Intensive Clinic Based Support

Definitions

Refer to Appendix A and the Telehealth Supplement for definitions of terms used in this Appendix. The following definitions are specific to this Appendix.

"Session" means one day of service consisting of the required service components (i.e. clinical interventions and restorative group interventions).

"Skills Restoration" means a service to assist individuals in the restoration of lost skills that are necessary to achieve the goals established in the individual's plan of care. Services include assisting the individual in restoring the following skills: self-management, symptom management, interpersonal, communication, community living, and problem-solving skills through modeling, coaching, and cueing.

Mental Health Intensive Outpatient Services (MH-IOP)

MH-IOP Level of Care Guidelines	
Service Definition Critical Features	Mental Health Intensive Outpatient (MH-IOP) is a structured program of skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. MH-IOP is based on a comprehensive, coordinated and individual service plan (ISP) that involves the use of multiple, concurrent service components and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery and relapse prevention and reducing the need for a more acute level of care. MH-IOP is provided to individuals who do not require the intensive level of care of inpatient, residential or partial hospitalization services, but require more intensive services than outpatient services and would benefit from the structure and safety available in the MH-IOP setting. MH-IOP can also serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. Critical features of MH-IOP include: • MH-IOP services include structured schedules for participants. Treatment goals should be measurable, person-centered, recovery oriented, trauma-informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission.

	• Tapers in intensity as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care. • Services are provided in groups or on a one-to-one basis as clinically indicated. • The integration and documentation of evidence-based practices to address family, social and community risk factors and provide coping skills to improve symptoms and functioning; and • The promotion of behavior change in the individual's natural environment, with the overriding goal of empowering the individuals and their identified natural supports to promote improved functioning; and • The inclusion of quality assurance mechanisms that focus on achieving individual outcomes through monitoring treatment fidelity and progress and adjusting treatment goals and plans to address individual needs and barriers as they arise.
Required Activities	In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-IOP: **<u>Treatment Program:</u>** • The MH-IOP treatment program must be available: 9-19 hours a week for individuals 18 years old and above or 6-19 hours a week for youth under age 18. • The MH-IOP treatment program must be available at least 3 days of services weekly (Sunday-Saturday). Covered service components include: • Assessment • Care Coordination • Crisis Intervention • Health Literacy Counseling • Individual, Family and Group therapy • Medication Management • Occupational Therapy • Peer Recovery Support Services • Psychological assessment and testing • Skills Restoration

- Treatment Planning

- The individual must participate in a minimum of 2 distinct service components daily. If the session involves a Comprehensive Needs Assessment no other service component is required to bill the per diem.

- If the minimum service components are not met, providers must document the reason in the individual's medical record.

- MH-IOP providers must be able to provide any of the above listed service components if the need is identified in the individual's assessment.

- The requirement that peer recovery support services, psychological testing and occupational therapy be available may be met through MH-IOP program staff or by referral to a qualified provider.

- If an individual does not participate in the minimum clinical service hours per week (9 for adults and 6 for youth), the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record. Documentation of any ISP deviation as well as reason for the deviation should be submitted with the next service authorization request.

- If the individual consistently deviates from the required services in the ISP, the provider should reassess for another level or care to better meet the individual's needs.

Assessment:

- At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant must conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-IOP and cannot be used as a comprehensive needs

assessment by the provider for other mental health services (see Chapter IV for details).
An assessment completed by the provider within the 30 days prior to admission can meet the above initial assessment requirements if the required components are included and there is a documented review and update at admission by the LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant.

- A psychiatric evaluation must be conducted by a physician, nurse practitioner or physician assistant within 72 hours of admission into the service either in-person or through telemedicine. The psychiatric provider must coordinate medication management with existing medical and psychiatric providers.
  A psychiatric evaluation completed within the 30 days prior to admission can meet the above initial psychiatric evaluation requirement if there is a documented review and update at admission by the physician, nurse practitioner or physician assistant.

- An updated assessment conducted by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant is required every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued stay.

