CHAPTER IV
COVERED SERVICES AND LIMITATIONS

CHAPTER IV

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Behavioral Health Services Administrator (BHSA)
Magellan Health serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the behavioral health benefits program under contract with DMAS. Magellan is authorized to create, manage, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan. DMAS shall retain authority for and oversight of Magellan entity or entities.

MEDALLION 3.0
Some Medicaid enrollees may receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the MEDALLION 3.0 Program. For these MCO enrollees, assessment and evaluation, and outpatient psychiatric and substance abuse therapy services (individual, family, and group) are handled through the individual's MCO.

MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the enrollee's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the enrollee's MCO directly for information regarding the contractual, coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

The following community mental health and substance abuse rehabilitative services are **carved-out** of the MCO contracts and are covered by Magellan, for MCO enrollees, in accordance with DMAS fee-for-service established coverage criteria and guidelines. The MCOs are responsible to assist with care coordination for enrollees to assist them in being referred to carved-out services and also to cover transportation for carved-out services.

Coverage for MEDALLION 3.0 MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

Intensive In-home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance, and for Adults with Serious Mental Illness
Mental Health Day Treatment/Partial Hospitalization Services
Psychosocial Rehabilitation
Mental Health Crisis Intervention
Intensive Community Treatment
Crisis Stabilization
Mental Health Skill-building Services

Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)
Substance Abuse Crisis Intervention
Substance Abuse Intensive Outpatient Treatment
Substance Abuse Day Treatment
Opioid Treatment
Residential Substance Abuse Treatment for Pregnant and Post-Partum Women
Substance Abuse Day Treatment for Pregnant and Post-Partum Women
Substance Abuse Case Management

Coverage for FAMIS MCO Enrollees*
Intensive In-Home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention
Substance Abuse Crisis Intervention
Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance
Note—No other CMHRS other than those listed above are covered by DMAS for FAMIS MCO Enrollees*

Medicaid managed care organizations receive data on the community mental health rehabilitative services utilized by their members. Providers of community mental health rehabilitative services may be contacted by the managed care organizations to discuss the care of these individuals.

DEFINITIONS

"**Activities of daily living"** means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.

"Adolescent or child" means the individual receiving the services described in this manual. For the purpose of the use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"At risk of hospitalization or out of home placement" means one or more of the following: (i) within the two weeks before the intake, the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 days; (v) the treatment team or family assessment planning team (FAPT)

recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of residential treatment facility Level C services, (b) transitioning out of a group home Level A or B services, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

"Behavioral health services-Children's/EPSDT Services" that shall be covered only for individuals from birth through 21 years of age are set out in 12VAC30-50-130 B 5 and include: (i) intensive in-home services (IIH), (ii) therapeutic day treatment (TDT), (iii) community based services for children and adolescents (Level A), and (iv) therapeutic behavioral services (Level B).

"Behavioral health services-Adult Services" that shall be covered for individuals regardless of age are set out in 12VAC30-50-226 and include: (i) day treatment/partial hospitalization, (ii) psychosocial rehabilitation, (iii) crisis intervention, (iv) case management as set out in 12VAC30-50-420 and 12VAC30-50-430, (v) intensive community treatment (ICT), (vi) crisis stabilization services, and (vii) mental health support services (MHSS).

"Behavioral health services administrator" or **"BHSA"** refers to Magellan as the entity that manages and directs a behavioral health benefits program under contract with DMAS.

"Behavioral health authority" or "BHA" means the local agency that administers services set out in § 37.2-601 of the Code of Virginia.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified prescreener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Children's residential facility" or "facility" means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia except:
1. Any facility licensed by the Department of Social Services as a child-caring institution as of January 1, 1987, and that receives public funds; and
2. Acute-care private psychiatric hospitals serving children that are licensed by the Department of Behavioral Health and Developmental Services under the Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse, the Individual and Family Developmental Disabilities Support Waiver, and Residential Brain Injury Services, 12VAC35-105.

"Clinical experience" (Adult Services) means practical experience in providing direct services on a full-time basis (or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013) to individuals with medically-documented diagnoses of mental illness or intellectual/developmental disability

or the provision of direct geriatric services or full-time (or the equivalent part-time experience) special education services, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, or (vi) crisis intervention services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. This required clinical experience shall be calculated as set forth in DBHDS document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Clinical experience" (Children's Services) means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

"Commonwealth Coordinated Care" Commonwealth Coordinated Care (CCC) is a program that offers, coordinates, and provides Medicare and Medicaid benefits by ensuring that all of the benefits currently provided under Medicare and Medicaid are combined into one plan with a designated care manager who ensures person-centered and efficient health care services are provided. CCC includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. Virginians presently eligible for CCC include those who are full Medicare and Medicaid beneficiaries (meaning entitled to benefits under Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits), are aged 21 or older, and live in designated regions around the Commonwealth.

"Community services board" or "CSB" means the local agency that administers services set out in § 37.2-500 of the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid

program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the member.
Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary.

"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

"Home or Household" means the family residence and includes a child living with natural parents, relatives, or a legal guardian, or the family residence of the child's permanent or temporary foster care or pre-adoption placement.

"Human services field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Independent assessor" means a professional who performs the independent clinical assessment who may be employed by either the behavioral health services administrator, community services boards/behavioral health authorities (CSBs/BHAs) or their subcontractors.

"The independent clinical assessment" (ICA), as set forth in the Virginia Independent Assessment Program (VICAP-001) form, shall contain the Medicaid individual-specific elements of information and data that shall be required for an individual younger than the age of 21 to be approved for intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) or any combination thereof.

"Individual" means the Medicaid-eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age or adolescents ages 12 through 20 years. Individuals may also be referred to as a "member".

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment. The ISP contains his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"Licensed mental health professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

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

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

"Marketing materials" means any material created to promote services through any media including, but not limited to, written materials, television, radio, websites, and social media.

"**New service**" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.

"Out-of-home placement" means placement in one or more of the following: (i) either a Level A or Level B group home; (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) Level C residential facility; (v) emergency shelter for the individual only due

either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"**Progress notes**" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed. Progress notes shall be documented for each service that is billed.

"Provider" means an individual or organizational entity that is appropriately licensed as required and credentialed with Magellan as a DMAS provider of community mental health and substance abuse rehabilitation services.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified mental health professional-child" or **"QMHP-C"** means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.

"Qualified mental health professional-eligible" or **"QMHP-E"** means a person who has: (i) at least a bachelor's degree in a human service field or special education from an accredited college without one year of clinical experience or (ii) at least a bachelor's degree in a nonrelated field and is enrolled in a master's or doctoral clinical program, taking the

equivalent of at least three credit hours per semester and is employed by a provider that has a triennial license issued by the department and has a department and DMAS-approved supervision training program

"Qualified paraprofessional in mental health" or **"QPPMH"** means a person who must, at a minimum, meet one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iii) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-Adult providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Qualified mental health professional-adult" or "QMHP-A" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Residential treatment program" means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive non-mental health special needs including, but not limited to, personal care, habilitation, or academic educational needs of the resident.

"Responsible Adult" shall be an adult who lives in the same household with the child receiving IIH services and is responsible for engaging in therapy and service-related activities to benefit the individual.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-specific provider intake" means the face-to-face interaction, in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child's or adolescent's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and
(xv) The dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"VICAP" means the Virginia Independent Clinical Assessment Program that is required to record an individual's independent clinical assessment information. VICAP may be referred to as the Independent Clinical Assessment in this manual.

COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES

Community mental health rehabilitative services (CMHRS) are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances.

Community Mental Health Rehabilitation Services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

All Services must be described with sufficient detail in an Individual Service Plan based on assessed needs of the individual defined in the service specific provider intake and as defined in the individual service plan and most recent clinical supervision and review of the individuals treatment needs. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.

Magellan Care Management, Provider Service Coordination and Coordination with CSB and TFC Case Managers

Care Coordination

Care Management is provided by Magellan employed clinical staff who are licensed behavioral health clinicians. The central purpose of Care Management is to help individuals receive quality services in the most cost-effective manner. The primary activities of care management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care transition, quality management, and independent review.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals:

1) to improve the health and wellness of individuals with complex and special needs; and
2) to integrate services around the needs of the individual at the local level by working to make sure members receive appropriate services and experience desirable treatment outcomes.

Examples when Magellan may provide care management to assist individuals and families include:

- Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management.
- An MCO liaison at Magellan will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care.
- Care coordination with Primary Care Physicians (PCPs).
- Assistance with transferring cases from one provider to another

Coordination Requirements of Service Providers with Case Managers

If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record. The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

Provider Service Coordination

"Care coordination" in the regulations defined in 12VAC30-50-130 means the same as Service Coordination defined in the DMAS manual as collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

The purpose of Service Coordination is to ensure that the individual receives all needed services and supports; that these resources are well-coordinated and integrated; and that they are provided in the most effective and efficient manner possible.

For an individual receiving CMHR services, this activity is meant to ensure an optimal Individual Service Plan be developed based on as much information as possible related to both the member's physical and behavioral clinical picture.

Service Coordination is done in the spirit of collaboration with the treatment team and is meant to support the member on his or her path of recovery**.**

Service Coordination includes:

- Assisting the individual to access and appropriately utilize needed services and supports;
- Assisting them to overcome barriers to being able to maximize the use of these resources;
- Actively collaborating with all internal and external service providers;
- Coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer's life);
- Assessing the effectiveness of these services/supports;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the service plan as clinically indicated and to ensure that service planning is consistent with other services being provided to the individual.

Service coordination between different providers is required and must be documented in the ISP and Progress Notes. Service Coordination serves to help align services to prevent duplication and is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and share information among other health care providers and individuals who routinely come in contact with the individual, i.e. PCPs, Case Managers, Probation Officers, Teachers, etc. and who are involved with the individual's health care and overall wellbeing in order to improve care.

Independent Clinical Assessment for Children's Rehabilitative Services

Magellan contracts with the local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) (herein referred to as the "independent assessor") to conduct the independent clinical assessment.

Each child or youth must have an independent clinical assessment prior to the initiation of Intensive In-Home, Therapeutic Day Treatment and Mental Health Skill Building (for persons aged 16-20).
Children and youth who are being discharged from residential treatment (DMAS Levels A, B, or C), or from a psychiatric inpatient hospitalization **do not need** an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of any subsequent service reauthorization.

Service lapses of greater than 31 days without member or guardian contact do not require a new independent clinical assessment prior to resuming services. All service lapses of greater than 31 days require a new service specific provider intake to be completed prior to resuming services.

Independent assessors shall meet the DBHDS definition of a licensed mental health professional (LMHP) including persons who have registered with the appropriate licensing board and are working toward licensure (LMHP-Resident, LMHP-RP or LMHP-Supervisee).

The Independent Clinical Assessment Process

1. A parent or legal guardian of a child or youth who is believed to be in need of Intensive In-Home, Therapeutic Day Treatment or Mental Health Skill-building Services (aged 16-20) must contact the local CSB/BHA to request an independent clinical assessment. If a service provider receives a request to provide one of the affected services, the service provider must refer the parent/legal guardian to the local CSB/BHA first to obtain the independent clinical assessment. The independent clinical assessment must be completed prior to service initiation. If the child or youth is in immediate need of behavioral health treatment, the independent clinical assessor will make a referral to appropriate, currently reimbursed Medicaid emergency services in accordance with 12 VAC 30-50-226 and may also contact the child or youth's MCO to alert the MCO of the child's needs with parental or guardian consent.

2. Once the CSB/BHA is contacted by the parent or legal guardian, the independent clinical assessment appointment will be offered within five (5) business days of the request for IIH Services and within ten (10) business days of the request for TDT and MHSS services. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian. CSBs/BHAs will attempt to accommodate working schedules of parents and legal guardians. Medicaid transportation may be used to transport the child or youth and parent/legal guardian to the independent clinical assessment appointment.

3. The independent clinical assessor will conduct the independent clinical assessment with the child or youth and the parent or legal guardian using a standardized format and make a recommendation for the most appropriate, medically necessary services, if indicated. Only the parent or legal guardian and child or youth will be permitted in the room during the independent clinical assessment. Recommendations may include community mental health rehabilitative services, psychiatric, or outpatient behavioral health services.

4. The independent clinical assessor will inform the parent or legal guardian about the recommended behavioral health service options and their freedom of choice of providers. This discussion must be documented by the independent clinical assessor.

    a. The family or legal guardian will be asked if they have a service provider in mind for the recommended service(s).
    b. If a service provider has been identified, the independent assessor will note the choice of service provider on the Choice form.
    c. The independent assessor will ask the parent or legal guardian to sign a release of information if the parent agrees to share clinical assessment information with the chosen service provider(s).
    d. If a service provider has not been identified, the independent assessor will provide the parent or legal guardian with instructions on finding and selecting a provider using the Magellan website or by directly assisting the parent or guardian with contacting a Magellan Care Manager. For outpatient behavioral health services, the independent clinical assessor will refer the parent or legal guardian to the child or youth's MCO or the parent or guardian may contact the primary care physician.

5. If the individual is in immediate need of treatment the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with 12VAC30-50-226 and shall **also** alert Magellan and the individual's managed care organization.

6. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation or the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically indicated, the service provider may submit the supplemental information with a service authorization request to Magellan. Magellan will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

7. The independent clinical assessor will electronically submit the independent clinical assessment summary data within one (1) business day of completing the assessment into Magellan web portal service authorization system. The independent clinical assessment will be effective for a 30 day period from the date the assessment was completed with the child. The independent clinical assessor will complete assessment documentation within three (3) business days of the assessment.

8. If a community mental health rehabilitative service has been recommended, the parent or legal guardian may choose and contact a CMHRS service provider. Prior to the initiation of services, the CMHRS service provider must request a copy of the fully completed independent clinical assessment document. If the parent or legal guardian consents to the release of information, the independent clinical assessor will mail, fax or send a copy of the full independent clinical assessment to the service provider within five (5) business days of the request. The service provider (supported by the independent clinical assessment) will then conduct a service specific provider intake for

IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill-building Services (H0032, U8) and develop an initial service plan. Service providers may choose to conduct a service specific provider intake prior to receiving a copy of the independent clinical assessment if it can be confirmed that the ICA has already been completed.

9. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age. If the child was screened and determined to be "at risk" for physical injury, the service provider must complete the intake within 14 days from when the individual was deemed "at risk" of physical injury. Refer to the IIH and TDT service requirements for more detail.

10. If the selected service provider concurs that the child meets criteria for the service recommended by the independent clinical assessor, the selected service provider will submit a service authorization request to Magellan. A copy of the fully completed independent clinical assessment must be in the service provider's medical record for the individual. The service provider's service specific intake for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill-building Services (H0032, U8) must not occur prior to the independent clinical assessment.

11. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual's life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian
12. If the independent clinical assessment is greater than thirty (30) days old, another independent clinical assessment must be obtained prior to the initiation of a new CMHRS service.

Service-Specific Provider Intake

The Service-Specific Provider Intake is the initial face-to-face interaction encounter in which the provider obtains information from the individual, and parent/caregivers or other family members about the individual's mental health status. The intake serves to gather information to assess the needs and preferences of the individual as it relates to the delivery of a specific CMHR service. The intake serves to gather information to assess the needs and preferences of the individual as it relates to the delivery of a specific CMHR service.

Service-specific provider intakes shall be required prior to developing an Individual Services Plan (ISP) and shall be required as a reference point for the ISP during the entire duration of services. Services based upon incomplete, missing, or outdated (more than a year old or not reflective of the individuals current level of need) intakes/re-assessments and ISPs shall be denied reimbursement.

