Covered Services and Limitations (MHS)

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Covered Services and Limitations (MHS)

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Mental health services covered in this manual include: Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health Services (EBH), Mental Health Case Management (MHCM), and Treatment Foster Care Case Management (TFC-CM). This chapter describes general requirements for the provision of these mental health services and service specific requirements for the provision of CMHRS, MHCM and TFC-CM. Provider specific requirements for EBH are located in Appendices to this manual. EBH includes Assertive Community Treatment, Mental Health Intensive Outpatient (MH-IOP) and Mental Health Partial Hospitalization Program (MH-PHP) services. Effective 12/1/2021, EBH also includes Mobile Crisis Response, Community Stabilization, 23-Hour Crisis Stabilization, Residential Crisis Stabilization Unit, Multisystemic Therapy (MST) Functional Family Therapy (FFT) and Applied Behavior Analysis (ABA).

Information on additional Behavioral Health services covered by the Department of Medical Assistance Services (DMAS) are located in the Addiction and Recovery Treatment Services (ARTS) Manual, Psychiatric Services Manual, and Residential Treatment Services Manual located on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

All providers of CMHRS, EBH, MHCM and TFC-CM are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the Managed Care Organizations (MCOs) and the fee for service (FFS) contractor, all DMAS policies and state and federal regulations.

BEHAVIORAL HEALTH FFS CONTRACTOR

Magellan of Virginia serves as the current behavioral health FFS contractor and is responsible for the management and administration of the FFS behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving FFS Medicaid-covered behavioral health services.

Magellan of Virginia'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 of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Medicaid Managed Care (MHS)

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid Managed Care Organizations (MCOs). MCOs must adhere to all Mental Health program requirements, service authorization criteria and reimbursement rates, and MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the individual'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 individual's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Certain services, including TFC-CM, are carved out of Medicaid MCOs and continue to be obtained through FFS. Refer to each managed care program's website for detailed information and the latest updates.

Information on the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs is located at the websites below:

- Medallion 4.0:

  https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/

- Commonwealth Coordinated Care Plus (CCC Plus):

  https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/

Managed Care Coverage of Mental Health Services

The following services are included in CCC Plus and Medallion 4.0 contracts utilizing DMAS' current Mental Health coverage criteria and program requirements. :

- Assertive Community Treatment (H0040)*
- Mental Health Intensive Outpatient (MH-IOP) (S9480)*

- Mental Health Case Management (H0023)
- Therapeutic Day Treatment (TDT) / Assessment (H2016/H0032 U7)
- Mental Health Partial Hospitalization Program (MH-PHP) (H0035)*
- Mental Health Skill-building Services (MHSS)/Assessment (H0046/H0032 U8)
- Intensive In-Home/Assessment (H2012/H0031)
- Psychosocial Rehab (H2017/H0032 U6)
- Mobile Crisis Response (H2011)* effective 12/1/2021
- Community Stabilization (S9482)* effective 12/1/2021
- 23-Hour Crisis Stabilization (S9485)* effective 12/1/2021
- Residential Crisis Stabilization Unit (H2018)* effective 12/1/2021
- Multisystemic Therapy (H2033)* effective 12/1/2021
- Functional Family Therapy (H0036)* effective 12/1/2021
- Applied Behavior Analysis (97151 – 97158, 0362T and 0373T)* effective 12/1/2021
- Mental Health Peer Support Services or Family Support Partners – Individual (H0024)*
- Mental Health Peer Support Services or Family Support Partners – Group (H0025)*

**Service specific information related to these services is located in Appendices and Supplements to this manual*

For additional information, please refer to the “Mental Health Services Doing Business with CCC Plus and Medallion 4.0 MCO’s” document available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

Carved Out Services

TFC-CM and Therapeutic Group Home Services (formerly known as Level A and Level B) are carved-out of CCC Plus and Medallion 4.0 at this time and remain covered through Magellan of Virginia. For additional information on Therapeutic Group Home Services, please see the Residential Treatment Services Manual.

FAMIS and FAMIS MOMS

FAMIS enrollees and FAMIS MOMS enrollees under age 21 who are covered by Medallion 4.0 have limited mental health services benefits that include:

- Mental Health Partial Hospitalization Program (MH-PHP)

- Mental Health Intensive Outpatient (MH-IOP)
- Assertive Community Treatment (ACT)
- Mobile Crisis Response (effective 12/1/2021)
- Community Stabilization (effective 12/1/2021)
- 23-Hour Crisis Stabilization (effective 12/1/2021)
- Residential Crisis Stabilization Unit (effective 12/1/2021)
- Multisystemic Therapy (effective 12/1/2021)
- Functional Family Therapy (effective 12/1/2021)
- Applied Behavior Analysis (effective 12/1/2021)
- Intensive In-Home Services
- Therapeutic Day Treatment
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance
- Peer Recovery Support Services

Medallion 4.0 MCOs manage mental health services for their enrolled members.

Program of All-Inclusive Care for the Elderly (PACE)

Mental Health Services for individuals enrolled in PACE are provided by the individual's PACE Program. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

Definitions (MHS)

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

"Adolescent or Child" adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

“Assessment” means the face-to-face interaction in which the provider obtains information from the individual, and parent, guardian, or other family member or members, as appropriate, about the individual’s behavioral health status. It includes documented history of the severity, intensity, and duration of behavioral health problems and behavioral and emotional issues.

"At Risk of Hospitalization” means one or more of the following: (i) within the two weeks before the Comprehensive Needs Assessment, the individual shall be screened by an LMHP, LMHP-R, LMHP-S or LMHP-RP for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that comprehensive crisis services, 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, or LMHP-R, LMHP-S, or LMHP-RP 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 mobile crisis response, community stabilization, outpatient psychotherapy, outpatient substance use disorder services, or mental health skill building) within the past 30 calendar days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who, within the past thirty calendar days, is either: (a) transitioning out of residential treatment services, either psychiatric residential treatment facility (PRTF) or therapeutic group home TGH), (b) transitioning out of acute psychiatric hospitalization, or (c) transitioning between foster homes, mental health case management, mobile crisis response, community stabilization, outpatient psychotherapy, or outpatient substance use disorder services.

“At Risk of Out-of-Home Placement" means placement in one or more of the following: (i) Therapeutic 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) PRTF; (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.

"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 locating and coordinating services across health providers to include sharing of information among health care providers and others who are involved with the individual's health care to improve the restorative care and align service plans.

"Certified Pre-Screener" 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.

"Commonwealth Coordinated Care (CCC) Plus" CCC Plus is a mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from one of the Department's home and community-based services (HCBS) 1915(c) waivers.

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

"Comprehensive Needs Assessment" means the face-to-face interaction, in which the provider obtains information from the individual, and parent or other family member or members, as appropriate, about the individual'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.

"Counseling" means the same as defined in § 54.1-3500 of the Code of Virginia. The

application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Counseling must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP acting within their scope of practice.

"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, Diagnostic and Treatment (EPSDT)" EPSDT is Medicaid's comprehensive and preventive child health benefit 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.

"Individual" means the Medicaid-eligible person receiving services. . Individual 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 Comprehensive Needs Assessment. The ISP contains, but is not limited to, the individual's 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 minor child, the ISP shall also be signed by the individual's parent/legal guardian as appropriate. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"Licensed Mental Health Professional" or "LMHP" means the same as defined in 12VAC35-105-20.

"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.

"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 spent in the delivery of 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 by the Department of Behavioral Health and Developmental Services and/or the Department of Health Professions and credentialed with the FFS contractor and/or MCO as a Medicaid provider of community mental health and 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.

Qualified Mental Health Case Manager” means the same as defined in 12VAC30-50-420 and 12VAC30-50-430 and as described in Chapter II of this manual.

"Qualified Mental Health Professional-Adult" or "QMHP-A" the same as the term is defined in § 54.1-3500 of the Code of Virginia.

"Qualified Mental Health Professional-Child" or **"QMHP-C”** means the same as the term is defined in § 54.1-3500 of the Code of Virginia. A QMHP-C may only provide services to individuals under the age of 22.

"Qualified Mental Health Professional-Eligible" or **"QMHP-E"** means the same as the term is defined in § 54.1-3500 of the Code of Virginia.

QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

"Qualified Paraprofessional in Mental Health" or **"QPPMH"** means the same as the term is defined in 12VAC35-105-20.

"Register" or "Registration" means notifying the FFS contractor or MCO that an individual will be receiving services that do not require service authorization.

"Residential Treatment Services" means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance use disorder, cognitive, or training needs of a youth 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 counseling 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 the FFS contractor or MCO 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.

“**Treatment Planning”** means the development of a person-centered plan of care that is specific to the individual’s unique treatment needs, developed with the individual, in consultation with the individual's family, as appropriate.

"**Youth**" means an individual under 21 years of age.

Care Coordination (MHS)

The purpose of care coordination is to ensure that the individual receives all needed services and supports in the most effective and efficient manner. Care coordination facilitates informed and congruent treatment planning, enables open communication among all treating providers, and ensures needed resources are integrated and well-coordinated. Care coordination is based on 1) an assessment conducted by a care coordinator and 2) a centralized plan of care. Care Management includes care coordination, but is primarily conducted telephonically and is typically performed by a benefits administrator or managed care company. This is in order to include network and claims data and trend analysis for enhanced care planning for individual cases.