Medication Management:

- Ongoing medication management by the psychiatric provider must occur at a minimum of monthly or more frequently as clinically indicated in the ISP.

Treatment Planning:

- ISPs (see Chapter IV for requirements) shall be required during the entire duration of services and must be current. Other staff may assist with treatment planning through collaborative behavioral health services but the treatment plan must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.

- ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.

Individual, Family and Group Therapy:

- The individual must participate in a minimum of 2 hours of therapy (individual, group or family) per week. See Chapter IV for information on group sizes.

Crisis Intervention:

- The provider must have an individualized crisis intervention plan that is accessible to the individual 24/7.

Care Coordination:

- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). Care coordination should include a focus on identification of additional needs to support recovery (e.g. housing, employment, food stability, mentoring, and parenting supports) and connecting the individual and natural supports to appropriate referrals to meet these needs.

- If the individual continues to also meet with an existing outpatient therapy provider, the MH-IOP provider must coordinate the ISP with the provider.

- Care coordination through referrals to higher and lower levels of care, as well as community and social supports, must include the following:

    1. The provider must collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;

    2. The provider must collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.

MH-IOP Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Must meet all of the following criteria: 1. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual that requires and can reasonably be expected to respond to treatment interventions. 2. Within the past 30 days, a. the individual has experienced persistent or increasing symptoms associated with a primary DSM disorder. These symptoms have contributed to decreased functioning in home, school, occupational or community settings and difficulties maintaining relationships with others. and b. The individual is transitioning from a higher level of care or interventions at lower levels of care or alternative, community-based rehabilitation services have been attempted but have been unsuccessful in adequately addressing the symptoms; 3. The individual is at risk for admission to inpatient hospitalization, residential treatment services, residential crisis stabilization or partial hospitalization as evidenced by acute intensification of symptoms, but does not exhibit evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; **or** the individual is stepping down from one of these settings and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; 4. The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours; 5. The individual requires an intensive structured treatment program with a multidisciplinary team; 6. The individual can reliably attend, and actively participate in, all phases of the treatment program; 7. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and

	8. For youth under age 18, there is a family/caregiver resource that is available to engage with treatment providers and support and reinforce the tenets of the MH-IOP services.
Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	Individuals must meet **one** of the following: 1. The individual continues to meet admission criteria; 2. Another less intensive level of care would not be adequate to address the individual's needs; 3. Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care; 4. The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the ISP has been revised to incorporate new goals; In addition, **all** of the following must be met: 1. The ISP contains evidence that the identified symptoms and functional capacity are likely to respond to treatment; 2. Documentation indicates that the individual is making progress towards goals, or the ISP is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals; 3. A psychiatric medical evaluation documents that medication options have been considered or initiated; 4. The provider is engaging the individual's natural supports in treatment as clinically indicated; and 5. Documentation demonstrates that coordination of care and discharge planning has been ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and resources related to school, occupational or other community functioning. If the above continued stay criteria are not met, service authorizations may be extended for up to 10 calendar days to give additional time to ensure successful transition to the after-care plan. Providers must submit a service authorization request and documentation supporting the need for the extension to the MCO or FFS Service Authorization Contractor. Individuals may also be authorized to participate in less than the required weekly minimum service hours as a transitional step down

	to a lower level of care for up to two weeks prior to discharge. The plan for transition must be documented in the ISP.
Discharge Criteria	The individual meets discharge criteria if any of the following are met: • The individual no longer meets medical necessity criteria; • The individual has met ISP goals and an appropriate aftercare plan has been established; • The individual does not appear to be participating in the treatment program and has not benefited from MH-IOP despite documented efforts to engage the individual;
Exclusions and Service Limitations	Individuals meeting any of the following are ineligible for MH-IOP: • Functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100; • Presenting issues are primarily due to Substance Use Disorder; in this case, the individual should be evaluated for Addiction and Recovery Treatment Services. In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • MH-IOP may not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0 (with the exception of ASAM level 3.1), Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or inpatient admission. A seven day overlap is allowed for care coordination and continuity of care. • If an individual has an authorization for a behavioral health service prior to admission to MH-IOP that is not allowed to be authorized concurrently with MH-IOP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-IOP within 31 days. Contact the individual's MCO or FFS service authorization contractor for authorization requirements. • MH-IOP may be billed only within 7 days prior to discharge from Residential Levels of Care, as the individual is transitioning to a lower level of care.