Service-Specific Provider Intakes for all Mental Health Services shall be conducted by a licensed mental health professional (LMHP); or

LMHP *"Types" including:*
- LMHP-supervisee in social work or LMHP-S;
- LMHP-resident or LMHP-R; or
- LMHP-resident in psychology or LMHP-RP

A service specific provider intake must be completed prior to initiating each of the following services:

Intensive In-home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention* (only if an ISP is developed-refer to service details)
Mental Health Crisis Stabilization
Mental Health Day Treatment/Partial Hospitalization Services
Psychosocial Rehabilitation
Intensive Community Treatment
Mental Health Skill-building Services
Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)

**MH and SA Case Management intakes do not require the same credentials as the direct MH services. MH Case Management intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services.*

Providers must adhere to licensing rules as they relate to service provision:
http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section650/

A service specific provider intake must be completed prior to initiating each of the following services in accordance with each service specific licensing requirements:

Substance Abuse Residential Treatment for Pregnant Women
Substance Abuse Day Treatment for Pregnant Women
Substance Abuse Case Management
Substance Abuse Crisis Intervention
Substance Abuse Intensive Outpatient
Substance Abuse Day Treatment
Opioid Treatment
Mental Health Case Management

For services that require a service authorization, the service specific provider intake must be used to determine the medically necessity for each service requested on behalf of the individual.

The Service Specific Provider Intake must contain a documented history of the severity, intensity, and duration of behavioral health care problems and issues and shall contain all of the following elements:

All fifteen elements must be addressed in the service specific provider intake to qualify for reimbursement.

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.

2. Behavioral Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. Previous Interventions by providers and timeframes and response to treatment: include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.

4. Medical Profile: Describe significant past and present medical problems, illnesses and injuries, known allergies, current physical complaints and medications. As needed, conduct an individualized fall risk assessment to indicate whether the individual has any physical conditions or other impairments that put her or him at risk for falling. *All children aged 10 years or younger should be assessed for fall risks based on age-specific norms*.

5. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

6. Educational/Vocational Status: School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.

7. Current Living Situation, Family History and Relationships: Describe the daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.

8. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

9. Drug and Alcohol Profile: Describe substance use and abuse by the individual and/or family members; specify the type of substance with frequency and duration of usage.

10. Resources and Strengths: Document individual's strengths, preferences,

extracurricular, community and social activities, extended family; activities that the individual engages in or are meaningful to the individual.

11. Mental Status Profile-May include the DMAS "At Risk of Physical Injury Screening Tool" (DMAS P502) or other clinical tools used if they apply

12. Diagnosis: The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis

13. Professional Service Specific Intake Summary and Clinical Formulation includes a documentation of medically necessary services as defined by the service provider which:
    a. Defines if there are any additional clinical issues that may need to be addressed that were not identified in the VICAP-as appropriate to the service being requested
    b. Compares the presenting issues identified in the VICAP to those identified during the intake;
    c. Identifies as much as possible, the causes of presenting treatment issues, and
    d. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual specific service plan can be developed.

14. Recommended Care and Treatment Goals
15. Dated signatures of the clinicians and case managers* who completed the intake. **For case management services only: A dated signature of the case manager who completed the intake is required.*

Continued Care Requests and Service Lapses of more than 31 days

If there is a lapse in service for more than 31 consecutive calendar days without contact from the family member or individual receiving services, the reason for the lapse and the rationale for the continued need for the service must be documented. A new service specific intake must be completed for any case that has a lapse in services beyond 31 days without contact from the individual or family/caregiver in that time period.

The Service Specific Provider Intake must be completed annually for all services or more frequently as service needs change.

Individual Services Plan (ISP) Requirements

Community Mental Health Rehabilitative Services require an Individualized Service Plan (ISP) which is completed by the servicing provider. The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service coordination and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements.

These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.

If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed as long as the treatment for the substance abuse

condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the ISP and the progress notes.

The "Individual Service Plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment. The ISP contains his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services.

- Intensive In-Home providers must ensure that all interventions and the settings of the intervention are defined in the Individual Service Plan

The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated annually or as the needs, goals and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on the needs and progress of the individual change shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete and not meeting the reimbursement requirements.

All ISPs shall be completed, signed, and contemporaneously dated by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E preparing the ISP within 30 days of the date of the completed intake (except for crisis intervention and crisis stabilization services which have specific rules on ISP development). The child's or adolescent's ISP shall also be signed by the parent/legal guardian and the adult individual shall sign his own. If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or refuses to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual refuses to sign or is unwilling to sign the ISP.

The ISP must be reviewed and updated, at a minimum, on a quarterly basis to determine if the goals and objectives meet the needs of the individual based on the most recent clinical review of the service documentation and assessment of functioning. The updated ISP must be signed by the individual and/or family. If the provider feels a more comprehensive service specific provider intake is needed, they may choose to complete a comprehensive service specific provider intake and bill the appropriate service specific provider intake code that corresponds to the service/treatment. Please refer to the Service Limit Chart in the exhibits section of this chapter for service specific provider intake billing codes and instructions.

Individual Specific Treatment Goals and Objectives

Goals and Intervention/Strategies should be based on the individuals presenting areas of needs as identified per the provide specific assessment

Goals:

Should reflect an individualized specific overview of the objectives and will address the larger presenting needs. Goals are longer term than objectives

Objectives:
Should demonstrate shorter term, measurable, achievable, action-oriented, strength-based activities that the individual/family will engage in toward completion of the goal.

Intervention/Strategies:
- Should define specific steps that the provider and individual will engage in toward the attainment/achievement of each objective
- Interventions are developed based on the individual's specific strengths and needs (i.e. developmental level, level of functioning, academic/literacy ability, interests, etc)
- Interventions should clearly reflect service coordination
- Parent and Caregiver objectives *included in IIH services* must be related to increasing functional and appropriate interpersonal interactions with the individual authorized to receive services and must include the individual-specific program purpose of the goals to be achieved within the authorized time period;

Frequency:
- The ISPs should include the frequency with which the overall service will be provided
- The ISP must be reviewed, at a minimum, on a quarterly basis to determine if the goals and objectives meet the needs of the individual based on the most recent clinical review of the service documentation and assessment of functioning.
- The review of progress as well as any changes to the ISP must be documented in the quarterly report. All revised service plans must be signed by the individual and/or family.

Discharge Goal:

- All ISPs should include an individualized discharge plan. Describe the discharge planning to summarize an estimated timetable to achieving the goals and objectives in the service plan, include discharge plans that are specific to need of the individual at the time the service needs are reviewed.

Service Coordination:

- All ISPs should clearly include service coordination as necessary toward the attainment of the objective
- Service coordination activities must be defined related to the specific treatment needs and the related service goals and objectives and describe any psycho-educational or service coordination strategies as they relate to other care providers and persons (other CMHRS services, Outpatient/Clinic Services, Foster Care, Judicial or Educational related staff, Relatives, etc.) who routinely come in contact with the individual.

Continuity of Care:

- All ISPs should clearly identify all current professionals involved in the individual's care and with whom all is actively coordinated during the duration of the service (i.e. educational, psychiatric, medical, case management, probation, etc.)

Service Requirements for All Services

- All services require a Service Specific Provider Intake to be completed at the onset of services. The Service Specific Provider Intake must be completed face to face by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP for all services except Crisis Intervention and Crisis Stabilization which allow the use of an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP and a Certified Pre-Screener.

- All fifteen Service Specific Intake elements are required to be documented by providers of Substance Abuse Treatment Services and Case Management services. The 15 required service specific provider intake elements must be completed by staff as defined in the Department of Behavioral Health and Developmental Services licensing requirements for assessments as described in 12VAC35-105-650. Intakes for substance abuse treatment services and case management must be conducted by staff who meet the licensing requirements defined by DBHDS and defined in the DMAS CMHRS provider manual.

- Each Intake must be completed and reimbursed every 12 months for services that continue for 12 months or more.

- If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new service specific provider intake shall be completed and a new service authorization shall be required.

- The ISP, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual. Documentation shall be provided if the individual, who is a minor child, is unable or unwilling to sign the ISP.

- The ISP must include the estimated timetable for achieving the goals and objectives, describe how progress will be measured and include discharge plans that are specific to needs of the individual at the time the service needs are reviewed. Service plans shall incorporate an individualized discharge plan that describes transition from current services to other appropriate less intensive services. The discharge plan must describe the methods that will be used to facilitate a successful transition to services.

- The ISP must be reviewed by the service provider every three months

- LMHPs must adhere to the practice guidelines outlined by the ethical guidelines of the assigned professional board governing that license.

- Professional clinical services must be provided by a LMHP, LMHP-R, LMHP-RP or an LMHP-S.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services including efforts to schedule well visits for kids and as needed physician visits for adults.

- If an individual receiving CMHR services is also receiving case management services the provider **must** collaborate with the case manager and provide notification of the provision of services. In addition, the provider **must** send written monthly updates to the case manager on the individual's progress. A discharge summary **must** be sent to the case manager within 30 days of the service discontinuation date.

- Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of the information in the electronic health records.

- The provider must maintain a copy of the entire fully completed Independent Clinical Assessment in each individual's file. After the Independent Clinical Assessment is completed and prior to admission, a face-to-face service specific provider intake must be conducted and documented.

- Progress notes must contain individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and case-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP.

- The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. Progress notes shall be documented for each service unit that is billed. The content of each progress note shall corroborate the time and specifically document the service provided to support each of the units billed.

- DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

- Staff travel time is not reimbursable.

Marketing Requirements

Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.

1. Marketing and promotional activities (including provider promotional activities) shall comply with all applicable federal and state laws.

2. Providers shall provide clearly written materials that completely and accurately describe the Medicaid or FAMIS behavioral health service or services offered, the beneficiary eligibility requirements to receive the service or services, applicable fees and other charges, and all other information required for beneficiaries and their families to make fully informed decisions about enrollment into the service or services offered by the provider that is marketing its services.

3. Providers shall distribute their marketing materials only in the service locations approved within the license issued by the Licensing Division of the Department of Behavioral Health and Developmental Services.

4. Providers shall receive DMAS approval of all marketing materials and all changes to prior-approved marketing materials prior to their use or dissemination. Providers shall receive the DMAS marketing plan approval before engaging in any marketing activity.

a. Within 30 calendar days of receipt of providers' submissions, DMAS shall review submitted individual marketing materials and services and either approve them or deny their use or direct that specified modifications be made.

b. Providers failing to implement DMAS' required changes, or those which use unapproved or disapproved materials, shall be subject to termination of the provider agreement pursuant to 12VAC30-130-2000 E.

Marketing Limits and Prohibitions

1. Providers shall not offer cash or noncash incentives to their enrolled or prospective members for the purposes of marketing, retaining beneficiaries within the providers' services, or rewarding behavior changes in compliance with goals and objectives stated in beneficiaries' individual service plans.

2. While engaging in marketing activities, providers shall not:

   a. Engage in any marketing activities that could misrepresent the service, Magellan or DMAS;

b. Assert or state that the beneficiary must enroll with the provider in order to prevent the loss of Medicaid or FAMIS benefits;

c. Conduct door-to-door, telephone, unsolicited school presentations, or other cold call marketing directed at potential or current beneficiaries;

d. Conduct any marketing activities or use marketing materials that are not specifically approved by DMAS;

e. Make home visits for direct or indirect marketing or enrollment activities except when specifically requested by the beneficiary or family;

f. Collect or use Medicaid or FAMIS confidential information or Medicaid or FAMIS protected health information (PHI), as that term is defined in Health Insurance Portability and Accountability Act of 1996 (HIPAA), that may be either provided by another entity or obtained by marketing provider, to identify and market services to prospective beneficiaries;

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about beneficiaries for any purposes other than the performance of the provider's obligations relative to its DMAS provider agreement;

h. Contact, after the effective date of disenrollment, beneficiaries who choose to disenroll from the provider except as may be specifically required by DMAS;

i. Conduct service assessment or enrollment activities at any marketing or community event; or

j. Assert or state (either orally or in writing) that the provider is endorsed either by the Centers for Medicare and Medicaid Services, DMAS, or any other federal or state governmental entities.

Termination of Providers for Violating Marketing Requirements

Providers that (i) conduct any marketing activity that is not specifically approved by DMAS, (ii) violate any of the prohibitions in this section, or (iii) fail to meet requirements shall be subject to termination of their provider agreements for the services affected by the marketing plan/activity. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

Transportation Benefits

- Provider transportation of the individual receiving services is not reimbursable.

- Fee For Service (FFS) members with transportation benefits receive services through the Non-Emergency Medical Transportation (NEMT) broker. The NEMT program serves members going to Medicaid covered services, including psychiatric appointments. Transportation services must be "preauthorized" by the FFS NEMT broker. Members assigned to a Managed Care Organization (MCO) or are not included as parts of any CMHRS service please contact the MCO for transportation services. Individual providers and agencies may seek mileage reimbursement through the FFS transportation broker or MCO for services under which transportation is covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

- If you have any FFS transportation questions, need to check transportation eligibility, want to make transportation arrangements or discuss the gas reimbursement process please contact LogistiCare at (866) 386-8331. For more additional information regarding the NEMT program please refer to the DMAS NEMT website http://transportation.dmas.virginia.gov. Individuals enrolled in an MCO must contact the individual's MCO directly in order to arrange transportation.

Service Authorization

For more service detail please refer to the Service Limit Chart in Appendix C.

All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Service Authorization is required for the following services:

- Intensive In-Home (H2012)
- Community Residential Treatment, Level A (H2022 HW (CSA) H2022 HK (non CSA)
- Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (non-CSA)
- Therapeutic Day Treatment for Children up to age 21 (H0035)
- Day Treatment / Partial Hospitalization (H0035)
- Intensive Community Treatment (H0039)
- Psychosocial Rehabilitation (H2017)
- Mental Health Skill-building Services (H0046)

Registration is required for the following services:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Case Management

SERVICE CRITERIA AND DEFINITIONS –

Intensive In-Home Services (IIH) for Children and Adolescents (H2012)

Service Definition
Intensive in-home services (IIH) for children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings.

All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual.

At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family.

Beginning on January 30, 2015 children who meet the medical necessity criteria to receive IIH services may also simultaneously be approved for either Mental Health Case Management or Treatment Foster Care Case Management services.

Medical Necessity Criteria

Individuals receiving IIH Services must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the individual's residence. The service-specific provider intake shall describe how the individual's clinical needs put the individual at risk of out-of-home placement and shall be conducted face-to-face in the individual's residence.

To qualify for Intensive In-Home reimbursement individuals must MEET ALL of the criteria including Diagnostic, At Risk, Family Involvement and Level of Care.

Diagnostic Criteria

Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities.

The diagnosis must be the primary clinical issue addressed by services and meet the following criteria:

MEET ONE:

The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.

At Risk Criteria

The impairments experienced by the member are to such a degree that they meet the criteria for being at risk of out of home placement as defined in the below section.

MEET TWO

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are **at risk of hospitalization* or out-of-home placement** because of conflicts with family or community.
b. Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services or judicial system are or have been necessary resulting in being at risk for out of home placement.
c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior resulting in being at risk for out of home placement.

"**At Risk**" **of Hospitalization*** means one or more of the following:

MEET ONE:

(i) within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted; **REFER to Emergency Services for Assessment if necessary;**

(ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;

(iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;

(iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;

(v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:

(a) Transitioning (within the last 30 days) out of residential treatment

facility Level C services,
(b) Transitioning (within the last 30 days) out of a group home Level A or B services,
(c) Transitioning (within the last 30 days) out of acute psychiatric hospitalization, or
(d) Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

Out of Home Placement:
Means placement in one or more of the following:

(i) either a Level A or Level B group home;
(ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is **at risk** of being placed in the custody of the local department of social services;
(iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is **at risk** of removal to a higher level of care;
(iv) Level C residential facility;
(v) emergency shelter for the individual only due either to his mental health or behavior or both;
(vi) psychiatric hospitalization; or
(vii) juvenile justice system or incarceration.