Case Management is case specific; it is a covered service rendered by network providers in collaboration with a care coordinator or care manager. Case Managers partner with care coordinators or care managers to ensure needed services are covered for reimbursement and community resources are maximized to best support the individual's opportunity for recovery and treatment success.

Magellan of Virginia provides care management services to youth who are enrolled in FFS and receiving behavioral health services. Magellan of Virginia care management staff are licensed behavioral health clinicians. The central purpose of care management is to help individuals receive quality services in the most cost-effective manner in order to maximize the use of benefits and covered services with consideration of care trends and best practices. The primary activities of care management include utilization management, triage (including telephonic assessment) and referral, service authorizations, facilitating open communication among identified providers, aligning care plans, proactive discharge planning following acute and other higher levels of care, appropriate transition and continuity of care between levels of care, quality management, and independent clinical review.

Individuals enrolled in Medallion 4.0 and CCC Plus receive care coordination that integrates the medical and psychosocial models of care through a person centered approach through a MCO assigned care coordinator. Shortly after becoming enrolled in CCC Plus, the member's care coordinator will complete a comprehensive Health Risk Assessment (HRA), often face to face for higher risk individuals. During the assessment, the Care Coordinator works closely with the individual to identify the individual's unique medical and behavioral health needs, as well as the individual's strengths and supports. HRAs are also utilized by the Medallion 4.0 MCOs Care Management staff for individuals with special health care needs.

Coordination with Targeted Case Management

Targeted Case Management (TCM) is a covered service provided by contracted community providers. TCM includes case management for Addiction and Recovery Treatment Services (ARTS), mental health, developmental disabilities, treatment foster care, early intervention, and high risk prenatal and infant services. If an individual is receiving TCM, the assigned care coordinator or care manager will work collaboratively with the TCM provider to coordinate needed services in the community.

Care Coordination Requirements of Mental Health Providers

Mental Health providers provide care coordination in order to centralize comprehensive care planning efforts among various service types and providers. Service provider care coordination is done in the spirit of collaboration with the treatment team and is meant to support the youth on his or her path of recovery. Mental health providers are responsible for care coordination activities that include both behavioral health and medical needs as documented in the ISP.

These care coordination activities include:

- Assisting the individual access and appropriately utilize needed services and supports;
- Assisting the individual overcome barriers in order to maximize the use of these resources;
- Actively collaborating with all internal and external service providers to achieve open communication and integration of all needed services;
- Coordinating all services and supports, including all active treating service providers and the individual's family members and significant others involved in the individual's life;
- Assessing the effectiveness of these services/supports based on the individual's progress and unique circumstances;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and

- Revising the ISP as clinically indicated and ensuring that service planning is inclusive of and consistent with other services being provided to the individual.

Care coordination between different providers is required and must be documented in the ISP and Progress Notes. Coordination serves to help align services to prevent duplication is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and openly communicate with other treating health care providers regarding active clinical care planning. Persons who routinely come in contact with the individual, or are involved in the individual's health care and recovery (i.e. PCPs, Case Managers, Probation Officers, Teachers, etc.), shall be included in the care coordination process to help support the individual and their overall wellbeing and care.

If an individual is receiving any mental health service and is also receiving TCM services, the mental health provider shall collaborate with the case manager by notifying the case manager of the provision of mental health services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the 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 mental health provider shall determine who the primary care provider is and inform him of the individual's receipt of mental health services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

MENTAL HEALTH SERVICES

Requirements for All Services

Mental health services 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.

Mental health services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by a Licensed Mental Health Professional (LMHP), LMHP-R, LMHP-S or LMHP-RP within the scope of their practice.

All services must be described with sufficient detail in an Individual Service Plan (ISP) based on the Comprehensive Needs Assessment and the most recent clinical supervision and review of the individual's 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.

Providers must adhere to DBHDS licensing rules as they relate to service provision:

http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/

Telehealth

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.

Comprehensive Needs Assessment

The Comprehensive Needs Assessment is the initial face-to-face interaction encounter in which the provider obtains information from the individual, and parent, guardian or other family members as appropriate about the individual's mental health status and behaviors. The Comprehensive Needs Assessment serves to gather information to assess the needs, strengths and preferences of the individual.

Comprehensive Needs Assessments shall be required prior to developing an 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 assessments and ISPs as defined in this manual shall be denied reimbursement.

A valid Comprehensive Needs Assessment is required prior to initiating any of the following services:

- Assertive Community Treatment
- Intensive In-Home (IIH) Services
- Therapeutic Day Treatment (TDT)
- Mental Health Intensive Outpatient (MH-IOP)
- Mental Health Partial Hospitalization (MH-PHP)
- Psychosocial Rehabilitation (PSR)
- Mental Health Skill-building Services (MHSS)
- Multisystemic Therapy (MST) (effective 12/1/2021)
- Functional Family Therapy (FFT) (effective 12/1/2021)
- Applied Behavior Analysis (ABA) (effective 12/1/2021)

A Comprehensive Needs Assessment that follows the guidelines in this manual shall be required for the EBH and CMHRS services listed above. A single Comprehensive Needs Assessment shall be used when recommending one or more of the above mental health services provided by the same DBHDS licensed agency except when written justification is provided.

The Comprehensive Needs Assessment must document the medical necessity for each recommended EBH and CMHRS service provided by the agency. The Comprehensive Needs Assessment for EBH and CMHRS shall be conducted face-to-face by a LMHP, LMHP-R, LMHP-S or LMHP-RP. For services that allow a professional other than a LMHP, LMHP-R, LMHP-S or LMHP-RP to conduct an initial assessment,

that assessment must include the required elements of a Comprehensive Needs Assessment but may be used for that service only and cannot be used as a Comprehensive Needs Assessment for other services.

The Comprehensive Needs Assessment must include the 15 elements outlined in this section.

Providers of Mobile Crisis Response, Community Stabilization, 23 Hour Crisis Stabilization and Residential Crisis Stabilization Unit services may choose to complete a Comprehensive Needs Assessment but a Comprehensive Needs Assessment is not required for these services.

Mental health case management may be included as a recommended service on a Comprehensive Needs Assessment completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S. A qualified mental health case manager who is also a LMHP, LMHP-S, LMHP-R or LMHP-RP may conduct a Comprehensive Needs Assessment to include CMHRS and EBH services in addition to mental health case management. Individuals receiving mental health case management may continue having their assessments and reassessments completed by a qualified mental health case manager who is not a LMHP, LMHP-S, LMHP-R or LMHP-RP. Mental health case management assessments completed by a qualified mental health case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S shall be used only for mental health case management. Assessments completed by a qualified mental health case manager may not be used as a Comprehensive Needs Assessment or updated by a LMHP, LMHP-R, LMHP-S, or LMHP-RP to be used as a Comprehensive Needs Assessment.

DBHDS licensed providers who are implementing the Daily Living Activities (DLA)-20 may use the DLA-20 as the Comprehensive Needs Assessment as long as the DLA-20 is performed by an LMHP, LMHP-R, LMHP-RP or LMHP-S, all 15 elements for the Comprehensive Needs Assessment are captured as well as all requirements are met as set forth in this manual. If not all 15 required elements are included in the DLA-20, a LMHP, LMHP-R, LMHP-RP or LMHP-S may create an addendum to a DLA-20 completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S to address any of the missing elements required for a Comprehensive Needs Assessment to recommend CMHRS and EBH services.

A DBHDS licensed agency may use a Psychiatric Diagnostic Interview (90791, 90792) completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S employed or contracted by the agency as the Comprehensive Needs Assessment as long as all 15 required elements for the Comprehensive Needs Assessment are included. If not all 15 required elements are included in the Psychiatric Diagnostic Interview, a LMHP, LMHP-R, LMHP-RP or LMHP-S may create an addendum to address any of the missing elements required for a Comprehensive Needs Assessment to recommend CMHRS and EBH services. Providers shall not bill for this addendum to the Psychiatric Diagnostic Interview under CMHRS assessment codes.

Assessments completed prior to January 1, 2019, Service Specific Provider Intakes (SSPIs) and Psychiatric Diagnostic Interviews, may not be used as a Comprehensive Needs Assessment.

All providers shall ensure they meet the DMAS requirements as well as the DBHDS licensing requirements for completion of assessments.

Billing for the Comprehensive Needs Assessment

- Providers shall only bill for one Comprehensive Needs Assessment when these services are

provided by the same agency. The provider shall bill the most appropriate assessment code, and if recommending more than one service, may choose the higher reimbursed assessment code of the services that are being recommended.
- Providers shall only bill under an assessment code for a service that they will be providing.
- Service authorization is not required for billing the Comprehensive Needs Assessment.
- If the provider later reviews and updates the Comprehensive Needs Assessment due to the changing treatment needs of the individual, the addendum to the Comprehensive Needs Assessment is not billable under a service assessment code but face-to-face time necessary to conduct the review and update to the assessment may be billable under the service billing code.
- Required reviews and updates, including the annual review and update of the Comprehensive Needs Assessment and any other service specific review as described in this chapter are not billable under service assessment codes. Face-to-face assessment time required for any review and update may be billed as part of a service billing code.
- If a provider has a current, valid Comprehensive Needs Assessment but needs to conduct a full, new Comprehensive Needs Assessment based on the clinical needs of the individual, and bills under a service assessment code, the provider shall document the justification for the additional assessment billing.
- If the Comprehensive Needs Assessment becomes outdated as defined in this chapter, the provider may bill for the completion of a new Comprehensive Needs Assessment required to resume services under an assessment code, if available, for a service that they will be providing.

