 Services offered by the ACT team shall include:

(a) Mental health-related medication prescription, administration, and monitoring;

(b) Crisis assessment and intervention;

(c) Symptom assessment, management, and individual supportive therapy;

(d) Substance abuse treatment for consumers with a co-occurring addictive disorder;

(e) Psychosocial rehabilitation and skill development;

(f) Interpersonal, social, and interpersonal skill training; and

(g) Education, support, and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.

3423.5 ACT services shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the consumer's mental health condition that is provided in non-office settings by the consumer's ACT team.

3423.6 The ACT team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings. ACT team meetings shall be held a minimum of three (3) times a week.

3423.7 ACT services and interventions shall be highly individualized and tailored to the needs and preferences of the consumer, with the goal of maximizing independence and supporting recovery.

3423.8 Each ACT provider shall have policies and procedures included in its Service Specific Policies that address the provisions of ACT (ACT Organizational Plan) which include the following:

(a) A description of the particular treatment models utilized, types of intervention practice, and typical daily curriculum and schedule; and

(b) A description of the staffing pattern and how staff are deployed to ensure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences and illnesses are accommodated.

3423.9 At a minimum, the ACT team shall include the following members:

(a) A full-time team leader or supervisor who is the clinical and administrative supervisor of the ACT team and who is a qualified practitioner;

(b) A psychiatrist working on a full-time or part-time basis for a minimum of four (4) hours per week per twenty (20) consumers that provides clinical and crisis services to all consumers served by the ACT team, works with the ACT team leader to monitor each consumer's clinical status and response to treatment, and directs psychopharmacologic and medical treatment;

(c) A registered nurse working on a full-time basis and providing nursing services for all ACT team consumers who works with the ACT team to monitor each consumer's clinical status and response to treatment and functions as a primary practitioner on the ACT team for a caseload of consumers;

(d) An addiction counselor working on a full-time basis and providing or accessing substance abuse services for ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers;

(e) A clinically trained generalist practitioner working on a full-time basis and providing individual and group supportive therapy to ACT team consumers who functions as a primary practitioner on the ACT team for a caseload of consumers and is a qualified practitioner; and

(f) Recovery specialists carrying out rehabilitation and support functions who may be consumers in recovery that have been specially credentialed based on their psychiatric and life experiences. Recovery specialists are fully integrated ACT team members who provide consultation to the ACT team, highly individualized services in the community, and who promote consumer self-determination and decision making.

3423.10 The ACT team shall maintain a minimum consumer-to-staff ratio of no more than twelve (12) consumers per staff person, and such ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

3423.11 Pre-authorization from DMH is required prior to enrollment for ACT.

3423.12 ACT shall not be billed on the same day as any other MHRS except for Crisis/Emergency.

3423.13 ACT shall be provided in:

(a) The MHRS provider's service site; or

(b) The consumer's home or other community setting.

3423.14 Qualified practitioners of ACT are:

(a) Psychiatrists;

(b) Advance Practice Registered Nurses;

(c) RNs; and

(d) Addiction counselors.

3423.15 Credentialed staff shall be authorized to provide ACT under the supervision of a qualified practitioner as set forth in §3413.3.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3482 (April 22, 2011).

3424 REIMBURSABLE SERVICES

3424.1 Reimbursement for the provision of MHRS shall be on a per unit basis as indicated in §3424.4.

3424.2 Each covered service shall have a unique billing code as established by DMH.

3424.3 Units of service reported for part of an hour shall be rounded to the nearest fifteen minute unit.

3424.4 Reimbursement shall be limited as follows:

MHRS	LIMITATIONS AND SERVICE SETTING	BILLABLE UNIT OF SERVICE
Diagnostic/ Assessment	● One (1) every six (6) months ● Additional units allowable when pre-authorized for periodic assessment, pre-hospitalization screening, neuropsychological assessment and re-admission to Rehabilitation/Day Services ● Shall not be billed the same day as ACT ● Provided only in a community-based	An assessment, which is at least three (3) hours in duration
Medication/ Somatic Treatment	● No annual limit ● Shall not be billed the same day as ACT ● Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	Fifteen (15) minutes