Level of Care:

The service-specific provider intake shall describe how the individual meets either subdivision a or b of this subdivision

MEET ONE
These services shall be provided in this level of care when the clinical needs of the individual put him at risk for out-of-home placement, as these terms are defined in this section:
a. When services that are far more intensive than outpatient clinic care are required to stabilize the individual in the family situation, or
b. When the individual's residence as the setting for services is more likely to be successful than a clinic.

Family Involvement:

MEET BOTH

- At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family.
- In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

Reimbursement shall not be made for this level of care if the following applies:

a. The individual is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms; and
b. The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.
c. The child is no longer in the home.
d. There is no parent or responsible adult actively participating in the service.

Discharges shall also be warranted when the service documentation does not demonstrate that services meet the IIH service definition or when the services progress meets the "failed services" definition:

"Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues (12VAC30-60-61). Discharge is required when the individual has achieved maximal benefit from this level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted.

Service Requirements

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- An individual service plan shall be fully completed, signed, and dated by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.

- It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. The ISP, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual.

Required Activities when individual is screened and determined to be "AT Risk of Physical Injury":

For all individuals that have been screened by an LMHP and meet criteria "i" of the "At Risk Criteria" they are deemed "at risk for physical injury" and the service-specific intake and service authorization process must be managed by the provider according to the following requirements:

1. If the individual is deemed at risk of physical injury or the risk screening determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment to assess for the most appropriate level of care. *(The individual should always be immediately referred to the local CSB Emergency Services Program if he/she is presenting imminent risk to self or others.)*
2. Once the individual is referred for community based services the Service Specific Provider Intake must be completed by the provider selected by the individual's caregivers. If the SSPI is not completed within 14 calendar days of the LMHP who deemed the individual to be a physical danger to self or others, an additional risk screening must be completed.
3. This risk screening must be done by an LMHP. It may be the same LMHP who performs the service-specific intake for IIH or TDT.
4. If an Independent Clinical Assessment (VICAP) was done, the original VICAP assessor may update that assessment if they are available to do so.
5. The risk screening will be submitted along with the Service Request Application to Magellan for review.
6. If the service request is submitted to Magellan for a child who is at risk of physical danger to self or others more than 14 days after the VICAP, the case will be pended and the submitting provider will be contacted and asked to submit a risk screening to Magellan within three business days.
7. Once the risk screening is received, the information will then be reviewed and a decision made.
8. If the provider does not submit the additional requested information, the service may not be authorized.

- Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per individual/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive services.

- Emergency assistance shall be available to the family, and delivered, as needed, by the IIH service provider 24 hours per day, seven days a week.

- All interventions and the settings of the intervention shall be defined in the ISP.

- Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family's residence with the individual present.

- As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP.

- Observational sessions in the school setting must be defined in the ISP, the sessions must have a specific clinical rationale that supports a documented service need and is clinically necessary in the school setting.

- For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

Covered Services:

- Individual and family counseling;

- Training to increase appropriate communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.);

- Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The individual and responsible parent/guardian shall be available and in agreement to participate in the transition.

- Service Coordination

Service Limitations:

- Services that meet the definition of “Failed Services” will not be eligible for reimbursement approval.

- IIH may not be billed prior to the day of discharge from any Level A, Level B, Level C or inpatient hospitalization.

- Outpatient therapy must be either provided by the IIH provider or coordinated with another provider to align the service with ISP goals and objectives. The ISP and progress notes must reflect the need and coordination activities.

- Activities outside the home, such as trips to the library, restaurants, museums, health clubs, shopping centers, and the like, are not considered a part of the scope of services. There must be a clinical rationale documented for any activity provided outside the home. Services may be provided in the community instead of the home if this is supported by the service specific provider intake and the ISP.

- The unit of service for IIH service is one hour.

- For reimbursement of this service, a minimum of 3 hours per week of therapeutic intervention must be **medically necessary** for the individual, with a maximum of 10 hours per week. In exceptional circumstances only, and with appropriate supporting documentation that describes medical necessity, providers may bill for up to 15 hours per week. Magellan may authorize up to a maximum of 50 hours per calendar month based on medical necessity criteria and the needs of the individual.

- The information provided for service authorization must be corroborated and in the provider's clinical record. An approved Service Authorization is required for any units of service (H2012) to be paid. The process for requesting service authorization is detailed in Appendix C of this manual. Providers under contract with Magellan should contact Magellan directly for more information. A maximum of 26 weeks of IIH Services may be authorized annually with coverage under the State Plan Option service. Magellan stops payment when claims exceed the 26 week service limit allowed in the regulations. If an individual is in need of services beyond the 26 weeks limit, providers must request the service extension through Magellan under the rules for Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Therapeutic Day Treatment (TDT) for Children and Adolescents (H0035)

Service Definition

Covered services are a combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in programs of two or more hours per day

Medical Necessity Criteria

Individuals receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

To qualify for Therapeutic Day Treatment reimbursement individuals must MEET ALL including the Diagnostic, At Risk and Level of Care criteria

Diagnostic Criteria

Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities.

The diagnosis must be the primary clinical issue addressed with the service targeted for treatment and meet the following criteria:

MEET ONE:

The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.

At Risk Criteria

Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities.

MEET TWO:

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are **at risk of hospitalization* or out-of-home placement** because of conflicts with family or community.
b. Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services or judicial system are or have been necessary.
c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

"**At Risk" of Hospitalization*** means one or more of the following:

MEET ONE:

(i) within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted;
(ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;
(iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;
(iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;
(v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:
    (a) Transitioning (within the last 30 days) out of residential treatment facility Level C services,

(b) Transitioning (within the last 30 days) out of a group home Level A or B services,
(c) Transitioning (within the last 30 days) out of acute psychiatric hospitalization, or
(d) Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

Out of Home Placement:

Means placement in one or more of the following:

- either a Level A or Level B group home;
- regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is **at risk** of being placed in the custody of the local department of social services;
- treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is **at risk** of removal to a higher level of care;
- Level C residential facility;
- emergency shelter for the individual only due either to his mental health or behavior or both;
- psychiatric hospitalization; or
- juvenile justice system or incarceration.

Level of Care:

MEET ONE (a-e)

a. The individual must require year-round treatment in order to sustain behavior or emotional gains.
b. The individual's behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:
   (1) TDT programming during the school day; or
   (2) TDT programming to supplement the school day or school year.
c. The individual would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.
d. The individual must (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.
e. The individual is placed or pending placement in a preschool enrichment and/or early intervention program but the individual's emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted in these programs without TDT services.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

- Reimbursement shall not be made for this level of care if the following applies:
  - The individual no meets the at risk criteria; or
  - The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

Discharge is required when the individual has achieved maximal benefit from this level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted and the individual meets all of the discharge criteria:.

- The individual does not require year-round treatment in order to sustain behavior or emotional gains.
- The individual's behavior and emotional problems are successfully managed in a self- contained or resource emotionally disturbed (ED) classrooms without:
  - TDT programming during the school day; or
  - TDT programming to supplement the school day or school year.
- The individual is no longer at risk of being placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.
- The individual no longer needs supports or does not (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.
- The individual is able to be placed or admitted into a preschool enrichment and/or early intervention program but the individual's emotional/behavioral problems without the documented need for supports provided by TDT services.

Required Activities:

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the parent/guardian within 30 days of initiation of services and shall meet all requirements of an ISP as defined in 12VAC30-50-226.

Required Activities when individual is screened and determined to be "AT Risk of Physical Injury":

For all individuals that have been screened by an LMHP and meet criteria "i" of the "At Risk Criteria" they are deemed "at risk for physical injury" and the service-specific intake

and service authorization process must be managed by the provider according to the following requirements:

1. If the individual is deemed at risk of physical injury or the risk screening determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment if clinically necessary to assess for the most appropriate level of care. (*The individual should always be immediately referred to the local CSB Emergency Services Program if he/she is presenting imminent risk to self or others.)*
2. Once the individual is referred for community based services the Service Specific Provider Intake must be completed by the provider selected by the individual's caregivers. If the SSPI is not completed within 14 calendar days of the LMHP who deemed the individual to be a physical danger to self or others, an additional risk screening must be completed.
3. This risk screening must be done by an LMHP. It may be the same LMHP who performs the service-specific intake for IIH or TDT.
4. If an Independent Clinical Assessment (VICAP) was done, the original VICAP assessor may update that assessment if they are available to do so.
5. The risk screening will be submitted along with the Service Request Application to Magellan for review.
6. If the service request is submitted to Magellan for a child who is at risk of physical danger to self or others more than 14 days after the VICAP, the case will be pended and the submitting provider will be contacted and asked to submit a risk screening to Magellan within three business days.
7. Once the risk screening is received, the information will then be reviewed and a decision made.
8. If the provider does not submit the additional requested information, the service may not be authorized.

Covered Services

- Completing diagnostic evaluations, identifying treatment needs;

- Consultation with teachers and others involved in the individual's treatment and observation in the classroom.

- Planning and implementing individualized pro-social skills curriculums and interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.),

- Monitoring progress in demonstrating the acquisition of pro-social skills (anger management, problem-solving skills, identification and appropriate verbalization of feelings, conflict resolution, etc.); (monitoring includes providing feedback to the individual on the acquisition of these skills);

- Implementing cognitive-behavioral programming

- Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family, and others

involved in the individual's treatment; Family contacts, either in person or by telephone, occurs at least once per week.

- Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day; services should include a "de-briefing" with the individual and family to discuss the incident; how to recognize triggers, identify alternative coping mechanisms and providing feedback on the use of those alternative coping mechanisms.

- Providing individual, group, and family counseling based on specific TDT objectives identified in the ISP;

- Collaborating with all other community practitioners providing services to the individual, including scheduling appointments and meetings, and

- If the individual is on medication related to their behavioral health needs, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the individual and parent/ guardian and documented. Response to medication and education, as well as compliance must also be documented.

Limitations

- The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., before school, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group counseling/therapy and psycho-educational activities.

- Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C or QMHP-E.

- Therapeutic group activities, such as counseling, psychotherapy, and psycho-education are limited to no more than 10 individuals.

- Medicaid will only reimburse for allowed service activities as defined in the ISP.

- Activities that are not allowed / reimbursed:
    - Inactive time or time spent waiting to respond to a behavioral situation;
    - Transportation; and
    - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions

- Services must not duplicate those services provided by the school.

Service Units and Maximum Service Limitations

There is a maximum of 780 units that are allowed based on medical necessity per fiscal year.

One unit = 2 to 2.99 hours
Two units = 3 to 4.99 hours

Three units = 5 plus hours
No more than three units may be billed per day.

Claims must be billed with an HA modifier. (Please note the special billing instructions included in Chapter V of this manual). Providers under contract with Magellan should contact Magellan directly for more information.

Community-Based Residential Services for Children and Adolescents under 21 (Level A) - H2022 HW (CSA), H2022 HK (non CSA)

Service Definition

Community-Based Residential Services for Children and Adolescents under 21 (Level A Group Homes) are a combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan. The individual must also receive at least weekly individual psychotherapy services (provided by an LMHP or LMHP Resident/Supervisee) in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the individual. Service authorization is required for Medicaid reimbursement.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the individual's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following (A-E) are met:

A) The individual is medically stable, but needs intervention to comply with mental health treatment; and

B) The individual's mental health needs cannot be met with a less intense service; and

C) An intake demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool (CANS) must be completed by the locality for Comprehensive Services Act (CSA) individuals and must be current to within 30 days prior to placement. For non-CSA individuals, a service specific provider intake must be completed by the independent referring clinician noting at least two moderate impairments within

the past 30 days. A moderate impairment is evidenced by, but not limited to:

(1) Frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

(2) Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

(3) Severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

(4) Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

D) Limited ability to consider the effect of one's inappropriate conduct on others and interactions consistently involving conflict, which may include impulsive or abusive behaviors. ; For non CSA children the service specific provider intake must be completed by the independent referring clinician prior to admission. The service specific provider intake must contain all of the following elements:

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.

2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk assessment: Does the individual have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

4. Developmental History: Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. Educational/Vocational Status: School, grade, special education. /IEP status,

academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.

6. Current Living Situation and Family History and Relationships: Daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.

7. Legal Status: Indicate individual's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. Drug and Alcohol Profile: Substance use / abuse by individual / family members. Type of Substance, Frequency/Duration

9. Resources and Strengths: Document individual's strengths. Extracurricular activities, church, extended family; activities that the individual engages in or are meaningful to the individual.

10. Mental Status Profile

11. Diagnosis: Diagnosis - Includes DSM Code & Description—Diagnosis must be made by an LMHP.

12. Professional Service specific provider intake Summary/ Clinical Formulation: Documentation of needed services. Clinical formulation includes: 1) determining if clinical issues that need to be addressed that were not identified in the CON 2) relating the presenting issues identified in the CON and during the intake to one another 3) identifying the causes of these presenting issues, and 4) predicting treatment options, outcomes, and barrier to progress, so that an individual specific service plan can be developed.

13. Recommended ISP with time frames. An ISP means a comprehensive and **regularly updated** document specific to the individual being treated containing, but not necessarily limited to, his treatment or training needs, his goals and measureable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives and estimated timetable for achieving the goals and objectives. To regularly update the ISP, the provider must provide feedback to the individual and determine incremental progress or lack of progress toward the goals and objectives.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

E) Independent Team Certification The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission.**; and**

For CSA individuals, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and Management Team's (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the individual's primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA individuals only, the placing agent must give the provider the name of the locality fiscally responsible for the individual. The provider will submit this information to Magellan.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent's PCP and an LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a Level A Group Home may only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; and

2. Proper treatment of the child's psychiatric condition requires services in a community-based residential program.

3. The services may reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the LMHP and the physician prior to the start of services (see "Exhibits" section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:

1) Includes a licensed physician who:

(i) Has competence in diagnosis and treatment of pediatric mental illness; and
(ii) Has knowledge of the individual's mental health history and current situation.

B. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:

1) Be made by the team responsible for the CIPOC;
2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and

3) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

The Initial Plan of Care (IPOC) must be completed upon admission at least by a QMHP and must be signed and dated by the program director. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the child;

3. Treatment objectives with short-term and long-term goals;

4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and;

6. Plans for discharge.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

Continued Stay Criteria for Level A
Service authorization through Magellan for continued stay is required. A qualified mental health provider (QMHP) must re-assess the medical necessity for service after six consecutive months and prior to the initial service authorization expiration. The re-assessment must also be signed by a licensed mental health provider (LMHP). The LMHP for the re-assessment and continued service authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must also be in the individual's record.

1. For continued treatment beyond the initial six month authorization, the current (within 30 days) Comprehensive Individual Plan of Care (CIPOC) update of progress related to the goals and objectives must document the need for the continuation of the service.

2. For re-authorization to occur, either the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the individual's CIPOC or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains, and use of less intensive services will not achieve stabilization. InterQual Criteria must be met as well as any one of the following must apply:

   A) The individual has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

   B) The individual is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

   C) The individual is not making progress, and the CIPOC has been modified to identify more effective interventions.

   D) There are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

   Required Activities:

   - Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the QMHP within 30 days of authorization for Medicaid reimbursement. The CIPOC must be re-written annually. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

  The CIPOC must:

  1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and must reflect the need for residential psychiatric care;

  2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);

  3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

  4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

  5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community;

  6. The CIPOC must be reviewed and signed by a QMHP every 30 days. The review must include:
     - The response to services provided; and
     - Recommended changes in the plan as indicated by the individual's overall response to the ISP interventions; and
     - Determinations regarding whether the services being provided continue to be required; and
     - Updates must include the dated signatures of the QMHP service provider.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues indicated in the individual's IPOC and the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual's behavioral, mental, or emotional condition. The child

must participate in seven (7) psycho-educational activities per week. Program activities must be documented at the time the service is rendered and must include the dated signatures of qualified staff rendering the service.