One or More CMHRS Services Provided by the Same DBHDS Licensed Agency

When the initial Comprehensive Needs Assessment recommends several CMHRS and EBH services for an individual, the provider shall use this assessment for all CMHRS and EBH services recommended within the same DBHDS licensed agency. If additional service needs are identified after the completion of the initial Comprehensive Needs Assessment and the Comprehensive Needs Assessment is not outdated as defined in this chapter, the provider shall review and update the initial Comprehensive Needs Assessment to include a description of how the individual meets medical necessity criteria for the additional service.

One or More CMHRS Services Provided by different DBHDS Licensed Agencies

Providers should share assessments that recommend CMHRS and EBH services to be provided by a different DBHDS licensed agency, with appropriate consent from the member, to coordinate services. The agency receiving the referral shall complete a new Comprehensive Needs Assessment for the service they are to provide. For example, if Provider A is recommending Mental Health Skill Building and Psychosocial Rehabilitation in the initial Comprehensive Needs Assessment, but is only licensed to provide Mental Health Skill Building, Provider A shall bill the Mental Health Skill Building Assessment code/H0032 U8. Provider A would refer the individual to Provider B who is licensed for Psychosocial Rehabilitation. Provider B would conduct a new Comprehensive Needs Assessment documenting the medical necessity for services and bill for the Psychosocial Rehabilitation Assessment/H0032 U6.

Providers should only bill under the assessment code for a service that they will be providing. In the

above example, if Provider A is licensed to provide both MHSS and PSR but will only be providing MHSS, the assessment shall be billed under the MHSS assessment code and not under the PSR assessment code.

Services Eligible for the Comprehensive Needs Assessment

Assessment Code	Service	Assessment Requirements Effective 1/1/19
H0031	IIH Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U6	PSR Assessment	Must meet Comprehensive Needs Assessment requirements
See Appendix F	Mental Health Intensive Outpatient (MH-IOP)	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
See Appendix F	Mental Health Partial Hospitalization (MH-PHP) Assessment	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
H0032 U7	TDT Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U8	MHSS Assessment	Must meet Comprehensive Needs Assessment requirements
See Appendix E	ACT Assessment	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
See Appendix D	Multisystemic Therapy	Effective 12/1/2021, must meet Comprehensive Needs Assessment requirements
See Appendix D	Functional Family Therapy	Effective 12/1/2021, must meet Comprehensive Needs Assessment requirements
See Appendix D	Applied Behavioral Analysis	Effective 12/1/2021, can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S.[2]
Billed as part of service component	Mobile Crisis Response, Community Stabilization, 23 Hour Crisis Stabilization, Residential Crisis Stabilization Unit	Providers may choose to complete a Comprehensive Needs Assessment
Billed as part of service component	Mental Health Case Management	Can be used as a Comprehensive Needs Assessment if completed by a qualified mental health case manager who is a LMHP, LMHP-R, LMHP-S or LMHP-RP and all 15 required elements are included.[3]

90791	Diagnostic Interview Exam	Can be used as a Comprehensive Needs Assessment if all 15 required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.
90792	Diagnostic Interview Exam Add on with Medical Services	Can be used as a Comprehensive Needs Assessment if all 15 required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.

[1]An assessment conducted by a physician assistant or nurse practitioner who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S can be used for that service only. The assessment cannot be used as a Comprehensive Needs Assessment for other services or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

[2] An assessment conducted by a Licensed Assistant Behavioral Analyst (LABA) who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S can be used ABA only. The assessment cannot be used as a Comprehensive Needs Assessment for other services or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

[3] The assessment for mental health case management does not need to be completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S, however, a qualified mental health case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may conduct the assessment for mental health case management only. This assessment may not be used as a Comprehensive Needs Assessment or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

Services Not Eligible for the Comprehensive Needs Assessment

Treatment Foster Care Case Management cannot be included in a Comprehensive Needs Assessment for other services. Providers should follow the assessment requirements in the Treatment Foster Care Case Management section of this chapter.

Comprehensive Needs Assessment - 15 Required Elements

The Comprehensive Needs Assessment must contain a documented history of the severity, intensity, and duration of behavioral health care problems and behavioral and emotional issues and shall contain all of the following elements:

All fifteen elements must be addressed in the Comprehensive Needs Assessment 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 by the individual and/or family members; specify the type of substance with frequency and duration of usage. Include any treatment or other recovery related efforts.
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. These elements are key to developing an ISP that supports the individual's recovery and resiliency efforts and goals.
11. **Mental Status Profile:** Include findings and clinical tools used.
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 Comprehensive Needs Assessment Summary and Clinical Formulation:** Includes a documentation of medically necessary services as defined by the service provider which:
    a. Identifies as much as possible, the causes of presenting treatment issues, and

b. 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 LMHP, LMHP-R, LMHP-RP or LMHP-S**

Definition of Valid and Outdated Comprehensive Needs Assessment

The Comprehensive Needs Assessment is considered to be valid as long as all of the following are met:

- The Comprehensive Needs Assessment is conducted face-to-face and completed, signed, and contemporaneously dated by the LMHP, LMHP-R, LMHP-RP or LMHP-S conducting the assessment;
- The Comprehensive Needs Assessment shall include the above 15 elements;
- The Comprehensive Needs Assessment shall describe how each recommended CMHRS and EBH service is medically necessary; and
- The Comprehensive Needs Assessment shall be appropriately reviewed and updated as necessary as described in the next section.

The Comprehensive Needs Assessment is considered to be outdated and no longer valid if any of the following occurs:

- A LMHP, LMHP-R, LMHP-RP, LMHP-S has not completed an annual, face-to-face review and update of the Comprehensive Needs Assessment as defined in the next section; or
- Within the past 31 calendar days, the provider has not provided any CMHRS or EBH service recommended by the Comprehensive Needs Assessment or a MHCM billable activity if MHCM is included in the Comprehensive Needs Assessment; or
- The Comprehensive Needs Assessment is not reflective of the individual’s current level of functioning. If there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual, the Comprehensive Needs Assessment shall be updated within 31 calendar days of the change to remain valid.

If one of the above conditions occur, the Comprehensive Needs Assessment is outdated and a new Comprehensive Needs Assessment is required for any additional CMHRS or EBH services provided by the agency.

Review and Update of the Comprehensive Needs Assessment

Review and Update - Annual requirements

A LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an annual face-to-face review and update that includes all of the following:

- A review of the Comprehensive Needs Assessment;
- Any necessary updates to the 15 elements of the Comprehensive Needs Assessment to reflect the individual’s current level of functioning;
- An updated description of how the individual meets medical necessity criteria for all of the services recommended by the Comprehensive Needs Assessment; and
- A contemporaneously dated signature of the LMHP, LMHP-R, LMHP-RP or LMHP-S.

The annual review and update of the Comprehensive Needs Assessment must be conducted face-to-face and documented in an addendum to the Comprehensive Needs Assessment by the LMHP, LMHP-R, LMHP-RP or LMHP-S. A chart review by a LMHP, LMHP-R, LMHP-RP or LMHP-S to review the medical necessity criteria for CMHRS and EBH services is not sufficient to meet this requirement.

Review and Update – Clinical Indication

In addition, the Comprehensive Needs Assessment shall be reviewed and updated when there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual. The licensed practitioner shall make the clinical determination of how this review is completed to ensure the Comprehensive Needs Assessment is current. Any significant change in the medical, psychiatric or behavioral symptoms of the individual, to include any admissions to crisis or inpatient psychiatric services shall be included in the Comprehensive Needs Assessment. If there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual, the Comprehensive Needs Assessment shall be updated within 31 calendar days of the change to remain valid.

Services not initiated within 31 days

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, and a CMHRS service included in the Comprehensive Needs Assessment was not initiated within 31 calendar days from the date the service was recommended by a LMHP, LMHP-R, LMHP-RP or LMHP-S, the Comprehensive Needs Assessment shall be reviewed and updated prior to initiating services. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the review and update shall complete an addendum to the Comprehensive Needs Assessment to include documentation of an updated description of how the individual meets medical necessity criteria for the service.

If a CMHRS or EBH service has not been initiated for more than 31 days and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to initiate CMHRS or EBH services.

Lapse in services

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, and there is lapse in a CMHRS or EBH service included in the Comprehensive Needs Assessment for more than 31 calendar days, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall review and update the existing Comprehensive Needs Assessment. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the review and update shall complete an addendum to the Comprehensive Needs Assessment explaining the lapse and providing an updated description of how the individual meets medical necessity criteria for the service.

If a CMHRS or EBH service has lapsed for more than 31 days and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to resume CMHRS services.

Comprehensive Needs Assessment After Discharge

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall review and update the Comprehensive Needs Assessment to continue providing a CMHRS or EBH service after an individual is discharged from the service. This

update shall include a current description of how the individual meets medical necessity criteria for the service.

If an individual has been discharged from a CMHRS or EBH service and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to resume services.

Providers must follow MCO and FFS Contractor guidelines for initial service authorization or registration if individuals are readmitted to a service after the provider has discharged the individual from the particular service.