Counseling	● One hundred sixty (160) units per year ● Additional units allowable with prior authorization by DMH ● Shall not be billed the same day as Rehabilitation/Day Services, Intensive Day Treatment, CBI or ACT ● Shall be rendered face-to-face, when consumer is present, unless there is adequate documentation to justify why the consumer was not present during the session ● May be provided in individual on-site, individual off- site or group ● Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	Fifteen (15) minutes
Community Support	● No annual limits ● Shall not be billed on the same day as ACT ● May be provided individually or in a group ● Provided only in a community-based MHRS provider or other community	Fifteen (15) minutes
Crisis/ Emergency	● No annual limits ● Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	Fifteen (15) minutes
Rehabilitation/ Day Services	● Ninety (90) days within a twelve (12) month period ● Additional units allowable with prior authorization by DMH Shall not be billed on the same day as Counseling ● Shall not be billed on the same day as Counseling or ACT ● so Provided only in a community-based MHRS provider or other community setting, or residential facility of sixteen (16) beds or less	One (1) day (which shall consist of at least three (3) hours)

Intensive Day Treatment	• Seven (7) days • Additional units allowable after seven (7) days or for the second and any additional episodes of care within a twelve (12) month period with prior authorization by DMH • Shall not be billed on the same day as any other MHRS, except for Crisis/Emergency, Community Support and CBI. • Up to three (3) hours of Diagnostic/Assessment may be billed during each episode of Intensive Day Treatment • Provided only in a community-based	One (1) day (which shall consist of at least five (5) hours)
CBI	• Prior authorization from DMH required for enrollment • Shall not be billed on the same day as ACT, Counseling or Intensive Day Treatment • Provided only in a community-based MHRS provider or other community setting, or residential facility of	One (1) hour (or part thereof)
Assertive Community Treatment,	• 0 Prior authorization from DMH required for enrollment • Shall not be billed on the same day as any other MHR.S, except for Crisis/Emergency with retrospective authorization	One (1) hour (or part thereof)

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 53 DCR 9197 (November 10, 2006).

3425 NON-REIMBURSABLE SERVICES

3425.1 Services not covered as MHRS include, but are not limited to:

(a) Room and board residential costs;

(b) Inpatient hospital services, including hospital, nursing facility, intermediate care facility for the mentally retarded and institutions for mental diseases;

(c) Transportation services;

(d) Vocational services;

(e) School and educational services;

(f) Services rendered by parents or other family members;

(g) Socialization services;

(h) Screening and prevention services (other than those provided under Early and Periodic Screening, Diagnosis and Treatment requirements);

(i) Services which are not medically necessary as recommended in an approved IRP/IPC;

(j) Services which are not provided and documented in accordance with these certification standards;

(k) Services which are not mental health services; and

(l) Services furnished to persons other than the consumer when those services are not directed primarily to the well-being and benefit of the consumer.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005).

3499 DEFINITIONS

3499.1 The following terms have the meaning ascribed in this section:

"Addiction counselor" - a person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations. An addiction counselor is a qualified practitioner.

"Advance Practice Registered Nurse" or "APRN" - a person licensed as an advance practice registered nurse in accordance with applicable District laws and regulations, with psychiatry as an area of practice and working in a collaborative protocol with a psychiatrist. An Advance Practice Registered Nurse is an approving qualified practitioner.

"Affiliation agreement" - an agreement in the form approved by DMH by and between a CSA and a specialty provider or sub-provider that describes how they will work together to benefit consumers.

"Approving practitioner" - the qualified practitioner responsible for overseeing the development of and approval of the Individual Recovery Plan or Individual Plan of Care ("IRP/IPC"). The approving practitioner serves on the Diagnostic/Assessment team and may also serve as the clinical manager.

"Approving qualified practitioner" or "AQP" - the qualified practitioner responsible for overseeing the development and approval of the Individual Recovery Plan or Individual Plan of Care (IRP/IPC). The approving qualified practitioner serves on the Diagnostic/Assessment team and may also serve as the clinical manager. Only a psychiatrist, psychologist, LICSW, APRN or LPC may act as an AQP.