- In addition to the residential services, the child must receive at least weekly, individual psychotherapy that is provided by an LMHP. Family psychotherapy may also to be provided if there is continued family involvement. Therapy sessions are limited to no more than three (3) sessions in a seven-day period, including individual, family and group psychotherapy. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized (see the *Psychiatric Services* Provider Manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and documentation criteria.) If the weekly psychotherapy is missed due to the individual's illness or refusal, justification must be documented in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up a missed session.

- The facility/group home must coordinate services with other providers.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of this community mental health rehabilitative service.

- If an individual receiving Community-Based Services for Children and Adolescents under 21 (Level A) is also receiving case management services the provider must collaborate with the case manager by notifying the case manager of the provision of Level A services and send written monthly updates on the individual's progress. A written discharge summary must be sent when the service is discontinued.

- The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of residents at all times, including off campus activities.

- <u>The program director supervising the program/group home must be, at a minimum, a qualified mental health professional and employed full time.</u>

- <u>At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.</u>

- Ensure that entry level staff are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV;

- <u>Services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP-C, QMHP-E and QPPMH.</u>

Therapeutic Passes

Therapeutic passes are permitted if the goals of the pass are part of the CIPOC. The goals

of a particular visit must be documented prior to granting the pass. When the individual returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the pass is to assess the individual's ability to function outside the structured environment and to function appropriately within the family and community.

A. Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic passes must be documented. No more than 24 days of therapeutic passes annually are allowed. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the previous placement the child/adolescent may be granted overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active therapeutic services while on overnight therapeutic passes is required to bill for days away from the facility.

B. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

- None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a MAGELLAN residential service authorization.

Limitations

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

DMAS does not pay for programs/facilities that only provide independent living services.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included.

Service authorization is required for payment of all residential services billed to Magellan. Please note that the service authorization process is described in Appendix C of this

manual. Providers under contract with Magellan should contact Magellan directly for more information.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization. Reimbursement shall not be made for this level of care if any of the following applies:

a. The level of functioning has improved with respect to the goals outlined in the CIPOC and the individual can reasonably be expected to maintain these gains at a lower level of treatment; or

b. The individual no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 days.

c. InterQual® Behavioral Health criteria and Community Based Treatment criteria is no longer met.

Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) **H2020 HK** (non-CSA)

Service Definition

Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the ISP. The individual must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the members. Service authorization is required for Medicaid reimbursement. See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Eligibility Criteria

Individuals qualifying for this service must demonstrate medical necessity for the service arising from a condition due to mental, behavioral, or emotional illness, which results in significant functional impairments in major life activities in the home, school, at work, or in the community. The service must reasonably be expected to improve the individual's condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following (A-D) are met:

A. The individual is medically stable, but needs intervention to comply with mental health treatment; AND

B. The individual's needs cannot be met with a less intense service; AND

C. An assessment demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment (CANS) tool must be completed by the locality for Comprehensive Services Act (CSA) children/adolescents and must be current to within 30 days prior to placement. For non-CSA children, a service specific provider intake and a CANS must be made by the EPSDT physician and an independent LMHP noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

1. Frequent conflict in the family setting; for example, credible threats of physical harm. Frequent is defined as more than expected for the child's age and developmental level.

2. Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

3. Severely limited involvement in social support; which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

4. Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

5. Limited ability to consider the effect of one's inappropriate conduct on others and/or interactions consistently involving conflict, which may include impulsive or abusive behaviors.

D. Independent Team Certification - The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission; **and**

For CSA children, the Family Assessment and Planning Team's (FAPT) identification of the need for the service and the Community Policy and Management Team's (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the child or adolescent's primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA children only, the placing agent must give the provider the name of the locality fiscally responsible for the child. The provider will be submitting this information to the service authorization contractor.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent's PCP and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a community residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual;

2. Proper treatment of the individual's psychiatric condition requires services on in a community-based residential program; and

3. The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the screener and the physician prior to the start of services (see "Exhibits" section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:

1) Includes a licensed physician who:

   (i) Has competence in diagnosis and treatment of pediatric mental illness; and
   (ii) Has knowledge of the individual's mental health history and current situation.

B. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:

1) Be made by the team responsible for the CIPOC;
2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and
3) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

The Initial Plan of Care (IPOC) must be completed upon admission by the QMHP and must be signed and dated by the program director. (See the "Exhibits" section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the child;

3. Treatment objectives with short-term and long-term goals;

4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

5. Plans for continuing care, including review and modification to the plan of care; and;

6. Plans for discharge.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

Continued Stay Criteria for Level B

Service authorization through Magellan for continued stay is required. A qualified mental health provider (QMHP) must re-assess for medical necessity for service after consecutive six months. The re-assessment must also be signed by a licensed mental health provider (LMHP). The LMHP for the re-assessment and continued service authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must also be in the individual's record.

1. For continued treatment beyond the initial six month authorization a current CIPOC and a current (within 30 days) progress update related to the goals and objectives on the CIPOC must document the need for the continuation of the service.

2. For authorization to occur past the initial six months, either the desired outcome or level of functioning has not been restored or improved in the time frame outlined in the individual's ISP, or the individual continues to be at risk for relapse based on recent

history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. InterQual® criteria must be met as well as any one of the following:

A. The individual has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

B. The individual is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

C. The individual is not making progress, and the CIPOC has been modified to identify more effective interventions.

D. There are current indications that the individual requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic passes or stays in a non-treatment residential setting or in a lower level of care.

Service Requirements

- A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the LMHP within 30 calendar days of admission;

  The CIPOC must:

  1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child's situation and must reflect the need for residential psychiatric care;

  2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);

  3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;

  4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

  5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual's family, school, and community; and

  6. The CIPOC must be reviewed signed by the LMHP every 30 calendar days. The review must include:

     - The response to services provided;

     - Recommended changes in the plan as indicated by the individual's overall response to the CIPOC interventions;
     - Determinations regarding whether the services being provided continue to

be required; and
- Updates must be signed and dated by the LMHP service provider.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues indicated in the individual's IPOC and the CIPOC.

- Daily documentation of services provided must clearly reflect behaviors, activities, and treatment methodologies that indicate attention to and movement toward stated goals and objectives in the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual's behavioral, mental, or emotional condition. The individual must participate in seven (7) psycho-educational activities per week. Program sessions must be documented at the time the service is rendered and must be signed and dated by the qualified staff rendering the service.

- In addition to the residential services, the individual must receive at least weekly, individual psychotherapy that is provided by a LMHP. Family psychotherapy may also to be provided if there is continued family involvement. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* provider manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and criteria) If the weekly psychotherapy is missed due to the individual's illness or refusal written justification must be in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions.

- Individuals receiving Therapeutic Behavioral Services (Level B) must also receive group psychotherapy that is provided as part of the program. If provided by a Medicaid-enrolled LMHP, group psychotherapy may be billed separately and must be prior authorized in addition to the authorization for the residential services (See *Psychiatric Services* provider manual, Chapter IV and Appendix C, for details on outpatient requirements and pre-authorization procedures).

- The facility/group home must coordinate services with other providers.

- <u>The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of this community mental health rehabilitative service.</u>

- If an individual receiving Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is also receiving case management services the provider must collaborate with the case manager by notifying the case manager of the provision of Level B services and send written monthly updates on the individual's progress. A written discharge summary must be sent when the service

is discontinued.

- The staff ratio must be at least 1 staff to 4 children during the day and at least 1 staff to 8 children while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of individuals at all times, including off campus activities.

- In order for Medicaid reimbursement to be approved, at least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.

- Ensure that entry level staff are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV;

- These services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP-C, QMHP-E, and QPPMH.

Therapeutic Passes

Therapeutic passes are permitted if the goals of the therapeutic pass are part of the CIPOC. The goals of a particular therapeutic pass must be documented prior to granting the pass. When the individual returns from the therapeutic pass, the response to the pass must be documented. Therapeutic passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the therapeutic pass is to assess the individual's ability to function outside the structured environment and to function appropriately within the family and community.

A. Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic pass must be documented. Therapeutic passes may not exceed more than 24 days annually. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the most recent previous placement the individual may be considered for overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active therapeutic services by the Level B provider while on overnight therapeutic passes is required to bill for days away from the facility.

B. If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 consecutive days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

C. None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a /MAGELLAN residential service authorization.

Limitations

Magellan will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Programs/facilities that only provide independent living services are not reimbursed.

The caseload of the clinical director must not exceed a total of 16 clients including all sites for which the clinical director is responsible.

Service Units and Maximum Service Limitations

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the individual. Room and board costs are not included in the rate. Service authorization is required for payment of all residential services. The service authorization process is described in Appendix C of this manual. Providers under contract with Magellan should contact Magellan directly for more information.

The fiscal years will be run from July 1 through June 30.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if any of the following applies:

    a. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

    b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

    c. InterQual® Behavioral Health Criteria, and Residential and Community-Based Treatment criteria is no longer met.

Day Treatment/Partial Hospitalization (H0035 HB)

Service Definition
Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

Day treatment/partial hospitalization services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for individuals with serious mental health disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require psychiatric inpatient treatment.

Medical Necessity Criteria
The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

Individuals must meet **at least two** of the following criteria on a continuing or intermittent basis:

1. Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

2. Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

3. Exhibit such inappropriate behavior that the individual requires repeated **documented** interventions or monitoring by the mental health, social services, or judicial system; or

4. Exhibit difficulty in cognitive ability such as difficulties with information processing, problem solving and decision making abilities such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Continued Stay

Upon admission the individual must receive a clinical evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist. For continued stays of more than 90 days, each service authorization requires that the individual receive an evaluation to document medical necessity for service extensions longer than 90 calendar days. All

services must be authorized based upon a face-to-face evaluation. The evaluation process shall include a review to determine if the individual continues to meet medical necessity criteria. The results of this evaluation must be presented to receive approval of reimbursement for continued services.

Discharge Criteria

Individuals are ready for discharge from this service when other less intensive services may achieve stabilization.

Reimbursement shall not be made for this level of care if the following applies:

a. The individual is no longer in an acute psychiatric state and at risk of psychiatric hospitalization and;

b. The individual's level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

Required Activities

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- Evaluation activities including the required face-to-face evaluation to assess whether the individual meets the medical necessity criteria and to define treatment goals that would be included in the ISP for continued services.

- An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, the QMHP-A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 days of service initiation.

- A physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist must perform a face-to-face evaluation when services are provided longer than 90 calendar days to assess whether the individual meets the medical necessity criteria and to define treatment goals that would be included in the ISP for continued services. This evaluation must be completed no later than 90 calendar days from the start of services.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP-A or LMHP or LMHP Resident/Supervisee, by a QMHP-A,

QMHP-E, LMHP, or LMHP Supervisee or Resident.

- Supervision by the QMHP-A, LMHP or LMHP Supervisee or Resident is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual's clinical record and signed by the QMHP-A, LMHP or LMHP Supervisee/Resident. Individual, group, or a combination of individual and group supervision is acceptable. The program must operate a minimum of two continuous hours in a 24-hour period.

Service Units and Maximum Service Limitations

- Day treatment/partial hospitalization services shall only be provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-C, QMHP-E, or an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP

A maximum of 780 units of Partial Hospital / Day Treatment is allowable annually.

- One unit= 2-3.99 hours/day
- Two units= 4-6.99 hours/day
- Three units= 7+ hours/day
-

Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial Rehabilitation is a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Medical Necessity Criteria

The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

Individuals must **MEET BOTH** Criteria **A and B** to qualify for reimbursement.

A.

Individuals must **MEET TWO** of the following criteria on a continuing or intermittent basis:

1. Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

2. Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

3. Exhibit such inappropriate behavior that repeated interventions **documented** by the mental health, social services, or judicial system are or have been necessary; or

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "Cognitive" here is referring to the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

B. The individual must **MEET ONE** of the following criteria:

1. Have experienced long-term or repeated psychiatric hospitalizations; or

2. Experience difficulty in activities of daily living and interpersonal skills; or

3. Have a limited or non-existent support system; or

4. Be unable to function in the community without intensive intervention; or

5. Require long-term services to be maintained in the community.

Covered Services

- Assessment

- Social skills training, peer support and community resource development oriented toward empowerment, recovery, and competency.

- Psycho educational activities to teach the individual about mental illness and appropriate medication to avoid complications and relapse,

- Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the individual's understanding or ability to access community resources and this is an identified need in the intake and ISP.

- Provide opportunities to learn and use independent living skills, and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

Required Activities

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- An ISP shall be completed by either the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, or the QMHP-A, QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 calendar days of service initiation.

- Psychosocial rehabilitation services may be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

- Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP to determine if the individual continues to meet the the medical necessity criteria. The results of the review must be presented to receive approval of reimbursement for continued services.

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

Service Limitations

Annual limit of 936 units

One unit = 2 to 3.99 hours per day
Two units = 4 to 6.99 hours per day
Three units = 7 + hours per day.

The following services are specifically excluded from payment for psychosocial rehabilitation services:

- vocational services,
- prevocational services,
- supported employment services

Crisis Intervention (H0036)

Service Definition

Crisis intervention shall provide immediate mental health care, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention services must be available 24 hours a day, seven days per week.

Crisis Intervention Objectives

- Prevent the exacerbation of a condition
- Prevent injury to the individual or others; and
- Provide treatment in the least restrictive setting.

Medical Necessity Criteria

The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Assessment time is allowed to document the medical necessity and assess the level of services needed.

There must be documentation of an immediate mental health service need with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

Crisis intervention services are provided following a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Individuals must **MEET BOTH** Criteria **A and B** to qualify for reimbursement.

A. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.
B. Individuals must **MEET TWO** of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;
(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
(3) Exhibit such inappropriate behavior that immediate interventions **documented** by mental health, social services, or the judicial system are or have been necessary; or
(4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

Service Requirements

- An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a Certified Pre-Screener, shall conduct a face-to-face service-specific provider intake as defined in 12VAC30-50-226.

- Crisis intervention shall be provided only by an LMHP, LMHP-Supervisee, LMHP-Resident, LMHP-RP, or a Certified Pre-Screener.

- During Emergency Custody Order (ECO) related Crisis Intervention services CSB's may use the DMH 224-Preadmission Screening Report to document the required elements of the service specific provider intake as defined in Chapter 6 of this manual.

- An ISP shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

- For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised by the fourth face-to face contact to reflect the short-term counseling goals

Covered Services

- Services may include office visits, home visits, pre-admission screenings, telephone contacts, or other client-related activities for the prevention of institutionalization.

- Note: Pre-admission screenings related to an ECO or Temporary Detention Order (TDO) are covered as crisis intervention **only** when the service is provided **by a CSB or BHA** as required by law **and** the encounter meets the crisis intervention service requirements. (Refer to Chapter 6 for more detail)

- The use of crisis intervention is allowed to certify necessity for an admission of an individual below the age of 21 to a freestanding inpatient psychiatric facility if the certification occurs as a result of an admission to the crisis intervention service, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met (refer to the DMAS Psychiatric Services Manual for clarification on independent team certifications).

- Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

- Crisis intervention services may be provided to eligible individuals in settings that are clinically/programmatically appropriate based on the needs identified in the service specific provider intake.

- Crisis intervention may involve contacts with the family or significant others with or without the individual present.

- If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.
- Client-related activities provided in association with a face-to-face contact are reimbursable.
- Assessment of the crisis situation,
- Provision of short-term clinical care and counseling designed to stabilize the individual or family unit,
- Providing access to further immediate assessment and follow-up services;
- Service Coordination to include linking the individual and family with ongoing care to prevent future crises.

Service Limitations

- Registration is required for reimbursement of this service within one business day from the provision of services or completion of the service-specific provider intake whichever comes first.
- A unit of service is 15 minutes of Crisis Intervention.
- A maximum of 720 units of Crisis Intervention may be provided annually.

Intensive Community Treatment (H0039)

Service Definition

Intensive Community Treatment (ICT) is an array of mental health services for individuals with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT has been designed to be provided through a designated multi-disciplinary team of mental health professionals and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community.