Additional Requirements for MHSS and PSR

An LMHP, LMHP-R, LMHP-RP or LMHP-S shall review MHSS and PSR services at a minimum of every six months to determine continued medical necessity for the service and update the assessment if necessary. The six month review may be conducted through a chart review or a face-to-face assessment. The review shall be documented in a progress note or as an addendum to the Comprehensive Needs Assessment. Providers of more than one of these services that require review every six months may complete the reviews together but shall include distinct documentation to support the medical necessity criteria for each service. Face-to-face time necessary to complete this review may be billed as part of the service component.

Additional Requirements for MH-PHP and MH-IOP

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 stay. DMAS or its contractor(s) may request the results of this assessment to evaluate approval of reimbursement for continued services.

Review and Update - billing

Unless indicated in this section that a face to face is required, the LMHP, LMHP-R, LMHP-S or LMHP-RP may determine that the review and update can be appropriately conducted through chart review and information received from staff and family members. Time spent face-to-face with the individual to complete a necessary review to update the Comprehensive Needs Assessment may be billed under the service code. Providers should only bill under the assessment code for a CMHRS service if there is a documented need for a new Comprehensive Needs Assessment.

The FFS Contractor and the MCOs have the discretion to request that providers submit the Comprehensive Needs Assessment for review. Providers shall follow up with the FFS Contractor and/or MCO for specific requirements. MCO requirements are posted on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

Individual Service Plan (ISP) Requirements

The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service provider care coordination, and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements. Some CMHRS

and EBH services, such as comprehensive crisis services, have different requirements for treatment planning, providers should refer to the service specific sections of this manual for details.

The ISP means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the comprehensive needs assessment. A comprehensive ISP is person-centered, includes all planned interventions, aligns with the individual’s identified needs, care coordination needs, is regularly updated as the individual’s needs and progress change, and shows progress throughout the course of treatment.

The ISP contains, but is not limited to the following:

- the individual’s treatment or training needs;
- the individual’s 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.

In addition, to the DMAS requirements above, providers shall follow the ISP requirements included in DBHDS licensing regulations (12VAC 35-105-665).

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.

All ISPs shall be completed, signed, and contemporaneously dated by the LMHP, LMHP-S, LMHP-R, LMHP-RP, nurse practitioner, physician assistant, QMHP-A, QMHP-C, or QMHP-E as specified by the service preparing the ISP within 30 days of the date of initiation of services. The member’s signature shall also be obtained. A youth’s ISP shall also be signed by the parent/legal guardian as appropriate. If the member or guardian is unable or unwilling to sign the ISP, then the service provider shall document the reasons why the individual was not able or refuses to sign the ISP.

Providers must ensure that all interventions and the settings of the interventions are defined in the Individual Service Plan.

The ISP shall be reviewed quarterly (90 calendar days), updated annually, and as the needs, goals and progress of the individual changes. Review of ISP means that the service provider reviews the ISP, evaluates and updates the member's progress toward meeting the ISP objectives, and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall:

- Update the goals, objectives, and strategies of the ISP, as clinically appropriate, to reflect any change in the individual's progress and treatment needs as well as any newly identified problems;
- Be conducted in a manner that enables the individual to participate in the process; and
- The review shall be documented and placed in the individual's medical record no later than 15 calendar days from the date of the review as evidenced by the dated signatures of the qualified staff as specified by the service, and the individual and/or guardian, as

appropriate, when a minor child is the recipient of services.

Some mental health services require that ISP reviews occur more frequently than every 90 calendar days. Providers should refer to the service specific sections of this manual for additional ISP requirements. For services that require a 30 calendar day ISP review, the 30 calendar day ISP review requirements can be met through a progress note that clearly documents the following:

- the treatment plan, including goals and progress towards them has been discussed with the team and the individual;
- any alterations to the ISP;
- the review and any necessary changes have been discussed with the individual and the individual's response. The individual's signature is not required.

During months where a quarterly review or annual ISP update is conducted, no additional documentation is necessary to meet 30 day ISP review requirements.

An ISP that is not updated either annually or as 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.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed as long as the treatment for the substance use condition is intended to positively impact the mental health condition and providers are appropriately licensed and acting within the scope of their expertise. The impact of the substance use condition on the mental health condition must be documented in the provider's assessment, ISP and the progress notes.

DBHDS licensed providers must follow all DBHDS regulations including staffing requirements related to supervision and approval of ISPs (12VAC35-105-590).

Individual Specific Treatment Goals and Objectives

Goals, Objectives and Intervention/Strategies should be based on the individuals presenting areas of needs as identified in the provider's 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 care 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 must include the recommended service frequency needed to accomplish the goals, objectives and interventions/strategies that will meet the needs identified in the provider's assessment.
- The ISP must be reviewed, at a minimum, every 3 months (every 90 calendar days) to determine if the goals and objectives continue to meet the needs of the individual or require revision.
- The ISP shall be updated annually and as the needs, goals and progress of the individual changes.

Discharge Goal:

- All ISPs shall 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 Provider Care Coordination and Continuity of Care:

- All ISPs should clearly include care coordination as necessary to improve the care.
- All ISPs should clearly identify all current professionals involved in the individual's care and with whom is actively coordinated during the duration of the service (i.e. educational, psychiatric, medical, case management, probation, etc.)
- Care coordination activities must be defined related to the specific treatment needs and the related service goals and objectives and describe any psychoeducation or care 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.

Additional Service Requirements for All Mental Health Services

- LMHPs must adhere to the practice guidelines outlined by the ethical guidelines of the assigned professional board governing that license.
- Clinical services including assessments, Comprehensive Needs Assessments and counseling must be provided by a LMHP, LMHP-R, LMHP-RP or an LMHP-S. Refer to the Comprehensive Needs Assessment section of this chapter for exceptions to this requirement.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS or EBH services including efforts to schedule well visits for kids and as needed physician visits for adults.
- 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.
- 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 and delivered the service. 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 dated 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 when documentation does not demonstrate unique differences particular to the individual or support the time/units billed.
- Providers shall discharge individuals if consent for treatment is withdrawn except during mandated assessments under the Code of Virginia §37.2-800 et. seq. for adults and §16.1-335 et seq. for youth under age eighteen.

Non-Reimbursable Activities for all Mental Health Services

The following activities are not reimbursable and shall not be included for billable time for reimbursement.

- Staff travel time;
- Staff time spent completing documentation without the individual present;
- Services that have not been rendered;
- Services rendered that are not in accordance with an approved service authorization or required registration;
- Services based upon an incomplete, missing or outdated assessment or ISP;
- Services not identified on the individual’s authorized ISP or treatment plan;
- Services that are not documented;
- Services provided to children, spouse, parents, or siblings of the eligible individual under treatment or others in the individual’s life to address problems not directly related to the individual’s issues and not listed on the individual’s ISP or treatment plan;
- Services provided that are not within the provider’s scope of practice;
- Time spent when the individual is employed and performing the tasks of their job;

- Time spent in any activity that is not a covered service component (examples include, but are not limited to: child care, respite care, housing, time spent in snacks and meals, time spent in transportation);
- Contacts that are not medically necessary;
- Time when the individual is participating in recreational activities;
- Services provided by one staff member to two or more individuals at the same time when group delivery of either the service or the service component is not allowed;
- Time when the individual is participating in educational instruction;
- Inactive time or time spent waiting to respond to a behavioral situation. Inactive time is defined as time when the provider is not providing a covered service component.

Marketing Requirements

Providers shall comply with marketing requirements as required by state regulations (12VAC30-130-2000). Violations of marketing requirements could result in provider contract termination.

1. Marketing and promotional activities (including but not limited to provider promotional activities, written materials, television, radio, websites, and social media) shall comply with all applicable federal and state laws.
2. Marketing and promotional materials must include the following: Clear, written descriptions of the Medicaid or FAMIS behavioral health service; eligibility requirements for the service; application fees and other changes; and all other necessary information for beneficiaries and their families to make an informed decision about enrollment into the service.
3. Provider marketing and promotional materials shall be distributed only in the service locations listed on the Department of Behavioral Health and Developmental Services (DBHDS) license addendum.

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

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

    b. Assert or state that the member 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 members;

d. Conduct any marketing activities or use marketing materials that are in violation of marketing requirements;

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

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about members 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, members 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 violate any of the prohibitions in this section, shall be subject to termination of their provider agreements for the services affected by the marketing activity. See Chapter II of this provider manual for any applicable appeal rights for providers.

Transportation Benefits

- Provider transportation of the individual receiving services is not reimbursable.
- 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.
- For members assigned to a Managed Care Organization (MCO), 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 mileage 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

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.

For information on services that require service authorization and services that do not require service authorization but require registration, please refer to the FFS contractor or the individual’s MCO. Additional information is also available in Appendix C of this manual.

Service Criteria and Definitions (MHS)

Intensive In-Home Services (IIH) for Youth (H2012)

Service Definition

Intensive in-home services (IIH) for youth under age 21 are intensive therapeutic interventions provided in the youth’s residence (or other community settings as medically necessary and documented in the Comprehensive Needs Assessment and ISP), to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth’s mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the youth, and gradually transition the youth to less restrictive levels of care and supports. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and include clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote benefits of psychoeducation in the home setting of a youth 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 youth.

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

Effective January 30, 2015 youth 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 for IIH

Youth 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 youth’s functioning. It is unlikely that youth with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Prior to the start of services, a valid Comprehensive Needs Assessment, as defined earlier in this chapter, shall be conducted by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the youth's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the youth's residence. The Comprehensive Needs Assessment describes how the youth's clinical needs put the youth at risk of out-of-home placement.