	• Providers shall not bill the MH-IOP per diem when the individual is not present at the program; • Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.
MH-IOP Provider Participation Requirements	
Provider Qualifications	MH-IOP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. MH-IOP service providers shall be: 1. enrolled with DMAS; and 2. licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of Mental Health Intensive Outpatient Services; and 3. One of the following: • Medicare certified to provide intensive outpatient or • Accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), DNV Healthcare or Joint Commission Providers have one year from the date they enroll with DMAS as a MH-IOP provider to become Medicare certified or two years from their enrollment to becoming fully accredited with CARF, COA, DNV Healthcare or Joint Commission. Documentation from Medicare, CARF, COA, DNV Healthcare or Joint Commission that certification/accreditation has been initiated must be submitted to DMAS during enrollment.
Staff Requirements	MH-IOP service providers shall meet the staff requirements as follows: A multidisciplinary treatment team is comprised of LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, Nurse Practitioners, Physician Assistants, Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Occupational Therapists. At a minimum, staff requirements include: • Clinical Director – Licensed Clinical Psychologist (LCP), Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Licensed Marriage and Family Therapist (LMFT);

	• Physician/Nurse Practitioner/Physician Assistant • Occupational Therapists (Required only for specialty programs, provided at least 2 days per month) Staffing ratios should not exceed one staff member per five individuals in the program. Clinical supervision of staff should not exceed one supervisor for six direct care workers. Assessments must be completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S. Skills Restoration/Development, Crisis Intervention and Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T. Health literacy counseling / psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a Registered Nurse (RN) or Licensed Practical Nurse (LPN) with at least one year of clinical experience. Peer recovery support services must be provided by a Registered Peer Recovery Specialist. Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine. Occupational therapy must be provided by an occupational therapist or occupational therapy assistant licensed by the Virginia Board of Medicine.

MH-IOP Service Authorization and Utilization Review	
Service Authorization	Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Initial service authorization requests must include, at a minimum, a complete service authorization request form. Continued stay requests must include, at a minimum, the following: • A complete service authorization request form; • Initial assessment; • Current addendum to the initial assessment (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and • Updated ISP If services are provided through telemedicine, providers must include, at a minimum, on the initial and all continued stay authorization requests the following information: 1. A schedule that includes when or under which conditions services will be provided through telemedicine and when services are scheduled to be provided in-person. 2. Clinical evidence that the amount, duration and scope of the use of telemedicine is a clinically appropriate modality to meet the treatment needs of the individual. 3. Evidence of how a provider will meet the identified treatment needs documented in the ISP via an in-person modality, when needed. Additional information on service authorization is located in Appendix C of the manual.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.
MH-IOP Billing Requirements	
One unit of service is one day. A maximum of 5 units shall be billed per week.	

Programs that bill using modifier GO for individuals receiving occupational therapy must provide occupational therapy services at least 2 days a month.

Services provided outside of the MH-IOP program can be billed outside of the MH-IOP per diem using appropriate CPT/HCPCS codes and following program/CPT guidelines for the service provided. Examples include Psychotherapy for Crisis and Peer Recovery Support Services.

Coverage of services delivered by telemedicine are described in the “Telehealth Services Supplement”. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Procedure Code	Unit	Description	Notes	Provider Qualifications
S9480	Per Diem	Mental Health Intensive Outpatient Program	Only one unit can be billed per day.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
90791, 90792	n/a	Psychiatric Diagnostic Evaluation	May be used to bill the comprehensive needs assessment.	Qualified providers

Mental Health Partial Hospitalization Program (MH-PHP)