ICT is available either directly or on call 24 hours per day, seven days per week and 365 days per year.

Medical Necessity Criteria

To qualify for ICT, the individual must meet at least one of the following criteria:

1. The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.
2. The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance abuse disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within ICT as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Continuation of Services:

ICT may be reauthorized for up to an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider LMHP, LMHP-S, LMHP-R, and LMHP-RP RP to determine if the individual continues to meet the medical necessity criteria. The results of the review must be presented to receive approval of reimbursement for continued services.

Service Requirements

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- Psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting will be provided to individuals who are best served in the community.

- ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

- An individual service plan must be fully developed by either the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E and approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 days of the initiation of services.

- ICT may be provided based on an initial service specific provider intake. This service may be provided for a maximum of 26 weeks with a limit of 130 units available annually.

- Continuation of service may be reauthorized at 26-week intervals based on written service specific provider re-assessment and certification of need by a LMHP.

- ICT services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

- Service Coordination to ensure there is no duplication in services or billing and to ensure continuity of care.

- The purpose of ICT Service Coordination is to ensure that the individual receives all needed services and supports; that these resources are well-coordinated and integrated; and that they are provided in the most effective and efficient manner possible.

- ICT Service Coordination includes assisting the individual to access and appropriately utilize needed services and supports; assisting them to overcome barriers to being able to maximize the use of these resources; actively collaborating with all internal and external service providers; coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer's life); assessing the effectiveness of these services/supports; preventing duplication of services or the provision of unneeded interventions; and revising the service plan as clinically indicated.

Service Units and Limitations

- ICT services may be billed if the individual is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the individual's clinical record.

- Billing is prohibited during the same time period as outpatient psychotherapy and psychiatric services unless designated as part of the plan of care to transition services to a lower level of care.

- As part of ICT, psychotherapy and medication management are generally expected to be provided outside the clinic, hospital, or office setting. In preparation for transition to a lesser level of care, if an ICT member goes to the clinic independently (as part of the plan of care for transitioning to less intensive services) psychotherapy and medication management services may be billed as ICT services. The ICT plan of care must continue to document the need for the intense level of services provided in ICT. (If the individual regularly attends office based medical appointments that are no more than twenty five percent of billed ICT time, the need for continuance of ICT services based on resistance and/or inability to benefit from a lesser level of intensity than ICT shall be documented in the clinical record). Time billed for psychotherapy, medication management, and other clinic services may not exceed twenty-five percent of the total time billed for ICT during this transition period. The transition period is limited to a maximum of eight (8) weeks.

- The annual unit limit shall be 130 units with a unit equaling one hour.

Crisis Stabilization (H2019)

Service Definition

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Medical Necessity Criteria

The service-specific provider intake must document the need for crisis stabilization services. To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.

Individuals must **MEET** at least **TWO** of the following criteria at the time of admission to the service:

1. Experiencing difficulty in establishing and maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports.
2. Experiencing difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.
3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are or have been necessary.
4. Exhibiting difficulty in cognitive ability (such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).

Individuals may not receive Crisis Stabilization when they meet the exclusion criteria below:

Exclusion Criteria:

Service is neither appropriate nor reimbursed for:

MEET ONE

(1) Individuals with medical conditions which require hospital care;
(2) Individuals with a primary diagnosis of substance abuse;
(3) Individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others.

Required Activities

- An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a Certified Pre-Screener, shall conduct a face-to-face service-specific provider intake as defined in 12VAC30-50-226. If the intake is completed by the pre-screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.

- The program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

- The Individual Service Plan (ISP) must be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, certified prescreener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.

- Services are provided by a QMHP-A, QMHP-C, or QMHP-E, an LMHP, LMHP Supervisee or Resident, **or** a Certified Pre-screener.

- Services may be authorized for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

- Crisis stabilization may be provided up to **15 consecutive days in each episode,** up to 60 days annually. Daily service provision is limited to the times when the individual meets the clinical necessity and service definition requirements.

Service Limitations

- DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility, regardless of whether or not the services are billed Medicaid. If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart) the bed count will only apply to each residence. Each residence that is 16 beds or less and not categorized as an IMD will be eligible for Medicaid reimbursement.

- A billing unit is one hour.

- Room and board, custodial care, and general supervision are not components of this service.

- Service may be provided in any of the following settings, but shall not be limited to: (1) the home of an individual who lives with family or another primary caregiver; (2) the home of an individual who lives independently; or (3) community based programs licensed by DBHDS to provide crisis stabilization or emergency services which are not institutions for mental disease (IMDs).

- The services must be provided consistent with the ISP in order to receive Medicaid reimbursement.

- Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

- The provision of this service to an individual shall be registered with Magellan within one calendar day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination. See 12VAC30-50-226 B for registration requirements.

- Individuals may not receive IIH or ICT while receiving Crisis Stabilization services since both of those services include crisis response.

Mental Health Skill-building Services (H0046)

Service Definition

Mental health skill-building services shall be defined as goal directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS shall include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the individual's health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. Providers shall be reimbursed only for training activities related to these areas, and only where services meet the revised service definition, service eligibility, and service provision criteria and guidelines as described in the regulations and this manual.

Medical Necessity Criteria

An Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for MHSS services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

For adult members 21 and older an Independent Clinical Assessment is not required.

1. Individuals qualifying for Mental Health Skill-building Services must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized training to achieve or maintain stability and independence in the community.

2. Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

a. The individual shall have one of the following DSM diagnoses:

(1) Schizophrenia or other psychotic disorder as set out in the DSM,
(2) Major Depressive Disorder – Recurrent;
(3) Bipolar I; or Bipolar II;
(4) Any other DSM defined mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.

b. The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.

c. The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization, ICT or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or TDO pursuant to the *Code of Virginia* §37.2-809(B) evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service.

d. The individual shall have had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service.

3. Individuals younger than 21 years of age shall meet all of the above criteria in order to be eligible to receive mental health skill-building services and the following:
   The individual shall be in an independent living situation or actively transitioning into an independent living situation. (If the individual is transitioning into an independent living situation, Services shall only be authorized for up to six months prior to the date of transition). Independent living situation means a situation in which an individual, younger than 21 years of age, is not living with a parent or guardian or in a supervised setting and is providing his own financial support.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance abuse disorder. If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Mental Health Skill-building Services as long as the treatment

for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the ISP, and the progress notes.

Required Activities

For individuals under 21, the provider must maintain a copy of the fully completed Independent Clinical Assessment in each individual's file.

1. The initial face-to-face service specific provider intake (H0032, U8) and the six month re-assessment must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The service specific provider intake may be completed no more than 30 days prior to the initiation of services and must indicate that service needs can best be met through mental health skill-building services.

   Continuation of services may be approved at six-month intervals or following any break in services of more than 30 days by a LMHP, LMHP-R, LMHP-S or LMHP-RP based on a service specific provider intake and documentation of continuing need.

   Service authorization is not required to bill for the face-to-face service specific provider intake (Note Chapter V for the service specific provider assessment code and billing instructions). Providers under contract with Magellan may contact Magellan for more information.

2. The service specific provider intake must be updated annually. Every six months, the LMHP, LMHP-R, LMHP-S or LMHP-RP must review the individual ISP and services being received in order to determine if a continuation of services is necessary. The LMHP, LMHP-R, LMHP-S or LMHP-RP must then document the need for the continuation of services by indicating that the individual is continuing to meet eligibility requirements and is making progress towards ISP goals. Clinically it may be helpful for the LMHP, LMHP-R, LMHP-S or LMHP-RP to complete a new service specific provider intake to review clinical progress and assess the medical necessity of continuing MHSS. However, DMAS regulations do not specifically require the provider to complete a service specific provider intake every six months when providing MHSS. Providers may bill for service hours or bill for the service specific provider intake to complete the six month MHSS review requirement.

3. The LMHP, QMHP-A, or QMHP-C shall complete, sign and date the Individualized Service Plan (ISP) within 30 days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall include the dated signature of the LMHP, QMHP-A, or QMHP-C and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service.

4. Every three months, the LMHP, QMHP-A or QMHP-C shall review the ISP with the individual, modify as appropriate, and update the ISP. This review shall be documented in the record, as evidenced by the dated signatures of the LMHP, QMHP-A or QMHP-C and the individual. The ISP must be rewritten annually.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows of or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, QMHP-A or QMHP-C shall be informed of any medication regimen non-adherence. The LMHP, QMHP-A or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, QMHP-A or QMHP-C and the prescribing physician: a. name and title of caller; b. name and title of professional who was called; c. name of organization that the prescribing professional works for; d. date and time of call; e. reason for care coordination call; f. description of medication regimen issue or issues that were discussed; and g. resolution of medication regimen issue or issues that were discussed.

8. The provider shall document evidence of the individual's prior psychiatric services history, as required above under eligibility requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Family member statements shall not suffice to meet this requirement. The provider shall document the following minimum elements: a. name and title of caller; b. name and title of professional who was called; c. name of organization that the professional works for; d. date and time of call; e. specific placement provided; f. type of treatment previously provided; g. name of treatment provider; and f. dates of previous treatment.

   Providers may use their own records to validate prior history, however they must clearly document in the MHSS note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. If an individual sees a psychiatrist outside of the agency and the medication area of the record is documented to reflect the psychiatric history and prescribed medications, then in that section of the record each of the required elements in the regulation including: the worker who checked the record, what record was viewed and the person who wrote the note that was viewed, the name of the organization that the record belongs to, the date and time the record was reviewed, the specific placement provided, the type of treatment previously provided, the name of the treatment provider, and the dates of the previous treatment must be provided. A MHSS note directing the reader to

refer to another section of the individual's medical record with the same provider agency will be accepted as meeting the requirement. Again, it must clearly document in the MHSS note where in the electronic record substantiating information can be found.

9. The provider shall document evidence of the psychiatric medication history, as required by above under eligibility requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy or after obtaining written consent from the individual. The current provider shall document the following minimum elements: a. name and title of caller; b. name and title of prior professional who was called; c. name of organization that the professional works for; d. date and time of call; e. specific prescription confirmed; f. name of prescribing physician; g. name of medication and ; f. date of prescription.

   The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however they must clearly document in the MHSS note where in the electronic record substantiating information can be found.

10. Only direct face-to-face contacts and services to an individual shall be reimbursable.

11. Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

12. Any services provided to individuals that are strictly vocational in nature shall not qualify for Medicaid reimbursement. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

13. Room and board, custodial care, and general supervision are not components of this service and are NOT eligible for Medicaid reimbursement.

14. Provider qualifications. The enrolled provider of mental health skill-building services shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP Resident/Supervisee, QMHP-A, QMHP-C or QMHPP. The LMHP, QMHP-A or QMHP-C will supervise the care weekly if delivered by the qualified paraprofessional. Documentation of supervision shall be maintained in the MHSS record.

15. Mental health skill-building services, which may continue for up to six consecutive months, must be reviewed and renewed at the end of the period of service authorization by an LMHP who must document the continued need for the services.

16. Mental health skill-building services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

17. If MHSS is provided in a group home (Level A or B) or assisted living facility the ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

Limitations and Exclusions

1. Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the providers' respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside. **"Affiliated" means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.**

2. MHSS shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.

3. MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSA-funded independent living skills programs.

4. Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.

5. Medicaid coverage for MHSS shall not be available to individuals who reside in ICF/IDs or hospitals.

6. Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of MHSS.

7. Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Centers – Level C facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.

8. MHSS shall not qualify for Medicaid reimbursement if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS), the Elderly or Disabled with Consumer Direction Waiver, and the EPSDT services.

9. Medicaid coverage for MHSS shall exclude services that are considered to be duplicative of other reimbursed services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, QMHP-A or QMHP-C to avoid duplication of services.

10. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving/ will not qualify for Medicaid coverage for MHSS unless their physician issues a signed and dated statement indicating that this service would benefit the individual by enabling them to achieve and maintain community stability and independence.

11. Medicaid coverage for MHSS for individuals with disorders such as personality disorders and other mental health disorders that may lead to chronic disability, will not exclude provided that the individuals have a DSM diagnosis listed above and the provider can document and describe how the individual is expected to actively participate in and benefit from services, and where the remaining MHSS service criteria and guidelines are satisfied.

12. Academic services are not reimbursable.

13. Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.

14. Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.

15. Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.

16. Only direct face-to-face contacts and services to the individual members are reimbursable.

17. Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 to 6.99 hours per day
- Four units = 7+ hours per day

Time may be accumulated to reach a billable unit. Service delivery time must be added consecutively to reach a billable unit of service.

These services may be authorized for up to six consecutive months.

A maximum of 372 units of MHSS may be authorized annually with coverage under State Plan Option service. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to: VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

MHSS (H0046) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider's service specific provider intake will continue to be allowed to be billed without service authorization.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with Magellan may contact Magellan directly for more information.

SUBSTANCE ABUSE TREATMENT SERVICES

Substance Abuse Residential Treatment for Pregnant Women (H0018 Modifier HD)

Service Definition

Substance Abuse Residential Treatment for Pregnant Women services are comprehensive and intensive intervention services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Eligibility Criteria

The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully

participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:

   a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or

   b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

   c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

Service specific provider assessments to determine level of need shall use the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Third Edition, Revised 2013.

The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.

2. Initial and ongoing assessments must be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

3. Documented on the service specific provider assessment that Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) criteria are met for this service.

4. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

5. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

6. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

7. Personal health care training and assistance, including:
   - Education and referral for testing, counseling, and management of HIV;
   - Education and referral for testing, counseling, and management of tuberculosis; and
   - Education and referral for testing, counseling, and management of hepatitis.

8 Case coordination with providers of primary medical care, including obstetrical and gynecological services.

9 Training in decision-making, anger management, and conflict resolution.

10 The ISP must be fully developed by the qualified substance abuse professional within one week after admission, involving the woman, and a representative of the appropriate service agencies. The ISP must be reviewed and updated every two weeks. The ISP must be cosigned by the member.

11 Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

12 A contractual relationship with a Medicaid enrolled OB/GYN.

13 An obstetric assessment must be completed by and documented within a 30 day period following admission.

14 The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural differences, and counseling.

15 Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical

services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

16 A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff.

17 Access to services either through staff or contract:

a) Psychiatric assessments, as needed, by a physician licensed by the Virginia Board of Medicine;

b) Psychological assessments, as needed, by a licensed clinical psychologist licensed by the Board of Psychology of the Virginia Dept. of Health Professions;

c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist;

d) Medication management, as needed or at least quarterly, by a physician licensed by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate; and

e) Primary health care, if not available through other means including gynecological and obstetrical care.

18 Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

19 The program director must document the reason for granting any absence in the clinical record of the member.

20 Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.

21 The provider must ensure that individuals have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.

Limitations

- No reimbursement for any other Community Mental Health Rehabilitative Services is available while the individual is participating in this program.

- Residential capacity shall be limited to 16 adults. No services may be provided to children of mothers in the program.

- The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

- Days of unauthorized absence cannot be billed.

Service Units and Maximum Service Limitations

- A billing unit is one day.

- There is a limit of 300 days per pregnancy, not to exceed 60 days postpartum that can be used annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- Unauthorized absence of less than 72 hours is included in this limit.

- An unauthorized absence of more than 72 hours will result in termination of Medicaid reimbursement or retraction of payments already made.

Substance Abuse Day Treatment for Pregnant Women (H0015 Modifier HD)

Service Definition

Substance Abuse Day Treatment for Pregnant Women Services are comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Eligibility Criteria
The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:

    a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or

    b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or

    c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

Service specific provider assessments to determine level of need shall use the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Third Edition, Revised, 2013.

The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.

2. Initial and ongoing assessments must be provided specifically for substance abuse, including, but not limited to, psychiatric and psychological assessments.

3. Documented on the service specific provider assessment that Level II.1 (Intensive outpatient Treatment) or II.5 (Partial hospitalization) criteria are met for this service.

4. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

5. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

6. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

7. Personal health care training and assistance, including:

- Education and referral for testing, counseling, and management of HIV;

- Education and referral for testing, counseling, and management of tuberculosis; and;

- Education and referral for testing, counseling, and management of hepatitis.

8. Case coordination with providers of primary medical care, including obstetrical and gynecological services.
9. Training in decision-making, anger management, and conflict resolution.
10. The ISP must be developed by the qualified substance abuse professional within 14 days after admission involving the woman, appropriate significant others, and representatives of appropriate service agencies. The ISP must be reviewed and updated every four weeks. The ISP must be cosigned by the member.
11. Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.
12. A contractual relationship with a Medicaid enrolled OB/GYN.
13. An obstetric assessment must be completed and documented within a 30 days period following admission.
14. The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural variances and counseling.
15. Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.
16. A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff. The provider shall ensure that recipients have access to emergency services on a 24-hour basis seven days per week, 365 days per year, either directly or via an on-call system.
17. Access to services either through staff or contract:

a) Psychiatric assessments, as needed, by a physician licensed by the Virginia Board of Medicine;

b) Psychological assessments, as needed, by a licensed clinical psychologist licensed by the Board of Psychology of the Virginia Department of Health Professions;

c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist

d) Medication management, as needed or at least quarterly, by a physician licensed by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate; and

e) Primary health care, if not available through other means including gynecological and obstetrical care.

18. Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.
19. The program director must document the reason for granting any absence in the clinical record of the member.
20. Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.
21. The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

Limitations

- Only mental health crisis intervention services or mental health crisis stabilization may be reimbursed for members of day treatment services.

- More than two episodes of five-day absences from scheduled treatment without prior permission from the program director, or one absence exceeding seven (7) days of scheduled treatment without prior permission from the program director, shall terminate the services.

Services Units and Maximum Service Limitations

- A billing unit is a minimum of two (2) hours but less than four (4) hours.

There is a limit of 400 units per pregnancy, not to exceed 60 days postpartum. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. The fiscal year period is July through June 30.

- One unit = 2 - 3.99 hours
- Two units = 4 - 6.99 hours
- Three units = 7+ hours

Mental Health Case Management (H0023)

Service Definition

Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services.

Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental

health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Population Definitions

The following Department of Behavioral Health and Developmental Services definitions are referred to in the discussion of the appropriate populations for Mental Health Case Management services.

1. Serious Mental Illness

Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis

There must be a major mental disorder diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a "well patient" diagnosis cannot be used to satisfy these criteria.

b. Level of Disability

There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.

2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.

3) Has difficulty establishing or maintaining a personal social support system.

4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.

5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness

The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:

1) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).

2) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. Serious Emotional Disturbance

Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM-IV, or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year's time; and

b. Problems that are significantly disabling based upon the social functioning of most children that age; and

c. Problems that have become more disabling over time; and

d. Service needs that require significant intervention by more than one agency.

Children diagnosed with Serious Emotional Disturbance and a co-occurring substance abuse or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

3. At Risk of Serious Emotional Disturbance

Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

a. The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or

b. Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious

emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Eligibility Criteria

The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

- There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.
- The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate service specific provider assessment and supporting documentation.
- To receive case management services, the individual must be an "active client," which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days.

Required Activities

The following services and activities must be provided:

- A comprehensive service specific provider assessment must be completed by a qualified mental health case manager to determine the need for services. The CM service specific provider assessment is part of the first month of CM service and requires no service authorization.
- Service specific provider assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such).
- This service specific provider assessment then serves as the basis for the ISP.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services, specifically mental health case management.
- The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third

month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

- Linking the individual to needed services and supports specified in the ISP.

- Provide services in accordance with the ISP.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.
- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the member's status.

- Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing

that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

- The ISP shall be updated at least annually.

Service Units and Maximum Service Limitations

- A billing unit is one calendar month.
- Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for SPO CM services.
    - Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.
- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.
- No other type of case management, from any funding source, may be billed concurrently with targeted case management.
- Reimbursement for case management services for individuals age 21-64 in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals who are age 65 and older and under age 21. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

- To bill for case management services for individuals that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management services for the same individual must be billed by only ONE type of case management provider. See Chapter V for billing instructions.

While service authorization for this service is not required, registration of this service with Magellan is required. If the individual qualifies for case management through a different population definition ('at risk', SED, or SMI) a new registration is required Providers under contract with Magellan should contact Magellan directly for more information.

Case Management Agency Requirements

1. The service specific provider intake and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider intake must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired

outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the "Exhibits" section at the end of this chapter.

6. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of The Service Need By The Case Manager

The case manager must continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Substance Abuse Case Management (H0006)

Service Definition

Substance Abuse case management assists children, adults, and their families with accessing needed medical, psychiatric, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs.

If an individual has co-occurring mental health and substance abuse disorders, the case manager shall include activities to address both the mental health and substance use disorders. Only one type of case management may be billed at one time. Please see the Limitations section.

Population Definitions

The Medicaid eligible member shall meet the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria for an substance-related disorder. Nicotine or caffeine abuse or dependence, or tobacco use disorder is not covered.

Eligibility Criteria

There must be documentation of the presence of a substance-related disorder which Meets DSM-criteria.

- The individual must require case management as documented on the ISP, which is developed by a qualified substance abuse case manager at the initiation of services and based on an appropriate service specific provider assessment and supporting documentation.

- To receive case management services, the individual must be an "active client," which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days. There must be at least one direct or client-related contact every 30 days.

Required Activities

The following services and activities must be provided:

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing service specific provider assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment but does include referral for such assessment).

- With the exception of the 30-day period following the initiation of case management services the individual must be receiving another substance abuse treatment service.

- A service specific provider intake must be completed by a qualified substance abuse case manager to determine the need for services. This service specific provider intake then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of community mental health rehabilitative services.

- The ISP must document the need for case management and be fully completed within 30 days of the initiation of the service. The ISP must be cosigned by the individual receiving services. The case manager must modify the ISP as necessary, review it every three months, and rewrite it annually. The first quarterly review will be due the last day of the third month from the date of the ISP. Each subsequent review will be due by the last day of the third month following the month in which the last review was due and not on the date when the review was actually completed in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

- Linking the individual to services and supports specified in the ISP. When available, service specific provider assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service.

- Provide services in accordance with the ISP.

- Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.
- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, substance abuse, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the individual's status.

Case Management services are intended to be an individualized person-specific activity between the case manager and the individual. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity

provided simultaneously to two or more individuals was person-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

Service Units and Maximum Service Limitations

- The billing unit for case management is 15 minutes.
- Billing can be submitted for case management only when direct or client-related contacts, activity, or communications occur.
- Reimbursement is provided only for "active" case management.
- No other type of case management may be billed concurrently with substance abuse case management including mental health, treatment foster care, or services that include case management activities such and Intensive Community Treatment or Intensive In-Home Services.
- Reimbursement for case management services for individuals who reside in an Institution for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness or substance abuse and is greater than 16 beds.
- A claim edit is place that will cut back payment or deny claims for services beyond the maximum number of units allowed. The maximum service limit for substance abuse case management services is 52 hours or 208 units annually. Each July 1st service limits will be set to zero. The fiscal year is from July 1-June 30.
- To bill for case management services, for individuals that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the institutional discharge planner, and the community case management services provided to the institutionalized individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for institutionalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

Case Management Agency Requirements

- The service specific provider intake and subsequent re-assessments of the individual's medical, mental, substance use, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider assessment must also include current documentation of a medical examination, a psychological/psychiatric/substance abuse evaluation, and a social assessment.
- All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state

laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate a document verifying freedom of choice of providers was offered and this provider was chosen.

- A release form must be completed and include the dated signature of the individual for the release of any information.

- There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the "Exhibits" section at the end of this chapter.

- There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of the Service Need By the Case Manager

The case manager must continuously monitor the appropriateness of the member's ISP and make revisions as indicated by the changing support needs of the member. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the member and a face-to-face contact with the member at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Substance Abuse Crisis Intervention (H0050)

Service Definition

Crisis intervention services are substance abuse treatment services, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

Eligibility Criteria

Substance abuse crisis intervention services are provided following a marked reduction in the member's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Crisis Intervention Services.

Required Activities

- A Certified CSB/BHA Pre-screener or Qualified Substance Abuse Professional (QSAP) must complete and document a face-to-face service specific provider intake of the crisis situation; provide short-term counseling to stabilize the individual or family unit; provide access to further immediate assessment and follow-up; and link the individual and family with ongoing care to prevent future crises.
- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.
- There must be documentation of immediate substance abuse treatment with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.
- Services may include office visits, home visits, telephone contacts, or other client related activities for the prevention of institutionalization.
- <u>The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member's receipt of community mental health rehabilitative services.</u>
- Monitoring and face to face support may be provided by a QSAP, a certified pre-screener, or a paraprofessional to ensure the individual's safety. A paraprofessional must be under the supervision of at least a QSAP and provide services in accordance with a plan of care.

NOTE: Medicaid cannot be billed for substance abuse crisis intervention services for an individual under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends without a TDO being called, services rendered after the ECO ends may be billed. Documentation of TDOs and ECOs must clearly delineate

the separation of time. Refer to the *Hospital* Provider Manual, Appendix B, for further information.

- Staff travel time is excluded from billable time.
- Substance Abuse Crisis intervention services may involve the individual's family or significant others.
- An ISP is not required for newly admitted individuals. Inclusion of the service on the ISP is not required for the service to be provided to an active case on an emergency basis.
- An ISP prepared by a Certified Pre-screener or QSAP by the **fourth** face-to-face contact must be developed or revised to reflect treatment goals and interventions for scheduled short-term counseling. The ISP must be cosigned by the individual receiving services.
- Services are provided by a Certified Pre-screener ***or*** QSAP.
- If case management is being provided, there must be coordination with the case management agency.
- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals.

Service Units and Maximum Service Limitations

- A unit of service is 15 minutes of Substance Abuse Crisis Intervention. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. A maximum of 720 units of Substance Abuse Crisis Intervention can be provided annually. Each July 1st all service limits will be set to zero.
- The fiscal year period is July 1 through June 30.
- A face-to-face contact with the individual must occur during the crisis episode in order to bill Medicaid for Substance Abuse Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts which are directed toward crisis resolution for the individual may occur prior to the face-to-face contact.
- Reimbursement will be provided for short-term crisis counseling contacts scheduled within a 30-day period from the time of the first face-to-face crisis contact.

Substance Abuse Intensive Outpatient (H2016)

Service Definition
Substance Abuse Intensive Outpatient Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours per week. This service should be provided to those individuals who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. The maximum annual limit is 600 hours.

Eligibility Criteria
In order for individuals to receive Medicaid-reimbursed Substance Abuse Intensive Outpatient Treatment Services, individuals must meet the Diagnostic Statistical Manual diagnostic criteria for a Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence or tobacco use alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Intensive Outpatient Services.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Substance Abuse Intensive Outpatient Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a dated staff signature.
- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.
- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.
- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the individual's status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

- Substance Abuse Intensive Outpatient services may not be provided concurrently with substance abuse day treatment services or opioid treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

- A maximum of 600 hours per year is allowed. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Substance Abuse Day Treatment (H0047)

Service Definition
Substance Abuse Day Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week.

Eligibility Criteria
In order for individuals to receive Medicaid-reimbursed Substance Abuse Day Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for a Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence, or tobacco use. A diagnosis of nicotine or caffeine abuse or dependence, or tobacco use alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Day Treatment.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Substance Abuse Day Treatment must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a staff signature.
- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.
- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.
- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented in the clinical record monthly.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when less intensive services may achieve stabilization.

- Substance abuse day treatment may not be provided concurrently with Substance Abuse Intensive Outpatient or opioid treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

- A maximum of 1,300 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number

of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is from July 1 through June 30.

Opioid Treatment (H0020)

Service Definition
Opioid Treatment is provided in daily sessions. The treatment year service limit is 600 hours.

Eligibility Criteria
In order for individuals to receive Medicaid-reimbursed Substance Abuse Opioid Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for a Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence, or tobacco use disorder alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Opioid Treatment.

Required Activities

- Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member's behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider intake and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the individual's receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the individual receiving services.

- Services must be provided in accordance with the ISP.

- Progress notes for Opioid Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a staff signature.

- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.
- The QSAP must supervise the paraprofessional at least twice a month Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the clinical record of the individual receiving services and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.
- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual's progress towards achieving ISP goals and objectives, and recommendations for change based on the member's status. Supervision must occur and be documented in the clinical record monthly.

- A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

- If case management is being provided, there must be coordination with the case management agency.

Limitations

- Individuals shall be discharged from this service when less intensive services may achieve stabilization.

- Opioid treatment may not be provided concurrently with Substance Abuse Intensive Outpatient or Substance Abuse Day Treatment services.

- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

- A maximum of 600 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year is from July 1 through June 30.

- Providers may submit reimbursement claims for opioids which are administered to persons receiving Opioid Treatment Services. Providers may enroll as a Pharmacy provider (please refer to the Pharmacy Manual) or submit the appropriate Healthcare Common Procedure Coding System (HCPCS) identifier for medication administration.

Pharmacies bill as point of sale. If the drug is provided through a clinic, then the appropriate HCPCS, J-code or S-code would be billed. For example, S0109 indicates 5 mg. of oral methadone. The HCPCS code, J8499 (unclassified non-chemotherapeutic drug, oral administration) may also be used to bill for the opioid drug. Members have the right to appeal and a fair hearing for any service.

Notification Requirements

Whenever an adverse action is taken, the individual receiving services must receive written notification of the pending action at least 10 days before the effective date of the action, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and

2. Advance notice does not need to be sent if:

    - The individual has stated in writing that he or she no longer wishes to receive Medicaid services;

    - The individual gives information that requires the termination of Medicaid, and the member knows that this action is the result of giving the information;

    - The individual has been admitted to an institution where he or she is ineligible for services under the Virginia *State Plan for Medical Assistance*;

    - The individual moves to another state and has been determined eligible for Medicaid in the new jurisdiction; or

    - The individual's whereabouts are unknown. The agency will determine that the individual's whereabouts are unknown if mail sent to the member is returned as undeliverable.

Service Registration

Any included covered behavioral health (mental health or substance abuse) service that does not require a Service Authorization must be registered with Magellan of Virginia. This registration is a means of notifying Magellan that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should register the start of any new service within two (2) business days of the service start date. A list of services requiring registration is available on the

DMAS website at http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx under Behavioral Health Services Administrator.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include:

(i) the individual's name and Medicaid/FAMIS identification number;
(ii) the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and
(iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Claim payments will be delayed if the registration is not completed.

Qualified Medicare Beneficiaries - Coverage Limitations

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the individual's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with Magellan should contact Magellan directly for more information.

Qualified Medicare Beneficiaries - Extended Coverage Limitations

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These individuals are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

Providers under contract with Magellan should contact Magellan directly for more information.

Client Medical Management (CMM) Program

As described in Chapters I and VI, the Medicaid Program may designate certain individuals to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the individual's Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these individuals only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;

- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and

- For other services covered by DMAS, which are excluded from the CMM Program requirements.

The mental health services described in this chapter are excluded from the CMM Program, and none of the specific CMM provisions apply to these services. However, mental health providers are encouraged to coordinate treatment with the primary physician whose name appears on the individual's eligibility card as other services and medications are monitored routinely.