Youth shall meet all of the following criteria including Diagnostic, At Risk, Level of Care and Family Involvement to qualify for IIH services.

1. Diagnostic Criteria

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

2. At Risk Criteria

The impairments experienced by the member are to such a degree that they **shall meet at least two** of the criteria below, on a continuing or intermittent basis, for being at risk of out of home placement as defined in definitions section.

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 as defined in the definition section of this manual because of conflicts with family or community; and/or

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; and/or

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.

3. Level of Care:

The impairments experienced by the member are to such a degree that they **shall meet one** of the criteria below:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the youth in the family situation, or
b. When the youth's residence as the setting for services is more likely to be successful than a clinic.

4. Family Involvement:

At least one parent/legal guardian or responsible adult with whom the youth is living shall be willing to

participate in the intensive in-home services with the goal of keeping the youth 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 counseling and service-related activities to benefit the youth.

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 apply:

a. The youth is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms;
b. The level of functioning has improved with respect to the goals outlined in the ISP and the youth can reasonably be expected to maintain these gains at a lower level of treatment;
c. The child is no longer in the home; or
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. Discharge is required when the youth 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.

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 youth with the service provider, the provider shall discharge the youth.

Service Requirements

- Prior to the start of services, a valid Comprehensive Needs Assessment as described earlier in this chapter shall be conducted by the LMHP, LMHP-S, LMHP-R or LMHP-RP, documenting the youth’s diagnosis and describing how service needs match the level of care criteria. ISPs shall be required during the entire duration of services and shall be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement;
- An ISP developed within 30 calendar days of initiation of services. The ISP shall meet all of the requirements as defined in 12 VAC 30-50-130, 12VAC30-50-226 and the ISP Requirements section of this chapter;
- Individual and family counseling is a required component of this service and must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Counseling may be provided by the IIH provider or an outpatient service by a private provider as long as it is documented in the ISP and coordinated by the IIH provider. If the counseling is provided by a private provider, the private provider would bill as an outpatient psychiatric services separate from the IIH services (Providers should consult with the Medicaid MCOs to determine if they recognize unlicensed providers (LMHP-R, LMHP-RP, LMHP-S) to provide outpatient psychiatric services prior to providing services);
- The ISP shall be in effect and demonstrate the required need for a minimum of three hours a week of IIH. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the youth and family as documented in the ISP. In

preparation of discharge, the ISP can be updated to show a reduction in the services to transition the child and family to a lower level of care. The individualized discharge plan shall describe the transition from IIH to a lower level of care;

- 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 youth and delivered primarily in the family's residence with the youth 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 youth and describe how it facilitates the implementation of the ISP;
- Training to increase appropriate communication skills (e.g., counseling to assist the youth and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.);
- Service provider care coordination; and,
- Services 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 youth and responsible parent/guardian shall be available and in agreement to participate in the transition.
- All services must be provided on a one-to-one basis with one staff person and one Medicaid member with the exception of family counseling and care coordination.

Service Limitations:

- Services that meet the definition of “Failed Services” will not be eligible for reimbursement approval.
- IIH may be billed only within 7 days prior to discharge from any residential treatment service or inpatient hospitalization.
- Recreational activities outside the home, such as trips to the library, restaurants, museums, health clubs and shopping centers, 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 Comprehensive Needs Assessment and the ISP.
- The unit of service for IIH service is one hour.
- IIH may not be authorized or billed concurrently with Multisystemic Therapy (MST) Functional Family Therapy (FFT), Applied Behavior Analysis (ABA), Assertive Community Treatment, Mental Health Intensive Outpatient or Mental Health Partial Hospitalization Program services. IIH may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.

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.

Therapeutic Day Treatment (TDT) for Youth (H2016)

Service Definition

Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement the school day or year. The supporting diagnosis must be made by an LMHP practicing within the scope of his or her license. This service shall include assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. Services may be provided in groups or on a one-to-one basis as clinically indicated. These services shall be provided for two or more hours per day.

Youth 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 youth’s functioning. It is unlikely that youth with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Recommendations for Service Provision

Successful service provision includes the active engagement of the service provider, any involved school, and the member’s parent/guardian. The service provider shall engage with the school and parent/guardian to reach the desired outcomes as outlined in the ISP. Ideally, if a school is involved, it will provide a secure space for service provision and liaison with the service provider. The licensed practitioner shall determine the frequency of visits based on the individual needs of the member. DMAS recommends that family involvement, to include family counseling, family meetings or family contacts, occurs at least weekly from the beginning of treatment unless contraindicated as documented in the ISP and Comprehensive Needs Assessment. The licensed practitioner shall document justification for less than weekly family involvement if weekly involvement is contraindicating to the member’s needs.

Members receiving TDT should experience improvement on measurable objectives and goals documented in the ISP and ISP reviews that enable the member to transition to a lower level of care. TDT is intended for youth who reside in the community with their parent(s)/guardian(s) in the family home or in a group home placement. TDT should provide stabilization during the school day or to supplement the school day or year, as medically necessary, for youth who are at risk to be placed in a higher level of care in order to address current symptoms, or who are transitioning from an acute or residential level of care to a home environment.

It is expected that the pattern of service provision may show more intensive services and more frequent contact with the youth and family initially, with gradually reduced intensity progressing toward discharge.

Medical Necessity Criteria

Youth must meet all of the following to include the Diagnostic, Clinical Necessity, and Level of Care criteria.

1. Diagnostic Criteria

Youth 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. The diagnosis must be the primary clinical issue addressed with the service targeted for treatment. The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.

2. Clinical Necessity Criteria

Youth shall **meet at least two** of the following:

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** as defined in the definitions section of this chapter because of conflicts with family or community; and/or
b. Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services or judicial system are or have been necessary: and/or
c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

3. Level of Care

Youth shall **meet at least one** of the following:

a. The youth must require year-round treatment in order to sustain behavior or emotional gains;
b. The youth's behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:
   i. TDT programming during the school day; or
   ii. TDT programming to supplement the school day or school year;
c. The youth would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning;
d. The youth 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; or
e. The youth is placed or pending placement in a preschool enrichment and/or early intervention program but the youth'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 any of the following applies:
    - The youth no longer meets the diagnostic, clinical necessity, or level of care criteria; or
    - The level of functioning has improved with respect to the goals outlined in the ISP, and the youth can reasonably be expected to maintain these gains at a lower level of treatment.
    - When the youth has achieved baseline functioning (his or her level of functioning has not improved despite the length of time in treatment and interventions attempted) and his or her needs can be met in a less intensive service..

If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the youth.

Service Requirements:

- Prior to the start of services, a Comprehensive Needs Assessment, as defined earlier in this chapter, shall be conducted by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the youth's diagnosis and describing how service needs match the level of care criteria. ISPs shall be required during the entire duration of services and be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.
- An ISP developed within 30 calendar days of initiation of services that meets all requirements of an ISP as defined in 12 VAC30-50-130, 12VAC30-50-226 and the ISP Requirements section of this chapter.
- Individual, group and/or family counseling is a required component of this service and must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. Counseling may be provided by the TDT provider through an outpatient service by a private provider, another CMHRS Services provider or by the local education agency behavioral health staff, as long as it is documented in the ISP and coordinated by the TDT provider. If the counseling is provided by a private provider, the private provider would bill as an outpatient psychiatric service separate from the TDT services. If the counseling is provided by the local education agency, then the local education agency would need to provide services according to the Local Education Agency DMAS Provider Manual. If this child is also receiving other CMHRS Services and counseling is a required component of that service, the counseling services shall be coordinated between service providers and documented in the child's ISP and would be billed by the servicing provider.

TDT and outpatient service providers should consult with the Medicaid MCOs to determine if they recognize unlicensed providers (LMHP-R, LMHP-RP, LMHP-S) to provide outpatient psychiatric services prior to providing service.

- Services must be therapeutic in nature and align with the member's ISP.
- The ISP, including the individualized discharge plan contained in the ISP, should be reviewed every 3 months (defined as 90 calendar days) at a minimum, but as frequently as medically necessary.

- The ISP must be updated between school and summer programs based on the activities being provided.
- Family meetings and contacts, either in person or by telephone, occurs at least once per week to discuss treatment needs and progress. Contacts with parents/guardian include at a minimum the youth's progress, any diagnostic changes, any ISP changes, and discharge planning. The parent/guardian should be involved in any significant incidents during the school day and be informed of any changes associated with the ISP. Family meetings are not considered to be the same as family therapy.
- Service provider care coordination including consultation, collaboration, and coordination with teachers, concurrent service providers, and others involved in the youth's treatment to include scheduling appointments and meetings to improve care; planning and implementing individualized behavior modification programs; and monitoring treatment and ISP progress. The provider will be asked to explain what care coordination has taken place during treatment as well as in preparation for discharge and step down to lower levels of care with every request for services.
- If the youth is prescribed 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 youth and parent/ guardian and documented in the Comprehensive Needs Assessment, the ISP and progress notes. A QMHP-C must remain within the boundaries of their level of expertise and may consult with the service provider's clinical director, consult with current prescribing physician and school personnel such as school nurse, coordinate referrals for medication evaluation, monitor compliance, and provide developmentally appropriate education to the youth regarding medication adherence and side effects. The QMHP must involve the parent/guardian to monitor the youth's medication compliance/adherence. Response to medication and education, as well as compliance must be documented.
- Providing individual and group therapeutic interventions and activities based on specific TDT objectives identified in the ISP planning and implementing individualized pro-social skills interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.
- For school based TDT, providing feedback to the youth and direct skills training in the classroom based on specific TDT objectives identified in the ISP.
- For school based TDT, 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 youth 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. A crisis plan should be kept onsite and in the medical record and reviewed throughout treatment.