MH-PHP Level of Care Guidelines	
Service Definition Critical Features	Mental Health Partial Hospitalization (MH-PHP) services are highly structured, short-term, non-residential clinical programs designed to provide an intensive combination of interventions and services similar to an inpatient program, but available on a less than 24-hour basis. MH-PHP is intended to treat and stabilize acute psychiatric symptoms experienced by youth or adults. Services are delivered under physician direction with individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result in significant functional impairments in major life activities. Critical features of MH-PHP include: • MH-PHP services are appropriate when an individual requires at least four hours of clinical services a day, over several days a week, totaling a minimum of 20 hours per week. • MH-PHP involves a multidisciplinary team approach under the direction of a physician. MH-PHP programs include structured schedules for participants. Treatment goals should be measurable, person-centered, recovery oriented, trauma-informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission. • MH-PHP tapers in intensity and frequency as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care. • Services are provided in groups or on a one-to-one basis as clinically indicated.
Required Activities	In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-PHP: **<u>Treatment Program:</u>** • MH-PHP must be available at a minimum of four hours a day, five days per week (totaling a minimum of 20 hours per week). • The individual must participate in a minimum of three distinct covered service components daily.

- If the session involves a Comprehensive Needs Assessment as a service component, only one other covered service component shall be required in order to bill the per diem that day.

The following covered service components must be available to individuals in the treatment program and provided in accordance with the individual's ISP:

- Assessment
- Individualized treatment planning
- Individual, group or family therapy
- medication management
- Skill restoration/development
- Health literacy counseling/psychoeducation interventions
- Occupational and/or other therapies performed by a professional acting within the scope of their practice
- Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral
- Crisis intervention and safety planning support available 24/7
- Peer recovery support services, offered as an optional supplement
- Care Coordinatio

- If an individual does not participate in the minimum number of service hours (four) per day or the minimum number of days (five) per week, the provider shall document the reason for the ISP deviation and notify the MCO or the FFS service authorization contractor staff at the time of the next authorization review.

- If the individual consistently deviates from the required services in the ISP, the provider should reassess for another Level of Care or model to better meet the individual's needs.

Assessment:

- At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse

	practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-PHP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details). An assessment completed by the provider within the 30 days prior to admission can meet the above initial assessment requirements if the required components are included and there is a documented review and update at admission by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant • An updated assessment conducted by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant is required at every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued services. • Psychiatric oversight by a physician, nurse practitioner or physician assistant is required. An initial psychiatric evaluation must be conducted by the psychiatric provider with the individual either in-person or through telemedicine within 48 hours of admission. The provider must coordinate medication management with existing medical and psychiatric providers. A psychiatric evaluation completed within the 30 days prior to admission can meet the above initial psychiatric evaluation requirement if there is a documented review and update at admission by the psychiatric provider. • Ongoing medication management by the psychiatric provider must occur at a minimum of weekly or more frequently as clinically indicated in the ISP. • Assessments and psychiatric evaluations completed by the provider within 30 days of admission can meet the above initial assessment requirements if there is a documented review and update at admission by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant.

Treatment Planning:

- ISPs (see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial ISP shall be completed on the day of admission to the service. Other staff may assist with treatment planning through collaborative behavioral health services but the treatment plan must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.

- ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.

Individual, Family and Group Therapy:

- The individual must participate in daily individual, family or group therapy provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.

- See Chapter IV for information on group sizes.

Crisis Intervention:

- The provider must have an individualized crisis intervention plan that is accessible to the individual 24/7.

Skills Restoration:

- The individual must participate in a minimum of 3 sessions of group-based delivery of skills-restoration/development per week.

Care Coordination:

- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

	• If the individual continues to also meet with an existing outpatient therapy provider, the MH-PHP provider must coordinate the ISP with the provider. • Care coordination through referrals to higher and lower levels of care, as well as community and social supports, should include the following: 1. The provider must collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care; 2. The provider must collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists and substance use disorder providers. 3. If an individual participates in medication for SUD, the MH-PHP shall coordinate with the appropriate provider. 4. If an individual participates in Assertive Community Treatment and MH-PHP, the MH-PHP provider shall coordinate with the ACT team to assure alignment of the ISP and avoid any duplication of services.
MH-PHP Medical Necessity Criteria	
Admission Criteria – Diagnosis, Symptoms, and Functional Impairment	Must meet all of the following criteria: 1. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual that requires and can reasonably be expected to respond to treatment interventions; 2. There is a clinical determination that in the last 14 days, the individual has experienced persistent or increasing symptoms associated with a primary DSM disorder. These symptoms have contributed to decreased functioning in home, school, occupational or community settings and difficulties maintaining relationships with others; 3. The individual is at risk for admission to inpatient hospitalization, residential treatment services or residential crisis stabilization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; or the

	individual is stepping down from one of these settings and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; 4. The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours; 5. The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team, including psychiatric interventions for medication management; 6. The individual can reliably attend, and actively participate in, all phases of the treatment program; 7. The severity of the presenting symptoms cannot be safely or adequately addressed in a less intensive level of care; 8. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and 9. If an individual is being admitted to MH-PHP primarily for an eating disorder, the following must also be met: a. The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least two of the following: i. As a result of eating disorder behaviors, weight stabilization above 80% IBW (or BMI 15-17); or ii. Daily, or near daily supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight management behavior, such as caloric restriction, intake refusal, vomiting/purging, excessive exercise, compulsive eating/binging; or iii. Individual misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) and cannot be treated at a lower level of care. b. Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require 24-hour medical monitoring or procedures provided in a hospital level of care. c. If the above criteria are not met, service authorization requests and medical necessity will be assessed on an individualized basis to determine if the individual's treatment needs can be best met in this setting and can be delivered in a safe and effective manner.
Continued Stay Criteria - Diagnosis, Symptoms, and	Individuals must meet all of the following: 1. One of the following must be met:

Functional Impairment	a. The individual continues to meet admission criteria; b. Another less intensive level of care would not be adequate to address the individual's needs; c. Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care; or d. The individual has manifested new symptoms or maladaptive behaviors and the ISP has been revised to incorporate new goals. 2. In addition, documentation indicates all of the following: a. The ISP contains evidence suggesting that the identified symptoms and functional capacity are likely to respond to treatment; b. Documentation indicates that the individual is making progress towards goals, or the ISP is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals; c. A psychiatric medical evaluation documents that medication options have been considered or initiated; d. The provider is engaging the individual's natural supports in treatment as clinically indicated; e. Documentation demonstrates that coordination of care and discharge planning has been ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and resources related to school, occupational or other community functioning; and f. If an individual is being admitted to MH-PHP for an eating disorder, then one of the following must also be met: i. Individual has had no stabilization of weight since admission or there is continued instability in food intake; or ii. The eating disorder behaviors persist and continue to put the individual's medical status in jeopardy. If the above criteria are not met, service authorizations may be extended for up to 10 calendar days to give additional time to ensure successful transition to the after-care plan. Providers must submit a

	service authorization request and documentation supporting the need for the extension to the MCO or FFS Service Authorization Contractor.: Individuals may be authorized to participate in less than 20 hours a week as a transitional step down to lower level services for up to two weeks prior to discharge. The plan for transition must be documented in the ISP.
Discharge Criteria	The individual meets discharge criteria if any of the following are met: • The individual no longer meets medical necessity criteria; • The individual has met ISP goals and an appropriate aftercare plan has been established; • The individual does not appear to be participating in the treatment program despite documented efforts to engage the individual; • For eating disorders, individual has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care;
Exclusions and Service Limitations	Individuals meeting any of the following are ineligible for MH-PHP: • The individual's functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100 • Presenting issues are primarily due to Substance Use Disorder (individual should be referred for evaluation for Addiction and Recovery Treatment Services). In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • MH-PHP shall not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Applied Behavior Analysis, Mental Health Intensive Outpatient Services, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or Inpatient Hospitalization. A seven day overlap is allowed for care coordination and continuity of care.