EXHIBITS

Community Services Board/Behavioral Health Authority: _____ Consumer ID# _____

Date: _____ Time: From _____ ☐am ☐pm To_____ ☐am ☐pm
Time under court order: _____ Time not under court order: _____

Emergency Custody Order: ☐Yes ☐No ☐Magistrate Issued ☐ Law Enforcement Issued (Paperless)
Date and Time Executed: _____
Extension: ☐Yes ☐No Reason: _____ (identify facility/medical evaluation/other good cause)
Evaluation: ☐ In-person or ☐ Two-way electronic video and audio
Petitioner _____ Phone:_____
Translator and language: _____ Phone: _____

DISPOSITION ☐Recommitment ☐TDO ☐Voluntary ☐CSU ☐ Safety Plan ☐Release ☐Referral ☐Other _____

HOSPITAL/FACILITY _____ Case/TDO #: _____

Personal Information

First Name: _____ Middle: _____ Last Name: _____ DOB: _____Age: ____

SSN: _____ - _____ - _____ ____M / F_____ _____ _____
(Gender) (Race) (Hispanic Origin) (Height) (Weight) (Hair Color) (Eye Color)

Address: _____
(Street) (City) (State) (Zip Code) (County)

Phone: (___)_____Home/Cell Marital Status: _____ Spouse Name: _____

School Division (If applicable): _____ School Attending: _____Grade: _____ Special Ed.: Y or N

(If under age 18)
Mother: _____ Address: _____ Phone: _____ Home/Cell

Father: _____ Address: _____ Phone: _____ Home/Cell

Legal Custodian ☐ Unknown Name: _____Phone: _____Address:_____
Legal Guardian ☐ Unknown Name: _____Phone: _____Address:_____

Emergency Contact: Name _____Relationship to Person: _____ Phone _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

CSB of Residence: _____

CSB Code: _____Contacted: ☐Yes ☐ No _____
(Name) (Phone)

Employment Status: ☐ Unknown_____ Education Level: (All ages)_____
Employer: _____Phone: _____
Military Status: ☐ Unknown _____Start Year: _____ End Year: _____
SSI ☐Yes ☐ No ☐ Unknown SSDI ☐Yes ☐ No ☐ Unknown

Medicaid: ☐Yes ☐ No ☐ Unknown # _____Subscriber Name: _____

Medicare: ☐Yes ☐ No ☐ Unknown # _____ Part D: ☐Yes ☐No _____Plan

Insurance: ☐Yes ☐ No ☐ Unknown _____
(Name of Company/ Group/Plan/Number)

Local Use

Collateral Sources

☐ Individual Requesting Evaluation ☐ Family/Significant Other/Guardian ☐ Treatment Records
☐ Treating Physician/Psychiatrist ☐ CSB Case Manager or Other Staff ☐ Police/First Responders
☐ CIT Officer ☐ WRAP Plan ☐ Advance Directive ☐ Safety & Support Plan
Is CSA (Comprehensive Services Act) involved with minor? ☐Yes ☐ No ☐ Unknown
Is Department of Social Services involved with individual? ☐Yes ☐ No ☐ Unknown
Comments:_____
_____

Presenting Crisis Situation

Referral Source: _____ Consultation Location: _____
Reason for Referral: _____
_____
_____
_____
Assessment:

Behavioral Health Treatment/Services

Current Outpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

☐ Private Provider or ☐ CSB Name: _____ Phone: _____

Case Manager: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Prior Inpatient Treatment: ☐ Yes ☐ No ☐ Unknown ☐ Behavioral Health (MH - SA) ☐ Developmental Services

Name/Location of Last Tx facility: _____ Adm. Date: _____Discharge Date: _____

Number of Hospitalizations: _____

Ever in a State facility? ☐ Yes ☐ No Name: _____ Date: _____

Ever in a Crisis Stabilization Unit? ☐ Yes ☐ No Name: _____ Date: _____

Other: _____

☐ WRAP Plan ☐MOT ☐ PACT/ICT ☐ NGRI ☐ Advance Directive ☐ Safety & Support Plan ☐ Group Home
☐ Day Treatment ☐ Prevention Services ☐ In-Home Provider Name: _____ ☐ Other: _____

Substance Abuse Assessment

☐ No current use ☐ No history of use ☐ Refuses to answer

Current use listed below:

Drug Type	Priority	Age 1st Use	Frequency of Use and Amount	Method of Use	Date of Last Use and Amount
	Primary				
	Secondary				
	Tertiary				

History of substance abuse ☐ (Drugs, alcohol, mood altering substances, marijuana, prescription medications, inhalants)

Comment: _____

_____

_____

Have you or anyone else ever felt you had a drug or alcohol problem? ☐ Yes ☐ No

Have you received inpatient or outpatient SA treatment? ☐ Yes ☐ No Maintenance services? ☐ Yes ☐ No

Number of prior episodes of any drug: _____ Detoxification treatment? ☐ Yes ☐ No

Name/Location of last treatment facility: _____ Date of Discharge: _____

	Current withdrawal (Past 24 hours)	**History** of withdrawal
Tremors		
Headaches		
Vomiting (Blood present) ☐ Yes ☐ No		
Nausea		
Diarrhea (Blood present) ☐ Yes ☐ No		
Sweating		
Paranoia		
DT's		
Other		

BAC: _____Time: _____ Lab Results: _____ ☐ Unable to Test

Tobacco use? ☐ Yes ☐ No Type: _____

Pregnant Status: ☐ Yes ☐ No ☐ Unknown Pregnant and using substances? ☐ Yes ☐ No ☐ Unknown

Mental Status Exam

Appearance: ☐ WNL ☐unkempt ☐poor hygiene ☐ tense ☐ rigid

Behavior/Motor Disturbances: ☐ WNL ☐agitated ☐guarded ☐tremor ☐manic ☐impulsive ☐psychomotor retardation ☐ tearful ☐easily startled ☐distracted ☐hysterical ☐ restless

Orientation: ☐ WNL ☐ Disoriented to: ❍time ❍place ❍person ❍situation

Speech: ☐ WNL ☐ pressured ☐ slowed ☐soft ☐loud ☐slurred ☐ incoherent

Mood: ☐ WNL ☐depressed ☐angry ☐hostile ☐euphoric ☐anxious ☐anhedonic ☐withdrawn

Range of Affect: ☐ WNL ☐constricted ☐blunted ☐flat ☐labile ☐inappropriate

Thought Content: ☐ WNL ☐impaired ☐unfocused ☐unreasonable ☐preoccupation ☐delusions ☐thought insertion ☐grandiose ☐ideas of reference ☐paranoid ☐obsessions ☐phobias

Thought Process: ☐ WNL ☐ illogical ☐abstract ☐concrete ☐incoherent ☐ perseverative ☐impaired concentration ☐ loose associations ☐ flight of ideas ☐circumstantial ☐blocking ☐tangential

Sensory: ☐ WNL ☐ illusions ☐ flashbacks ☐ Hallucinations: ❍auditory ❍visual ❍olfactory ❍ tactile

Memory: ☐ WNL ☐ Impaired: ❍ recent ❍ remote ❍ immediate

Appetite: ☐ WNL ☐ increased ☐decreased Weight: ❍ stable ❍ loss ❍ gain

Sleep: ☐ WNL ☐ hypersomnia ☐onset problem ☐ maintenance problem

Insight: ☐ WNL ☐ blaming ☐little ☐ none

Judgement: ☐ WNL ☐ impaired ☐ poor

Estimated Intellectual Functioning: ☐Above average ☐ Average ☐Below average ☐Diagnosed MR ☐Unable to determine

Able to provide historical information: ☐ Yes ☐ No Explain: _____

Reliability of self report ☐ Good ☐ Fair ☐ Poor Explain: _____

Significant Clinical Findings (further describe any symptoms checked above)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical

Primary Care Provider: _____ Phone: _____

Medical history and current medical symptoms or issues:

_____

_____

_____

_____

_____

Medication: **Please see attached medication list** ☐ **Please see attached medical addendum** ☐

Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

	Name	Dose	Schedule	Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Has individual followed recommended medication plan? ☐ Yes ☐ No Explain: _____

Has individual followed recommended recovery plan? ☐ Yes ☐ No N/A ☐ Explain: _____

Recent medication change? ☐ Yes ☐ No ☐ Unknown Date of change: _____

Describe change: _____ _____

Allergies (including food) or adverse side effects to medications: ☐ Yes ☐ No ☐ Unknown

Describe: _____

_____

Legal Data

Legal Status: _____ ☐ Unknown

Is individual serving a sentence? ☐ Yes ☐ No ☐ Unknown Details: _____

Is individual NGRI Conditional Release? (Adults only) ☐ Yes ☐ No ☐ Unknown Details: _____

Is individual on probation or parole? ☐ Yes ☐ No ☐ Unknown Contact Person: _____

Pending legal charges? ☐ Yes ☐ No ☐ Unknown Charges: _____

Date of hearing if known: _____ Court of Jurisdiction _____

If a minor: Judge: _____ Attorney: _____ GAL: _____

Has individual come from detention? ☐Yes ☐ No ☐ Unknown

Juvenile Detention Center: _____

(Facility Name) (Address) (Telephone) (Fax)

Diagnosis DSM IV R (P- Provisional, H-Historical)

Axis I _____ Axis I _____ Axis I _____

Axis II _____ Axis II _____

Axis III _____

Axis IV Psychosocial and Environmental (Check all that apply) _____

☐ Support group ☐ Social /Environmental ☐ Educational ☐ Domestic ☐ Occupational ☐ Housing ☐ Economic

☐ Health Care ☐ Legal System ☐ Other _____

Axis V GAF Current: _____ Highest past year, if known: _____

Individual Service Planning

Individuals who may be helpful in treatment planning.

	Name	Telephone	Relationship
1.			
2.			
3.			

☐ Family Member ☐ Guardian Name:_____may be contacted with information that is directly relevant to their involvement with the individual's health care, including location and general condition. (32.1-127.1:03(D34))

☐ Individual agrees ☐ Individual lacks capacity

☐ Individual objects ☐ Emergency makes it practically impossible to agree or object.

Outcome of the emergency evaluation or ECO ☐

No further treatment required, or

☐ Individual declined referral and no involuntary action taken, or ☐

Referred to voluntary crisis stabilization unit, or

☐ Referred to voluntary outpatient or community treatment other than crisis stabilization, or ☐

Referred to voluntary inpatient admission and treatment,

and

☐ Petitioner and ☐ Treating physician notified of disposition if TDO not recommended. ☐

Recommitment recommended by CSB

☐ TDO recommended by CSB

☐ Hearing and commitment process has been explained to the individual.

CSB consulted with magistrate about alternative transportation ☐ Yes ☐ No

☐ CSB does not recommend alternative transportation.

☐ CSB recommends alternative transportation by _____.

(Name)

37.2-805.1

☐ Consideration of 10 day inpatient admission by health care agent pursuant to advance directive _____.

(Name of Agent)

☐ Consideration of 10 day inpatient admission by designated guardian pursuant to guardianship order_____.

(Name of Guardian)

Risk Assessment/Clinical Options

Minor 16.1-340.1

Because of mental illness:

☐ The minor presents a serious danger to ☐self or ☐others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or

☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, as evidenced by: ☐delusional thinking or ☐by a significant impairment of functioning in hydration, nutrition, self protection or self control; and

☐The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment.

Findings:_____

_____

The minor's parents/guardians ☐were or ☐were not consulted. The minor's treating or examining physician, if applicable, ☐ was or ☐was not consulted.

Treatment and support options:

Inpatient treatment ☐is or ☐is not the least restrictive alternative that meets the minor's needs ☐

Outpatient or less restrictive services has been tried with the following results:

_____

_____

☐ Outpatient or less restrictive service has *not* been tried and is *not* likely to be adequate because:

_____

_____

Adult 37.2-809

It appears from all evidence readily available that the person:

☐ Has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future:

☐ Cause serious physical harm to ☐ self or ☐ others as evidenced by recent behavior, causing, attempting, or threatening harm, and other relevant information, or,

☐ Suffer serious harm due to his lack of capacity to:

☐protect himself from harm or

☐provide for his basic human needs (not applicable under Virginia Code 19.2-169.6), and

☐ Is in need of hospitalization or treatment.

Findings:_____

_____

Capacity for adults and minors age 14 and older

Able to maintain and communicate choice	☐ Yes	☐ No	Able to understand consequences	☐ Yes	☐ No
Able to understand relevant information	☐ Yes	☐ No	Willing to be treated voluntarily	☐ Yes	☐ No

Risk Factors

☐ Aggressive behavior ☐ Sexual acting out ☐ Self injurious behavior ☐ Elopement ☐ Actively psychotic

☐ Suicidal ideation ☐ Homicidal ideation ☐ Plan ☐ Access to weapons

☐ Other _____

Protective Factors _____

_____

Final Disposition:

_____

_____

_____

_____

_____

_____	_____
Preadmission Screening Evaluator Signature Date Board	Preadmission Screening Evaluator Signature Date Board
Electronically signed ☐	Electronically signed ☐

Name: _____

Print Name Here (not required if electronically signed) _____ Print Name Here (Not required if electronically signed) _____

CSB report to court and recommendations for the individual's placement, care and treatment pursuant to 16.1-340.4 (Minor) or 37.2-816 (Adult)

Name of Individual: _____ Date: _____ Time: _____ ☐am ☐pm

☐ No further treatment required.

☐ Has or ☐ does not have sufficient capacity to accept treatment (N/A for minors under age 14 except for Outpatient treatment) ☐

Is or ☐ is not willing to be treated voluntarily (* not applicable under Virginia Code19.2-169.6)

☐ Voluntary community treatment at the ☐ CSB (specify) _____

Or ☐ other (specify) _____

☐ Voluntary admission to a crisis stabilization program (specify) _____ ☐

Adult: Voluntary inpatient treatment because individual requires hospitalization and has indicated that he/she will agree to a voluntary period of treatment up to 72 hours and will give the facility 48 hours notice to leave in lieu of involuntary admission.

☐ Minor: Voluntary inpatient treatment of minor younger than 14 or non-objecting minor 14 years of age or older.

☐ Minor: Parental admission of an objecting minor 14 years of age or older pursuant to 16.1-339.

Minor 16.1-340.4 ☐ Under age 14 ☐ Age 14 or Older

Parent or guardian ☐is or ☐is not willing to consent to voluntary admission (for inpatient treatment only)

☐ **Because of Mental Illness meets the criteria for involuntary admission or mandatory outpatient treatment as follows:**

☐ The minor presents a serious danger to self or others to the extent that severe or irremediable injury is likely to result, as evidence by recent acts or threats or: ☐ Is experiencing a serious deterioration of his ability to care for himself in a developmentally age appropriate manner, evidenced by: delusional thinking or significant impairment of functioning in: ☐hydration ☐nutrition ☐self protection ☐ self control. ☐ The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment. Is the parent or guardian with whom the minor resides willing to approve any proposed commitment? ☐ Yes ☐ No ☐ Unavailable

If no, is such treatment necessary to protect the minor's life, health, safety or normal development? ☐ Yes ☐ No

❖**Therefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment, as there are no less restrictive alternatives to inpatient treatment.

☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (16.1-345.2) not to exceed 90 days because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and determined to be appropriate; and ☐ providers of the services have agreed to deliver the services: The minor, if 14 years of age or older, and his parents or guardians ☐have sufficient capacity to understand the stipulations of the minor's treatment, ☐ have expressed an interest in the minor's living in the community and have agreed to abide by the minor's treatment plan, and ☐ are deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and ☐ the ordered treatment can be delivered on an outpatient basis by the Community Services Board or a designated provider(s): specify:_____

C. ☐ Do the best interests of the minor require an order directing either or both of the minor's parents or guardian to comply with reasonable conditions relating to the minor's treatment? ☐Yes ☐No

Adult 37.2-816

☐ **Because of Mental Illness** meets the criteria for involuntary admission or mandatory outpatient treatment (* not applicable under Virginia Code19.2-169-6)as follows:

☐ There is a substantial likelihood of serious physical harm to ☐self or ☐others in the near future as a result of mental illness as evidenced by recent behavior causing, attempting or threatening harm and other relevant information, if any, or

☐ There is substantial likelihood that, as a result of mental illness, in the near future he/she will suffer serious harm due to lack of capacity:

☐ to protect him/herself from harm or

☐ to provide for his/her basic human needs (* not applicable under Virginia Code19.2-169.6).