Limitations

- The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., school based, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group therapeutic interventions and activities.
- Services shall be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP, LMHP-S.
- Therapeutic group activities are limited to no more than 10 youth.

- 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;
  - Time spent in documentation of youth and family contacts, collateral contacts, and clinical interventions;
  - Time required for academic instruction when no treatment activity that align with the goals and objectives in the youth's ISP is taking place;
  - Time spent monitoring behavior during the classroom when no treatment activity is occurring; and
  - Time when the youth is not present.
- Services must not duplicate those services provided by the school, including interventions identified on the school's IEP for the member.
- TDT may not be authorized or billed concurrently with Assertive Community Treatment, Mental Health Intensive Outpatient or Mental Health Partial Hospitalization Program services. TDT may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit Services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.

Service Units

Service units are based on medical necessity.

- One unit = 2 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 plus hours per day

Effective 12/1/2016, claims must distinguish whether the TDT services rendered are school based, after school, or summer with the addition of modifiers UG or U7, as follows:

DBHDS License Crosswalk with DMAS Billing Codes		
DBHDS License/Number	**DMAS Service**	**DMAS Billing Code**
02-014 through 02-018 (non-school based TDT)	After School TDT	H2016 -UG
02-029 through 02-031 (school based TDT)	School Based TDT	H2016
02-014 through 02-018 (non-school based TDT	Summer TDT	H2016- U7

Please note: If a child was receiving school based TDT services with a provider under their 02-029 license and the child will continue in the TDT service at a school location in conjunction with summer school programming; this would fall under the scope of the same licensed service so a new assessment would not be required.

If a child was receiving school based TDT services with a provider under their 02-029 license and the child is going to be receiving TDT services during the summer that is not in conjunction with summer school, even if the TDT is provided in a school building, this would fall under a different service

(02-014) and an assessment would be required.

If a provider only has one license, then they should only be providing services that are covered under the scope of that license.

An assessment for a new services does not necessarily need to be a completely new assessment. The assessment can be an update that addresses the required elements and time frames in 12VAC35-105-650.E and 12VAC35-105-650.F, which includes assessing the youth's current needs and how the new service is the most appropriate method to address this. When a child transitions from school based TDT to non-school based TDT or from non-school based TDT to school based TDT, providers shall review and update the Comprehensive Needs Assessment as described in the Comprehensive Needs Assessment of this chapter.

Additionally, if the youth changes service settings and a modifier is changed, then the provider will be expected to provide supportive clinical information on the continued stay authorization request to support the modified service. Information gathered from an assessment or an updated assessment should be used to document the need for services on the authorization request along with the specific treatment goals and objectives as they are revised for summer programming.

Day Treatment/Partial Hospitalization

Effective 7/1/2021, the Day Treatment / Partial Hospitalization service has been replaced with the Mental Health Partial Hospitalization Program. Effective 7/1/2021 Mental Health Partial Hospitalization Program providers must follow the service specific guidelines found in Appendix E of this Manual.

Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial Rehabilitation is a program of two or more consecutive hours per day provided to groups of individuals in a community, nonresidential setting who require a reduction of impairments due to a mental illness and restoration to the best possible functional level in order to maintain community tenure. This service provides a consistent structured environment for conducting targeted exercises and coaching to restore an individual's ability to manage mental illness. This service provides education to teach the individual about mental illness, substance use, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a consistent program structure and environment. Services may be provided in groups or on a one-to-one basis as clinically indicated.

Medical Necessity Criteria

The Comprehensive Needs Assessment, as defined earlier in the chapter, 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:
2. 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;
3. 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;
4. Exhibit such inappropriate behavior that repeated interventions **documented** by the mental health, social services, or judicial system are or have been necessary; or
5. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. “Cognitive” is defined as 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.

Service Requirements

- Prior to the start of services, a Comprehensive Needs Assessment, as defined earlier in this chapter, shall be conducted by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. ISPs shall be required during the entire duration of services and be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessments or ISPs shall be denied reimbursement.
- An ISP shall be completed as described in the ISP Requirements section of this chapter within 30 calendar days of service initiation.
- Psychosocial rehabilitation services may be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, QMHP-C, LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-S, LMHP-R, or LMHP-RP to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service as described in the Comprehensive Needs Assessment section of this chapter. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services.
- Social skills training, community resource development, and peer support among fellow members, which are oriented toward empowerment, recovery and competency.
- Psycho educational activities to teach the individual about mental illness and appropriate medication to avoid complications and relapse
- 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.
- Service provider care coordination
- The program shall operate a minimum of two continuous hours in a 24-hour period.
- 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 assessment and ISP.

Service Units

Service Units are based on medical necessity:

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

Limitations

- The following services are specifically excluded from payment for psychosocial rehabilitation services:
  - Vocational services,
  - Prevocational services,
  - Supported employment services
- Psychosocial rehabilitation may not be authorized or billed concurrently with Mental Health Intensive Outpatient, Mental Health Partial Hospitalization Program or Applied Behavior Analysis services. Psychosocial rehabilitation may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.
- Providers shall not bill for time when the individual is not present at the program.

Please see the Comprehensive Crisis Services Appendix for information on available crisis services effective 12/1/2021. The last day for Medicaid coverage of Crisis Intervention (H0036) and Crisis Stabilization (H2019) is 11/30/2021. Psychotherapy for crisis CPT codes (90839, 90840) are also covered through outpatient psychiatric services effective 7/1/2021.

Intensive Community Treatment (H0039)

Effective July 1, 2021, the Assertive Community Treatment program replaces Intensive Community Treatment. The last day for Medicaid coverage of H0039 is June 30, 2021. For service specific information on Assertive Community Treatment, please refer to Appendix D to this Manual.

Mental Health Skill Building Services (H0046)

Service Definition

Mental health skill-building services (MHSS) shall be defined as goal directed training and supports to enable restoration of an individual to the highest level of baseline functioning and achieve and

maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services shall provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. MHSS shall include goal directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities.

Medical Necessity Criteria

Individuals qualifying for MHSS 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.

Individuals age 21 and over shall **meet all** of the following criteria in order to be eligible to receive MHSS:

A. The individual shall have one of the following as a primary mental health diagnosis:

    1. Schizophrenia or other psychotic disorder as set out in the DSM-5,
    2. Major Depressive Disorder;
    3. Bipolar I or Bipolar II;
    4. Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) the individual requires individualized training in order to achieve or maintain independent living in the community.

5. The individual shall require individualized goal directed training in order to acquire or maintain self-regulation of basic living skills such, as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.
6. The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) community stabilization, 23-hour crisis stabilization or residential crisis stabilization unit services, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation pursuant to the Code of Virginia §37.2-809(B). This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.
7. The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the Comprehensive Needs Assessment. 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 MHSS 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. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, including psychiatric medication history, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

Individuals 18-20 years shall **meet all** of the above medical necessity criteria listed in paragraphs 1 through 2 (A-D) in order to be eligible to receive MHSS and the following:

E. The individual shall not be in a supervised setting as described in §63.2-905.1 of the Code of Virginia. 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.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within MHSS as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the Comprehensive Needs Assessment, the ISP, and the progress notes.

Service Requirements

1. A Comprehensive Needs Assessment shall be required prior to the start of services. The Comprehensive Needs Assessment must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The Comprehensive Needs Assessment, as defined earlier in this chapter, shall document the individual's behavior and describe how the individual meets criteria for this service. After any lapse in services of more than 31 calendar days, a new Comprehensive Needs Assessment shall be required unless the provider has a valid Comprehensive Needs Assessment as defined in the Comprehensive Needs Assessment section of this chapter. If the provider has a valid Comprehensive Needs Assessment, the provider shall update the Comprehensive Needs Assessment following any lapse of greater than 31 calendar days. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the Comprehensive Needs Assessment shall document the primary mental health diagnosis on the Comprehensive Needs Assessment.

2. MHSS services that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service in the individual's medical record as described in the Comprehensive Needs Assessment section of this chapter. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services.
3. The ISP shall be developed as described in the ISP Requirements section of this chapter within

30 calendar 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 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. The ISP shall include the dated signature of the individual, if the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.

4. Every three months (defined as 90 calendar days), the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in the manner in which he may participate with the process, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall 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 believe that the individual is not adhering to the medication regimen, medication compliance shall be a goal in the individual's ISP. If the care is delivered by the QPPMH, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-compliance. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-compliance concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:

- name and title of caller;
- name and title of professional who was called;
- name of organization that the prescribing professional works for;
- date and time of call;
- reason for care coordination call;
- description of medication regimen issue or issues to be discussed; and
- resolution of medication regimen issue or issues that were discussed.

8. Documentation of prior psychiatric services history, to include psychiatric medication history, as described in Chapter VI of this manual shall be maintained in the individual's MHSS medical

record.

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

10. 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. However, any service provided to individuals that are strictly vocational in nature shall not be billable.

11. Provider qualifications. The enrolled provider of MHSS shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide MHSS 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-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the MHSS record. All Registered QMHPs shall follow DHP licensing requirements for supervision.