	If an individual has an authorization for a behavioral health service prior to admission to MH-PHP that is not allowed to be authorized concurrently with MH-PHP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-PHP within 31 days. Contact the individual's MCO or FFS service authorization contractor for authorization requirements. • Providers shall not bill the MH-PHP per diem when the individual is not present at the program; • Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.
MH-PHP Provider Participation Requirements	
Provider Qualifications	MH-PHP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. MH-PHP service providers shall be: • Enrolled with DMAS; and • Licensed by DBHDS as a provider of a Mental Health Partial Hospitalization Program; and • Credentialed and contracted with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care; and • One of the following: o Medicare certified to provide partial hospitalization or o Accredited by one of the following: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), DNV Healthcare or Joint Commission Providers have one year from the date they enroll with DMAS as a MH-PHP provider to become Medicare certified or two years from their enrollment to becoming fully accredited with CARF, COA, DNV Healthcare or Joint Commission. Documentation from Medicare, CARF, COA, DNV Healthcare or Joint Commission that certification/accreditation has been initiated must be submitted to DMAS during enrollment.

Staff Requirements	MH-PHP service providers shall meet the staff requirements as follows: A multidisciplinary treatment team is comprised of LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, Nurse Practitioners, Physician Assistants, RNs, LPNs, QPPMHs and Occupational Therapists. At a minimum, the team must consist of the following: • Board certified/board eligible psychiatrist. For children under age 14, the psychiatrist must be a board certified/board eligible child and adolescent psychiatrist; and • Licensed Mental Health Professional (LMHP) Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Health literacy counseling/psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a RN or LPN with at least one year of clinical experience. Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T. Skills restoration/development and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T. Peer recovery support services must be provided by a Registered Peer Recovery Specialist. Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians, Physician Assistants, Occupational Therapists and Occupational Therapy Assistants shall hold an active license issued by the Virginia Board of Medicine.

	Occupational therapy must be provided by an occupational therapist or occupational therapy assistant licensed by the Virginia Board of Medicine.
MH-PHP Service Authorization and Utilization Review	
Service Authorization	MH-PHP requires service authorization. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Initial service authorization requests must include, at a minimum, a complete service authorization request form. Continued stay requests must include, at a minimum, the following: • A complete service authorization request form; • Initial assessment; • Current addendum to the initial assessment (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and • Updated ISP If services are provided through telemedicine, providers must include, at a minimum, on the initial and all continued stay authorization requests the following information: 1. A schedule that includes when or under which conditions services will be provided through telemedicine and when services are scheduled to be provided in-person. 2. Clinical evidence that the amount, duration and scope of the use of telemedicine is a clinically appropriate modality to meet the treatment needs of the individual. 3. Evidence of how a provider will meet the identified treatment needs documented in the ISP via an in-person modality, when needed. Additional service authorization information is located in Appendix C to this manual.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

MH-PHP Billing Guidance

Rates are based off of the minimum staff to individual ratio of no more than 1:12, one full-time equivalent staff for each twelve adults, and 1:5, one full-time equivalent staff to five youth with the ability to increase staff to client ratio based on the acuity of individuals.

One unit of service is a one day session with four hours of covered service components required to bill the per diem.

Services provided outside of the MH-PHP program can be billed in addition to the MH-PHP per diem using appropriate CPT/HCPCS codes and following program/CPT guidelines for the service provided. Examples include Psychotherapy for Crisis and Peer Recovery Support Services.

Coverage of services delivered by telehealth are described in the “Telehealth Services Supplement”. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Providers can bill any outpatient CPT codes within scope of practice for the following professionals in addition to the per diem:

- Psychiatrists and other physicians (including physician extenders)
- Licensed Clinical Psychologists, to include LMHP-RPs working under the delegation of the Licensed Clinical Psychologist

Billing Code	Unit	Description	Notes	Provider Qualifications
H0035	Per Diem	Mental Health Partial Hospitalization Program	Only one unit can be billed per day. May include assessment if the individual participates in the program on the day of the assessment.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
90791, 90792	n/a	Psychiatric Diagnostic Evaluation	Providers should bill CPT codes appropriate for the activity and professional conducting the assessment when an assessment is completed but the individual does not enter the service or does not participate in the	Qualified Providers

			program on the day of the assessment.	