❖T**herefore the CSB recommends:**

A. ☐ Involuntary admission and inpatient treatment as there are no less restrictive alternatives to inpatient treatment.

☐ Alternative transportation

B. ☐ Mandatory outpatient treatment (37.2-817 (D))because ☐ less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his/her condition have been investigated and ☐ are deemed to be appropriate; and the person ☐ has agreed to abide by his/her treatment plan, and ☐ has the ability to do so. The recommended treatment ☐ is actually available on an outpatient basis by the ☐ CSB or ☐ designated provider(s) specify: _____.

C. ☐ Physician discharge to mandatory outpatient treatment following inpatient admission pursuant to 37.2-817 (C1) and (C2). ☐The person has a history of lack of compliance with treatment for mental illness that at least twice within the past 36 months has resulted in the person being subject to an order for involuntary admission ☐ in view of the person's treatment history and current behavior, the person is in need of mandatory outpatient treatment following inpatient treatment in order to prevent relapse or deterioration of his condition that would be likely to result in the person meeting the criteria for involuntary inpatient treatment; ☐ as a result of mental illness, the person is unlikely to voluntarily participate in outpatient treatment unless the court enters an order authorizing discharge to mandatory outpatient treatment, and ☐ the person is likely to benefit from mandatory outpatient treatment.

_____ _____

Preadmission Screening Evaluator Signature or Electronically signed ☐ Date Board

_____ _____

Print Name Here (Not required if electronically signed) Representative CSB

Personal Comment Section

As appropriate, the individual receiving emergency services shall be offered the following opportunity to comment at the time of the preliminary evaluation and prior to the commitment hearing. If a minor, the parent or guardian may also comment.

☐ Individual
☐ Parent/Guardian
☐ Family member

☐ Yes (see comments below)
☐ Yes and does not choose to comment
☐ No, Explain: _____

How would you describe the current situation?

_____
_____
_____

Are there things you've already tried to help manage the current situation?

_____
_____
_____

What do you think would be the most helpful to you right now?

_____
_____
_____

If parent/guardian of minor: What do you think would be most helpful to your child right now?

_____
_____
_____

Are there any particular people you would like to be involved in your care and treatment (such as family members, friends, or peers)?

_____
_____
_____

If parent/guardian of minor: Are there particular people you would like to be involved in your child's care and treatment?

_____
_____
_____

What are your top three strengths?

_____
_____
_____

If parent/guardian of minor: What are your child's top three strengths?

_____
_____
_____

Would you like to comment on anything else?

_____
_____
_____

Individual's Signature: _____ Date: _____

Parent/Guardian/Family Member Signature: (if appropriate) _____ Date:_____

SAMPLE FORM

CERTIFICATION OF NEED FOR ADMISSION
TO
RESIDENTIAL PSYCHIATRIC TREATMENT

Child's Name_____

Under each of the three sections below, a child-specific explanation must be provided.

1. Ambulatory/outpatient care does not meet the specific treatment needs of the member:
_____
_____
_____
_____
_____

2. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.
_____
_____
_____
_____

3. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.
_____
_____
_____
_____

For children who are Medicaid members, this form must be completed and signed by the local CSA interdisciplinary team or FAPT and signed by a physician member of the team. The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON. For Non-CSA children, a licensed professional must complete this form.

Team Signatures: _____Date_____ _____Date_____

_____Date_____ _____Date_____

_____Date_____ _____ Date_____

Physician Signature: _____ Date: _____

CMHRS SERVICE LIMIT CHART

Service Code	Service Name	Unit Lengths	Annual Limit (per Fiscal year)	Other Limits
NON-TRADITIONAL SERVICES				
H0006-HO/HN	Substance Abuse Case Management	1 unit = 15 minutes	208 units	• No assessment code • 00 - Service authorization not required
H0015-HD	Substance Abuse Day Treatment for Pregnant Women	1 unit = 2 - 3.99 hours 2 units = 4 - 6.99 hours 3 units = 7+ hours	*400 units per pregnancy, not to exceed 60 days postpartum	• No assessment code • 00 - Service authorization not required
H0018-HD	Substance Abuse Residential Treatment for Pregnant Women	1 unit = 1 day	*300 units per pregnancy, not to exceed 60 days postpartum	• No assessment code • 00 - Service authorization not required
H0020-HM/HN/HO	Opioid Treatment	1 unit = 15 minutes	600 hours	• No assessment code • 00 - Service authorization not required
H0023	Mental Health Case Management	1 unit = 1 calendar month	12 units	• Registration required • No assessment code • Only provided by CSBs
H0023 UB	GAP Case Management – Low Intensity	1 unit = 1 calendar month	12 units	• Registration required • No assessment code • Only provided by CSBs
H0023 UC	GAP Case Management – High Intensity	1 unit = 1 calendar month	12 units	• Registration required • No assessment code • Only provided by CSBs
H0031	Intensive In-Home Assessment	1 unit = 1 assessment	2 per provider, per member, per fiscal year – per service	• VICAP required • 00 - Service authorization not required
H0032-U6	Psychosocial Rehab Assessment	1 unit = 1 assessment	2 per provider, per member, per fiscal year – per service	• 00 – Service authorization not required
H0032-U7 (child)	Therapeutic Day Treatment (TDT)	1 unit = 1 assessment	2 per provider, per member, per	• VICAP required • 00 – Service authorization not required

Service Code	Service Name	Unit Lengths	Annual Limit (per Fiscal year)	Other Limits
	Assessment		fiscal year – per service	
H0032-U7 (adult)	Day Treatment/ Partial Hospitalization Assessment	1 unit = 1 assessment	2 per provider, per member, per fiscal year – per service	• 00 – Service authorization not required
H0032-U8	Mental Health Skill-building Services (MHSS) Assessment	1 unit = 1 assessment	2 per provider, per member, per fiscal year – per service	• VICAP required for members under age 21 • 00 – Service authorization not required
H0032-U9	Intensive Community Treatment Assessment	1 unit = 1 assessment	2 per provider, per member, per fiscal year – per service	• 00 – Service authorization not required
H0032-UB or GT	GAP SMI Screening – Low Intensity	1 unit = 1 assessment	None	• 00 service authorization not required
H0032-UC or GT	GAP SMI Screening – High Intensity	1 unit – 1 assessment	None	• 00 service authorization not required
H0035-HA (child)	Therapeutic Day Treatment (TDT) for Children	1 unit = 2 to 2.99 hours 2 units = 3 to 4.99 hours 3 units = 5 plus hours	780 Units	• No more than 3 units can be billed per day. Assessment code H0032-U7 must be billed before the service code is billed. • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • Service is limited to members under the age of 21 • 01 – Service authorization always required • VICAP required • VICAP <u>not</u> required if member is within 30 days of being discharged from Level A or Level B Group Home, Level C Residential Treatment Center (RTC) or Psychiatric Hospital. VICAP <u>is</u> required for first continued stay request (Clinical note only. No claim impact)
H0035-HB (adult)	Day Treatment/ Partial Hospitalization	1 unit 2-3.99 hours 2 units 4-6.99 hours 3 units 7 or more hours	780 units	• Check claim history: • Assessment code H0032-U7 must be billed before the service code is billed • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • 01 - Service authorization always required

Service Code	Service Name	Unit Lengths	Annual Limit (per Fiscal year)	Other Limits
H0036	Crisis Intervention	1 unit = 15 minutes	720 units	• No assessment code • Registration required
H0039	Intensive Community Treatment	1 unit = 1 hour	130 units	• Assessment code H0032-U9 must be billed before the service code is billed. • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • 01 - Service authorization always required.
H0046	Mental Health Skill-building Services (MHSS)	1 unit = 1 to 2.99 hours per day 2 units = 3 to 4.99 hours per day 3 units = 5 to 6.99 hours per day 4 units = 7+ hours per day	372 units	• Time may be accumulated to reach a billable unit. • Service delivery time must be added consecutively to reach a billable unit of service. • Assessment code H0032-U8 must be billed before the service code is billed. • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • 01 - Service authorization always required. • For members under the age of 21 who wish to receive this service, a VICAP is required. • VICAP not required if member is within 30 days of being discharged from Level A or Level B Group Home, Level C Residential Treatment Center (RTC) or Psychiatric Hospital. VICAP is required for first continued stay request (Clinical note only. No claim impact).
H0047-HM/HN/HO	Substance Abuse Day Treatment	1 unit = 15 minutes	1,300 hours	• The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week • No assessment code • 00 - Service authorization not required
H0050, HM/HN/HO/HQ	Substance Abuse Crisis Intervention	1 unit = 15 minutes	720 units	• No assessment code • 00 - Service authorization not required
H2012	Intensive In-Home	1 unit = 1 hour	26 Weeks	• Assessment code of H0031 must be billed before service code is billed. • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • For weekly limits, see Chapter 4 of CMHRS manual, page 15: "a minimum of 3 hours per week of therapeutic intervention must be medically necessary for the member, with a maximum

Service Code	Service Name	Unit Lengths	Annual Limit (per Fiscal year)	Other Limits
				of 10 hours per week. In exceptional circumstances only, and with appropriate supporting documentation that describes medical necessity, providers may bill for up to 15 hours per week. The service authorization vendor will authorize up to a maximum of 50 hours per calendar month." • Billed per week (Sunday – Saturday). See Chapter 5 of CMHRS manual, exhibits page 8-9. • Service is limited to members under the age of 21. • 03 - Service authorization always required, per frequency. • VICAP required. • VICAP not required if member is within 30 days of being discharged from Level A or Level B Group Home, Level C Residential Treatment Center (RTC) or Psychiatric Hospital. VICAP is required for first continued stay request (Clinical note only. No claim impact).
H2016-HM/HN/HO	Substance Abuse Intensive Outpatient	1 unit = 15 minutes	600 hours	• The maximum number of service hours per week is 19 hours per week • No assessment code • 00 - Service authorization not required
H2017	Psychosocial Rehab	1 unit 2-3.99 hours 2 units 4-6.99 hours 3 units 7 or more hours	936 units	➢ : • Assessment code H0032-U6 must be billed before the service code is billed. • Effective 09/01/14: annual assessment code must be billed to allow continued reimbursement • 01 - Service authorization always required.
H2019	Crisis Stabilization	1 unit = 1 hour	60 days	• Limit for up to 15 consecutive days • No assessment code • GAP plan: Authorization required • Registration required
H2020 – HW or HK	Level B Group Home	1 unit = 1 day	Based on medical necessity	• Limited to members under the age of 21. Room and board not included in rate • 01 - Service authorization always required
H2022-HW or HK	Level A Group Home	1 unit = 1 day	Based on medical necessity	• Limited to members under the age of 21. Room and board not included in rate • 01 - Service authorization always required

Service Code	Service Name	Unit Lengths	Annual Limit (per Fiscal year)	Other Limits
T1016	Treatment Foster Care Case Management	1 unit = 1 calendar month	12 units	• No assessment code • 03 - Service authorization always required, per frequency
90889	VICAP	1 per day by BHSA contract provider; 1 unit no more frequent than every 30 days		• 01 - Service authorization always required • SA not based on medical necessity, but is a technical review • Only provided by CSBs
EPSDT ONLY SERVICES				
H2033	Multisystemic Therapy (ABA)	1 unit = 15 minutes	none	• 01 - Service authorization always required ➢ Initial authorization is for six (6) months ➢ Service continuation is authorized in 6 month increments • More intensive schedule based questions are considered if more than 20 hours per week is being requested • Less time may be approved if continuation is necessary for transition to discharge or to further analyze specific clinical issues • Service cannot be authorized to different providers for the same dates of service, e.g., No overlap allowed
H0032-UA (effective 07/01/2014)	Multisystemic Therapy (ABA) Assessment	Effective 04/01/15: 1 unit = 60 minutes Prior to 04/01/15: 1 unit = 15 minutes	2 per provider, per member, per fiscal year – per service – per service	• 02 - Service authorization required only if 5 hours or more is used (no service authorization if 5 hours or less is used) • Service cannot be authorized to different providers for the same dates of service, e.g., No overlap allowed

Service Authorization Types:

Code	Description
00	No Service Authorization required
01	Always needs Service Authorization
02	Only needs Service Authorization if service limits are exceeded
03	Always needs Service Authorization, with per frequency (has a monthly, yearly, fiscal year, etc. limit)

Modifiers used: (Not an all-inclusive list, just a list of modifiers found in this document)

Code	Description
GT	Via interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system
HA	Child/Adolescent Program
HB	Adult Program, Non-Geriatric
HD	Pregnant/Parenting Women's Program
HF	Substance Abuse Program
HK	Specialized Mental Health Programs for High-Risk Population (No CSA Funds used)
HM	Less than Bachelor Degree Level (Services by Paraprofessional)
HN	Bachelor's Degree Level (Services by QSAP with Bachelor's Degree)
HO	Master's Degree Level (Services by QSAP with Master's Degree)
HQ	Group Setting
HW	Funded by State Mental Health Agency (CSA Funds are used)
U6	State defined –Assessment, Psychosocial Rehab
U7	State defined –Assessment, TDT
U8	State defined –Assessment, MHSS
U9	State defined – Assessment, Intensive Community Treatment
59	CSB's use to prevent denials based on same NPI for both services

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
COMMUNITY MENTAL HEALTH REHABILITATION SERVICES
Intensive In-Home and Therapeutic Day Treatment Services
At-Risk Of Physical Injury Screening

Name: **Date:**

Mental Status Examination

Consciousness: ☐ Alert ☐ Drowsy ☐ Delirious ☐ Stuporous

Appearance: ☐ Well-groomed ☐ Disheveled ☐ Thin ☐ Overweight

Attitude: ☐ Cooperative ☐ Uncooperative ☐ Friendly ☐ Hostile

Behavior: ☐ Appropriate ☐ Psychomotor Agitation ☐ Psychomotor Retardation

Speech: ☐ Non-verbal
☐ Verbal: ☐ Fluent ☐ Non-fluent ☐ Coherent ☐ Incoherent
☐ Pressured ☐ limited

Mood: ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Manic

Affect: ☐ Full ☐ Restricted ☐ Flat ☐ Appropriate ☐ Inappropriate

Thought Process: ☐ Logical/Linear ☐ Disorganized ☐ Loosening of Associations
☐ Flight of Ideas ☐ Circumstantial ☐ Tangential
☐ Unable to Assess

Thought Content: ☐ Auditory Hallucinations ☐ Visual Hallucinations
☐ Other Hallucinations ☐ Delusional
☐ Unable to Assess

	Yes	No
1. Within the past 30 days has the individual had any suicidal thoughts?	☐	☐
2. Within the past 30 days has the individual had a plan to harm themselves or someone else?	☐	☐
3. Within the past 30 days has the individual attempted suicide?	☐	☐

	Yes	No
4. Within the past 30 days has the individual experienced command hallucinations to harm self or others or engaged in reckless behavior?	☐	☐

If "yes," to reckless behavior state the behavior: _____

	Yes	No
5. Within the past 30 days has the individual engaged in self-mutilation/cutting or other self-injurious behaviors?	☐	☐
6. Within the past 30 days has the individual engaged in reckless behavior, i.e. fire setting, use of weapons, criminal activity, etc.?	☐	☐

If "yes," state behavior: _____

	Yes	No
7. Within the past 30 days has the individual run away from home?	☐	☐
8. Within the past 30 days has the individual exhibited any other behaviors that determine the individual is at risk of physical injury?	☐	☐

If "yes," state behavior: _____

	Yes	No
9. Within the past 30 days has the individual displayed an escalation in behavior that may result in the individual being removed from the home without intensive interventions being put in place?	☐	☐

If "yes," state behavior: _____

The person completing this risk screening must be a LMHP, LMHP-S, LMHP-R or LMHP-RP

Screener Name (printed)	
Screener Credentials	
Screener Employer	
Signature	
Date of Screening	