"Assertive Community Treatment" or "ACT" - intensive, integrated rehabilitative, crisis, treatment, and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness by an interdisciplinary team. ACT is provided with dedicated staff time and specific staff to consumer ratios. Service coverage by the ACT team is required twenty-four (24) hours per day, seven (7) days per week. ACT is a specialty service.

"Assertive Community Treatment team" or "ACT team" - the mobile inter-disciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

"Authorized" - MHRS services that are prior authorized or reauthorized by DMH, in accordance with these standards.

"Behavioral concern" - A behavioral and emotional disorder of childhood and adolescence that manifests by children acting out aggressively, expressing anger inappropriately, and engaging in a variety of antisocial and destructive acts, including violence towards people and animals, destruction of property, lying, stealing, truancy, and running away from home.

"CBI team" - The interdisciplinary team of qualified practitioners and other staff involved in providing CBI to a consumer.

"CMS" - Centers for Medicare and Medicaid services, formerly known as the Health Care Financing Agency.

"Certification" - the written authorization from DMH rendering an entity eligible to provide MHRS. DMH grants certification to community-based organizations that submit an approved certification application and satisfy the certification standards.

"Certification application" - the application and supporting materials prepared and submitted to DMH by a community-based organization requesting certification to provide MHRS.

"Certification standards" - the minimum requirements established by DMH in this Chapter that an MHRS provider shall satisfy to obtain and maintain certification to provide MHRS and receive reimbursement from DMH for MHRS.

"Child and Family Services Agency" or "CFSA" - The District agency responsible for the coordination of foster care, adoption and child welfare services and services to protect children against abuse or neglect.

"Clinical manager" - the qualified practitioner chosen by the consumer to coordinate service delivery. The clinical manager shall participate in the development and review of the consumer's IRP/IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA, except that a psychiatrist serving as a clinical manager may be under contract to the CSA.

"Clinical supervisor" - The qualified practitioner responsible for monitoring consumer welfare, ensuring compliance with professional standards of service delivery, monitoring clinical performance and

professional development of team members, and evaluating team members for performance, service delivery and credentialing purposes.

"Clinician" - An individual with either a Bachelor's or Master's degree in social work, counseling, psychology, family therapy or related social science or appropriate therapeutic experience with the target population. Clinicians are credentialed staff.

"Community-Based Intervention" or "CBI" - Time-limited, intensive mental health services delivered to children and youth ages six (6) through twenty-one (21) and intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. CBI is primarily focused on the development of consumer skills to promote behavior change in the child or youth's natural environment and empower the child or youth to cope with his or her emotional disturbance.

"Community Support" - rehabilitation and environmental support considered essential to assist a consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with the consumer. Community Support is a core service.

"Consumer" - a person eligible to receive MHRS as defined in the District of Columbia Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001, effective July 23, 2001 (D.C. Act 14-101).

"Core services" includes the following four categories of MHRS: Diagnostic/ Assessment, Medication/Somatic Treatment, Counseling and Psychotherapy, and Community Support.

"Core Services Agency" or "CSA" - a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

"Corporate Compliance Plan" - a written plan developed by each MHRS provider to ensure that the MHRS provider operates in compliance with all applicable federal and District laws and regulations.

"Corrective Action Plan" or "CAP" - a written plan prepared by either an applicant for certification or a DMH-certified MHRS provider

describing the actions that the provider intends to take to correct or abate the violations described in a CMP issued by DMH.

"Corrective Measures Plan" or "CMP" - a written statement of non-compliance issued by DMH, which describes the areas in which an applicant for certification or a DMH-certified MHRS provider fails to comply with the certification standards.

"Counseling" - individual, group, or family face-to-face services for symptom and behavior management, development, restoration, or enhancement of adaptive behaviors and skills, and enhancement or maintenance of daily living skills. Mental health supports and consultation services provided to consumer's families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the consumer. Counseling is a core service.

"Credentialed staff" - unlicensed staff or staff who are not qualified practitioners that are credentialed by the MHRS provider to perform certain MHRS or components of MHRS under the clinical supervision of a qualified practitioner.