12. MHSS 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.

13. If MHSS is provided in a Therapeutic Group Home, mental health supervised living setting 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 MHSS with the treatment plan established by the group home, mental health supervised living setting or assisted living facility and shall document all coordination activities in the medical record.

Covered Services

MHSS services include the following components:

- Providing opportunities to enhance recovery plans that include but are not limited to:
    - Daily living activities and trainings on personal care/hygiene to restore and regain functional skills and appropriate behavior related to health and safety; and,
    - Skills training and reinforcement on the use of available community resources, such as public transportation to improve daily living and community integration skills and independent use of community resources, etc.
- Recovery and symptom management activities that include but are not limited to:
    - Condition specific education and training and reinforcement of symptom identification designed to increase he individual’s ability to recognize and respond to symptoms; and
    - Goal directed and individualized stress management and coping skills training to increase the individual’s continued adjustment to management of mental illness; and
    - Training and coaching to facilitate improved communication, problems solving and appropriate coping skills, etc.

- Assistance with medication management.
- Conducting targeted exercises and coaching to restore and individual's ability to monitor and regulate their health, nutrition, and physical condition that includes but is not limited to:
    - Self-assessment exercises and recovery coaching that builds self-awareness of symptoms and how to identify and monitor symptoms; and
    - Coaching and training on maintaining adherence to recommended medical care such as scheduling and keeping medical appointments, etc.

All services must be provided on a one-to-one basis with one staff person and one Medicaid member with the exception of care coordination.

Limitations and Exclusions

1. TGH and assisted living facility providers shall not serve as the MHSS 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 intermediate care facilities for individuals with intellectual disabilities (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 calendar days prior to discharge. If the individual has not been discharged from the nursing facility during the 60 calendar day period of services, MHSS shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that MHSS 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 calendar days of MHSS.
7. Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.
8. MHSS shall be not reimbursed if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's MHSS 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 a Developmental Disabilities Waiver, CCC Plus Waiver, and EPSDT services.
9. MHSS shall not be duplicative of other 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, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP 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 physicians issue a signed and dated statement indicating that this service can benefit the individual by enabling them to achieve and maintain community stability and independence.
11. Individuals who are not diagnosed with a serious mental disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the MHSS services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 and that the provider can document and describe how the individual is expected to actively participate in and benefit from MHSS and the remaining MHSS service criteria and guidelines are satisfied.
12. Academic services are not reimbursable. 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.
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. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and guidelines as described in the regulations and this manual. Only direct face-to-face contacts and services to the individual members are reimbursable.
17. Staff travel time is excluded.
18. MHSS may not be authorized or billed concurrently with Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Applied Behavior Analysis. MHSS may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.

Service Units

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day

The provider shall clearly document details of the services provided during the entire amount of time billed. Authorization is required for Medicaid reimbursement. MHSS is service authorized based on medical necessity.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid

reimbursement. Providers may contact the FFS contractor or the MCO directly for more information.

SUBSTANCE USE DISORDER TREATMENT SERVICES

Effective April 1, 2017, DMAS implemented the Addiction and Recovery Treatment Services (ARTS) program for all members and enrollees. For information on substance use disorder treatment services, please refer to the ARTS Provider Manual.

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 use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the 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 use 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 V Code 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, 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 use disorder 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 use disorder, 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 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 calendar days.

Service Requirements

The following services and activities must be provided:

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such). An assessment must be completed by a qualified mental health case manager to determine the need for services or included as a recommended service on a Comprehensive Needs Assessment conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. If completed by a qualified case management who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the assessment is conducted as part of the first month of case management service. Case Management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services. The assessment serves as the basis for the ISP.

- The ISP must document the need for case management and be fully completed within 30 calendar 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. The ISP shall be updated at least annually.

- 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.

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

- Coordinating services and service planning with other agencies and providers involved with the individual.

- Enhancing community integration by contacting other entities to arrange community access and involvement including opportunities to learn community living skills, and use vocational, civic, and recreational services.

- Making collateral contacts, which are non-therapy contacts, with significant others to promote implementation of the service plan and community adjustment.

- Following up and monitoring to assess ongoing progress and ensuring services are delivered.

- 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.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS services, specifically mental health case management.

- A face-to-face contact must be made at least once every 90 calendar 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.

Service Units

- 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 Case Management 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 calendar 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.

- In accordance to 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds..

- Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 - 64 as long as the service was rendered prior to the date of the admission.

- Two conditions must be met to bill for Case Management services for individuals that are in an acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to one month of service, 30 calendar 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 the FFS contractor or the MCO 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 may contact the FFS contractor or the MCO directly for more information.

Case Management Agency Requirements

1. The assessment and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial assessment 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.

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 calendar days.

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

Treatment Foster Care-Case Management (T1016)

Treatment Foster Care - Case Management (TFC-CM) is a service that assists Medicaid eligible individuals in gaining and coordinating access to necessary care and services appropriate to their needs. Case management services will coordinate service to minimize fragmentation of care, reduce barriers, and link children with appropriate services to ensure comprehensive, continuous access to needed medical, social education, and other services appropriate to the needs of the child.

TFC-CM is directed toward children or youth with a behavioral disorder or emotional disturbance referred to Treatment Foster Care by the Family Assessment and Planning Team (FAPT) of the Comprehensive Services Act (CSA) for Youth and Families or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5208 of the Code of Virginia. "Child" or "youth" means any Medicaid-eligible child under age 21 years of age who is otherwise eligible for CSA services. Each individual must be assessed by a Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.2-5209 of the Code of Virginia. The team must assess the individual's immediate and long- range therapeutic needs, developmental priorities, personal strengths and liabilities, the potential for reunification with the individual's family, set treatment objectives, and prescribe therapeutic modalities to achieve the plan's objectives. The assessment must include the dated signatures of a majority (at least three) of the FAPT members.

The FAPT shall refer the individuals needing TFC-CM to a qualified participating treatment foster care case manager.

<u>TFC Medical Necessity Criteria</u>

TFC case management will serve children under age 21 in treatment foster care who are seriously emotionally disturbed or children with a behavioral disorder who in the absence of such programs would be at risk for placement into more restrictive residential setting such

as psychiatric hospitals, correctional facilities, residential treatment programs or group home.

The individual must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on the CANS. The individual's condition must meet one of the three levels described below:

a. **Level I:** Moderate impairment with one or more of the following moderate risk factors as documented on the CANS:

    1. Needs intensive supervision to prevent harmful consequences;
    2. Moderate/frequent disruptive or non-compliant behaviors in home setting that increase the risk to self or others; or
    3. Needs assistance of trained professionals as caregivers.

b. **Level II:** The individual must display a significant impairment with problems with authority, impulsivity, and caregiver issues as documented on the CANS. For example, the individual must:

    1. Be unable to handle the emotional demands of family living;
    2. Need 24-hour immediate response to crisis behaviors; or
    3. Have severe disruptive peer and authority interactions that increase risk and impede growth

c. **Level III:** The individual must display a significant impairment with severe risk factors as documented on the CANS. The individual must demonstrate risk behaviors that create significant risk of harm to self or others.

TFC-CM is a component of treatment foster care through which a treatment foster care case manager provides treatment planning, monitors the care plan, and links the individual to other community resources as necessary to address the special identified needs of the individual. Services to the individuals shall be delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented.

Services shall not include room and board. The following activities are considered covered services related to TFC-CM services:

1. Care planning, monitoring of the plan of care, and discharge planning;

2. Case management; and

3. Evaluation of the effectiveness of the individual’s plan of care.

Duties of a TFC Case Manager are to:

- Perform a periodic assessment to determine the individual’s needs for psychosocial, nutritional, medical, and educational services;

- Develop individualized treatment and service plans to describe the services and resources needed to meet the needs of the individual and to help access those services and resources. Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. The case manager shall collaborate closely with the FAPT and other involved parties in preparation of all case plans;

- Coordinate services and service planning with other agencies and providers involved with the individual including the FAPT;

- Refer the individual to services and support specified in the individualized treatment and service plans;

- Directly assist the child to locate or obtain needed services and resources; and

- Follow up and monitoring by assessing ongoing progress in each case to ensure

services are delivered. The case manager shall continually evaluate and review each child's plan of care. The case manager shall collaborate with the FAPT and other involved parties on review and coordination of services to youth and families;

If an individual is temporarily out of the home, documentation of active treatment foster care case management services is required to bill for the time the individual is out of the home in the following situations:

1. Placement for inpatient services, in cooperation with the facility, to assist in discharge planning for transition back to the home;

2. Runaway – if the treatment foster care case manager is actively involved in finding the individual to be returned to the home; and

3. Detention – refer to the Chapter III discussion on "inmate" and verify Medicaid eligibility.

4. No other type of case management may be billed concurrently with treatment foster care case management.

Caseload Size: The TFC Case Manager shall have a maximum of 12 individuals in his/her caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

1. The TFC-Case Manager's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor.

2. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents.

3. Exception: A TFC- Case Manger may have a maximum caseload of 15 individuals as long as no more than 10 of the individuals are in TFC and the above criteria for adjusting the caseload downward do not apply.

4. There shall be a maximum of six individuals in the caseload for a beginning trainee that may be increased to nine by the end of the first year and to 12 by the end of the second year.