"Crisis/Emergency" - face-to-face or telephone immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency services are provided to consumers involved in active mental health crisis and consist of immediate response to evaluate and screen the presenting mental health situation, assist in immediate crisis stabilization and resolution and ensure the consumer's access to mental health care at the appropriate level. Crisis/Emergency is a specialty service.

"Crisis support services" - mental health services that support the consumer through a crisis, such as meeting with the consumer in the community or an emergency department to help calm the consumer; implementing the crisis plan developed for the consumer; assisting the consumer to reach an emergency department; and providing pertinent mental health information about a consumer to an emergency department to assist in addressing a crisis.

"Cultural competence" - means the ability of an MHRS provider to deliver mental health services and mental health supports in a manner that effectively responds to the languages, values, and practices present in the various cultures of the MHRS provider's consumers.

"DHCF" - the Department of Health Care Finance, an agency which reports directly to the Mayor and which replaced MAA

"Department of Youth Rehabilitative Services" or "DYRS" - The District agency responsible for providing security, supervision and residential and community support services for committed and detained juvenile offenders and juvenile persons in need of supervision.

"Diagnostic/Assessment" - intensive clinical and functional evaluation of a consumer's mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery and may provide the basis for the development of the IRP/IPC. A Diagnostic/Assessment shall determine whether the consumer is appropriate for and can benefit from MHRS, based upon the consumer's diagnosis, presenting problems and recovery goals. Diagnostic/Assessment is a core service.

"Diagnostic/Assessment report" - the report prepared by the Diagnostic/ Assessment team that summarizes the results of the Diagnostic/Assessment service and includes recommendations for service delivery. The Diagnostic/Assessment report is used to initiate the IRP/IPC and, if necessary, the ISSP.

"Diagnostic/Assessment team" - at least two (2) qualified practitioners working together to complete the Diagnostic/Assessment and issue the Diagnostic/Assessment report.

"Director" - the director of DMH.

"Disaster Recovery Plan" - the policies and procedures developed by each MHRS provider to ensure that computerized data is properly maintained and can be retrieved in the event of a disaster.

"District of Columbia" or "District" - the government of the District of Columbia.

"District of Columbia State Medicaid Plan" - the plan approved by CMS that is developed and administered by MAA, pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act as added July 30, 1965 (79 Stat. 343; 42 U.S.C. §1396a et seq.), as amended. The program operated in accordance with the District of Columbia State Medicaid Plan is referred to as the "Medicaid" or "Medical Assistance" program.

"DMH" - the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

"DMH Consumer Enrollment and Referral System" - the system developed and administered by DMH to enroll eligible consumers into the MHRS system.

"DSM IV" - the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Emergency" - a situation in which a consumer is experiencing a mental health crisis and the immediate provision of mental health treatment is, in the written judgment of the consumer's attending physician, necessary to prevent serious injury to the consumer or others.

"Foster home" - a residence in which a foster parent is licensed by the District to provide care to a foster child in accordance with the requirements of Title 29, DCMR Chapter 60.

"**Functional Family Therapy**" or "**FFT**" – research-based prevention and intervention program for at-risk adolescents and their families provided by a team of trained therapists by a certified CBI Level IV provider with FFT site certification.

"Governing authority" - the designated individuals or governing body legally responsible for conducting the affairs of the MHRS provider.

"Grievance" - a description by any individual of his or her dissatisfaction with an MHRS provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations.

"Human Care Agreement" - the written agreement entered into by the DMH-certified MHRS provider and DMH which describes how the parties will work together.

"ICD-9CM" - the most recent version of the International Classification of Diseases Code Manual.

"Independent Living Program" - A residential program licensed by the District in accordance with Title 29 DCMR Chapter 63, Licensing of Independent Living Programs for Adolescents and Young Adults.

"Individualized Plan of Care" or "IPC" - the individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC is maintained by the consumer's CSA. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer's

identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

"Individualized Recovery Plan" or "IRP" - an individualized recovery plan for adult consumers, which is the result of the Diagnostic/Assessment. The IRP is maintained by the consumer's CSA. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IRP shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

"Inpatient mental health service" - residence and treatment provided in a psychiatric hospital or unit licensed or operated by the District of Columbia.

"Intensive Day Treatment" - a structured, intensive, and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an inter-disciplinary team to provide stabilization of psychiatric impairments. Its duration is time-limited. Intensive Day Treatment is provided in an ambulatory setting. Intensive Day Treatment is a specialty service.

"Intensive Home and Community-Based Services" or "IHCBS" - an intensive model of treatment adapted by DMH to prevent the utilization of out-of-home treatment resources by emotionally disturbed children and youth.

"Licensed independent clinical social worker" or "LICSW" - a person licensed as an independent clinical social worker in accordance with applicable District laws and regulations. An LICSW is an approving qualified practitioner.

"Licensed independent social worker" or "LISW" - a person licensed as a licensed independent social worker in accordance with applicable District laws and regulations. An LISW is a qualified practitioner.

"Licensed professional counselor" or "LPC" - a professional counselor licensed in accordance with applicable District laws and regulations. An LPC is an approving qualified practitioner.

"Long-term placement option" - either a permanent caregiver or permanent home. A group home or other residential placement is not a long-term placement option.

"MAA" - the Department of Health, Medical Assistance Administration, replaced by DHCF.

"MAA/DMH Interagency Agreement" - a written agreement entered into by MAA and DMH which describes how MAA and DMH will handle the operation and administration of the MHRS program.

"Medicaid or Medical Assistance" - the program described in the District of Columbia State Medicaid Plan, approved by CMS, and administered by MAA pursuant to Section 1(b) of An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program and for other purposes and Title XIX of the Social Security Act, as amended July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396a et seq.).

"Medical necessity" or "medically necessary" - those services contained in an approved IRP/IPC reasonably calculated to prevent the worsening of, alleviate, correct, cure, or ameliorate an identified mental health condition that endangers life, causes suffering or pain, causes physical deformity or bodily malfunction, threatens to cause or aggravate a disability, or results in an illness or infirmity. For children through age twenty (20), services reasonably calculated to promote the development or maintenance of age-appropriate functioning are also considered medically necessary.

"Medication/Somatic Treatment" - medical interventions, including physical examinations, prescription, supervision or administration of mental-health related medications, monitoring and interpreting the results of laboratory diagnostic procedures related to mental health-related medications, and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment is a core service.

"Mental Health Rehabilitation Services" or "MHRS" - mental health rehabilitative or palliative services provided by a DMH-certified community mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and this chapter.

"Mental illness" - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

"MHRS provider" - an organization certified by DMH to provide MHRS. MHRS provider includes CSAs, sub-providers, and specialty providers.

"**Mobile Crisis Response Team**" – a team of mental health clinicians who provide face-to-face and telephone support to children and families in crisis.

"Multisystemic therapy" or "MST" - an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions.

"Natural settings" - the consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

"Neglect" - any act or omission by an MHRS provider which causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury or death of a consumer.

"Out of home therapeutic resource" - a psychiatric hospital or psychiatric residential treatment facility.

"Permanent caregiver" - a natural or adoptive family or foster home that has cared for the consumer for at least six (6) consecutive months within the twelve (12) month period immediately preceding the referral for CBI. A group home or other residential placement is not a permanent caregiver.

"Permanent home" - a natural or adoptive family or foster home where the consumer has lived for at least six (6) consecutive months within the twelve month (12) month period immediately preceding the referral to CBI with a permanent caregiver. A group home or other residential placement is not a permanent home.

"Policy" - a written statement developed by an MHRS provider that gives specific direction regarding how the MHRS provider shall operate administratively and programmatically.

"Prior authorization" - approval by DMH in advance for the initiation of MHRS to a consumer, including the commencement of services such as Diagnostic/Assessment or Crisis Emergency services before a consumer is enrolled in the MHRS program.

"Procedure" - a written set of instructions describing the step-by-step actions to be taken by MHRS provider staff in implementing a policy of the MHRS provider.

"Psychiatric residential treatment facility" - shall have the meaning ascribed in 42 CFR Subpart G, Section 483.352.