5. There shall be a maximum of three individuals in a caseload for a student intern, if any work in the agency.

Treatment Teams in TFC-CM

The TFC-CM provider shall assure that a professional staff person provides leadership to the treatment team, which includes managing team decision-making regarding the care and treatment of the individual and services to the individual's treatment foster care family. The provider must provide information and training to the treatment team members as necessary. The provider must involve the individual and the individual's treatment foster care family in treatment team meetings, plans, and decisions and keep them informed of the individual's progress whenever possible. Treatment team members shall consult as often as necessary, but no less than quarterly.

Initial Plan of Care

The initial plan of care delineates the services that are to be provided to the individual at admission. This document must be completed within 14 calendar days of the placement or be subject to retraction until completed.

Treatment and Service Plans in TFC-CM

The TFC-CM provider shall prepare and implement an individualized comprehensive plan for

each individual in its care. When available, the birth parents shall be consulted unless parental rights have been terminated. If birth parents cannot be consulted, the agency shall document the reason in the individual's record.

When the treatment foster care case management provider holds custody of the child, a service plan shall be filed with the court within 60 calendar days after the agency receives custody unless the court grants an additional 60 calendar days, or the child is returned home or placed for adoption within 60 calendar days. Providers with legal custody of the child shall follow the requirements of § 16.1-281 and 16.1-282 of the Code of Virginia. The permanency planning goals and the requirements and procedures in the Department of Social Services Service Programs Manual, Volume VII, Section III, Chapter B, "Preparing the Initial Service Plan" may be consulted.

Comprehensive Treatment and Service Plan in TFC-CM

The treatment foster care (TFC) case manager and other designated child-placing agency staff shall develop and implement for each individual in care an individualized comprehensive treatment plan within the first 45 calendar days of placement that shall include:

1. A comprehensive assessment of the individual's emotional, behavioral, educational, and medical needs;

2. The treatment goals and objectives, including the individual's specific problems, behaviors, and skills to be addressed, the criteria for achievement, and target dates for each goal and objective;

3. The TFC-CM provider's program of therapies, activities, and services, including the specific methods of program of therapies, activities, and services, the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources to ensure a continuity of care with the individual's family, school and community;

4. The discharge plan and the target date for discharge from the program;

5. The discharge goals and objectives, services to be provided for their achievement, and plans for reunification of the child and the child's family, where appropriate. Unless specifically prohibited by court order, foster children shall have access to regular contact with their families.

6. For individuals age 16 and over, a description of the programs and services that will help the individual transition from foster care to independent living; and

7. The plan shall be signed and dated by the treatment foster care case manager. It shall indicate all members of the treatment team who participated in its development.

The TFC case manager shall include and work with the individual, the custodial agency, the treatment foster care parents, and the birth parents, where appropriate, in the development of the treatment plan, and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about the individual’s birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the TFC case manager shall document the reasons in the individual’s record.

The TFC case manager shall provide supervision, training, support, and guidance to foster families in implementing the treatment plan for the individual.

Progress Reports and Ongoing Services Plans in TFC-CM

The TFC case manager shall complete written progress reports beginning 90 calendar days after the date of the individual’s placement and every 90 calendar days thereafter. The progress report shall specify the time period covered and include:

1. Progress on the individual's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented, including:

    a. A description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each goal and objective;

    b. A description of the therapies, activities, and services provided during the previous 90 calendar days toward the treatment goals and objectives; and

    c. Any changes needed for the next 90 calendar days.

2. Services provided during the last 90 calendar days toward the discharge goals, including plans for reunification of the individual and birth family or placement with relatives, any changes in these goals, and services to be provided during the next 90 calendar days, including:

    a. The individual's assessment of his or her progress and his or her description of services needed, where appropriate;

    b. Contacts between the individual and the individual's birth family, where appropriate;

    c. Medical needs, specifying medical treatment provided and still needed and medications provided;
    d. An update to the discharge plans including the projected discharge date; and

    e. A description of the programs and services provided to individuals 16 and older to help the individual transition from foster care to independent living, where appropriate.

Annually, the progress report shall address the above requirements as well as evaluate and update the comprehensive treatment and service plan for the upcoming year. The case manager shall date and sign each progress report. The dated signature indicates the effective date of the report.

The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report. The case manager shall include and work with the child, the treatment foster parents, the custodial agency, and the birth parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

Contacts with the Child in TFC-CM

1. There shall be face-to-face contact between the TFC case manager and the individual, based upon the individual's treatment and service plan and as often as necessary, to ensure that the individual is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be with the individual in the treatment foster care home. One of the contacts shall include the individual and at least one treatment foster parent and shall assess the relationship between the individual and the treatment foster parents. The two required face-to-face contacts cannot occur on the same day.

3. The contacts shall assess the individual's progress and provide guidance to the treatment foster parents, monitor service delivery, and allow the individual to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Individuals who are able to communicate shall be interviewed privately at least once a month.

6. The TFC case manager shall record all medications prescribed for each individual and all reported side effects or adverse reactions.

Unless specifically prohibited by a court or the custodial agency, foster children shall have access to regular contact with their birth families as described in the treatment and service plan. The TFC case manager shall work actively to support and enhance the family relationships and work directly with the individual's birth family toward reunification as specified in the treatment and service plan.

Professional Clinical or Consultative Services in TFC-CM

In consultation with the custodial agency, the TFC case manager shall provide or arrange for an individual to receive psychiatric, psychological, and other clinical services as recommended or identified in the treatment service plan.

Case management (CM) services by any source other than the TFC agency is considered a duplication of services. Medicaid reimbursed targeted case management, including Mental Health CM, Intellectual Disability CM cannot be billed when the child is receiving TFC- CM. Duplication of services is subject to retraction.

Record Documentation in TFC-CM

Entries in Case Records: All entries shall include the dated signature of the staff person who performed the service. If a TFC-CM provider has offices in more than one location, the record shall identify the office that provided the service. Each individual's record shall contain documentation that verifies the services rendered for billing.

Narratives in the Individual's Record: Narratives shall be in chronological order and

current within 30 days. Narratives shall include areas specified in these regulations and shall cover: treatment and services provided; all contacts related to the individual; visitation between the individual and the individual's birth family; and other significant events. Each contact with the individual, his or her birth family, treatment foster care family, or other individuals in the course of providing case management services must be documented in the individual's record. Narratives must include the dated signature of the TFC case manager.

Plans of Care: Copies of all assessments and Plans of Care must be filed in the individual's case record.

Timeliness: The dated signature of the service provider on required documentation indicates the completion date of the document.

Discharge from Care

A discharge summary shall be developed for each child and placed in the child's record within 30 days of discharge. It shall include the date and reason for discharge, the name of the person with whom the child was placed or to whom he was discharged, and a description of the services provided to the child and progress made while the child was in care. Written recommendation for aftercare shall be made for each child prior to the child's discharge. Such recommendation shall specify the nature, frequency, and duration of aftercare services to be provided to the child and the child's family.

The discharge summary shall also include an evaluation of the progress made toward the child's treatment goals. Discharge planning shall be developed with the treatment team and the child, the child's parents or guardian, and the custodial agency. Children in the custody of a local department of social services or private child-placing agency shall not be discharged without the knowledge, consultation, and notification of the custodial agency.

Service Authorization

Treatment Foster Care Case Management requires service authorization within business 10

days of admission. Providers can submit service authorization requests up to 30 days prior to the requested start date. For additional information on submitting requests for Service Authorization, refer to Appendix C of this manual.

For an initial review request, the provider will need to submit demographic information, as well as the following information:

- The 3-digit locality code is required (The locality code will reflect the locality that has fiscal responsibility for the Medicaid individual and should be submitted to the provider by the referral source.);
- DSM Diagnosis;
- Confirmation of the timely completion of the FAPT assessment;
- A description of the child's behaviors immediately prior to admission that correlate to the state recognized uniform assessment instrument scores, and;
- The state uniform assessment instrument, which is the Child and Adolescent Needs and Strengths (CANS) instrument, scores a completion date. The completion date for CANS must be current within 90 calendar days prior to submission of the service authorization request.

For a continued stay review request, the provider will need to submit demographic information, as well as the following:

- Locality code confirmation;
- DSM Diagnosis;
- Confirmation that the Comprehensive Treatment and Service Plan is completed timely;
- Confirmation that continued TFC-CM is needed to meet the child's needs;
- Confirmation on face-to-face visits;
- A description of the individual's behaviors that both support the need for this level of care and correlate to the CANS scores, and;
- The CANS scores and completion date. The completion date for the CANS must be current within 90 calendar days.

If the individual has been in placement for more than 45 calendar days, the information required to be submitted will include both the initial review and continued stay review information noted above.

An authorization for TFC-CM will be for a single unit for each month. Only one provider is

eligible for authorization and payment for each month. If an individual is discharged during an authorized period, notify the FFS contractor of the discharge date. If an approval is for a full month, but the discharge date is mid-month, the FFS contractor will not change the authorization for that month, only for subsequent months, since only one unit is authorized for each month, and only one provider can bill for that unit. If a new provider begins service mid-month, and the previous provider already has authorization for the month, the new provider's authorization will begin on the first of the next month.

A notice of discharge must be sent to the FFS contractor within one week of the discharge date.

Qualified Medicare Beneficiaries (QMBs) - 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 member'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 the MMP should contact the MMP directly for more information.

Qualified Medicare Beneficiaries (QMBs)- Extended Coverage Limitations (MHS)

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.

EXHIBITS (MHS)

Virginia Pre-Admission Screening Report:
https://www.virginiamedicaid.dmas.virginia.gov/wps/PA_VAPiderFormsSearch/DMAS-P98.xls