"Psychiatrist" - a physician licensed in accordance with applicable District laws and regulations who has completed a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education and is eligible to sit for the psychiatric board examination. A Psychiatrist is an approving qualified practitioner.

"Psychologist" - a person licensed to practice psychology in accordance with applicable District laws and regulations. A Psychologist is an approving qualified practitioner.

"Qualified practitioner" - (i) a psychiatrist; (ii) a psychologist; (iii) an independent clinical social worker; (iv) an advance practice registered nurse; (v) a registered nurse; (vi) a licensed professional counselor; (vii) an independent social worker; and (viii) an addiction counselor.

"Reauthorized" - having received approval by DMH for the continued provision of medically necessary MHRS that are time-limited, such as Rehabilitation/Day Services, Intensive Day Treatment, CBI or ACT.

"Referral" - a recommendation to seek or request services or evaluation between a CSA and a sub-provider or specialty provider in order to assess or meet the needs of consumers.

"Registered nurse" or "RN" - a person licensed as a registered nurse in accordance with applicable District laws and regulations. An RN is a qualified practitioner.

"Rehabilitation/Day Services" - a structured, clinical program intended to develop skills and foster social role integration through a range of social, psycho-educational, behavioral, and cognitive mental health interventions. Rehabilitation/Day Services are curriculum-driven and psycho-educational and assist the consumer in the retention, or restoration of community living, socialization, and adaptive skills. Rehabilitation Day Services

include cognitive- behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling, and adjunctive treatment. Rehabilitation/Day Services are offered most often in group settings. Rehabilitation/Day Services is a specialty service.

"Residential placement" - a psychiatric residential treatment center, group home, independent living program or other residence where children or youth are temporarily receiving services. A permanent home is not a residential placement.

"Service specific standards" - the certification standards described in §3414, §3415, §3416, §3417, §3418, §3419, §3420, §3421, §3422 and §3423, which set forth the specific requirements applicable to each MHRS.

"Specialty provider" - a community-based organization MHRS provider certified by DMH to provide specialty services either directly or through contract. Each specialty provider shall enter into an affiliation agreement with each DMH-certified CSA.

"Specialty provider" - a community-based organization MHRS provider certified by DMH to provide specialty services either directly or through contract. Each specialty provider shall enter into an affiliation agreement with each DMH-certified CSA.

"Specialty services" - ACT, CBI, Crisis Intervention/Emergency, Intensive Day Treatment, and Rehabilitation.

"Subcontractor" - a licensed independent practitioner qualified to provide mental health services in the District. A subcontractor may provide one or more core service(s) under contract with a CSA. A subcontractor may also provide specialty service(s) under contract with a specialty provider.

"Subcontractor" - a licensed independent practitioner qualified to provide mental health services in the District. A subcontractor may provide one or more core service(s) under contract with a CSA. A subcontractor may also provide specialty service(s) under contract with a specialty provider.

"Subcontractor Agreement" - an agreement by and between an MHRS provider and a subcontractor that describes how they will work together to benefit consumers in the form approved by DMH.

"Subprovider" - a community-based organization certified by DMH to provide one or more core service(s) through an affiliation agreement with a CSA.

"Triaging" - prioritizing the level of crisis services required by a consumer, based upon the assessed needs of the consumer.

SOURCE: Final Rulemaking published at 48 DCR 10297 (November 9, 2001); as amended by Final Rulemaking published at 51 DCR 9308 (October 1, 2004); as amended by Final Rulemaking published at 52 DCR 5682 (June 17, 2005); as amended by Final Rulemaking published at 53 DCR 9197 (November 10, 2006); as amended by Final Rulemaking published at 57 DCR 10392, 10406 (November 5, 2010); as amended by Notice of by Emergency and Proposed Rulemaking published at 58 DCR 1482 (February 18, 2011)[EXPIRED]; as amended by Notice of Final Rulemaking published at 58 DCR 3476, 3482 (April 22, 2011); as amended by Notice of Final Rulemaking published at 58 DCR 8366, 8370 (September 30, 2011).